



# University of HUDDERSFIELD

## University of Huddersfield Repository

Ousey, Karen

Being a real nurse; nurses accounts of learning and working in practice

### Original Citation

Ousey, Karen (2007) Being a real nurse; nurses accounts of learning and working in practice. Doctoral thesis, University of Salford.

This version is available at <http://eprints.hud.ac.uk/id/eprint/4686/>

The University Repository is a digital collection of the research output of the University, available on Open Access. Copyright and Moral Rights for the items on this site are retained by the individual author and/or other copyright owners. Users may access full items free of charge; copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational or not-for-profit purposes without prior permission or charge, provided:

- The authors, title and full bibliographic details is credited in any copy;
- A hyperlink and/or URL is included for the original metadata page; and
- The content is not changed in any way.

For more information, including our policy and submission procedure, please contact the Repository Team at: [E.mailbox@hud.ac.uk](mailto:E.mailbox@hud.ac.uk).

<http://eprints.hud.ac.uk/>

**Being A Real Nurse; Nurses Accounts Of Learning and  
Working In Practice**

**Karen Jayne Ousey**

**Institute for Health and Social Care Research  
School of Nursing  
University of Salford, Salford, UK**



**Submitted in Partial Fulfilment of the Degree of Doctor of  
Philosophy, May 2007.**

Acknowledgements.....	vii
Abbreviations .....	viii

**ABSTRACT..... IX**

Introduction.....	1
What is Problem Based Learning?.....	3
Implementation of PBL .....	4
Potential Difficulties.....	5
Expectations.....	6
Implementation of PBL in this study.....	8
Findings .....	9
Division of labour.....	12
The structure of the thesis .....	14
What happens next?.....	16

**CHAPTER ONE..... 18**

Issues influencing the students' journey to being a real nurse .....	18
1.1 An effective learning environment .....	18
Table 1.1 Characteristics of an effective clinical learning environment.....	20
1.1.1 Education versus Training .....	20
1.2. The socialisation process.....	21
1.2.1 Support mechanisms for students in clinical placements.....	25
1.2.2 Learning through Observation.....	28
1.3 The newcomer .....	30
1.3.1 Role of the mentor in enabling students to learn .....	32
1.3.2 Planning of learning experiences .....	33
1.3.3 Emotional labour .....	35
1.3.4 Control Theory .....	37
1.3.5 Identifying issues affecting the students journey .....	38
1.4 Language .....	39
1.4.1 Language as a form of power .....	40
1.4.2 Discourse.....	41
1.4.3 Construction .....	42
1.5 Power.....	43
1.6 Culture .....	47
1.7 Conclusion .....	48

**CHAPTER TWO ..... 50**

Research strategy and methods.....	50
2.1 Introduction.....	50
2.2 Defining the question .....	50
2.3 Research in education .....	50
2.3.1 Descriptive.....	53
2.3.2 Explanatory .....	53
2.3.3 Generalization.....	53
2.3.4 Basic or theoretical .....	54
2.4 Qualitative research .....	55
2.4.1 Qualitative Research Methods.....	56

Table 2.1 Examples of qualitative research methods .....	56
2.5 Case study .....	57
Table 2.2 Characteristics of a case study approach .....	61
2.5.1 Why a case study approach was relevant to this study .....	62
2.6 Ethnography .....	65
Table 2.3 Features of an ethnographic approach .....	67
2.6.1 Key Components of ethnography .....	68
2.6.2 Characteristics of ethnographic research.....	69
2.7 Indexicality and reflexivity .....	71
2.8 Stepping back .....	72
2.9 Grounded theory techniques .....	74
2.9.1 What is grounded theory?.....	77
2.10 Accessing the information.....	82
2.10.1 Literature searches .....	82
2.10.2 Data base searches.....	83
Table 2.4 Databases searched .....	83
2.10.3 Keywords.....	83
2.11 The sample.....	84
2.12 Ethical considerations.....	87
2.13 Collecting the data .....	97
2.14 Interviewing techniques.....	98
2.15 Observing power .....	101
2.15.1 Observation techniques .....	102
2.15.2 Participant observation.....	104
2.15.3 Objective observation.....	106
2.15.4 Participation methods.....	107
Table 2.5 Participant observation .....	108
2.16 Analysing the data.....	108
Table 2.6 Purposes of analytical tools .....	108
2.16.1 Dealing with the information .....	109
2.16.2 Categorising the data .....	109
2.16.3 Developing the categories .....	110
2.17 Developing the themes.....	112
2.18 The audit trail .....	115

**CHAPTER THREE ..... 119**

Preparing student nurses to enter the profession.....	119
3.1 Development of clinical skills .....	120
Table 3.1 Examples of clinical skills.....	120
Table 3.2 Clinical skills taught in the school of nursing.....	122
3.1.1 Knowledge.....	122
3.1.2 Saliency .....	123
3.1.3 Theory versus practice .....	124
3.1.4 Knowing how.....	126
3.1.5 <i>Auxiliary work</i> .....	128
3.1.6 Acquiring knowledge.....	129
3.2 Learning to be a student.....	130
3.2.1 Knowing About Nursing.....	132
3.2.2 'I'll do it myself!'.....	133
3.3 The role of the practice development co-ordinator .....	136

3.3.1 Development of the role .....	137
3.3.2 Promoting clinical support.....	138
3.4 Fitting into the team.....	141
3.4.1 Meeting expectations.....	141
3.4.2 'Hands on' students! .....	142
3.4.3 Ever changing boundaries for student nurses .....	143
3.4.4 Who should teach? .....	145
3.4.5 Successful practice assessments. ....	148
3.4.6 The routine .....	149
3.4.8 <i>Developing an identity</i> .....	151
3.4.9 Social development.....	154
3.4.10 Developing Effective Communication Skills .....	154
3.4.11 Looking Busy .....	157
3.4.12 <i>Nursing practice – what is it?</i> .....	158
3.4.13 Trainee assistant practitioner (TAP) .....	159
3.4.14 Using PBL to understand and overcome clinical boundaries .....	160
3.4.15 Sharing of knowledge.....	160
3.4.16 <i>Belonging</i> .....	162
3.4.17 Integrating theory and practice using triggers .....	164
3.5 Effective mentors .....	164
3.5.1 Mentorship – being a support for the students?.....	164
3.5.2 Awareness of the curriculum .....	165
3.5.3 Intra-occupational tensions.....	167
3.5.4 Being an effective mentor .....	167
3.5.5 Worker versus student.....	168
3.5.6 Preparing the mentors .....	170
3.5.7 Student/mentor bond .....	173
3.6 Being a real nurse .....	173
3.6.1 Understanding the staff nurse role .....	176
3.6.2 Kinship .....	176
3.6.3 Transferring skills .....	177
3.7 Being professional.....	178
3.7.1 <i>Social relations in the clinical areas</i> .....	178
3.7.2 Social change .....	179
3.7.3 Developing professionalism.....	181
3.7.4 Observing professionalism .....	182
3.7.5 Changing boundaries of being professional .....	185
3.7.6 Division of labour.....	185
3.7 Reflecting In Practice .....	187
3.7.1 Students reflecting .....	187
3.7.2 Reality of reflecting in practice .....	189
3.7.3 With whom should I reflect? .....	190
3.7.4 Learning through reflection.....	190
3.7.5 Developing knowledge using reflection .....	192
3.7.6 Acquiring information .....	192
3.7.7 Experiential learning .....	194
3.7.8 Propositional, practical and experiential knowledge.....	195
3.8 Conclusion .....	196

<b>CHAPTER FOUR .....</b>	<b>201</b>
Exploring the boundaries of professionalism, culture, power and equality	201
4.1 Professionalism.....	201
4.1.1 Issues of professionalism.....	204
4.1.2 Boundaries .....	205
4.1.3 Nursing and medicine.....	207
4.2 Nursing knowledge.....	213
4.2.1 Financial concerns .....	214
4.2.2 The Nursing and Midwifery Council .....	215
4.2.3 Nursing as a vocation .....	217
4.3 Caring – A registered nurses role? .....	218
4.3.1 Perceptions of caring.....	219
4.3.2 Role of the nurse .....	220
4.4 Culture .....	221
4.4.1 Culture in the clinical areas .....	221
4.4.2 Culture as a boundary .....	222
4.4.3 Ordering.....	224
4.5 Social inequalities.....	224
4.5.1 Social structure .....	225
4.5.2 Socialisation .....	226
4.6 Power.....	227
4.6.1 The multi-disciplinary team and teaching.....	227
4.6.2 Identity.....	228
4.6.3 Resources and authority .....	230
4.6.4 Oppression of students .....	231
4.6.5 Surveillance.....	232
4.6.6 The students’ mentor as an oppressor?.....	234
4.7 Problem Based Learning.....	235
4.7.1 Problem solving.....	237
4.7.2 Advantages of PBL .....	238
4.7.3 Disadvantages of PBL.....	239
4.7.4 Exploring boundaries using PBL.....	241
4.7.5 Collection code .....	242
4.7.6 Integrated code.....	243
4.8 Conclusion .....	244
<b>CHAPTER FIVE.....</b>	<b>245</b>
The Research Experience .....	245
5.1 Reflexivity.....	245
5.1.1 Changing focus.....	247
5.2 Truth value .....	248
5.3 Applicability.....	249
5.3.1 Sampling.....	250
5.3.2 Transferability .....	252
5.4 Consistency .....	253
5.4.1 Reflecting on the research process.....	255
5.5 Neutrality .....	255
5.6 Recommendations for future investigation.....	256

5.7 Research.....	256
5.7.1 Role of the registered practitioner .....	256
5.7.2 Assessing the competency levels of students.....	257
5.7.3 Learning to be a real nurse.....	258
5.8 Practice .....	258
5.8.1 Clinical skills.....	258
5.8.2 PBL.....	259
5.9 Education .....	259
5.10 Theory .....	260
5.11 What contribution has this study made to knowledge and nurse education? .....	261
5.12 Outcomes .....	267
5.13 Conclusion.....	267
Appendix.....	270
Appendix one Excerpt from interview transcript.....	271
Appendix Two Examples of clustering.....	274
Appendix Three Themes.....	276
Appendix Four Publication based on the findings of this study .....	277
References .....	283

## **Acknowledgements**

I would like to thank all the participants in this study who generously gave their time to be interviewed and observed. Without their help I could not have completed the thesis.

I am indebted to Professor Martin Johnson, University of Salford, for his help, support, critical feedback, encouragement and patience that have enabled me to complete the work.

Thanks also need to be given to Karen Holland who supported me throughout and the School of Nursing, University of Salford and Department of Nursing, University of Huddersfield who gave essential financial support and study leave.

A final thanks needs to go to my family and friends who have been there with encouragement and support.



## **Abbreviations**

CCU	Coronary Care Unit
D.O.H	Department of Health
ECG	Electro-Cardiogram
ENB	English National Board
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HEI	Higher Education Institution
ICU	Intensive Care Unit
NHS	National Health Service
NMC	Nursing and Midwifery Council
NVQ	National Vocational Qualification
RCN	Royal College of Nursing
PBL	Problem Based Learning
SEN	State Enrolled Nurse
TAP	Trainee Assistant Practitioner
UKCC	United Kingdom Central Council

## **Being a real nurse; nurses accounts of learning and working in practice. Abstract.**

---

There has been much written regarding nurse education and the socialisation of student nurses in clinical areas in the past (Olesen & Whittaker 1968, Orton, 1981, Melia, 1987, 1997, Ogier, 1989, Castledine, 1995, Bradshaw 2001, Spouse, 2003). The originality of this thesis lies in the discussions and exploration of the concept of Problem Based Learning (PBL) as a teaching and learning strategy and the implementation of the *Making a Difference* (DoH, 1999a) recommendations in a nursing curriculum. It investigates whether or not these have indeed made a difference to the ability of the students to socialise into their clinical roles and effectively meet their ultimate aim of becoming a 'real nurse'.

The thesis is split into five chapters and employs qualitative research methods to present an ethnographic case study of the experiences of student nurses in clinical placement areas regarding the process of becoming effective student nurses who ultimately develop their knowledge and skills base to become 'real nurses'. The sample consisted of fifteen (15) students, fifteen (15) student mentors, eight (8) ward managers, one (1) practice development co-ordinator and one (1) senior nurse responsible for clinical development. Interviewing and observation techniques were used to obtain the data.

PBL as a teaching and learning strategy is investigated and discussed, in relation to the students' ability to develop critical problem solving skills that can be incorporated into their student roles. The disadvantages of PBL are also debated and issues highlighted that may cast doubt that this strategy and the *Making a Difference* curriculum has actually changed attitudes in the clinical areas towards the capabilities of the student nurse role.

Eight major themes arose from the data analysis; learning to be a student, fitting into the clinical team, being professional, being a real nurse, the role of the practice development co-ordinator, effective mentors, developing clinical skills and reflecting in practice. Integral to these were the concepts of professionalism, power, inequalities and culture that were identified as significant underlying issues for the students to recognize when performing and developing into their clinical roles.

The data suggest that the new curriculum and PBL have offered some solutions to help overcome the perceived boundaries of professionalism, power, inequalities and culture but by no means provides all the answers. Overall the study has highlighted the importance of clinical skills development and effective delivery of them by students in learning to become a 'real nurse'. Through their experiences the students have learnt how to overcome boundaries and to fit in with the culture of clinical areas thereby enabling them to learn the role of the student nurse. Furthermore, the newly developed roles of the practice development co-ordinator and established mentor roles are perceived to be invaluable sources of support for the students while in clinical placement areas.

## Introduction

The impetus for this study and resultant thesis was the implementation of a newly developed nurse training and education curriculum (*Making a Difference* curriculum) utilising recommendations contained in the Department of Health (1999) paper and the strategy of Problem Based Learning (PBL) as a teaching and learning strategy in a school of nursing, in a university in the North-West of England and one of its associated NHS Trusts. The school of nursing had been chosen as one of sixteen 'first wave sites' to implement these recommendations and to choose PBL as one of the main teaching and learning strategies. The thesis focuses on the experiences of registered practitioners working in the clinical areas and student nurses undertaking the adult branch-nursing course. The aim of the research was to investigate whether or not the *Making a Difference* curriculum and PBL had enabled students to socialise into their clinical roles.

The original aim of the study had been to investigate:

*'Has the Making a Difference curriculum and PBL enabled student nurses to socialise into their clinical roles and overcome boundaries?'*

Evolving from this original aim two research questions emerged:

1. What effect did PBL have on students in relation to the theory – practice gap?
2. What were the effects of PBL and the associated curriculum on the student experience in clinical practice?

However, during the fieldwork period and the subsequent data analysis it became apparent that the original focus of the thesis was to change due to participants identifying areas for discussion and analysis that I had not

previously considered. These were issues of power, professionalism, culture and language that the students highlighted were factors that affected their abilities to socialise into the clinical areas and ultimately achieve their aim of 'learning to be a real nurse.' Consequently this has led to an exploration and discussion of the data locating itself in a broad analysis of power, culture and language issues drawing on influences from Stephen Lukes and Michel Foucault. The original research questions that focussed on investigating the students experiences in practice remain integral to the study but what I had thought would be the most important area for discussion that of PBL, has become a somewhat secondary issue for exploration.

An ethnographic case study was used employing a relatively unstructured open-ended format of interviewing and non- participant observational methods to collect the data. The sample group studied consisted of fifteen (15) adult branch student nurses undertaking the *Making A Difference* curriculum, fifteen (15) student mentors, eight (8) ward managers, one (1) practice development co-ordinator and one (1) senior nurse for practice development. The sample size allowed for a broad spectrum of participants to share experiences and present their personal and professional viewpoints on the implementation of the new curriculum and its effects on the students' abilities to undertake their clinical roles. Pseudonyms have been used for all participants throughout the thesis. As a newly appointed nurse lecturer and a researcher I believed that this study was important to gain an insight into the experiences and perceptions of those registered practitioners and student nurses who were encountering these changes in the clinical areas of ophthalmology,

orthopaedics, medical and surgical wards, coronary care, intensive care and a medical admissions unit.

### **What is Problem Based Learning?**

It is possible to trace the origins of PBL to early forms of learning that demanded problem-solving skills (Savin-Baden, 1997). Dewey (1938) argued that knowledge was not something that was changeless but something bound up with activity, a process of discovery. Dewey's opposition to theories of knowledge, which considered knowledge to be independent of its role in problem solving enquiry, were played out in practice by its emphasis on learning by doing, which in turn can be seen as essentially a problem solving approach to learning (Savin-Baden, 1998).

PBL was popularised in the 1960's as a result of research by Barrows (Barrows and Tamblyn, 1980) into the reasoning abilities of medical students. They argued that PBL was based upon two assumptions. The first was that learning through problem solving is much more effective than memory based learning for creating a usable body of knowledge. The second was that the medical skills, which are most important for treating patients, are problem-solving skills, not memory skills. Nonetheless, PBL may be described as a means of learning characterised by diversity both educationally and philosophically. Savin-Baden (1998) argued that it may locate discourse on problem based learning outside a language of experiential learning, thus adopting learning methods, which deny learner identity and disregard the multifaceted nature of people's experience. One of the main objectives of PBL is to foster independent and life long learners, who want to take a degree of

responsibility for their own learning by formulating questions and learning needs in relation to a given problem.

The fascination of PBL appears to link quite closely with the changes in higher education and the changing relationships between universities and government, who now expect students to develop into flexible, adaptable problem solving scholars. Indeed, this concept relates well to the recent changes in nurse training following the publication of *Making a Difference* (DoH, 1999a) and *Fitness for Practice* (UKCC, 1999), which questioned the traditional nursing curriculum and its ability to produce practitioners who were 'fit for practice' and 'fit for purpose' upon registration.

### **Implementation of PBL**

The focus of PBL is to organize curricular content around problem scenarios rather than subjects or disciplines. Students work in groups or teams to solve or manage these situations but are not expected to acquire a predetermined series of right answers. Instead, they are expected to engage with the complex situation presented to them and decide what information they need to learn and what skills they need to gain in order to manage the situation effectively. There are many different ways of implementing PBL but the underlying philosophies associated with it as an approach are broadly more student centred than those underpinning problem solving learning. This is because students are offered opportunities, through PBL to explore a wide range of information, to link the learning with their own needs as learners and to develop independence in enquiry. PBL is thus, an approach to learning that is characterized by flexibility and diversity in the sense that it can be implemented in a variety of ways in and across different situations and

disciplines at different times depending upon the staff and students involved in the programmes utilizing it. However, what will be similar will be the focus of learning around problem scenarios rather than discrete subjects (Savin-Baden, 2000).

This form of a learning climate should promote autonomous motivators in which educators take the perspectives of students into account, provide relevant information and opportunities for choice thus encouraging students to accept more responsibility for their own learning and behaviour. It also includes teachers being meaningfully involved in students' learning through dialogue, listening and asking students what they want. It aims to provide satisfying rather than superficial replies to student generated questions, providing factual information and advice and involves suspending judgement when soliciting the opinions and reactions of students. Such an environment is said to minimize pressure and control while encouraging a high level of performance. PBL would appear to fit in easily with this concept rather than the traditional curriculum.

### **Potential Difficulties**

There have been reports of students undertaking PBL programmes suffering considerable stress for up to two years. This longitudinal qualitative piece of research was undertaken by Des Marchais (1993) at the Sherbrooke Medical School, Quebec, over a five-year period. He offered various reasons for this phenomenon. He argued that some students had difficulty adjusting to PBL and some of the PBL teachers experienced difficulties in defining their role. Many students lacked confidence in active rather than passive learning, and curricula tended to be overburdened with content. This view is portrayed by

students from the school of nursing in this study who, following evaluation of Year 1, commented that they would have liked more 'tests' to assess their depth of knowledge and understanding of the areas covered and that they would have appreciated more formal lectures to ensure that they were seeking out the correct information.

Miflin, Campbell and Price (1999) report that during the implementation of a PBL medical course at the University of Queensland, Australia, student stress was intense. They surmised that initially the anxieties were based on extended time away from study, family commitments and lifestyles and life experiences that made them different from students undertaking courses in other medical institutions. There were 234 students in their cohort with the average age being 26.5 years and a median age of 23.5 years. Several students already possessed a Masters degree or a PhD. Analysis of the situation revealed that a difficulty for both the students and teachers were differences of opinion about the meaning of self-direction as to how it was to be applied to the course.

### **Expectations**

There was an underlying tension between staff and students regarding the expectations of the PBL learning environment and to what extent the students should direct their own learning. Students reported that there was insufficient assessment and that, when it was provided, questions were alternatively too demanding or too simple in relation to their learning. They expressed doubts about the effectiveness of formative assessment in guiding their learning, and asked that the school's objectives be released so that they could check that what they were learning was appropriate to the summative assessment, on



which their progression to year 2 depended. Feedback to the students from monitoring of the course showed that learning objectives generated in the PBL groups matched those of the school at a rate of 80%-90%, this did not allay the concerns of the students because the PBL tutorial process failed to indicate how much to learn. This led to students trying to guess or persuade the teacher to tell them what their end of 'block' summative assessment would be.

Many students also withdrew from the PBL tutorials arguing that they would rather rote learn large amounts of information unrelated to a meaningful context. In essence, a lack of adequate guidance forced students to adulterate problem based learning in order to survive. In response to these concerns the University of Queensland, has developed a conceptual framework relating to the concept of self-directed study, to promote an agreed understanding of the concept for all people involved in the implementation and continuing development of the course.

This study is interesting in that the university had been self-critical and honest regarding the attitudes of academic staff and the tensions that became apparent between themselves and students regarding their own perceptions and expectations of the PBL process. They were honest in their findings in that the observations they reported could not be quantified, as the data generated was originally for other purposes and that this phenomenon came to their attention unexpectedly. They do not say what the original data was being collected for but do document that they plan to undertake a further study to explore these issues more thoroughly. The data only refers to one

group of students and cannot therefore be compared to previous groups for any forms of tensions that may have occurred under the old system.

### **Implementation of PBL in this study**

The school of nursing in this study was one of the first pilot sites to implement the recommendations from the *Making a Difference* (DoH, 1999a) document using PBL as its main learning and teaching strategy. September 2000 saw 256 students commence on the programme, 166 adult branch students of which 28 were seconded from the Trusts in which they were employed as unregistered staff, 45 mental health branch students of which 9 were seconded and 45 child branch students of which 4 were seconded. From this first cohort, 230 students registered in September 2003, equating to 153 adult branch students of which 28 were seconded students, 38 mental health branch students of which 9 were seconded and 39 child branch students of which 4 were seconded. The attrition rate was 7.4% as compared to 14% over the previous years.

The *Making a Difference* curriculum was not without its own limitations. The learning and teaching strategy of PBL meant a shift from teacher centred to student centred learning, with the lecturer facilitating sessions, rather than providing information. This proved challenging for some lecturers who needed to be able to form strong learning partnerships with their student group to enable effective facilitation of sessions while redefining their teaching strategies to meet the students learning needs as and when required. They needed to be able to motivate and encourage the students throughout their learning ensuring that they were accessing the relevant information and making sense of it.

Students themselves needed to learn a how to effectively undertake self directed learning and group work rather than being exposed to the traditional form of information giving through some lectures, Some students had little experience of group work and found it quite stressful, especially when they were expected to seek out information about a problem prior to any formal sessions being delivered. Edwards *et al* (1998) found this was indeed a potential problem and argued that the PBL process could prove to be an overwhelming and frustrating process for some students. Cost was also a concern as PBL demanded huge resources in terms of lecturing staff, providing not only facilitation for sessions but also personal tutor time and library resources.

PBL as the main learning and teaching strategy aimed to foster students who have a wish to maintain life long learning and to cultivate individuals who are able to question ritualistic practice, make changes in practice where appropriate, and become self-motivated registered practitioners who were able to function effectively in a multi-disciplinary team.

### **Findings**

A fundamental finding of the present study was the students' perceptions of the definition of a 'real nurse'. The school of nursing teaches the students the idealism of nursing practice based on patient need for example, personal hygiene, nutrition, elimination and mobility needs of patients continuing to enhanced skills that include cannulation and venepuncture. However when the students encountered clinical practice they often felt that this ideal being taught within the school of nursing did not portray the reality they experienced throughout their clinical placements. The students demonstrated in their

interviews that although it was important to learn about holistic care needs of the patients, the registered practitioners did not engage in this type of activity on a daily basis. Rather their role was that of an assessor, planner, evaluator and manager with the role of the unregistered staff being to deliver 'hands on' care.

Henderson (1991, p.21) argued that:

*'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he (sic) would perform unaided if he (sic) had the necessary strength, will or knowledge. And to do this in such a way as to help him (sic) gain independence as rapidly as possible'.*

She continued that no one member of the team should make heavy demands on another member of the team that prevents them from being able to perform their unique function. Neither should any member of the medical team be diverted by non-medical activities such as cleaning, clerking and filing. All members of the team should consider the person (patient) as the central figure and should realise that primarily they are all assisting them. However, Henderson (1991, p.22) stated that *'the more one thinks about it, the more complex the nurses' function as so defined proves to be'*. She contends that the nurse is, and should be legally an independent practitioner, who is able to make independent judgements as long as they are not diagnosing, prescribing treatment for disease, or making a prognosis, for these, she argues, are the physicians' functions. But what the nurse maintains is the authority on nursing care. However as the role of the registered practitioner has evolved since Henderson published her work the National Health Service (NHS) has seen some nurses take on the roles traditionally undertaken by

junior doctors, for example, nurse prescribing and running nurse-led clinics, both of which Henderson alluded to as being the physician's function.

The students and the registered practitioners during their interviews identified the concept of 'being a real nurse' and struggled to define fully what this means. The role of the registered practitioner is constantly evolving to a point that they no longer spend a large proportion of their time at the bedside but rather leave these duties to the unregistered staff. Indeed the perceptions of what it is to 'be a real nurse' have often been based on images of nurses by the general public. Foskett and Hemsley-Brown (1998) argue that historically nursing has relied on an occupational gender separation to sustain its workforce. The perception of a traditional female job has led to nursing being perceived as work based on common sense, 'women's work', primarily an emotional phenomenon and less objective than the scientific, curative work of male dominated medicine (Howard, 2001, Phillips, 1993). Media stereotypes often portray nurses as sex objects, obediently supporting medical practitioners, subservient as the doctor's handmaiden, with little independent professional and academic knowledge (Howard, 2001). These have contributed to a pervasive perception that the nurse's role is supportive, passive and subordinate to that of the doctor (Foskett and Hemsley-Brown 1998).

Cunningham (1999) reports that the doctor's handmaiden image remains particularly potent for nurses. Whilst the function of nursing is changing with the advent of the specialist practitioner and nurse consultant roles this has led to questions as to whether this is an upmarket version of doctor's handmaidens. These advances in nursing practice could also be viewed as

problematic in other ways. There could be an even greater loss of power as nurses expand their roles and as a consequence lose a nursing focus. This loss of focus can be argued as occurring through nursing allying itself to a semi-professional mini-doctor role, somewhat like a technician (Jinks and Bradley, 2003).

The students often enter their education and training programmes with these perceptions yet during the programme they realise that nurses require an in-depth knowledge base to carry out their clinical duties and responsibilities. Furthermore they are exposed to the reality of clinical practice where there is a lack of resources, both in terms of staff shortages and the lack of adequate resources that often make it difficult for them to effectively demonstrate the idealism of nursing theory that they have acquired in the classroom.

### **Division of labour**

This perceived division of labour by the students and the confusion it creates when they attempt to understand their clinical role is the focal point for the investigation of professionalism, power, inequalities and culture. These concepts are considered to cause boundaries for the students when they attempt to undertake their clinical role in an effective manner. Benedict *et al* (1984) argued that PBL as a teaching and learning strategy aimed to foster in students, the motivation to develop into life long learners in addition to developing critical thinking and problem solving skills. Walsh (1984, p.141) supports this notion but warns it is important for students to be involved in life long learning activities sharing with the educator the responsibility for their own progress.

Although more work needs to be done, tentative findings from the analysis of the data could be interpreted as suggesting that students who have undertaken the new curriculum have indeed begun to develop critical thinking and problem solving skills that they have been able to transfer into the clinical areas assisting them to overcome boundaries. The students believed that the small groups in which they were taught in the school enabled them to recognise their learning needs thus developing their confidence to discuss these needs with their facilitator in a 'safe' environment. Furthermore students have commented that the use of scenarios for presenting problems related to the outcomes of the curriculum has helped to bring their academic learning to life and has allowed them the opportunity to be able to integrate theory to practice. This may be attributed to the active involvement of practitioners in curriculum development that has developed a strong feeling of partnership and collaboration between the educational and service sectors.

The new curriculum incorporating the DoH (1999a) recommendations has clearly allowed for students to be self-directed in their learning and for lecturers to be facilitators of learning rather than merely givers of information.

As a qualitative piece of research the study findings relate to one area, however, data generated and analysed in this thesis could be seen to be t comparable to other educational institutions and clinical areas that have an interest in assessing the transition of student nurses into their clinical roles ultimately producing practitioners who are '*fit for practice*' and '*fit for purpose*' on registration.

## **The structure of the thesis**

This thesis contains five chapters. Chapter one explores and discusses the issues that influence the students' journey in learning to be 'a real nurse'. These include the importance of an effective learning environment, the role of the mentor and issues of professionalism, culture and language. Integral to this chapter is the discussion of how the concepts of power, language, professionalism and culture that were identified through the data analysis influenced boundaries that students had to overcome in their quest to learn to be a 'real nurse' and to become an accepted member of the team. The chapter commences with an overview of the learning and teaching strategy of PBL and how this was implemented into the school of nursing in this study and the importance of an effective learning environment.

Chapter two identifies and rationalises the methods used to collect and analyse the data. It gives an account of the research strategy and methods used for collection and analysis of the data. Qualitative research is discussed and analysed as the method of choice. A qualitative approach was chosen as it involves the studied use and collection of a variety of empirical materials including case study, personal experience, interviews and observational techniques that describe routine and problematic moments and meanings in individuals' lives (Creswell 1998). Case study was the research strategy of choice as individuals and groups had been focussed on for the research using a multi-source approach to data collection that provides an in-depth assessment of the research question appropriate to the population inquiry (Yin 2003). Furthermore, the case study strategy was chosen as the data collected and analysed contributes to the existing knowledge surrounding the



socialisation of student nurses. The data analysis identified the importance that the students and registered practitioners placed upon the acquisition of clinical skills, which complements and often supports the work previously undertaken by Melia (1987).

Chapter three identifies, discusses and explores the emergent themes and categories identified during the field work and data analysis periods. Excerpts from the data collected are used throughout this chapter to support the themes and to bring the dialogue alive.

Eight themes emerged from the data collected that include:

- Developing clinical skills
- Learning to be a student
- Role of the practice development co-ordinator
- Fitting into the clinical team
- Effective mentors
- Being a real nurse
- Being professional
- Reflecting in practice

Each theme is addressed using interviewing and observational data to illuminate the discussions. The concepts of professionalism, power, equality and cultural issues are explored in depth to clarify and support the themes. PBL is discussed in light of these issues and I question how far it has actually assisted the students to overcome the boundaries they may confront in clinical areas.

Chapter four builds on the themes from the previous chapter relating them to the theoretical context while investigating the boundaries that were identified

by students during the data collection and analysis process. It explores power relations, inequalities and cultural issues while examining whether or not the new curriculum and strategy of PBL assisted the students to overcome perceived boundaries. Fundamental to this chapter is a discussion surrounding the role of the registered practitioner and the participants understanding of this. The concept of professionalism is identified and examined as to how it impacts on the student role in clinical practice.

Chapter five reflects upon the research experience and concludes the thesis suggesting further areas for investigation and possible implications of this study for both academics and practitioners. Recommendations from the study are presented under four headings:

- Research;
- Practice;
- Education;
- Theory.

The merits and possible implications of the study are identified whilst highlighting any limitations.

The appendix provides an example of output in the form of a publication and an example of an interview transcript that identifies the emergent themes.

### **What happens next?**

Following analysis of the data I have offered various recommendations for readers to consider. I believe that one of the most important questions that require careful and in-depth consideration by the educational institutions and the NHS is “What is the role of the registered nurse?” As nurse researchers we can continue to interview and observe the performance of students in the

clinical areas and make decisions on how well they fit in or undertake their clinical role, but as educators we must be clear as to what we are expecting of them on registration. The Nursing and Midwifery Council (2004, 6.1, 6.2, 6.3, 6.4, 6.5) state that *'as a professional nurse or midwife, you must maintain your professional knowledge and competence.'* In addition they present a list of standards of proficiency that each student nurse must achieve during their training and educational period prior to being allowed to register as a nurse. However, I argue that without clear guidelines on the actual role of a registered nurse the educational system will fail to meet the needs of the clinical areas. We must ensure that we train and educate the students of today in light of the reality of the expectations of the health service

The next chapter will present a discussion and exploration of some of the issues that influence the students' journey in their quest to become a 'real nurse'. This includes the importance of an effective learning environment, the role of the mentor in supporting students and how the concepts of power, culture and language influence the students' ability to be able to socialise into the clinical areas.

## **Chapter One**

### **Issues influencing the students' journey to being a real nurse**

This chapter will offer the reader an overview and discussion of key sociological factors that can influence the students' journey to becoming a 'real nurse'. Integral to the chapter is an outline of the importance of an effective learning environment and the role of the mentor for students and how these affect their journey. The concepts of power, language and culture are identified and discussed as issues that students need to understand to become an accepted member of a team.

It is worth noting here that this chapter was written following completion of the fieldwork and data analysis. This was purposely done as I did not want to influence my analysis by undertaking an in-depth literature review and developing pre-conceived ideas prior to the fieldwork experience. The chapter is the first of the thesis to set the scene for the reader and to place the data collected in context.

#### **1.1 An effective learning environment**

Margaret Ogier was among a number of investigators to study ward culture and, in particular, the learning environment that students' experienced. She used a qualitative 'grounded theory' approach to attempt inductively to derive an explanation of how the learning environment was created and managed. Although done on a small scale, as is customary in such work, her study complimented findings by Fretwell (1982), Orton (1981) and others that much rested in the abilities and motivation of the ward sister. Fretwell used a mixture of observation and survey to determine key qualities of learning environments, and Orton had developed an instrument for assessing 'ward learning climate'.

Ogier (1989, p.67) argued that in order for learning to occur in the clinical area it had to be managed by a leader who was in touch with the needs and abilities of subordinates and who was able to create an atmosphere which was conducive to learning. She maintained that with the support of the ward leader, (then typically a sister or charge nurse) other staff would feel comfortable in taking on the mentor role and in developing the learning environment. To create an environment conducive to learning the ward or unit must have support from the ward leader.

To create this environment the students must be allowed to identify and observe specific skills, observe communication skills, observe problem-solving and prioritising and decision-making strategies. The members of the ward team need to act as role models for the students and to make time to involve the students in these activities, allowing them time to question the practices. Orton (1981) and Ogier (1982) undertook studies examining the preparation for practice for students who were then undertaking an 'apprentice' style of training. Although these studies may now be dated they did ask the students the pertinent question of whether or not they viewed themselves as learners or workers, a question that is still being asked today.

Table 1.1 identifies characteristics of a clinical environment that is conducive to learning according to Jarvis and Gibson (1997, pg.116).

**Table 1.1 Characteristics of an effective clinical learning environment**

Good and effective links with the educational establishment, perhaps through a link teacher
Dedicated and uninterrupted time for group and individual seminars and tutorials
The use of the multidisciplinary team in the delivery of teaching and the assessment of the educational processes
Adequate resources in the clinical environment -nursing publications -up-to-date books -access to research relevant to the clinical environment -staff who undertake research and who involve learners
Dedicated staff, committed to enabling others to learn through a variety of processes and who have been adequately prepared to undertake the roles as teachers and assessors.

Although Jarvis and Gibson identified these characteristics in 1997 they are still relevant in today's nursing culture. Students want staff who are dedicated to supporting them in practice and who can explain the research and evidence underpinning the interventions. In fact, within the Trust where my study was carried out they have employed a senior member of the nursing staff in to the role of practice development co-ordinator. Her role involved supporting the students in practice and delivering teaching sessions relating to clinical skills, for example, recording of blood pressure, temperature and respirations. This role will be further discussed chapter three.

### **1.1.1 Education versus Training**

The teaching of theory has often been equated with 'education' while the teaching of practical skills has been called 'training'. Education has been regarded as a high status process and training as low status. Yet, Jarvis (1987) and Pring (1993) argue that with the emergence of the idea of practical

knowledge, training may also be educational. This highlights the importance of the academic and practical settings working in partnership to bring together the theory and practice elements of the programme for the students. This therefore leads us to conclude that the development of an effective learning environment is essential in ensuring that theory influences practice and indeed that practice influences theory.

## **1.2. The socialisation process**

Professional socialisation has been defined as the process by which the individual learns the culture of a profession (White and Ewan, 1991). Cohen (1981) argued that professional socialisation is the complex process by which a person acquires knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalisation of the values and norms into the person's own behaviour and self conception. In the process the person gives up the societal and media stereotypes prevalent in our culture and adopts those held by the members of that profession.

Cohen and Jordet (1988) suggested that nursing students acquire their professional behaviour from practice in a variety of ways; interacting with faculty members, through classes and seminars and through experience in the practice of nursing. These behaviours include the knowledge, skills, attitudes and values necessary for professional practice. Meltzer (1978) maintained that individuals responded to one another on the basis of their interpretation of the intentions or meanings of behaviour, rather than on the actual behaviour itself. In fact individuals participated in creating their own

environment and learned behaviour was an interactive and not a static process in which behaviours were incorporated as a part of one's social role.

Simpson (1979) stated that education, orientation and relatedness to the occupation influenced professional behaviour and argued that in the educational dimension professional norms and values are presented to the student.

Davis (1975) in his very influential qualitative study of U.S student nurses identified six stages of socialisation.

1. Initial innocence - Davis (1975) found that the lay imagery brought by the students at the start of the programme emphasised 'doing' with humanitarian ethics of care, kindness and love for those who suffer. However conflict arose in the minds of students when instructors focussed on the nurse-patient relationship and suggested students observe rather than do.
2. Psyching out – Students attempt to understand what is expected of them and begin to behave 'for the instructor'. The students often perceive this behaviour to be artificial.
3. Role simulation – Davis (1975, p.127) states that this stage is difficult to distinguish from "psyching out" since it is the "performance implementation of psyching out". The students begin to accept their behaviour.
4. Provisional internalisation – This stage is characterised by two phenomena 1) the professional rhetoric, 2) positive and negative role models. The use of professional rhetoric indicated to students which events were important and which were not. It enabled the students to



communicate in a fashion meaningful to their instructors and fellow students. Frequently the students identified instructors as positive role models (Day *et al*, 2005). Davis (1975) stated that the negative role models tended to be practising registered nurses with less education.

5. Stable internalisation – Day *et al* (2005) suggest that this stage is when students look back at their perceptions of nursing on entering the programme and ignore the cognitive dissonance between their initial lay imagery and the professional perception of the institution.

However, Merton (1957) argued that the process of professional socialisation commenced before students enrolled in training programmes. He labelled this as 'anticipatory socialisation' and defined it as a process that occurs in fantasy as students anticipate their acceptance in actual training programmes. Unfortunately in his work he did not address the social conditions that may affect this process. According to Shuval (1980) professional socialisation is a process that takes place over time and consists of three stages:

1. The pre-socialisation stage, during which the stage is set for professional socialisation according to the nature of the secondary school population, its values, the values of significant socialisers and the images of the profession in the culture.
2. Formal socialisation, consisting of the cognitive sphere, during which students search for 'one right answer', and the interactional sphere, leaning to behave in an appropriate professional manner.
3. The post socialisation stage, the period of practice after formal socialisation until retirement, during which the 'outcomes' of socialisation are considered.

Gray (1997) in her study of the professional socialisation of student nurses undertaking the Project 2000, diploma programme identified that the mentor was the linchpin of students' experience and in becoming socialised. She undertook a longitudinal study exploring the effects of supernumerary status and mentorship on students undertaking practice placements. She had a purposive sample of seventeen students of which ten volunteered to be interviewed on five separate occasions and agreed to keep a diary to record their experiences of mentorship. The remaining seven participated by diary only and kept written accounts of their experiences of being supernumerary and of having a mentor while in clinical placement. She identified that the socialisation process of student nurses was through the progression of a hierarchical and sequential process accompanied by a developmental process. She established the following categories that portrayed this progression:

1. Anticipatory anxiety
2. Reality hits home
3. Becoming a branch student
4. Total surrender of supernumerary status
5. End is nigh
6. Anticipatory anxiety
7. Staff nurse role

The students experience anticipatory anxiety prior to their first placement which is replaced by a culture shock as the reality of the workplace when they commence their first placement. Students cope with the reality by learning the routine and fitting in. When the students enter the branch programme they

begin to feel like a nurse. As the students develop a more holistic approach to care that allows them to assess, plan, implement and evaluate they become more accepting of responsibility allowing them to surrender their supernumerary status as they enter rostered practice. In the latter stages of the course as the students contemplate the transition from student to staff nurse they return to the anticipatory anxiety state. The role of the mentor is crucial to the professional socialisation of the students to enable them to make this transition (Gray & Smith, 1999).

Gray (1997) maintains that her study offers an insight into the world of the higher education nursing student and presents a new theory of professional socialisation. She does indeed offer an interesting insight into the student's experiences and places a greater emphasis on the importance of the mentor role than had been in previous studies for example Melia (1981) and Seed (1991).

### **1.2.1 Support mechanisms for students in clinical placements**

Du Toit (1995) states that role models in any profession are considered by most adult educationalists as of extreme importance. She argues that unlike a child entering school, nursing students, being quasi-adults, must fit their desired roles with a constellation of roles and personality characteristics already established. She maintains that of equal importance are personality characteristics of the faculty, especially intelligence, motivation and latent identities which increases the possibility that all students will find an appropriate role model who will provide support through the cognitive stages of professional socialisation. Shuval (1980) points out that students reach a maturation stage causing them to be critical and selective about their role

models as they have accumulated considerable experience by which they feel able to judge practitioners. In this manner they select not only models but, equally important, anti-models, whose style of professional behaviour is to be avoided. Davies (1993) described the 'bad nurse', as seen by students, as the one who did not demonstrate caring, respect for others, positive attitudes towards work and service and a high level of ability and moral integrity.

Du Toit (1995) investigated the extent of professional socialisation in nursing in Australia and if this process had been modified by the changes in nursing education to mainstream education at tertiary institutions. Questionnaires were used to collect data and were sent to three hundred first and third year students, as it was believed the progression of socialisation would be more pronounced between these two groups. Of the three hundred questionnaires distributed, one hundred and seventy three were returned and all of these used in the research. A pilot study was undertaken on 10% of the sample and a few changes were made to the questionnaire in the form of re phrasing some questions. The return rate was acceptable and provided a viable amount of information on which to undertake the study. The questionnaires were distributed by the researchers in classroom situations and tutorial sessions with the researcher being available if there were any problems with interpretation of the questions. This may have produced bias as the researcher was present when participants completed the questionnaires. However the results of the research do provide an interesting insight into the views of student nurses on the socialisation process across two universities. In her recommendations she identifies that additional research should be undertaken to standardise the questionnaire with a new sample and that the

questionnaire may be combined with research done on a qualitative level for a more comprehensive view of professional socialisation.

Within my study support for students in clinical placement areas is provided primarily through their mentor/mentors in practice. Students may well be assigned more than one mentor during their clinical placement to allow for days off, annual leave, sickness and night duty commitments by the mentor. The intention is that the mentors support students in their experiential learning. The mentors are expected to have a recognised teaching and assessing qualification and to attend yearly updates on the role of the mentor and changes in the nurse education/training systems. However, the preparation and continued development of the mentors can often prove to be problematic, with practitioners finding it difficult to secure time away from the clinical areas to attend the relevant study sessions. Andrews and Wallis (1999) and Kavaini and Stillwell (2000) view the role of the mentor as being beneficial to the students in practice but do identify that the role is often hindered by staff workloads, insufficient time, inadequate staff levels, staff responsibility to patient care and lack of staff support and training. However the role of the mentor is paramount in supporting the students with the NHS Executive (1998) stating the role of the mentor was to allow the student nurse the ability to integrate theory to practice and to plan their occupational futures. Furthermore the DoH (1999a) stated that there should be more opportunities for experienced clinical staff to combine teaching and patient care thereby allowing students to acquire better practical skills. The Nursing and Midwifery Council (NMC) (2002) highlighted that mentors should support students in the clinical areas providing advice thus creating an environment that was

conducive to learning. The NMC (2002) were clear as to how the role of the mentor should be integrated into the students' learning. They maintained that the mentor should be able to demonstrate sufficient knowledge of the student's programme to identify current learning needs; be able to demonstrate strategies that would assist the integration of learning from practice and educational settings; be able to create and develop opportunities for students to identify and undertake experiences to meet their learning needs and be able to ensure effective learning experiences and opportunities that would achieve learning outcomes by contributing to the development and maintenance of a learning environment where research findings were identified, applied and disseminated in the clinical areas.

### **1.2.2 Learning through Observation**

In a study of American nursing students whom she interviewed, Windsor (1987) explains that in that context the major categories of learning were classified as nursing skills, time management and professional socialisation. Learning was also affected by preparation, the qualities of the teacher and the variety of clinical experience offered.

Windsor (1987) argued that students progressed in the socialisation process by observing and participating in nursing roles thus learning how to be a nurse in the clinical areas. Windsor (1987) concluded that this process resulted in the students becoming more confident in performing nursing tasks; more interested in expanding their roles and eventually promoted their independence.

White and Ewan (1991, pg.133) suggest that *'the process of becoming a nurse is a social one and as such it should be differentiated from the*

*academic process of earning a degree or qualification*'. They argue that the latter process signifies that the individual has the required skills and knowledge to practice competently. In contrast professional socialisation is the process by which the individual learns the culture of nursing. That is to say the combination of symbols, customs and shared meanings that makes nursing distinctive (White and Ewan 1991, pg.133).

Earnshaw (1995) suggested that the key to an effective mentor/student relationship is an equality of contribution to the partnership and reciprocal recognition of strengths and weaknesses. Indeed, Spouse (2000) stated that mentors were crucial in a student's development particularly in relation to communicating with patients and relatives where they could observe their mentor undertaking the skill and relate this to good practice. However, Taylor (1997) argued that this is a form of copying and is not limited to the mentor, but that the students may well copy other members of staff, including the unregistered and other students. If this is indeed the case, we have to question whether some practices being taught in the clinical area are being underpinned by the best available evidence and are related to what is taught in the classroom. Nonetheless the NMC (2002) have attempted to overcome this potential problem stating that mentors themselves should contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated. In addition to assessing and managing clinical developments ensuring safe and effective care based upon the available research and evidence.

### **1.3 The newcomer**

The mentor can help the student 'fit into' the clinical area and feel a welcome and valued member of the ward team. Although the students are classed as supernumerary they struggle to understand where it is they fit into the ward team. They are students who are in the clinical areas to learn; but in many respects they are also workers, all be it unpaid, they want to work alongside their mentors to learn and develop the skills expected of a nurse on registration. It is vital that they learn how to articulate the knowledge learnt within the academic and clinical settings into the practice areas in a safe and effective manner. Taylor *et al* (2001) believe that roles define the way individuals act by the internalisation of certain values, norms and participation in social action among other role references. The acquisition of a new role initiates the individual into a particular social group. In relation to the student nurses this can be clearly exemplified during their development and implementation of clinical skills. Once the students are able to perform clinical skills they feel a valued member of the team.

Narcisco, Throwe and Fought (1987) claimed that the role taking and socialisation process took place throughout the pre-registration programme in both the clinical and educational settings. They maintained that individuals who took on the role of a nurse were not only assimilating new facts and learning new skills, but also were becoming immersed in a new culture with norm and value expectations.

Spouse (1996, 1997, 1998a, 2000, 2001a) investigated factors influencing the professional development of pre-registration nurses and has published a number of articles based around the findings. The original study was



longitudinal using a constructive/naturalistic paradigm. It was a small study undertaken in a single education setting although participants visited nine or ten sites during their programme of twelve clinical placements (Spouse, 2001). The random convenience sample consisted of eight students from a group of thirty five in the first year of their four year BSc Nursing programme in the United Kingdom. Six students participated in the study from their first year and two more volunteered at the beginning of their second year. Although the study took place in the author's own educational establishment, assurances were given to the participants that involvement in the study would not affect their training programme, they were guaranteed of anonymity (as far as possible) and they were informed that they could withdraw from the study at any time. This aided in overcoming the potential power-relationship between teacher and student (Cook, 1991).

Spouse (1998a) used case studies to provide rich narrative accounts of the students' experiences. She analysed the data following an interval of a year ensuring that all themes and categories were re-evaluated for relevance and representativeness, with the resulting themes and data being indexed onto charts and a content analysis of all the data being repeated (Spouse, 2001). From the analysis of the data she developed a model of mentoring activities. The study is thorough and provides an insight into the importance of an effective mentor in the professional development of student nurses and reflects many of the comments that students in this study made regarding their own experiences of being mentored.

Spouse (2000) considers the issue of the student nurse often feeling like a 'newcomer' when they visit their various clinical placement areas during the

training programme. She concurs that these frequent changes of placement leave the student feeling alienated owing to the short time they spend in the placement area. Inevitably, these frequent changes mean the students are allocated a different mentor in each new clinical setting and this can disrupt any opportunity to create a meaningful relationship. The data collected identifies that students who received support from their mentors and were made to feel welcome in the clinical areas felt that they accomplished a more structured learning experience. If the students did not receive this support Spouse (2000) believed they were unable to function effectively within the environment and therefore their learning and professional development was negatively affected.

### **1.3.1 Role of the mentor in enabling students to learn**

Spouse (1996, 1998b) investigated the relationship between learners and their mentors. She identified four characteristics, *befriending*, *planning*, *confederation* and *coaching*. The befriending characteristic would appear to be the most complex issue that can help the student to understand the importance of using underpinning evidence to support their practices according to Spouse (2000). Spouse (2000, p.138) states that the affiliation between the learner and the mentor is based on social interaction initiated by the mentor and designed to promote trust and a sense of warmth and interest, thus establishing a feeling of security for the student. Furthermore, there should be a willingness of the learner to be open and to acknowledge feelings as well as to undertake preparatory work to identify learning needs. This in turn will promote the learner's personal and professional development within the social and professional context of the placement.

If the mentor is able to offer a befriending relationship then the student will be encouraged to assess their own learning needs and seek advice and information to fulfil those needs while on clinical placement. Similarly, with effective affiliation the students feel comfortable in their placement areas and will not be afraid to ask questions regarding practices that they observe. Additionally they will feel a valued member of the ward team and will enjoy working and learning in the clinical areas. In fact, Titchen (1998) compared the student/mentor relationship to that of a therapeutic relationship when caring for patients, in so far as the nurse and the mentor will develop a counselling relationship. This will help the students to bond with the ward team, thus allowing them to understand what is happening in the ward areas and learn.

### **1.3.2 Planning of learning experiences**

The role of the mentor remains important in planning for the students' learning experiences and encouraging them to link theory to practice while in the clinical areas.

Spouse (2000) identified four areas where the mentor could benefit the student's learning experience:

1. To provide a menu of experiences available in the clinical areas
2. To help the learner identify areas of the curriculum which are of special relevance
3. To help the learner organise learning opportunities or to organise visits (to clinical areas or other departments)
4. To select suitable patients and members of the clinical team for the learner to work with thus developing identified skills.

These are areas where the mentor can help the student understand their own personal learning needs while in clinical placement. The students enter their clinical placements with learning contracts/action plans that have been developed in conjunction with their personal teachers. It is vital that the mentor in practice can help the student to relate these identified learning needs to the practice areas which, not only enables the student to be able to link the theory learnt to the practice settings, but also highlights that the academic and practice settings are working together in a partnership fulfilling both learning needs and curriculum demands.

Indeed Wilson (1998) used a qualitative grounded theory approach to investigate the teaching, learning and support of pre-registration nursing students in medical and surgical wards of two Scottish hospitals. His sample size was admirable consisting of twenty-one students, twenty-one preceptors, six mentors, six mentees and two link teachers. He used theoretical sampling techniques of grounded theory research for mentors, mentees and link teachers, with students and preceptors being a purposive sample.

His findings identified different forms of mentoring relationships being described as 'discretionary' or 'appointed'. Appointed relationships referred to those mentors who had been routinely or 'bureaucratically' assigned to work with students. Discretionary relationships were infrequent but more satisfying and in line with the view that mentoring cannot be forced nor mentors chosen by anyone other than the mentee. Student assessment was seen as an accepted part of the role by the appointed mentors whereas discretionary mentors saw it as inappropriate to the development of a positive mentoring relationship. Through encouraging the student to identify their own learning

needs the concept of lifelong learning is being promoted and the students are becoming autonomous in assessing their own learning needs. Indeed, Rogers (1983) emphasised the benefits of encouraging students to be autonomous and to follow areas of interest as a means of promoting motivation and effectiveness.

The role of the mentor therefore, is to help the student enjoy their placement and to enrich the learning experience, thus allowing an understanding of the nature of nursing and the rationales underpinning their interventions. Morton-Cooper and Palmer (1993, pp.62-64) suggest the mentor has a number of functions in developing the students' experiences:

- Adviser
- Coach
- Counsellor
- Guide/networker
- Role model
- Sponsor
- Teacher
- Resource facilitator.

These will enable the student to reflect on their own practice, to learn from experiences, to improve their practices and to develop themselves both experientially and academically. In addition the role of the mentor has an impact on the emotional labour of the students.

### **1.3.3 Emotional labour**

Emotional labour can be defined as a task that requires human emotions to be amended or managed to serve production. Analogous perhaps to 'sentimental work' which is a key theme in much work emanating from the Glaser and Strauss stable, 'emotional labour' is a concept drawn out well in

Arlie Russell Hochschild's (1983) study of American flight attendants. Taking a feminist sociology of work approach Hochschild illustrated the importance of the management of emotions in much of women's work, a theme later applied to nursing by Pam Smith in the context of British student nurses. Whereas flight attendants are required to seem calm and pleasant at even the most stressful of times in order to reassure passengers, and to some extent other crew, nurses have similar responsibilities in dealing with patient anxiety and similarly that of co-workers.

Williams (1999) stated that a good mentor is helpful in organising reflection on emotional labour and helping the student to overcome transitions in their emotional experiences. These transitions in the students' emotions are monitored by the mentor in order to consult the student nurse. In this manner, the good mentor assists in sustaining the emotional labour of the student nurse and acts as an emotional support (Marquis and Huston, 1992). Darling (1985) identifies the poor mentor as being someone who tends not to facilitate the student nurse and reproduces poor nursing skills, if they pass any on at all. Smith (2000) in her study of the emotional labour of students argues that emotional labour is invisible, often devalued and goes unnoticed. She states that the mentors and other staff nurses do not receive any financial or 'time back' rewards for supporting the students emotionally. In her original study of the emotional labour of nursing (Smith, 1992), the importance of the ward sister to student nurse learning was demonstrated. Smith worked as a participant observer on four medical wards, interviewed most of the students and also gathered field notes of informal conversations with patients. With hindsight, rather like the present study, Smith's investigation evolved in its

focus from being first about the “learning environment” to having much of its focus on emotional labour undertaken by those concerned.

Care was seen as a form of emotional labour in relation to the care not only of patients but also nurses. In her 2000 study she found that the ward sister and charge nurses were mentioned less frequently and with less depth than the mentors. The mentor, she claims, plays a much fuller part in shaping the image and emotional labour of student nurses than in her original study.

#### **1.3.4 Control Theory**

We could argue then that the emotional labour of the students has an effect on their learning styles and to some extent controls how and when they learn. Control theory argues that everything we do is initiated by a satisfying picture of that activity which we store in our heads as a pleasant memory and that we choose our behaviours including emotions. It maintains that one must meet one or more needs in order to influence another person. The reason instruction fails is because it does not meet the needs of the learner.

When students start to learn they continually build upon their knowledge base, called scaffolding. One assumption underlying scaffolding is that cognitive dissonance exists between what learners know and can do on their own and what they know and can do with the assistance of a more knowledgeable person. Another assumption of scaffolding is that the interaction and dialogue between the teacher and the learner or between peers plays a central role. A more knowledgeable person can translate the metaphor of scaffolding into a model of learning through incremental assistance, with the prototypical interaction being one-to-one tutoring. According to Kaufman and Holmes (1998) individual tutoring is the gold standard of education against which the

value and effectiveness of other instructional methods can be measured profitably. However, there is little knowledge about the dynamics of the tutoring process. Lepper *et al* (1997) found that tutors give roughly equal attention to cognitive, motivational and social factors to tutoring.

Table 1.2 summarizes the characteristics of expert human tutoring.

**Table 1.2 Human tutoring characteristics (Lepper *et al*, 1997, pg 94)**

Expert tutors need to have subject matter knowledge but also subject specific pedagogical knowledge to deal with difficulties students experience with learning subject matter, and expert tutors need more pedagogical knowledge.
Expert tutors display a high level of affective support and nurturance in their interactions with students.
Expert tutors use a Socratic style of tutoring; that is they seek to draw as much as possible out of their students and to make learning an active and constructive process.
Expert tutors are committed to making increasing demands on the student in each tutoring session.
Expert tutors convey these high expectations in a very direct and unprepossessing manner.
Expert tutors are more likely to articulate and especially to encourage and help the student to articulate the reasoning and meaning underlying their thinking.
Expert tutors devote substantial effort to encouraging and motivating students.

### **1.3.5 Identifying issues affecting the students journey**

Language, power and culture are factors that influence the learning process for student nurses and their socialisation into clinical practice. I will explore these concepts in more detail in chapter four but I do believe that it is important that we identify them here first to allow an insight into the



complexities of students understanding the socialisation process and how they can 'fit in'.

Goldenberg and Iwasiw (1993, pg.4) described the professional socialisation process as: *'a complex interactive process by which the content of the professional role (skills, knowledge, behaviour) is learned, and the values, attitudes and goals integral to the profession and sense of occupational identity which are characteristic of a member of that profession are internalised'*. By learning these students can begin their journey to learning to be a real nurse. Yet Greenwood (1993) warns that the professional socialisation into nursing can lead to an apparent and relative desensitisation of some student nurses to human need. This can be characterised by the students becoming proficient in their new role as a student at the expense of early ideals. Why this happens is uncertain but Davis (1993) suggests it may be due to poor role models with Stevens and Crouch (1995) suggesting that it may be as a result of sudden exposure to the emotional demands of the role.

#### **1.4 Language**

In relation to language, the students have to learn nursing 'jargon' when they enter each new practice placement area. When they learn the language they begin to feel a part of the ward team as they can communicate with other members of the staff in their own language. Bernstein (1962) identified what he termed as 'a restricted language code' that is closely linked to education. He argued that people from a working class background used a limited vocabulary compared with the middle and upper classes. He continued that this affected the way in which people thought and made sense of the world around them. This can be linked to the student experiences of learning the

language in the clinical environments they visit during their training programmes. As the students progress through the programme their knowledge of terminology relating to nursing and medical conditions increases, allowing them to speak the same language as the registered staff and other members of the multi-disciplinary team.

#### **1.4.1 Language as a form of power**

In the field of psychology there are two types of analysts who have studied the use of language as a form of power. Discourse analysts study the way in which various forms of language work. Critical discourse analysts are concerned with the way in which these forms of language serve social, ideological and political interests. The term discourse comprises of the many ways that meaning is conveyed through culture. It includes speech and writing, nonverbal and pictorial communication, and artistic and poetic imagery. Parker (1997) argues that people develop and express their identity through the use of verbal, nonverbal and other symbolic means of communication, such as art. Indeed, Spouse (2003) in her research surrounding student nurse learning, used student nurses' examples of art to describe and discuss their learning needs and experiences in the clinical areas. The use of art portrayed how the students felt as they progressed through their training. The artwork changed in its nature as the students felt they were being accepted as a team member and as a part of the clinical culture that helped them develop their professional knowledge and enabled them to function like registered nurses.

### **1.4.2 Discourse**

Discourse analysis is important to my research question as the organisation of talk; the explanations the students offer for the importance of understanding the language in the clinical areas; the power and authority that understanding and being able to converse in that language allows the students; and the social actions performed are all vital elements in the analysis of the data and the answering of the research questions.

Discourse analysts treat the variety of things that psychologists tell us they have discovered inside us and among us as forms of discourse (Parker 1997). Parker claims that traditional psychology is treated with suspicion, as it presents its stories about the mind and behaviour as though they were factual accounts. He continues that discursive approaches in psychology can aid in the understanding of these stories and why language can be powerful. He states that we need to pay attention to the characteristics of variability, construction and function to fully understand language, which has also been described by Foucault (1972).

With variability, psychologists will seek to find an underlying consistency of response that will help to provide a meaning or explanation. In contrast, discourse analysts will attempt to find inconsistencies and variations in the accounts. Foucault (1972) focussed on contradictions between discourses and the ways in which 'self' is torn in different directions by discourses. Therefore, the notion of variability refers to the diversities of meaning. The notion of contradiction links more directly with struggle, power and the deconstruction of discourse in practice.

### **1.4.3 Construction**

Construction, as the second characteristic of discourse refers to the way in which symbolic activity makes use of cultural resources. Indeed, Garfinkel (1967) perceived aspects of language, for example, arguments, words and turns of phrase, to be connected with meaning and context. Foucault (1970) discusses forms of knowledge and argued that, in response to our knowledge increasing our day-to-day behaviour also changes. He sees that power is inextricably linked to knowledge. This concept may be linked to the role of the registered practitioners and the students in the clinical areas. During the data collection period students discussed with me, during their interviews, that they perceived the registered staff to be experts and possessed an in-depth knowledge base; as such they respected their authority. They also respected that when they were asked to perform certain procedures, they would often do so without question, as it was a more senior person that had asked them.

At times the students did not fully agree with what they were being asked to undertake but they would not directly question the staffs' instructions. Rather they would either increase their own knowledge base through reading information or asking a member of lecturing staff when they returned to the school.

Interestingly the respect that the students often showed the registered staff was not always replicated between the registered staff. There were often situations where various members of the ward team would possess quite different views on how a procedure should be carried out or how the ward routine should be organised for a particular shift. This led to confrontation between staff and a blurring of the professional territories of the various

grades of staff this was highlighted in interviews with mentors (further discussion of this issue may be found in chapter four). This again may be linked to the construction characteristic, where people will act in different ways dependent upon the situation they are in. However, this may also be linked to the notion of 'common sense'.

Howitt and Owusu-Bempah (1995) argue that the tension between common sense and expertise causes us to become aware of the context and the use of theoretical resources. The students may well have been taught the research and evidence underpinning a certain procedure in the school, but when in clinical practice they may experience some forms of ritualistic practice that do not reflect what they have been taught. Common sense would lead them to question the appropriateness of the clinical practice, yet they may well be aware that there are a lack of resources available to undertake the procedure in the manner they have been taught. They, therefore, have to decide whether to question the clinical practices and discuss with the staff their knowledge base, or to accept that the reality of practice does not always mirror the idealistic theoretical base.

Although students are encouraged to question practices while in clinical placement they are aware of the hierarchical structure of the nursing staff on the ward and often perceive that as students they do not possess the authority or power to ask questions.

### **1.5 Power**

Power operates at a formal level via structures that are in place; there is also power at an informal level. This informal level projects itself through those individuals who have charisma and the ability to influence others. This type of

power may well be held by an unregistered staff member rather than a registered staff member. This type of power base allows for the person to be able to control situations by the bending of rules or manipulating situations to their own advantage. Interestingly Foucault (1980) commented that we should not assume that power is exercised in a descending direction – from the lofty heights of the powerful down to the lowly depths of the powerless. He recommended an ascending rather than a descending analysis of power, where you would investigate the mechanisms of power and how they have led to social domination in a variety of institutions.

Foucault (1977, p.194) argued that: *'we must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power 'produces', it produces reality; it produces domains of objects and rituals of truth'*. He further argues that discipline is a form of power, disciplinary power. We could say that disciplinary power develops a general code for the transition from student to master which is put into practice in various fields of learning. It codifies segments or stages of training in terms of hierarchy, where each stage of the learning process is significantly more difficult than the last. This enables the development of skills to be carefully monitored while also providing a way to differentiate, or individualise, novices. This concept may be related to the stages involved in nurse training programmes where the students are expected to complete a specific set of practical competencies and academic work at increasing levels throughout their programme of study. Foucault (1982) further argued that power could be exerted over people simply by observing them. He maintains that a distinctive feature of modern

power (disciplinary control) is its concern with what people have not done (nonobservance), with, that is, a person's failure to reach the required standards. He contends that this is a form of discipline where the idea of 'normalisation' within society is persuasive. This can be exemplified in the students' curricula where they have to reach a pre-determined set of competencies and standards to be able to progress through the course and ultimately to become a registered practitioner. In order to achieve these they are required to be assessed in practice through observation.

The students, throughout their interviews discussed the importance of achieving a successful practice placement assessment. They would not question practices in depth or regularly, despite being concerned that they were not always based on the best available evidence, for fear of being referred in practice. Indeed they would emulate the behaviour of their mentors while in practice and on their return to the school of nursing, that they saw as being a safe environment, would then question practices with their lecturer. This is a clear example of power in the clinical areas and of what Foucault (1982) refers to as power/knowledge, that is to say, the need to complete assessments elicits the level of knowledge and understanding held by the student but also controls their behaviour by forcing them to study a particular curricula.

Lukes (2005) suggests that when discussing power we should consider that it has multiple and diverse meanings appropriate to different settings and concerns. He argues that power is a 'dispositional concept', comprising of a conjunction of conditional or hypothetical statements specifying what would occur under a range of circumstances if and when the power was exercised

(Lukes, 2005 p.63). Morriss (2002) further contends that the extent and distribution of power within a society has two broad perspectives; the extent to which citizens have the power to meet their own needs and wants and the extent to which societies give their citizens freedom from the power of others. The first indicates a lack of power; the second indicates that people are subject to the power of another. Morriss concludes from this that if people are powerless because they live in a certain sort of society, that is, they would have had more power if social arrangements were different then this a condemnation of society. He therefore suggests that we should be evaluating that society and not distributing praise or blame to people (Morriss, 2002, p. 40).

Locke (1975, p.111) defined power as being able to make, or able to receive, any change. Whereas Kenny (1975) observed that there are human powers that are not two way or subject to choice. He states that human powers are abilities activated by people choosing to do a certain thing. He uses the example of the starving and that people have the power to aid in their recuperation by offering nourishment yet we can choose not to offer food and drink. So although a rational person has been presented with all the necessary external conditions for exercising power they may choose not to do so (Kenny, 1975, p.53). This concept relates to organizations and institutions as well as individuals. Kenny's (1975) description of power can be related to the clinical environments in that the students entering their placement areas do so with an appreciation of the importance of assessing, planning, implementing and evaluating care using the best available research and evidence. However they will sometimes witness practices that are



ritualistically based and although they possess the underpinning knowledge to be able to question these practices they will not use that 'power' as they do not want to be labelled as troublesome or questioning students. They would prefer to reflect upon the incident and discuss it with their lecturer in the academic area. This will be discussed and exemplified by data collected from the interviews in chapter four.

## **1.6 Culture**

Culture is related to the shared beliefs, values and understandings shared by a particular group. Any student group will link into a culture or subculture of one type or another. The students learn to understand the culture on each ward they visit, for example, they learn the ward routine and as such they begin to form a rapport with the staff members. As they become established in the culture they learn what behaviour is acceptable and what is not while they are on placement. Students commented during their interviews with me that they had been asked to 'lift' patients up the bed, without the help of moving appliances. They are taught in school that they should only 'move' patients using the appropriate manual handling devices. However, when in the clinical areas they tend to emulate what their peers are carrying out, as they want to complete their practice assessment documents successfully. Their relationship with their peer group and seniors is important to them and as such are reluctant to question practices so that they can be accepted into the culture.

We can relate this behaviour to the work of Turner (1982, p.24) who describes 'symbolic behaviour which represents the detachment of the ritual subjects'. The ritual subjects here being the students who have become detached from

the academic sector where they learnt the 'correct' way to move and handle patients safely. Indeed Turner (1982, p.24) further describes the stage of 'social limbo' where the subject is neither in one state nor another. This stage affects the students each time they visit a new placement area when they feel like the 'newcomer' and do not fully understand the routine of the area. Turner focuses on the relationships between those who are undergoing the transition, the students, and those who they aspire to be, the registered practitioners. Holland (1999) argues that the registered nurses who act as the role models and mentors are the gatekeepers to the knowledge and skills required for the students to exist within the nursing culture.

### **1.7 Conclusion**

This chapter has highlighted issues that can influence the students' journey to being a real nurse, the importance of an effective learning environment and the role of the students mentor.

The role of the mentor is vital in the socialisation of student nurses into the clinical areas. Morle (1990) described a mentor as someone who smoothes progression up the career ladder as they are primarily selected because of their professional powers and personal characteristics. However Morle (1990) questioned whether or not the term mentorship was really appropriate within nursing educational systems and that perhaps the term preceptorship should be given careful consideration. Yet Spouse (1996) discovered in her studies that students' stress levels were significantly decreased if the mentor and clinical environment was friendly. Darling (1984) supports this, highlighting 14 mentoring roles, three of which are basic to mentoring: 'Inspirer' role; 'Investor' role and 'Supporter' role. From her research she developed the

Measuring Mentorship Potential (MMP) that enables individuals to be able to evaluate their own or others' mentoring potential. The findings from Darling's (1984) study demonstrated that there was no difference between what nurses and other professionals wanted from a mentor. However Andrews and Chilton (2000) argue that despite the prolific literature on mentors and the mentoring process there remains little agreement about the most effective method for mentoring or the selection of mentors.

The culture of the clinical environments also affects the learning experiences of the students. Wilkes and Wallis (1993) suggest that the caring attributes of students develop during their three year course and it may be speculated that that these caring attributes are best learned through experience. Napthine (1996) agrees stating that the quality of nurse education is dependent on the quality of a students' clinical experience. The concepts of power, culture and language are barriers that students need to be aware of and to overcome while in clinical placement if they are to be able to 'fit into' the team and to learn to be a 'real nurse'. This aim to learn to be a 'real nurse' forms the focal point of the thesis.

The following chapter identifies and discusses the research methodology used for this study.

## **Chapter Two** **Research strategy and methods**

### **2.1 Introduction**

This chapter provides an account of the research strategy and methods used for the collection and analysis of the data. An overview of qualitative methodology, ethnography, case study and grounded theory methods is offered and explored for the reader. Qualitative methodology was chosen for this piece of work as its subject is the social context of learning necessitating the collection and analysis of data concerned with meanings, attitudes and beliefs, rather than data that results in numerical counts from which statistical inferences can be drawn (Lanoë, 2002).

Prior to discussing the research strategy and methods used I will remind the reader of the original research aim and subsequent research questions to allow the study to be placed into context.

### **2.2 Defining the question**

The original aim of the study had been to answer the question:

*'Has the Making a Difference curriculum and PBL enabled student nurses to socialise into their clinical roles and overcome boundaries?'*

From this original aim two research questions emerged:

1. What effect did PBL have on students in relation to the theory – practice gap?
2. What were the effects of PBL and the associated curriculum on the student experience in clinical practice?

### **2.3 Research in education**

According to Anderson & Arsenault (2001), research in education is a disciplined attempt to address questions or solve problems through the

collection and analysis of primary data for the purpose of description, explanation, generalization and prediction. Experimental research is fundamentally a problem-solving activity, which addresses a problem, tests a hypothesis or explains phenomena. Hypotheses are derived and tested under variable conditions, then accepted or rejected, generally in accordance with pre-established conventions. It relies upon systematic and objective observation, recording and analysis seeking to answer questions and to address the problems posed by inquiring minds to find general principles and theories, which can lead to the prediction of behaviour and events in the future.

This type of research has to do with understanding, prediction and ultimately control and relies on controlled and accurate observation and the recording of information. Although I was using ethnography and case study I believed that some aspects of this would also relate to my work, for example, explaining phenomena that were particularly prevalent when I was in the field observing the behaviour of students, registered and unregistered staff.

The researcher must be unbiased as to the outcome, although it is natural for people to perform research in an area that is of interest to them, but it must not interfere with their ability to remain objective. This was in the forefront of my mind during this study, as I felt a certain commitment towards the successful implementation of the new curriculum and its ability to link the idealism of nursing theory with the reality of practice, therefore, ensuring that the students were competent and safe practitioners upon registration. This may suggest that there was a degree of bias in the study. However I believe that my exploration by direct fieldwork and interviews of the linking of theory to

practice has greater potential to illuminate both effective and efficient nursing care practices (and their opposites) and outweighs the potential for bias in this case. Within the study I have attempted to reduce the risk of bias through the use of unstructured interview techniques thus attaining the opinions of various registered practitioners and student nurses regarding their experiences of the curriculum and how it has affected them. In essence I wanted to ascertain the real impact the new curriculum and PBL had had upon the development of student nurses to undertake their clinical role.

Hansen (2006) argues that all qualitative research is social research yet, not all social research is qualitative research. She states that research may be defined by the purpose of inquiry:

- Descriptive
- Explanatory
- Applied
- Evaluation

Hansen (2006) explains that descriptive and explanatory research is undertaken because the researcher wants to contribute to the stock of knowledge and has interest and expertise in a particular field. In contrast, applied research is specifically designed to be problem solving and to have an outcome which is expected to be of immediate relevance (Macoun, 2001). Evaluation research is conducted to determine the success of programs and may be viewed as a type of applied research. Evaluation research can be undertaken during a program to assess the implementation and at the conclusion of a program to assess how well it met specified objectives (Hansen, 2006).

Anderson & Arsenault, (2001, p.9) described four levels at which research in education may take place: descriptive; explanatory; generalization and basic or theoretical.

### **2.3.1 Descriptive**

They state that descriptive research has two major branches: historical and contemporary. Historical research attempts to describe what was, whereas, contemporary research describes what is happening now.

Descriptive research is the first and most elementary level of research activity and helps the understanding and accumulation of knowledge. They assert that statistics can be used to quantify and simplify descriptions by grouping observations and describing words, symbols or numbers rather than lengthy prose. Descriptions may also be enhanced and brought to life through the use of quotations and stories.

### **2.3.2 Explanatory**

Explanatory research asks the question, what is causing this to happen? Anderson and Arsenault (2001) claim that this may also be referred to as internal validity i.e. focussing on understanding what is happening in a given observable setting. However it is only prospective experiments that can actually determine cause and effect with any certainty.

### **2.3.3 Generalization**

Generalization, Anderson and Arsenault (2001) argue attempts to discover whether similar things will happen in new situations. Dey (1995, p.261) distinguishes between two types of generalization. The first involves the process of induction, whereby we infer a general proposition on the basis of our empirical observations. Generalization in this sense refers to the

theoretical process of developing concepts and connections. The second involves the process of applying our theory to a wider population. This refers to ascertaining the empirical circumstances in which our theory may hold true. In both cases we generalize on the basis of available evidence. In the first sense we infer a general statement about the data, and in the second, we apply that statement beyond the data on which it is based.

#### **2.3.4 Basic or theoretical**

Their fourth level is 'basic' or 'theoretical' where Anderson and Arsenault (2001) explain that research attempts to discover underlying principles that are at work. Basic researchers, they argue, hold that the proper role of science is the study of basic scientific questions regardless of whether their solution has practical application and that basic or theoretical research is conducted in experimental settings, using contrived situations. Anderson and Arsenault (2001) maintain that such research has been motivated by a desire to understand theory. The four levels tend to be interrelated and build on one another; however, each researcher must commence at the descriptive phase and then progress through the levels. Arguably we could say that depending on the method, inductive research builds theory and deductive theory tests it. It may be noted that this study used explanatory, as ethnography, case study, observation, policy research, surveys and programme evaluation were a variety of the methods employed to answer the question. The descriptions were brought to life through the use of quotations and stories from the student nurses and registered practitioners, as this was a qualitative piece of work.



## **2.4 Qualitative research**

Qualitative research is a form of inquiry that explores phenomena in their natural settings and uses different methods to interpret, understand, explain and bring meaning to them. As a field of inquiry in the human sciences qualitative research has a long and distinguished history. A fundamental assumption of the qualitative research paradigm is that a profound understanding of the world can be gained from conversation and observation in natural settings rather than through experimental manipulation under artificial conditions. While the positivists or scientific research community, seek to confirm or reject hypotheses in search of the 'truth', the qualitative research community seeks an understanding of phenomena from multiple perspectives within a real world context (Anderson & Arsenault, 2001).

Strauss and Corbin (2003) argue that there are many valid reasons for undertaking qualitative research with one of those reasons being the preference and/or experience of the researchers. Some people are more orientated to doing this type of work and the researchers may come from various disciplines including anthropology or have sociological orientations. Another reason for choosing qualitative methods is the nature of the research problem. This may include research that attempts to understand the meaning and nature of experiences of persons with problems such as chronic illness, addiction and/or divorce. Qualitative research methods can be used to explore substantive areas about which little is known or about which much is known to gain novel understandings (Stern, 1980). Furthermore, qualitative methods can be used to obtain the intricate details about the phenomena such as feelings, thought processes and the emotions that are difficult to extract or

learn about through more quantitative research methods. Indeed, this study is primarily based on the thoughts, views and experiences of participants who were involved in the curriculum based on the *Making a Difference* (DoH, 1999a) recommendations and the strategy of PBL.

### 2.4.1 Qualitative Research Methods

There are five types of qualitative research methods, often used in educational research, when one considers the primary research interest of that approach. Table 2.1 demonstrates examples of qualitative research methods.

**Table 2.1 Examples of qualitative research methods**

<b>Method.</b>	<b>Research interest.</b>
Applied.	Research that aims to assess, describe, document or inform problems from the stakeholders' perspective.
Case study.	Examines specific phenomena.
Ethnography.	Concerned with the culture of people and organisations.
Grounded theory.	An inductive approach to deriving theory.
Phenomenology	Aimed at understanding the meaning of experiences in our everyday lives.

(Anderson & Arsenault, 2001, p.121)

For this study the two main research methods used were case study and ethnography. Certain elements of the principles of grounded theory were also absorbed into the collection and analysis of the data (these will be discussed in more detail later in this chapter). The research necessitated a qualitative exploration of the experiences of staff and students, portrayals of personal meaning frameworks and issues of social structures. Hammersley & Atkinson (1995), Coffey & Atkinson (1996) and Silverman (1997) all state that it is the

latter issue in particular that determines the use of an interpretative methodology informed by ethnographic principles. The following section will briefly explain the case study and ethnographic methods.

## **2.5 Case study**

There are multiple definitions and understandings of the case study. According to Bromley (1990, p302), it is a "systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest". The unit of analysis can vary from an individual to a corporation. While there is utility in applying this method retrospectively, it is most often used prospectively. Data come largely from documentation, archival records, interviews, direct observations, participant observation and physical artefacts (Yin, 1994). The key features of a "case study" are its scientific credentials and its evidence base for professional applications. A "case review" might emphasize a critical reappraisal of a case. A "case report" might refer to a summary of a case or to the document reporting a case. Knowing the disciplinary context and meaning of these terms is important to convey to the reader (Bromley, 1990).

Case studies of individual patients often involve in-depth interviews with participants and key informants, review of the medical records, observation, and excerpts from patients' personal writings and diaries. Case studies have a practical function in that they can be immediately applicable to the participants' diagnosis or treatment. When the unit of analysis is an individual, for example, an important concept to consider is life history. Bromley (1991, p.86) states, "The case study emphasizes the proximal causes of the behaviour and circumstances, where as life history emphasizes the remote

origins, and the continuities and discontinuities in the organization of behaviour over a relatively long period of time". According to Stake (1995) the case study researcher may be somewhat of a biographer focused on a phase or segment of the life of an individual. Various contemporary reports in psychology (Bromley, 1986), sociology (Creswell, 1997; Yin, 1984, 1994), and education (Stake, 1978, 1995) have studied the individual as the unit of analysis, and have used the case study method to develop rich and comprehensive understandings about people.

Yin (2003) states that the case study is but one of several ways of undertaking social science research. Other ways include experiments, surveys, histories and the analysis of archival information. Each strategy has peculiar advantages and disadvantages depending on three conditions:

- (a) The type of research question
- (b) The control an investigator has over actual behavioural events
- (c) The focus on contemporary as opposed to historical phenomena

He maintains that in general, case studies are the preferred strategy when 'how' or 'why' questions are being posed, when the investigator has little control over events and when the focus is on contemporary phenomena within some real life context.

Robson (2003) further describes case study as a development of detailed, intensive knowledge about a single case, or of a small number of related cases. These may include the study of an individual, organisation or a particular setting. It typically involves multiple methods of data collection techniques including observation, interview and documentary analysis. The case can be virtually anything. A single simple case study would focus on one

individual, for example in a clinical or medical context. In more complex multiple case studies several individuals would be highlighted either as a group, an institution.

Yin (2003) differentiates between two versions of a single case study on the basis of the level of each unit of analysis. A study where the concern remains at a single, global level is referred to as holistic. This is typically (though not necessarily) how a case study of an individual would be viewed, but would also apply to the study of an institution that remained at the level of the whole rather than seeking to look at and analyse the different functioning of separate sub-units within the institution. Holistic case studies are appropriate in several situations with the critical case being a clear example. This occurs when theoretical understanding is such that there is clear, unambiguous and non-trivial set of circumstances where predicted outcomes can be found. The extreme case provides a rationale for a simple, holistic case study. The extreme and the unique can provide a valuable 'test bed' for which case study is appropriate. Extremes include the 'if it can work here it will work anywhere' scenario, to the 'super realisation' where, say, a new approach is tried under ideal circumstances, perhaps to obtain understanding of how it works before its wider implementation.

Furthermore Yin (2003, p.13) suggests that '*a case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident*'. Consequently, case studies:

- Can deal with complex situations where there are many variables of interest

- Utilise multiple sources of evidence, with data needing to converge in a triangulating fashion
- Benefit from the prior development of theoretical propositions to guide other data collection and analysis

Yin (1994) argued that there is a need for a new interpretation of case study that raises its status from that of a 'weak sibling' to a method of first choice. Indeed Adelman *et al* (1980) had noted that although case study had emerged during the 1960's it was still viewed by many with caution, lacking the credibility of more established experimental approaches. Stake (1995) identified three types of case study that could be adopted:

- Intrinsic
- Instrumental
- Collective

He maintains that in an intrinsic case study the researcher is primarily interested in the case itself, not what it might say about similar cases but because it is intrinsically interesting. In an instrumental case study the researcher is interested primarily in what the instance might say about a wider class of related instances. The collective case study is a variant on the instrumental case study that involves the use of multiple related methods to enhance the degree of generalisability.

Table 2.2 below highlights the main points relevant to case study as presented by Robson (2003, p.179).

**Table 2.2 Characteristics of a case study approach**

A <i>strategy</i> i.e. a stance or approach, rather than a method, such as observation or interview
Concerned with <i>research</i> , taken in a broad sense and including, for example evaluation
<i>Empirical</i> in the sense of relying on the collection of evidence about what is going on
About the <i>particular</i> : a study of that specific case (the issue of what kind of generalisation is possible from the case, and of how this might be done, will concern us greatly)
Focussed on a <i>phenomenon in context</i> , typically in situations where the boundary between the phenomenon and its context is not clear
Undertaken using <i>multiple methods</i> of evidence or data collection

The central defining characteristic of case study is the concentration on a particular case, or small set of cases, studied in its own right. Miles and Huberman (1994, p.27) suggest that in some circumstances the term 'site' may be preferable to the terms 'context' or 'setting', because it reminds us that a 'case' always occurs in a specified social and physical setting: we cannot study individual cases devoid of their context in a way that a laboratory researcher does.

Bromley (1986) maintains that the individual case study or situation analysis is the bedrock of scientific investigation with Valsiner (1986) arguing that the study of individual cases has always been the major (albeit often

unrecognised) strategy in the advancement of knowledge about human beings.

### **2.5.1 Why a case study approach was relevant to this study**

These explanations regarding case study clearly represent the participants and the fieldwork areas that were used in this study. As my work was primarily focussed upon the education and training of pre-registration nursing students a case study and ethnographic approach to the data collection with observations and unstructured interviews were appropriate methods to use. In relation to Stake (1995) and his three types of case study the present study may be referred to as instrumental.

Hammersley (1985) recognised the potential of case study in the field of education with Anleu (1992) recommending that case study be used in health services research as it can address the complexity of implementing change in practice. Yin (1999) suggested that case studies can deal with the increasing pace of change and complexity in the modern health service, particularly where affiliations and motivations are difficult to track and understand, and where traditional data sources are reported to struggle to answer questions in this changing environment. In relation to this study I was originally investigating the effect that a change, the implementation of a new curriculum, had had on students' experiences in practice, this clearly relates to the previous discussion of the effective use of case study.

A defining characteristic of case study is that it investigates a contemporary phenomenon within its real life context (Yin, 2003). Some approaches to research for example, randomised controlled tests (RCT), control events to ensure that the results of their work are applicable irrespective of context,



case study researchers make a deliberate choice to include data relating to context. For example a study will focus on the impact of a new service compared with usual care, an RCT would then be appropriate. However, if the focus were on describing and evaluating a service in context, a case study approach would be more appropriate (Walshe *et al*, 2004).

Gray (1998) states that case study is a realistic study of practice and thus have strong and obvious relationships with practice. Findings address both practice issues and the environment within which practice is embedded. A key argument for the appropriateness of case study strategies in practice orientated disciplines is that care is organised around cases: the individual patient, the organisation or the social context of work. This study integrated the concepts of a *social group* study whereby the occupational groups of student nurses and registered practitioners were observed and interviewed. The study of organisations and institutions was also used in the context that the information being collected related to the education and training of student nurses in the academic and clinical areas. Furthermore, events, roles and relationships were studied, as the focus was on boundaries student nurses have to overcome in their quest to socialise into their clinical roles and learn to be a 'real nurse'.

Yin (2003) argues that much case study literature emphasises the strength of using different sources of evidence to corroborate a phenomenon. Data collection in this study was undertaken by the use of interviews and observations with a literature review following completion of the data analysis stage that is indicative of using various forms of evidence to support the findings. Indeed the data collected produced narratives from participants on

their own feelings and views relating to the role of the student nurse and their socialisation into clinical practice which Greenhalgh and Hurwitz (1999) argue engage readers in a meaningful way and is being increasingly recognised as an important adjunct to more empirical approaches.

Although there has been debate surrounding the role of case studies in generating valid theories (Dyer & Wilkins, 1991), Robson (2003) suggests that theory can be defined in broad terms as an explanation of situations or phenomena ranging from formal academic theories to speculations made by research participants. Within this study the theory arose from the research participants and their experiences.

One of the main reasons that case study is the most appropriate method to have been used in this study is that the focus of the study changes following the data analysis period. Eisenhardt (1991) explained that although early identification of the research question and possible constructs is helpful prior to commencing the fieldwork, it is equally important to recognise that both are tentative. No construct is guaranteed a place in the resultant theory, no matter how well it is measured. Also the research question may shift during the research, which is what happened during this study. Bettenhausen and Murnighan (1986, p.352) wrote about their study and stated that 'we observed the outcomes of an experiment on group decision making and coalition formation. Our observations of the groups indicated that the unique character of each of the groups seemed to overwhelm our other manipulations'. In light of this they proceeded to change their research focus to a theory-building study of group norms rather than a theory-testing study.

It would be reasonable to conclude that the work undertaken for this study was a form of enquiry that took place at a particular time, in a particular place with particular people. As such we can safely say that it was indeed a case study that used more than one method of data collection and did indeed present the views and personal experiences of the participants. It would be most difficult to replicate these findings, yet the premise and principles of the study could be used in further studies with different participants. The following section will offer the reader an overview of ethnography as a method.

## **2.6 Ethnography**

Ethnography has a long and respected history in the fields of anthropology and sociology. In fact, Spradley (1980, p, 3) claims ethnography is the work of describing culture and learning from people.

Anthropologists initially focussed their studies on exotic cultures, such as the Trobriand Islanders of New Guinea, whereas, sociologists focussed their attentions on groups and cultures within modern urban society (Rowe, 1965). Atkinson and Hammersley (1994, p.250) stated that the beginning of ethnography occurred in the late 19<sup>th</sup> century as individuals began to acknowledge cultural differences 'or deviations from the norm'. They continue to identify two key phases in the development of ethnography in the 20<sup>th</sup> century, the work of the founders of modern anthropology, Boas, Malinowski and Radcliffe-Brown, and that of the Chicago school of sociology.

Ethnography generally refers to research which has one or more of the following features: a strong emphasis on exploring phenomena within their natural setting; a tendency to work with data which is not pre-coded in terms of its analytical categories; investigation of a small number of cases and a

form of analysis which emphasizes description and explanation rather than quantification and statistical analysis (Anderson & Arsenault, 2001).

Social scientists share an interest in and a commitment to discovery. Anthropologists as a particular group of social scientists are committed to the discovery of cultural knowledge. Individuals interested in culture found that the ways of traditional science were inadequate to discover the nuances of people who live together and share similar experiences. This inadequacy led to the beginnings of ethnography, a means of studying groups of individuals' lifeways or patterns. As early as the 1960's references can be found regarding the value of an ethnographic approach as a means to study nursing culture (Olesen & Whittaker, 1968, Leininger, 1970, Boyle, 1994).

Olesen & Whittaker (1968) undertook their study entitled '*The Silent Dialogue*' using an ethnographic approach. They rejected the sociological assumption that in professional education the student was a passive recipient of external influences. Instead, they adopted an existential perspective in which the students were seen to be actively involved in influencing the events of their own socialisation. They derived their data from student nurses over their three-year training period, 1960-1963, at the University of California, school of nursing. To collect the data they embarked on participant observation, annual interviews, questionnaires and the use of psychological measurement. The psychological measurement scales were given to the students upon entry to the school to provide psychological data to supplement their sociological observations regarding the public image of the nurse. Two of their main conclusions from the study were that the students struggled when in clinical placement fully to understand their role. In addition, there was a theory-

practice gap that they described as a *'gap between the culture of the profession transmitted in the teaching institution and the actualities of practice in sectors of the field'* (Olesen & Whittaker, 1968, p.297). This clearly exemplifies that the theory-practice gap is by no means new, but does require further consideration on how it may be bridged using an ethnographic approach.

Robson (2003, p.188) outlined six features of the ethnographic approach, which can be seen in table 2.3.

**Table 2.3 Features of an ethnographic approach**

1. The shared meanings of the behaviour, actions, events and contexts of a group of people are central to understanding the group. The task is to uncover these meanings.
2. To do this, requires the researcher to gain an insiders perspective.
3. Hence, you need both to observe and study the group in its natural setting, and to take part in what goes on there.
4. While participant observation in the field is usually considered essential, no method of data collection is ruled out in principle.
5. The central focus of the study and detailed research questions will emerge and evolve as involvement continues. A prior theoretical orientation and initial research question is not ruled out, but you should be prepared for these to change.
6. Data collection is likely to be prolonged over time and to have a series of phases. It is common to focus on behaviours, events etc which occur frequently so that you have the opportunity to develop an understanding of their significance.

Doordan (1998) believes that ethnography is the detailed study of a cultural group that describes and interprets their cultural patterns and worldview that originated in anthropology. The researcher observes the behaviour and conversations of cultural groups in their natural (field) setting and information is obtained on the meanings and patterns of the participants' experiences. The researcher becomes immersed in the culture to gain an understanding of their view of the world. The method of researching a culture group or sub-

culture in which the researcher becomes part of the culture to conduct the fieldwork and collects and analyses information in the context of the culture is referred to as ethnomethodology.

### **2.6.1 Key Components of ethnography**

Fundamentally, there are three components of qualitative research. First, there is the data, which can be derived from various sources such as interviews, observations, documents, records and films. Second, are the procedures that researchers use to interpret and organise the data. These usually consist of conceptualising and reducing data, elaborating categories in terms of their properties and dimensions, and relating through a series of propositional statements. Conceptualising, reducing, elaborating and relating are often referred to as coding (Lofland, 1971, Miles and Huberman, 1994, Strauss and Corbin, 2003). The third component is writing up the memos and verbal reports that may be presented in journals, as a book or at conferences. Dey (1995, p.14) argued that qualitative research had become a fashionable term to use for any method other than the survey: participant (and non-participant) observation, unstructured interviewing, group interviews, the collection of documentary materials and the like. Interestingly, Dey (1995) does not refer to the use of experiments and would view these as a quantitative approach to data collection rather than qualitative. Data produced from such sources may include field notes, interview transcripts, documents, photographs, sketches, video or tape recordings. What these various forms of research often have in common is a rejection of the supposedly positivist 'sins' associated with survey methods of investigation, most particularly where

data are elicited through closed questions using researcher-designed categories.

Dey (1995) further argued that an exception might be allowed for open questions in a questionnaire survey. The hallmark of qualitative data, he explains, is that it should be a product of 'unstructured' methods of social research. If qualitative research is equated with the use of unstructured methods, it follows that qualitative data is therefore seen as unstructured. The difference between structured and unstructured data turns on whether or not the data has been classified. With structured responses the data has been classified and divided into separate statements denoting distinctive advantages of closed questions relating to the conduct of the interview, the ease of data processing and the communication of meaning. By contrast, the unstructured response is descriptive but unclassified. The response covers a range of points, not all of them relevant, which are not organised and presented as distinctive elements.

In relation to the data collected for this study it was relatively unstructured and in the main a descriptive account of the participants' views, experiences and ideas that related to the *Making a Difference* recommendations (DoH, 1999a) and the strategy of PBL. From these data developed a number of themes that encompassed the information collected through a process of unstructured interviews and participant observation techniques.

### **2.6.2 Characteristics of ethnographic research**

Muecke (1994) asserts that the four major ethnographic schools of thought are: *classical*, *systematic*, *interpretive* or (*hermeneutic*) and *critical*. *Classical* ethnography requires that the study includes both a description of behaviour

and demonstrates why and under what circumstances the behaviour took place. The objective of *systematic* ethnography is to define the structure of culture, rather than to describe a people and their social interaction, emotions and materials. *Interpretive* ethnography is to discover the meanings of observed social interactions. Interpretive ethnographers are interested in studying the culture through analysis of inferences and implications found in behaviour. *Critical* ethnography relies on critical theory where a culture is not believed to be known but rather the researcher creates a culture schema (Streubert & Carpenter, 1999, p.146). According to Simon and Dippo (1986), critical ethnography attempts to enable people to see their actions in a wider socio-historical context that should encourage people to understand their own actions and the historical and social context in which they are acting. Critical ethnographers need to acknowledge that their own work is constituted and regulated through historical relations of power and existing material conditions. This leads to a demand for the researchers to become reflective practitioners and to challenge thus becoming more aware of the historical and cultural influences that shape their own beliefs and values.

The observation of the behaviour of student nurses and registered practitioners within the clinical environment was an integral aspect of my data collection and, therefore the principles of interpretive ethnography can be applied as one of the methods used in the research process.

Ethnographic research consists of six characteristics, three that could be claimed to be qualitative methods (Streubert & Carpenter, 1999); the researcher as instrument; fieldwork and the cyclic nature of data collection and analysis. The remaining three could be said to be exclusive to



ethnography; the focus on the culture; cultural immersion and the tension between researcher as researcher and researcher as cultural member, also called reflexivity.

## **2.7 Indexicality and reflexivity**

According to Robson (2003) by identifying the 'taken for granted' assumptions characterizing any social situation and the ways in which the people involved make their activities rationally accountable are the notions 'indexicality' and 'reflexivity.' *Indexicality* refers to the ways in which actions and statements are related to the social contexts producing them; and to the way their meanings are shared by the participants but not necessarily stated explicitly. Indexical expressions are the designations imputed to a particular social occasion by the participants in order to locate the event in the sphere of reality. *Reflexivity* refers to the way in which all accounts of social settings; descriptions; analyses, criticisms and the social settings occasioning them are mutually interdependent. However, Abbott and Sapsford (1997) describe *reflexivity* as a process of constantly reflecting on the content and process of the research and trying to be one's own critic. They maintain that the researcher needs to be aware of the little things that could determine the nature of the data, interpretations and the presence of outsiders or the injudicious use of a theoretical concept by the researcher.

Abbott and Sapsford (1997) argue that reflexivity can appear in two places during the research process, one visible and one invisible. The visible place for it is in the research report, where the researcher uses reflexive discussion of the research process to demonstrate that the conclusions drawn are valid, or to discuss the extent to which validity may be claimed. The invisible form is

in the conduct of the research. The methodological imagination requires constant vigilance, constant self questioning about what may be producing information which is not typical of how the participant might normally speak or behave but be due to something which the researcher has done or some way in which the situation has been presented. Abbott and Sapsford (1997) maintain that the reflexive process in the research is what ensures the validity of what is reported.

The interpretation of what is going on can be complicated by the fact that the observer may be a participant both in the situation and the research. Abbott and Sapsford (1997) warn that we do not record facts in a neutral way, but attempt to make sense of them to ourselves that is influenced by our attitudes, our social location and our preconceptions. It is therefore necessary to put these aside and try to understand the situation in the way the participants understand it, but at the same time to maintain distance from the participants. I achieved this during the fieldwork phase by 'stepping back' during the analysis stage.

## **2.8 Stepping back**

This was particularly relevant when the students commented to me that they could not learn anything from the unregistered staff or that they 'knew everything' about the administration of basic nursing care. I found that in these instances my instincts as a previous registered ward practitioner came into play and I found myself feeling a little surprised that the students could not always appreciate the importance of performing some areas of care, for example, bed bathing. I was, at times, disappointed that they could not understand that the process of effective communication with the patients and

indeed gaining their trust could be achieved during these very personal procedures. I had to 'step back' at these times and remove myself from the clinical environment to be able to understand the beliefs of the students and not instil into the data my own personal feelings.

Lincoln and Guba (1985, p.365) identify that during a case study the writing should not be '*interpretative or evaluative except in those sections explicitly intended for such purposes*'. They continue to argue that the writer's attempt to portray the constructions of respondents ought not to be confused with his or her reconstructions. However, they do recognise that interpretations or evaluations offered by respondents are valuable data, but the reader should not be placed in the position of wondering whether these interpretations or evaluations are the writer's or the respondent's. In the case of doubt, the differences should be highlighted when they appear in a presumable factual section of the case study.

During the analysis stage the field notes and interview transcripts were scrutinised and split into discrete parts to develop categories. It was during this coding process that I kept 'stepping back' to review the data. This was to ensure that I was being as objective as possible in my analysis and not interpreting the data with any preconceived ideas I may have held. As I analysed the data I become conscious that all participants were discussing the issue of clinical skills at some point in the interview schedule. This became one of the main phenomena that helped to shape the study. Merttens (1998, p.352) explains that during the coding process:

*'You build a model of the phenomenon that includes the conditions under which it occurs (or does not occur), the context in which it occurs, the action and interactional strategies that describe the phenomena, and the consequences of these actions. You continue to*

*ask questions of the data; however, now the questions focus on relationships between the categories'.*

This is indeed what happened when I had categorised clinical skills. I questioned why this was so important and how they had influenced the students' journey through their clinical experiences and helped them to overcome boundaries they faced. In actual fact, it was this phenomenon that helped to link all the categories and to provide the discussion surrounding how the students learnt to socialise into clinical practice helping them to overcome boundaries and become effective and safe practitioners.

## **2.9 Grounded theory techniques**

The following section will offer the reader an overview of grounded theory techniques. I am aware that grounded theory was not fully used in this study, however, some of its guiding principles were used to construct the methodological approach and as such I believe that it is important to identify them.

The basic idea of the grounded theory approach is to read (and re-read) a textual database (such as a corpus of field notes) and "discover" or label variables (called categories, concepts and properties) and their interrelationships. The ability to perceive variables and relationships is termed "theoretical sensitivity" and is affected by a number of things including one's reading of the literature and one's use of techniques designed to enhance sensitivity. Open coding is the part of the analysis concerned with identifying, naming, categorizing and describing phenomena found in the text. Essentially, each line, sentence, paragraph etc. is read in search of the answer to the repeated question "what is this about? What is being referenced here?" These labels refer to things like hospitals, information gathering, friendship, social

loss, etc. They are the nouns and verbs of a conceptual world. Part of the analytic process is to identify the more general categories that these things are instances of, such as institutions, work activities, social relations, social outcomes, etc (Borgatti, 2007). In relation to this study I read and re-read all the interviews identifying recurring words, sentences and concepts that led to the development of categories and themes.

Grounded theory contains many unique characteristics that are designed to maintain the "groundedness" of the approach. Data collection and analysis are consciously combined, and initial data analysis is used to shape continuing data collection. This is supposed to provide the researcher with opportunities to increase the "density" and "saturation" of recurring categories, as well as to assist in providing follow-up procedures in regards to unanticipated results. Interlacing data collection and analysis in this manner is also designed to increase insights and clarify the parameters of the emerging theory. At the same time, the method supports the actions of initial data collection and preliminary analyses before attempting to incorporate previous research literature. This is supposed to guarantee that the analysis is based in the data and that pre-existing constructs do not influence the analysis and/or the subsequent formation of the theory. If existing theoretical constructs are utilized, they must be justified in the data (Davidson, 2002).

Grounded theory provides detailed and systematic procedures for data collection, analysis and theorizing, but it is also concerned with the quality of emergent theory. Strauss & Corbin (1998) state that there are four primary requirements for judging a good grounded theory:

- 1) It should fit the phenomenon, provided it has been carefully derived from diverse data and is adherent to the common reality of the area;
- 2) It should provide understanding, and be understandable;
- 3) Because the data is comprehensive, it should provide generality, in that the theory includes extensive variation and is abstract enough to be applicable to a wide variety of contexts;
- 4) It should provide control, in the sense of stating the conditions under which the theory applies and describing a reasonable basis for action.

Grounded theory as a methodology was originally developed by two sociologists: Barney Glaser and Anselm Strauss. Strauss came from the University of Chicago and was influenced by Integrationists and Pragmatist writings, including John Dewey. Robson (2003) explains that Dewey was interested in mankind and its problems believing in democracy and what would happen to it. Furthermore he saw the universe as a constantly developing entity in which we should concentrate on what we do, our experiences and how they influence future behaviour. For Dewey (1938), the inquiry itself produces the reality, with reality being the interaction between the inquirer and the environment.

This inspired their thinking and their views on what should be included in this research method.

These ideas included:

- The need to be out in the field;
- The importance of theory grounded in reality, to the development of a discipline;

- The nature of experience; the active role of persons in shaping the world we live in; an emphasis on change and process;
- The variability and complexity of life and the interrelationships among conditions, meaning and action.

Glaser came from a very different background receiving his training at Columbia University being influenced by Paul Lazarsfeld, known as an innovator of quantitative methods. While doing qualitative research he saw the need for a well thought out, explicitly formulated and systematic set of procedures for both coding and testing hypotheses generated during the research process. The Columbia tradition emphasised empirical research in conjunction with the development of a theory. The union of these two men led to an approach which enables the researcher to develop a substantive theory that meets the criteria for doing 'good' science; significance, theory-observation, compatibility, generalizability, reproducibility, precision, rigour and verification, via, systematic techniques and procedures of analysis (Strauss and Corbin, 1990).

### **2.9.1 What is grounded theory?**

A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed and provisionally verified through systematic data collection and analysis of the data pertaining to that phenomenon. However, Glaser (1978) argued that the purpose of grounded theory methods was to generate theory and not to verify it. Yet Glaser and Strauss (1967) implied that reality is independent of the observer and the methods used to produce it. Furthermore, Denzin and Lincoln (2000, p.521) suggest that through 'fracturing the data', that is to say,

creating codes and categories as the researcher develops themes within the data, can lead to separating the experience from the experiencing subject, the meaning of the story and the viewer from the viewed. In essence they argue that these criticisms assume that the grounded theory method:

- Limits entry into the subjects' world thus reducing understanding of their experience
- Curtails representation of both the social world and the subjective experience
- Relies upon the viewer's authority as expert observer
- Posits a set of objectivist procedures on which the analysis rests

Strauss and Corbin, (1990) argue that data collection, analysis, and theory stand in reciprocal relationship with one another. One does not begin with a theory, and then 'prove' (or rather confirm) it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. It is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon. The research findings constitute a theoretical formulation of the reality under investigation and ultimately will be related to others within the researcher's discipline. The main purpose of using grounded theory is to develop a theory, which will allow the researcher to refine and specify the research question through analysis of the data.

Indeed, Morse (1992) claims that grounded theory has a theoretical basis in symbolic interactions that suggests individuals order their world by engaging in a process of negotiation and renegotiation; by making reflexive use of symbols, and by interpreting and eliciting meanings in situations. Individuals



respond and create meanings in situations, and this meaning is shared. Grounded theory, therefore, provides a means for eliciting these meanings and describing the psychological and social processes that have been developed to assist people make sense of the world.

Grounded theory relies primarily on unstructured interviews, observation and other sources of data with the method being process orientated. Anderson & Arsenault (2001) describe it as an inductive approach to theory development that can be thought of as two funnels joined where they narrow, at the centre. At the top new data is collected in multiple stages, emergent themes are identified, interpreted, compared and refined. This process creates a funnel of new information from which constructs and theories are developed (the middle). These theories are then cast out into various sampling groups to determine the strength of the similarities and differences of the theoretical constructs with different populations. The stronger the support for the theoretical propositions the wider the base at the bottom.

However Thorne (1991) has criticised grounded theory as being an inappropriate starting point for researchers. She argues that grounded theory reflects a serious bias against the naturalism and relativism of ethnographic tradition, and it favours emerging theories as the only meaningful goal. According to Stein (1985) grounded theory allows the researcher to discover a conceptual framework that offers explanations of the scene under study. The scene cannot be tested, as in empirical study, because the variables relevant to the concept have not been identified.

It might be said that many phenomenologists believe that there is no objective reality in the phenomenological world. However in a grounded theory

approach working hypotheses are generated from theory development and these can later be transferred to another setting and either become saturated or confirmed (Sheldon, 1998). This method would confirm Thorne's criticism (1991) for those theorists who believe the methodology to be emulating positivist paradigms by claiming an objective reality separate to the subjective researcher (Glaser, 1978). Sheldon (1998) maintains that although explanation and prediction are characteristics of positivist inquiry, to interpret a phenomenon it must be studied as a whole in a natural setting, and knowledge must be related to context. Values, subjectivity, intuition, history and tradition are useful for interpretation.

The interviews and observations that I carried out were meant to explore the beliefs of students and registered practitioners regarding whether or not the new curriculum had prepared the students to cope with the clinical areas in a more positive and competent way than the previous curriculum had achieved. This would allow me to gain an insight into the participants' perceptions of these issues.

I am aware that there was no definitive theoretical sampling that relates to the case study approach used, yet the concept and philosophy of grounded theory did aid in the collection of the data. It can, therefore, be argued that that the principles of grounded theory were relevant to my study, which focused on the use of observation with the students in addition to interviews with student nurses, registered practitioners, the practice development coordinator and the senior nurse for practice development. It has also allowed for changes over time for the description of stages and phases within the student and staff experiences.

You may recall from the previous chapter that the literature review had been undertaken following the data collection so as not to influence my thoughts and ideas of what I should be seeing and learning during this stage. In fact Streubert and Carpenter (1999) explain that qualitative researchers may undertake a cursory review of the literature to focus the study, but the reason for not conducting an in-depth review is to protect the investigators from leading the participants in the direction of what the researcher is interested in developing a theory about. If the researcher reviews all the literature related to the study prior to the data collection then he or she may develop preconceived notions about the subject under investigation. The researcher may not have held beliefs before the review, but, following the literature review, now has the information that could affect how he or she collects and analyses the data. Pinch (1993) has suggested that researchers learn more about phenomena when conducting qualitative studies if they are 'strangers'. One way to remain a stranger is to limit the intake of information about the focus of the study before conducting the study. It is important to conduct the literature review after analysing the data. The purpose of reviewing the literature in a qualitative study is to place the findings in the context of what is already known.

Whyte (1951) asserts that the theory should emerge from the observation and that there should be minimal initial theoretical orientation prior to the observations. I wanted to know about the 'hows' of my ideas, for example, how did the students adjust to their student nurse role? Indeed, much of the observation information I gained influenced the subsequent interviews. This was due to the students discussing what I had been observing them

undertaking during that period of time. For example, I observed the staff on one particular ward encouraging the student to observe and take part in procedures being carried out by the medical staff. During the interview the student had asked me if I had *'seen the staff asking me to go with the doctor'*. I answered *'yes'* and she replied *'then you can see how good the staff are here they are always like that'*. This comment encouraged us to discuss the teaching and learning environment in that clinical area and others the student had visited during their training period.

## **2.10 Accessing the information**

### **2.10.1 Literature searches**

A selective literature search had been undertaken prior to the fieldwork and data analysis occurring, however, this was only to ascertain whether or not specific research had been undertaken in this area previously. A more in-depth literature review was undertaken during and following completion of the data analysis, to reduce prejudgements and premature closure of ideas (Stern, 1980). The literature searched at the beginning of the study suggested that very little had been written regarding the implementation of the new nursing curriculum due to the fact that it had only been introduced in September 2000. However, there was a plethora of material relevant to teaching and learning strategies; registered practitioners perspectives of student nurses and student nurse perspectives of their own training programmes, which was integrated into the discussion of my own findings.

### 2.10.2 Data base searches

Numerous databases were searched for information relating to student nurse education, problem based learning, student experiences and the transition from student nurse to registered practitioner.

Table 2.4 displays the databases searched.

**Table 2.4 Databases searched**

Cinahl
Medline
Department of Health
Nursing and Midwifery Council
English National Board
Internet using the search engine 'Google Scholar'

I wanted to know if there was any research or evidence available relating to the information I required from an international perspective. This provided a plethora of information relating to Problem Based Learning, boundaries and socialisation relating to student nurses.

### 2.10.3 Keywords

The key words used were

- Peach Report
- Fitness for Practice
- Making A Difference
- Problem based learning
- Theory-practice gap
- Socialisation of student nurses

The literature search and review allowed for a provisional outline for the case study to be developed although I had intuitively developed an outline as to how the study would progress.

### **2.11 The sample**

The sample group consisted of fifteen (15) students, fifteen (15) student mentors, eight (8) ward managers, one (1) practice development co-ordinator and one (1) senior nurse responsible for clinical development at Trust Board level, who were all interviewed. In addition, the fifteen students were observed for part of a shift within the clinical environment and field notes taken at the time.

A purposive sample is one which is selected by the researcher subjectively. The researcher attempts to obtain sample that appears to him/her to be representative of the population and will usually try to ensure that a range from one extreme to the other is included. Subjects are selected because of some characteristic. Patton (1990) has proposed the following cases of purposive sampling.

- **Extreme or Deviant Case** - Learning from highly unusual manifestations of the phenomenon of interest, such as outstanding success/notable failures, top of the class/dropouts, exotic events, crises.
- **Intensity** - Information-rich cases that manifest the phenomenon intensely, but not extremely, such as good students/poor students, above average/below average.

- **Maximum Variation** - Purposefully picking a wide range of variation on dimensions of interest...documents unique or diverse variations that have emerged in adapting to different conditions. Identifies important common patterns that cut across variations.
- **Homogeneous** - Focuses, reduces variation, simplifies analysis, and facilitates group interviewing.
- **Typical Case** - Illustrates or highlights what is typical, normal, average.
- **Stratified Purposeful** - Illustrates characteristics of particular subgroups of interest; facilitates comparisons.
- **Critical Case** - Permits logical generalization and maximum application of information to other cases because if it's true of this once case it's likely to be true of all other cases.
- **Snowball or Chain** - Identifies cases of interest from people who know people who know people who know what cases are information-rich, that is, good examples for study, good interview subjects.
- **Criterion** - Picking all cases that meet some criterion, such as all children abused in a treatment facility. Quality assurance.
- **Theory-Based or Operational Construct** - Finding manifestations of a theoretical construct of interest so as to elaborate and examine the construct.
- **Confirming or Disconfirming** - Elaborating and deepening initial analysis, seeking exceptions, testing variation.
- **Opportunistic** - Following new leads during fieldwork, taking advantage of the unexpected, flexibility.

- **Random Purposeful** - (still small sample size) adds credibility to sample when potential purposeful sample is larger than one can handle. Reduces judgment within a purposeful category. (Not for generalizations or representativeness).
- **Politically Important Cases** - Attracts attention to the study (or avoids attracting undesired attention by purposefully eliminating from the sample politically sensitive cases).
- **Convenience** - Saves time, money, and effort. Poorest rationale; lowest credibility. Yields information-poor cases.
- **Combination or Mixed Purposeful** - Triangulation, flexibility, meets multiple interests and needs. (Patton, 1990)

From Patton's (1990) examples the sample I chose was a typical case as all the participants were involved in student nurse teaching and were involved in the implementation of the new curriculum. Indeed the sample may have been referred to as a convenience sample as the selection of participants was based on easy availability and/or accessibility. That is to say the students chosen were those that were on clinical placement during the field work process. This method of sampling was the most feasible as I had restricted time to undertake the data collection and had no financial resources that would have enabled me to employ an assistant to assist with the interviews and observations.

All students were interviewed following the observation period and the mentors and ward managers interviewed on the same day or the following day. An unstructured open-ended format of interviewing was used to conduct the interviews. This provided the opportunity for the interviewees to discuss



their own thoughts, experiences and viewpoints. The interview agenda was modified for each of the participants in relation to the answers and discussions we held. The fields in question were an orthopaedic, ophthalmic, medical and surgical ward, an intensive care, a coronary care and a medical admissions unit.

There was no direct patient/client involvement in the data collection. However, as I was observing how the students interacted with them on a day-to-day basis, it was inevitable that they too were being observed on an indirect level to ensure that the care being administered was safe. I did not interact directly with any of the patients during the fieldwork. This was achieved by not wearing a uniform, sitting in an unobtrusive position in the clinical areas and if the patients asked the participants what I was doing they explained that I was a lecturer from the university observing the ward routine.

## **2.12 Ethical considerations**

Thompson, Melia and Boyd (2003, p.62) describe ethics as being fundamentally about power and responsibility, about the conditions for power sharing and the criteria for the responsible exercise of power in our relations with one another. In relation to this study I believed that it was important to focus my attention on the structure of power relationships in the clinical settings and the possible power that may have been asserted between myself, as an academic, and the participants. Here ethics may be related to the power of myself as the researcher. Power in this context is related to the '*power to act*', that is to say, that I possessed the authority to act autonomously during the field work and that I 'belonged' to the university rather than the health care setting.

The participants were aware that I was a registered practitioner and a nurse lecturer and as such they wanted to share their ideas and experiences with me in a knowledgeable fashion. They did not want me to think that they were outdated in their knowledge or skills base. Macintyre (1981) uses the example of Aristotle to discuss the issue of *intellectual virtues* that combines scientific knowledge with competence in the application of scientific method and technical expertise. He continues to discuss the issue of *moral virtues* that are personal competencies and include prudence. Prudence he defines as competence based on skilled application of relevant moral and practical knowledge to specific situations. The participants in this study were keen to display that they were competent practitioners and competent students who possessed the underpinning knowledge to support their practices.

During the fieldwork period the participants did indeed display competency in their actions and their discussions. The students did not undertake any practices unsupervised, although two students often worked together to make beds and to assist patients with their hygiene needs a registered practitioner was always on duty who had responsibility for ensuring the students were supervised. Although I was not directly supervising the students during the observation periods had they displayed any signs of poor or dangerous practices I would have been professionally and morally obliged to intercede if it I were witnessing poor practices. If the participants had informed me of any poor or dangerous practices during the interviewing process I would again have been morally and professionally obliged to report these to the nurse in charge. This would be despite the fact that I had promised anonymity and confidentiality of the information. Ethically I remain a registered practitioner

who holds a responsibility to ensure that safe practice is delivered to the patients.

Streubert and Carpenter (1999) highlight that ethical issues in a qualitative investigation are unclear and despite efforts to inform the participants and to anticipate outcomes, there is little control over what might surface in a qualitative interview. They suggest that researchers must observe certain basic principles when conducting an investigation. First, participants must not be harmed, thereby supporting the principle of nonmaleficence. In any qualitative investigation, if researchers sense that the interview is causing issues to surface that may result in serious consequences, they must protect the welfare of the participant, perhaps by ending the interview or providing follow up counselling. I would have to disagree with this point for the reasons mentioned previously as the NMC code of conduct (2004) would instruct me as a registered practitioner to report any issues that I believed were or could be detrimental to patients.

Streubert and Carpenter (1999) continue to state that researchers must obtain informed consent, and informant participation must be voluntary thereby supporting the principle of autonomy. However it must be remembered that this is often impractical from all who might appear as data in a study for example, visiting porters. Furthermore, researchers must assure participants will be treated with respect and dignity. During my study I ensured that these principles were complied with.

The honesty with which the participants discussed issues and experiences with me, I believe was partly attained as I had assured them confidentiality for individuals when I wrote the study up. In addition I had informed the

participants both verbally and in writing the purpose of the study and that the findings may be used to influence future curriculum development issues. All participants had the option to withdraw from the study at any time and I had informed them that I would not be involved in the assessment of their academic work so that they would not feel pressurised to give me the 'right answers' during the interviews. Indeed the responses during the interviews were so diverse and different from what I had expected that, as mentioned earlier, the whole focus of the study changed. This reassured me that my status as a lecturer was not having a detrimental effect on the interview process and that the students did not have any feelings of being oppressed. The participants were happy for me to refer to the field by the name of the Trust and the University but they did not wish to be named in the study itself. The reason for the research was explained to all participants both verbally and in writing by me. I met all participants on a one-to-one basis prior to the fieldwork and explained the reason for my fieldwork, in that I was undertaking a PhD and wanted to investigate:

1. What effect did PBL have on students in relation to the theory – practice gap?
2. What were the effects of PBL and the associated curriculum on the student experience in clinical practice?

In addition I gave all the participants written information regarding the study that identified the background for the study and the fact I was undertaking my PhD. I also highlighted that all information given would be anonymous and that I would destroy the tape recordings of the interviews after I had

transcribed them, Ethics approval had been sought and successfully gained from both the university and the local research and ethics committee.

I did not identify any of the wards, so although the Trust was identifiable the clinical areas were not. This was with the exception of ICU, CCU and the ophthalmic unit as these were single specialised units so they have been named with the participants' permission. Furthermore, as I was a solo researcher they were further assured that there would only be me reading and analysing the data. I had also asked the participants if they were content for me to analyse the data without them first hearing or reading the transcripts I had made and they all replied in the affirmative.

At the time of the fieldwork one aspect of my role was that of a base group facilitator and intake co-ordinator for the September 2000 cohort of adult branch student nurses. Although some of the students who participated in the study were from the September 2000 cohort none of them were from my particular base group. During my study I did not allow my own group of student nurses to be involved in the observation and interviewing procedures. This was because I believed that they might act in a way that they thought was correct while they were in their clinical placement areas or that they may not be totally honest with me during the interviews feeling that they had to give me the 'correct answers'. Indeed this had been identified during the research and ethics committee meeting and we had agreed that I would not involve my own group of students in the data collection phase.

I was aware that the students may have viewed me as an 'expert' or an 'authority figure' as I was a nurse lecturer but I do not believe that the quality

or transferability of the data collected was affected, as all the students were open and honest in their discussions with me.

Murphy and Dingwall (2001, pg.344) stated that it was important that the researcher and the researched were aware of a balance of power between the two and that allowing a researcher into the life of the participant could imply a loss of power on the side of the participant. I was open and honest with all the participants about what my role was that is to say, a researcher in the field. They were all aware that I was a nurse lecturer and was not in the field to assess their nursing abilities. I gained their agreed consent to taking part in the study; by consenting to participation the people involved in the study have agreed, to allow me, the researcher, into their lives. Arguably the participants have the power in the research situation as Iphofen (2005, pg.31) states *'the ultimate test of the enhanced power of research participants lies in their knowing that they have the ability to withdraw from the study at any point. No matter how inconvenient this may be to the researchers'*.

Luker (1984, p.2) during her fieldwork interviewed students who she had been teaching and argued that:

*'I was an insider in the sense that it was obvious to the students that I knew what it was like to become a nurse through an unorthodox route. It seemed that in this context I was seen as a past student rather than a lecturer and I see this as a methodological strength rather than a weakness'*.

I agree with Luker in that the students appeared comfortable discussing various issues with me and at times they reflected on their experiences in the clinical areas. I too reflected following each interview and examined my own experiences of being a researcher. These reflections enabled a greater understanding of both the research topic and the research process (Taylor,

2005). Indeed, Spencer *et al* (2003) suggest that reflexivity may promote quality of the work being undertaken as the researcher is displaying an awareness of the importance of the research on the researcher and vice versa; recognising how values, assumptions and the presence of the researcher may impact on the data.

Lincoln and Guba (1985) commented that reflecting on the interview process can help to identify ways of improving the interview guide and by recording any changes to the research process the researcher is able keep a useful record for subsequent audit trails ensuring the trustworthiness of the research process.

Ethical procedures are important in any research with the overriding imperative '*to do no harm*'. Indeed, Daniel (1993, p.14) states that one of the major guiding principles for ethical consideration '*is a respect for confidentiality and the anonymity of informants and advisors.*' In case study evaluation, where it is often not possible to anonymise participants and where individuals may have different perceptions of what took place and different interests in the outcomes, an ethical code of conduct is essential for the gathering and sharing of information (Treacy & Hyde, 1999).

The method of participation has been identified as problematic in relation to obtaining informed consent. Merrell and Williams (1994) discussed the difficulties associated with obtaining informed consent when the researcher occupied a variety of roles and entered into a variety of relationships in participant observation studies. They argued that the researcher might be a colleague and friend as well as researcher to those whom they encountered in

the field, and when someone in the field imparts the information, it is sometimes unclear under which of these roles it was done.

Merrell and Williams (1994) also discuss 'situational limitations and opportunities' of performing observation studies and the implications they have for gaining informed consent. The limitations refer to the lack of control the researcher has in determining whether and when an individual enters and departs from the field of study. Paddison (1995) also identified the problem of multiple roles in interviewing colleagues. She acknowledged that in her study, interchange with informants after the tape recorder had been switched off yielded copious data, a large proportion of which was wasted because she did not perceive herself to be in the researcher role at that point in time. Interestingly, I also found that some of the participants discussed many issues following the tape recorder being turned off yet they claimed this was, as they felt '*silly*' talking to me when they knew they were being recorded. With regard to this information I made notes both on paper and via the tape recorder when the participants had left. I did, however, ask and gain the participants permission to do so.

Treacy & Hyde (1999) identify that access to personnel can be a sensitive issue in case study evaluation and so the principle of double access should be considered. That is to say that the gatekeepers (the major stakeholders) and the participants should give their permission prior to evidence being sought. Furthermore, all individuals should agree to be interviewed and/or observed and informed how the data will be used and reported. In respect of my study ethical approval was sought and gained from the University and the local research and ethics committee. Each interview was taped, with the



permission of the interviewee, and was transcribed by myself. The interviewees were informed that they would be allowed to see the results of the interviews if they so wished and that they would remain anonymous. Each participant was informed that they could leave the study at any time. I also explained that the data was being collected for my doctorate and when completed they were welcome to access the thesis.

Finch (1984) argued that the use of interviewing might promote a high level of trust among research subjects, which in turn gives the researcher a special responsibility to ensure that this trust is not abused by reneging on commitments, acting deceitfully, or producing explanations that may damage the interests of the subjects. Throughout the collection of the data I have attempted to record the participant's interviews as accurately as possible ensuring that the meaning they intended has been transcribed.

Attention needs to be drawn to the comments of McHaffie (1996) who described a difficulty in relation to confidentiality that could challenge the simplicity of ethical guidelines. This is where potentially detrimental information is revealed by participants on which the researcher might, in another role, intervene. However, if researchers felt the urge to breach confidence on the basis of discrediting information they received that was deemed to be damaging to either the participant or others, our knowledge of the social world might be shut down through potential respondents' fears of research participation. This is an enormous ethical dilemma, which I considered prior to undertaking the fieldwork. During the research and ethics meeting we discussed actions I would take if I witnessed a potentially dangerous situation or if a participant imparted information that suggested

poor practice. It was agreed that as a registered practitioner I would intervene to prevent any injuries occurring. If a participant were to reveal any elements of poor practice that required intervention I would report this to the senior staff. Each required intervention would be different and would be dependent on personal experiences and judgement in each case.

Broom (2006) discusses integrity in the field where the researcher can be in a position of power when interviewing or observing participants. She states that during interviews participants may talk about issues that are sensitive and the researcher needs to be able to respond in a sensitive manner. Broom was referring to her experiences when interviewing patients with cancer, but I noted the importance of integrity in the field in relation to my interviews with the students. They were also discussing issues that were sensitive, for example, when they had felt unsupported in the clinical areas and when they did not understand what their role was. It was important that I constantly reviewed the degree to which the students wanted to provide this information and the degree to which the discussion was appropriate for the study (Broom, 2006). Gilbert (2001) suggests that qualitative interviewers should work through a 'guided conversation' that will help to prevent the imposition of predetermined issues. In this way the data remains true to the experience of the interviewee rather than an imposition of preconceived ideas by the researcher. Gilbert (2001) maintains that being ethical is also about being a good methodologist and ensuring that the data is of high quality and useful for informing policy and practice.

Murphy and Dingwall (2001, p342) discussed the issues of participants' anonymity and confidentiality stating that:

*'The rights of research subjects in ethnographic work will not be respected simply because consent forms have been signed: indeed, as in much biomedical research, these forms may offer more protection to the researcher than to the subject in the event of litigation...Signed consent forms may actually jeopardise the confidentiality of participants by making them identifiable. There are genuine difficulties about the means of respecting rights to autonomy and self-determination. The answers depend more on the moral sense of the researcher and their ability to make reasoned decisions in the field than upon regulative codes of practice or review procedures.'*

I believe that I entered the field with a moral sense of duty to answer the research questions posed in a truthful and factual manner and that the participants understood the rationale for the data collection process.

### **2.13 Collecting the data**

All ethnographic research occurs in the field with researchers going to their culture of interest. A question about the difference in human experiences found in foreign cultures leads researchers to determine those differences. Data collected by the ethnographer in the field to describe differences and similarities will no doubt lead to more questions about the culture. Ethnography is a research method whose sole purpose is to understand the lifeways of individuals connected through group membership that leads to the focus on the culture being unique. As Boyle (1994) stated ethnography focuses on a group of people who have something in common. The researcher's participation has been called '*cultural immersion*' requiring that the researcher live amongst the people being studied. In the case of my study I observed how the students functioned within the clinical environment, how they interacted with other members of the team and if they questioned members of staff regarding activities.

In addition, I observed how the registered practitioners reacted to the students within their clinical environment during placement. The influence of the observer on observation will be discussed later in this chapter. I made field notes during the observation period and extra ones following the observations. I did not want to appear to be documenting everything the participants were doing when I was in the clinical areas, as this may have made them nervous. However, I did want to maintain an accurate record of my observations. I also found that when I left the clinical areas I would record information that returned to me.

Lofland and Lofland (1995, pp.93-95) suggest that five types of material should be included in the record:

- Running descriptions – specific, concrete, descriptions of events, who is involved and conversations. Keeping any inferences out.
- Recalls of forgotten material – things that come back to you later.
- Interpretative ideas – notes offering an analysis of the situation.
- Personal impressions and feelings – subjective reactions.
- Reminder to look for additional information.

#### **2.14 Interviewing techniques**

Ethnographic interviewers allow their interviewees to talk from their own point of view and in their own language on a subject that they are expert in, that is, their own perceptions and experiences (Denzin, 1989). The flexibility and open-ended questions give the interviewer the opportunity to explore topics as they emerge and are conducive to rapport building, which is essential when participants are required to disclose information that may be sensitive (Fielding, 1993). The ethnographer must ensure that there is an element of

trust between the interviewer and interviewee that transcends the interview. There must be a desire to know, to learn people's views and perceptions of the facts, to hear their stories and to discover their feelings.

The aim of the interview is to secure what is in the minds of the interviewees, uncoloured and unaffected by the interview (Woods, 1979). This was achieved through using an unstructured interviewing technique in an informal manner in a room that was away from the clinical environment. I asked the participants some general questions surrounding the implementation of the new nursing curriculum, their ideas on the roles of the student nurse and the registered staff and then allowed the conversation to develop. I assured all the participants that it would only be me that had access to the transcripts and the field notes I had made and all of this information would be destroyed following completion of the study.

King (1994) suggests that this will aid in understanding individual perceptions of processes within a social unit, that is, the clinical areas. An array of information and viewpoints from all the participants arose out of these interviews that formed the themes for the data analysis. All participants were aware of the reason for collecting the data as I had informed them both verbally and had given them all an information sheet outlining the reasons for undertaking the study and that the information would be used to present a thesis with all participants being assured of anonymity. The length of the interviews varied from between half an hour to one hour and forty-five minutes, the longest was with the senior nurse for practice development.

All the participants chatted quite freely and often offered me far more information than I had originally hoped for. What was interesting was that

when the participants saw me visiting other wards they would stop me and continue to discuss issues we had identified in the interviews. I made field notes of these conversations following our informal meetings.

Triangulation of data collection methods (Robson, 2003) that is to say the use of two or more methods of data collection was used to increase the credibility of the findings. Triangulation is recommended by Cook (1983) as being useful in assisting the researcher to disprove previous biased research by replicating the original quantitative methods and comparing these findings with the results of qualitative methods. The benefits of the use of both methods are obvious but perhaps Cook's assumption that a previous quantitative study may have been biased, whereas the qualitative study will not be, is rather sweeping (Begley, 1996).

Redfern & Norman (1994 p. 52) describe the strengths of triangulation as:

- Overcomes the bias of 'single-method, single-observer, single theory studies'
- Increases confidence in the results
- Allows development and validation of instruments and methods
- Provides an understanding of the domain (completeness)
- Ideal for complex social issues
- Overcomes the elite bias of naturalistic research
- Overcomes the holistic fallacy of naturalistic research
- Allows divergent results to enrich explanation.

Begley (1996) states that the first three listed strengths plus the sixth all refer to the first purpose of triangulation; that is, confirmation of findings. The four remaining strengths refer to the second goal of triangulation, namely,

completeness. Redfern & Norman (1994), Fielding & Fielding (1986) and Jick (1983) maintain that triangulation is of prime importance to qualitative researchers in particular. The investigator with this goal of triangulation in mind is not expecting each new piece of data to confirm the existing data. Instead, he or she is expecting it to contribute 'an additional piece to the puzzle' (Knafl & Breitmayer 1991).

### **2.15 Observing power**

Dahl's (1986) position on power argues that it is a relation between actors who may be individuals, groups, roles, offices, governments, nation-states or other human aggregates. This position can be related to students and the staff they meet during their clinical placements. The students rely on the ward staff, in particular, their mentors to complete their clinical documentation and to teach them how to develop their skills while they learn how to be a 'real nurse'. The power in this example is held by the ward staff and mentors and not the students, the students accept this power relation to help them fit into the teams. The use of observation as a research tool enables observation of power examples in the clinical areas.

Foucault (1977) argued that society exerts power over individuals through dominant social discourses. He explores and discusses the concept of surveillance as a process by which individuals conform to behavioural norms. Surveillance relates well to the way that students' learning was managed in this study in that they are subjected to surveillance each time they enter their clinical areas. As such they conform to the behavioural norms of each environment, rarely questioning practice at the time, but waiting until they return to the educational arena. Indeed Durkheim (1957) identified that health

care professionals, through their access to technical knowledge and development of expertise within a particular discipline, were able to shape the experience and behaviour of others. Holmes (2001) contrasted the caring relationship of nurses to their patients to the surveillance of patients which occurs when they are observed by closed circuit television in some in-patient settings. This paradox of surveillance could arguably be related to the fact that I was observing the students and that through the observation I was indeed disempowering them to a greater degree than had I not been there.

Whilst Michel Foucault has had an enormous impact on ideas in social science and history, and I draw upon his ideas for my discussion of power, his approach has little to say about methodology as such.

### **2.15.1 Observation techniques**

Davidson and Layder (1994, p.165) argue that:

*'In order to truly grasp the lived experience of people from their point of view, one has to enter into relationships with them and hence disturb the natural setting. There is no point in trying to control what is an unavoidable consequence of becoming involved in peoples lives in this way'.*

They clearly note that when we undergo observation techniques we will, to some extent, influence the way people are going to behave. They will to a point 'act' in the way they think is appropriate when being observed. This point is interesting for me as during the observation periods I actually witnessed this occurring with a student nurse. I had observed her being encouraged to observe procedures away from the clinical area, yet when I interviewed her she said that this was an unusual occurrence as normally the staff wanted her on the ward to be 'an extra pair of hands.' From this comment it may be argued that I was not 'getting at the truth' during the fieldwork period. The



student explained that it was only because they were aware that I was going to the ward that day that they allowed her to observe the procedures (this will be discussed in more detail in chapter three). I believe that this episode was not a reflection of all the clinical areas I had visited as no other student reflected these concerns and neither did I witness this during my observation periods.

Indeed LeCompte and Goetz (1982) addressed the issues of reliability and validity in ethnographic research. They highlighted five areas where external reliability could be affected; the status position of the researcher; informant choices; the social context in which the data was collected; definitions and delineations of the constructs and their relationships and the methods of data gathering and analysis. I realise that my status as a lecturer may have precipitated some changes of the registered practitioners treatment of the students to produce what they perceived was an effective teaching and learning environment. Nonetheless, I do believe that the majority of the registered practitioners did not change their attitudes or behaviours towards the students when I was in the clinical environments. Indeed no other students when interviewed had stated that this had happened to them, in fact, the majority of students were complementary and positive regarding the learning opportunities that they had access to when in the clinical area.

An ethnographic approach is more a question of general style rather than following specific prescriptions with Hammersley (1992) stating that it is the idea that people construct the social world through their interpretations of it and the actions based upon those interpretations. Atkinson and Hammersley (1994) agree that there may be multiple designs associated with ethnographic

research and assert that while ethnography is a distinctive approach, it can be linked with either the case study or grounded theory approaches.

### **2.15.2 Participant observation**

Robson (2003, p.315) has highlighted that participant observation is more effective than other observation techniques when:

- Working with small groups so that the researcher can get to know virtually all the people involved that would not be feasible in a large group.
- Frequent events are occurring, for example, when there is a daily routine, which relates to a ward routine.
- Your prime motivation is to find out what is going on.

He maintains that the wealth of information available in a participant observation study is such that you can probably find supporting evidence for virtually any initial hypothesis. He does warn that it may be a dangerous technique for those simply wanting to confirm their pre-judgements.

I was working with small groups during my observation periods as I wanted to learn how the students interacted with the registered and unregistered staff. Although I did not wear a uniform or actually work on the wards during the observation periods arguably my close involvement could still be seen as participant observation. In addition, I wanted to see if they used the knowledge they had gained in school, through undertaking the *Making a Difference* curriculum and being exposed to PBL, to aid in their passage of student nurse to registered practitioner.

A key feature of participant observation is that the observer seeks to become some kind of member of the observed. This involves not only a physical

presence and a sharing of life experiences, but also entry into their social and 'symbolic' world through learning their social conventions and habits, their use of language and non-verbal communication. The observer also has to establish some role within the group (Robson, 2003). Manis and Meltzer (1967) argues that participant observation may be perceived as subjective and 'bad science' to those trained in traditional views of experimental design and quantitative analysis. However, it could be argued that when working with people scientific aims can be pursued by explaining the meaning of the experiences of the observed through the experiences of the observer. This arises from a perspective that the social world involves subjective meanings and experiences constructed by participants in social situations. The task of interpreting these meanings and experiences can only be achieved through participation with those involved.

Some of the most important things in human behaviour are the things that cannot be directly observed, such as intentions and feelings. These criticisms have led to a paradigm commonly known as '*post-positivism*.' This paradigm accepts values and perspectives as important considerations in the search for knowledge. What you see is dependent upon your perspective and what you are looking for. It is a qualitative approach, which has many elements of insightful observation though in its best manifestations is grounded in theory (Anderson & Arsenault, 2001, p.5). Post-positivism recognises the force of the criticisms made of positivism and attempts to come to terms with them. Essentially, positivists look for the existence of a constant relationship between events, or in the language of experimentation, between two variables (Robson, 2003). Arguably this can be relatively straightforward when dealing

with the natural world; however when people are the focus of the study, especially when it is taking place in a real world context, psychology and the social sciences do not appear to produce any scientific laws to be measured against (Robson, 2003). Positivists maintain that one reality exists and that it is the researcher's job to discover what it is. Post-positivists also believe that a reality does exist, but consider that it can be known only imperfectly and probabilistically because of the researchers' limitations.

### **2.15.3 Objective observation**

It should be remembered that objective observation is impossible as the participating observer is involved, not detached. By beginning to share in the members' world it enables the researcher to gain access to their own personal experience. This knowledge is introspective and while the description and conclusions may be public, the introspective knowledge is not. This means that a test of congruence or principle of variability must be pursued. The idea is that in any natural setting there are norms or rules of action in which members are competent. Understanding, on the part of the observer is achieved when the observer learns the rules. The adept observer is able to provide others with instructions of how to pass in the same setting.

It should be remembered that primary data collected are the interpretations by the observer of what is going on around them. The observer is the research instrument, and hence great sensitivity and personal skills are called for if worthwhile data are to be collected. Lincoln and Guba (1985, p. 195) warn that '*one would not expect individuals to function adequately as human instruments without an extensive background of training and exposure*'. Therefore, as my background is that of a registered practitioner I did possess

the skills and knowledge required to function as a human instrument effectively. With participant observation, it may be difficult to separate out the data collection and analysis phases of an enquiry. Analysis takes place in the middle of collection and is used to help shape its development

#### **2.15.4 Participation methods**

The process of participation was to a point overt, as all members of staff and students were aware of the reason for my presence i.e. to collect detailed data and not to be a new member of the team (Gilbert, 1999). As a registered practitioner I understood the rules of clinical areas and was able to communicate with staff members and understand many of their worries and concerns related to both the students and clinical issues.

Indeed my role could have been described as being the participant as observer. With this method the participant makes it clear to the group being observed that they are an observer and attempts to establish close relationships with members of the group. This stance means that as well as observing, the observer can ask members to explain various aspects of what is actually going on. Robson (2003) argues that one effect of the participant as observer is that members of the group, particularly key informants are led to more analytical reflection about processes and other aspects of the group's functioning.

Table 2.5 below identifies the areas where participant observation may be useful in a small project (Adapted from Robson, 2003, p. 315).

**Table 2.5 Participant observation**

With small groups where you will be able to know virtually all the people involved in a way that would not be feasible with a large group
For events/processes that take a reasonably short time
For frequent events – participation observation is in general more easily handled in situations where there is repetition of the central activities on a frequent basis
For activities that are accessible to observers. These may also be supplemented by the use of interviews or informal discussions with the group
When the prime motivation is to find out what is going on - the wealth of information available in a participant observation study is such that supporting evidence can often be found for virtually any initial hypothesis. It may, therefore, be a dangerous technique to employ to simply confirm pre-judgements
When there is no shortage of time – small participant observations can take up a lot of time for example, the time spent writing up field notes.

Once the fieldwork had been completed the next step was to analyse the data developing categories and themes.

### **2.16 Analysing the data**

Prior to analysing the data it was essential to attain an understanding of the purpose of the analytical tools being used. Strauss and Corbin, (1998, p.89), provide ten purposes for their use presented in table 2.6.

**Table 2.6 Purposes of analytical tools**

<ol style="list-style-type: none"><li>1. To steer a researcher's thinking away from the confines of both the technical literature and personal experience.</li><li>2. To avoid standard ways of thinking about phenomena.</li><li>3. To stimulate the inductive process.</li><li>4. To focus on what is in the data, and do not take anything for granted.</li><li>5. To allow for clarification or debunking of assumptions made by those being studied.</li><li>6. To listen to what people are saying or doing.</li><li>7. To avoid rushing past 'diamonds in the rough' when examining data.</li><li>8. To force the asking of questions and the giving of provisional answers.</li><li>9. To allow fruitful labelling of concepts, although provisionally.</li><li>10. To discover properties and dimensions of categories.</li></ol>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### **2.16.1 Dealing with the information**

I transcribed all the interviews within forty-eight (48) hours of them occurring, typed and imported them into the NVIVO computer aided qualitative data analysis package (appendix one provides an example of an interview transcript). I must admit that a majority of the coding was completed manually as I felt that I was able to understand and interpret the data in more detail if I were physically reading and writing it. The computer package, although useful, felt a little artificial at times. Observation data was also placed into NVIVO. The data was categorised through the selection of certain words and phrases that were relevant to the study being undertaken, comparing each one and joining them together as appropriate. I then reduced the categories allowing the major themes to emerge as suggested by Hutchinson (1986). This may also be referred to as microanalysis,

*'The detailed line-by-line analysis necessary at the beginning of a study to generate initial categories (with their properties and dimensions) and to suggest relationships among categories; a combination of open and axial coding'*

(Strauss and Corbin, 1998, p.57)

### **2.16.2 Categorising the data**

Categorising the data allowed for concepts to be developed from the data and links to be created. Categorising required a line-by-line examination of the data that led to some categories being discarded, as they did not relate to the foundation of the data. They were, rather, the participants discussing other issues, not directly relevant to the study. These included discussions regarding 'traditional' and 'Project 2000' training courses. Although, the data was valuable much of the information was the participant's own experiences

of their education and training and, therefore, I felt that this did not relate directly to the questions posed.

However, what did emerge were the registered staffs' perspectives of how the educational programme had changed and whether or not they felt that it was actually making a difference to the performance of the students while on clinical placement. The students' views and observations of how well the programme had prepared them for their role in clinical practice were also investigated. Although these issues were discussed in detail it was interesting that many other themes also occurred that I had not taken into account prior to undertaking the fieldwork, many of which have actually shaped and indeed reshaped the whole structure of this study.

In addition, some of the participants used the interviews to voice their opinions on management issues; again some of these were extremely personal and did not directly relate to the questions being investigated.

In essence, the categorisation process could be referred to as selective coding. I had developed an overall feeling of what this study was examining and as such these personal viewpoints from the participants did not accurately represent the reality of the study. I did however, acknowledge that these viewpoints were important for the participants, but felt that they were using the fieldwork experience as an opportunity for them to discuss their personal feelings with a person who was independent of their immediate workplace.

### **2.16.3 Developing the categories**

Mapping the data from the interviews and observation periods was an important task. In this study, principal data were derived from the interviews



and the observations. It was therefore necessary to assemble tables and grids to assist with the clustering of information (appendix two provides examples of clustering of information) and eventual formation of themes (appendix three identifies the themes). In addition following each interview I highlighted the words and phrases in different colours (appendix one) that I believed were relevant and assigned numbers. The numbers in each transcript were applied as a footnote for ease of coding as seen below.

1. No one tells us/don't know themselves/don't think there is a lot of knowledge – Red bars
2. Question/quizzing/at home – Brown bars
3. Not given a role/extra pair of hands/not learn/role of a student/student role/supernumerary/ needed on the ward – Blue bars
4. Observations/clinical skills – Silver bars
5. Staff nurse role/real nurse/auxiliary – Purple bars
6. No teaching/learning opportunities/teaching – Green bars
7. Support – Yellow bars

By this stage I found I had an enormous amount of information, but after careful consideration I managed to assign categories to the data.

These were:

- Understanding and learning boundaries
- Preparing to enter the profession
- Understanding and bridging the theory-practice gap
- Clinical support
- What is a student nurse role?
- What is the registered practitioners' role?

Following the categorisation of the information I re-read the entire interview and field notes that I had collected. Then through looking at the categories I managed to formulate the central themes, this stage proved to be exciting and interesting.

### **2.17 Developing the themes**

The themes that emerged are listed below:

- Learning to be a student
- Fitting into the clinical team
- Being professional
- Being a real nurse
- The role of the practice development co-ordinator
- Effective mentors
- Reflecting in practice
- Developing clinical skills

Although I had questions in mind that needed to be answered and discussed, the information that I had gathered had provided a diverse amount of material that not only related to the central questions but also raised more issues. Possibly one of the most surprising themes to emerge was that of clinical skills. I had not realised the importance that had been attached to these by both the students and registered practitioners. Indeed, the whole issue of clinical skills underpinned the themes of the role of the student nurse, progression from student to registered practitioner and fitting into the team.

Lincoln and Guba (1985) identified this phenomenon as being probable in a case study. In fact, they recommend that the first draft be a 'draft dump,' in which all the data, even those of presumably marginal relevance, are included. They argue that this is due to specific inclusion-exclusion criteria being virtually impossible to formulate in advance and until the writer has seen

at least a first draft he or she is not competent to make a solid relevance judgement. As when I first read and re-read the data I had collected, Lincoln and Guba (1985, p.365) state that the first draft is likely to be a surprise to the writer '*who will not have imagined it in just that way when the writing began.*'

What had to be remembered during the fieldwork and subsequently the analysis process was the issue of bias. I had entered the field believing that I held no preconceived ideas of answers or activities the participants would partake in. However, a certain element of bias did arise when participants did not behave in the way I perceived they would. Therefore, it was imperative that during the analysis stage I '*stepped back*' and examined the data objectively, by questioning words and phrases that were given and reviewing their meanings several times.

The data, interviews, observations and to a point my own personal interpretations of the data collected, were examined and interpreted carefully over several periods of time to allow for common and variable themes to emerge. At first I looked at the data in a very general sense and began to separate themes into groups relating to the staff I had interviewed, but after further more in-depth analysis, I realised that many of the themes actually cross linked together and I was then able to formulate definite themes. This analysis allowed for a comparison and classification of the information to provide a conceptual mode of analysis as described by Strauss and Corbin (1998).

This classification provided a grouping of concepts containing similarities and differences that would aid in the development of a theory. Comparison of the data enabled identification of variations in the patterns of the data. This was

particularly important when attempting to ascertain whether or not the registered practitioners actually believed that the new nursing curriculum was making a difference to how the students performed and fitted into in the clinical areas.

I was aware that generalization of case study findings is limited to the case itself or types of cases. However, attention to selected details enhances the analysis and increases clarity of reasoning. According to Yin (1994) analysis hinges on linking the data to the propositions and explicating the criteria by which findings are to be interpreted. While generalization limits the use of case study method by some social scientists, Yin (1984) further argues that theoretical generalization is to the domain of case study, what statistical generalization is to the true experiment. An important technique used to incorporate rigor into the study design is the use of the negative case to serve as a study "control". The use of the extreme case, the deviant case, and the normal case are helpful for making points of comparison.

Stake (1978) focuses on context-specific or "naturalistic" generalization. Such an approach resonates with readers' tacit knowledge, which helps people make connections and associations without the benefit of words. It is believed that people have the capacity for this kind of knowledge, and from it they build understandings. In this study, major themes emerged as focal areas of the analysis. One of the main factors was the practitioners and students perception of the importance of clinical skills development and how these impacted upon the student nurse role. This factor linked much of the information collected together particularly as it became apparent that the students ability to be able to effectively perform certain clinical skills related to

whether or not they fitted into the team and in addition they became a measure of how competent the student was in their ability to be able to perform their role while in placement.

### **2.18 The audit trail**

Lincoln and Guba (1985) regarded audit trails as one of the principal techniques for establishing the 'conformability' of qualitative findings. Cutcliffe and McKenna (2004) state that Lincoln and Guba drew heavily on a PhD dissertation by Halpern (1983), whose study was influenced by mathematical audit or audit of fiscal accounts. According to Halpern (1983), this audit algorithm could be used for all forms of inquiry. It identified six categories of information that could/should be collected to inform the audit process.

1. Raw data
2. Data reduction and analysis products
3. Data reconstruction and synthesis products
4. Process notes
5. Materials relating to intentions and dispositions
6. Instrument development information

Lincoln and Guba (1985) highlighted that not all of these six categories may be appropriate to qualitative studies arguing that auditors may not be consulted until the study is virtually complete and that there may be utility in waiting until the end to avoid the possibility that the auditor may be co-opted. Cutcliffe and McKenna (2004) state that the most crucial and often most problematic stage of this audit process is the assessment of conformability. They quote Lincoln and Guba (1985, p.323) who describe sub-steps to this process, for example:

*'Ascertain whether the findings are grounded in the data - a matter easily determined if appropriate audit trail linkages have been established.'*

Based on this information the auditor will be able to make an independent assessment of the study and as a result will be able to confirm the findings reported.

Within my study I used interviewing and observational techniques to collect the raw data. Data collected during the observational periods influenced the interviewing schedule with the students as they often referred to activities that had occurred during the observation period. This allowed for the incoming information from the participants to sharpen the focus of the research questions and related general questions (Strauss & Corbin, 1994), indeed this is one of the underpinning philosophies of the general techniques of grounded theory that I used. Furthermore as it was an unstructured interviewing technique being used the questions were open ended, again abiding to the grounded theory methodology of limiting influence on the participants from myself as the interviewer. The interview data was transcribed and analysed following the interview as the incoming information determines the information sought, referred to as theoretical sampling (Strauss & Corbin, 1990). I do recognise that theoretical saturation was not achieved in this study as I was using principles of grounded theory rather than grounded theory in its purest form.

The raw data from the interviews and observations was reduced following Miles and Huberman's (1984) suggestions of data reduction, data display and conclusion drawing. Data reduction refers to the process of selecting, focussing, simplifying, abstracting and transforming the data as the

researcher elicits meanings and insights from the words of the respondents (Marshall and Rossman, 1989). As discussed earlier I tape recorded all the interviews (with the participants permission) and transcribed them myself. I read and re-read all the data several times to familiarise myself with the data. I initially numbered each line of the interview data to allow cross-referencing of each interview. I highlighted words and phrases that related to one another and then re-read the data again to ensure that nothing had been missed and to keep track of multiple ideas ensuring that the overall intent of the data was maintained (Field & Morse, 1985). Following the colour coding process I was able to assign categories to the data that then allowed for me to re-visit the data and to further develop the categories into the emergent themes. Throughout this process I continually challenged and questioned the emerging patterns searching for other plausible explanations of the data (Marshall and Rossman, 1989). In line with recommendations from Strauss and Corbin (1990) I asked myself “What is happening in the data?” and “What action does each particular happening, incident, event or idea represent?” These two questions aided in developing the categories and themes.

In addition to this questioning I discussed the data with my supervisor to ensure that I was not inadvertently developing themes that were not there. Preliminary results of the data analysis have been presented at national and international conferences that allowed a discussion to develop surrounding the themes from parties that were not involved in the collection of data. Throughout this data analysis stage of the interviews I referred to the observational data I had collected to maintain development of the data. The participants own language was used at all levels of the coding process with

each word and relationship being referenced to the interview transcripts. The purposes of this qualitative study had been to investigate the effect of PBL in relation to the theory-practice gap and if there had been any effects of PBL and the associated curriculum on the students' experiences in clinical practice. Following data collection and analysis the focus of the study changed, consequently new areas became under investigation. The participants introduced concepts of professionalism, power and equality that led to the formation of a discussion surrounding the socialisation of student nurses in clinical practice with the identification of clinical skills proving to be the issue that linked the data together.

The concepts of professionalism, power and equality will be discussed and explored in future chapters. The next chapter will discuss the analysis of the fieldwork data and the themes that were developed.



### **Chapter Three**

#### **Preparing student nurses to enter the profession**

In this chapter I will discuss the themes that have arisen from the interviews and observations in relation to how students learn to be effective in their clinical roles. Given that it was my original aim, I will explore the influence that the new curriculum and the strategy of PBL may have had on them undertaking their clinical role. However, from the outset we must recognise that any conclusions in this respect are very tentative. The important features of the chapter will be how students and their ward based mentors appear to experience practice-based education and the contribution this makes to their socialisation.

Whilst my analysis was painstaking, and I have accounted in some depth in chapter two for the methods I used to collect, transcribe and analyse data, I nevertheless feel that qualitative, ethnographic, case-study type research is best presented in as readable a format as possible. To this end I have followed the tradition of Hammersley and Atkinson (1983) and not allowed the intuitive aspect of qualitative analysis to be overcome by too much reliance on audit trails for each specific theme. The data speak for themselves, and it is up to the reader partly to accept the responsibility for deciding the credibility of my argument.

I have used sub-headings have been used to identify the various themes. The interviewees have used the terms auxiliary, health care assistant and care assistant interchangeably and I have documented the term they use. They are using these terms to describe staff that do not possess a registrable professional nursing qualification; however, some of these staff members may

hold a National Vocational Qualification (NVQ) in health care at either level two or level three; when I refer to this grade of staff I have referred to them as unregistered staff. All the names of the interviewees are pseudonyms to maintain confidentiality. Following each interview excerpt is the name of the interviewee and their status. Student interviews are followed by their year and semester of study; qualified practitioners are followed by their job title and whether or not they are a mentor. This allows the reader an appreciation of the experience they possess.

### **3.1 Development of clinical skills**

One theme that emerged from the interviews with all participants, and underpinned our discussions, was that of clinical skills. The ability to be able to perform certain skills was viewed, by the students and registered practitioners, as being evidence that the students were competent and knowledgeable.

**Table 3.1 Examples of clinical skills**

Recording of vital signs
Injection administration.
Wound dressings.
Catheterisation.
Administration of Intra-venous fluids.
Communication.

The clinical skills that the students did not perceive as being a worthwhile part of their role, but was a role of the unregistered staff member included:

- Personal hygiene needs of patients
- “Toileting” – a term applied to assisting patients to and from the toilet or onto bedpans and commodes.

The registered practitioners believed that the clinical skills of venepuncture and cannulation were 'enhanced' roles of registered practitioners and they did not view these as essential skills of the student nurse. Samantha, a mentor, stated that:

*'It's all well and good them (the students) telling us they want to practice cannulation and taking bloods, but that's not their role when they are here.....they need to be doing the basic things, like feeding patients and bedbaths...'* (Samantha; mentor and staff nurse).

However, the students believed that these were important skills that they should be competent in, and be allowed to perform in their role as a third year student nurse. The students considered that these skills were needed to help them progress in their development as competent registered practitioners.

Adele explained:

*'Now we are in our third year the lecturers have taught us how to perform extra skills like venepuncture and cannulation.....but when we get on the wards they (the registered staff), won't let us do them. If we can't practice them then how can we learn how to do the staff nurse job properly? I think the staff are frightened that we know more than them!'* (Adele: Year 3; semester, 1).

Table 3.2 identifies the clinical skills the students learn throughout their training period within the school of nursing used in this study.

**Table 3.2 Clinical skills taught in the school of nursing**

- Hand washing
- Moving and Handling.
- Cardio-pulmonary resuscitation
- Venepuncture
- Recording of temperature, pulse, respirations and blood pressure.
- Cannulation
- Recording of electro-cardiograms
- Male and female catheterisation
- Personal hygiene needs
- Skin care
- Oral hygiene
- Serving meals and feeding patients
- Wound care
- Bandaging
- Collection of specimens
- Urine testing
- Testing blood glucose levels
- Measuring height and weight
- Injection technique
- Disposal of sharps
- Caring for the dying patient and last offices
- Care of the unconscious patient
- First aid
- Administration of medication
- Drug calculations
- Elimination needs
- Care of the patient with an intra-venous infusion
- Pain management
- Prevention of infection and cross infection
- Communication skills

I will explore how the students and registered practitioners differed in their perceptions of essential clinical skills throughout this chapter.

### **3.1.1 Knowledge**

The '*knowing how*' to perform a task within the clinical environment was seen to be more important when assessing a student's ability to that of '*knowing that*'. Benner (1984) considered the distinction between *propositional knowledge* and *practical knowledge* in depth. Propositional knowledge is the

ability to know how to perform a task either with or without the underpinning knowledge; for example, you may watch it being performed and then know how to perform it. She argued that practical knowledge differs in kind from propositional knowledge and that this knowledge amounted to the success in the performance of an activity, for example, the successful administration of an injection. The principle of the skill can be learnt in the classroom prior to observing it in the practice area, however, it is difficult to relate it to a patient at this time and therefore it is viewed as an '*abstract principle*'. Only when the student in practice applies it, do the theory and principles acquire some content. The student tends to focus upon specific aspects of a situation rather than assessing the whole, and as Benner (1984) states 'nursing is 'not procedural but holistic'.

It is not until the students have developed the ability to be able to link theory to practice and gained a certain amount of experience and confidence within the clinical areas that they are able to view the patient and the situation in a holistic fashion. This was supported through the interviews with the students who were eager to practice clinical skills while on placement regardless of whether or not they had received and understood the underpinning theory. For example, the first year students were keen to take and record the vital signs of patients, such as temperature, pulse, respirations and blood pressure, while in the clinical areas, despite not having being taught the theory to underpin the procedures in the school.

### **3.1.2 Salience**

Benner (1984) introduces the idea of 'salience' with the suggestion that the '*expert*', in the monitoring of a situation is able to home in on clinically salient

areas, whereas the 'novice' may be able to perform the task but will be unable to explain why they have done what they did. The students perceived that their level of knowledge was based upon their abilities to be able to undertake clinical tasks successfully with or without the underpinning knowledge to support their actions. It is important to note here that when Benner was referring to the novice to expert continuum in her work she was discussing registered practitioners; however, I do believe that these principles may also be related to the educational levels of student nurses for the purpose of my research. This was clearly exemplified through an interview with Louise, a first year student nurse who stated that:

*'If the sister asks me to set up a dressing trolley I will say OK, then go and find someone else to show me what to do and then go back to her [the sister] with it, so I don't look silly in front of the sister'. (Louise; year 1; semester 1)*

### **3.1.3 Theory versus practice**

Edwards (2001) refers to the influence of Plato on the acquisition of knowledge stating that each component or step of the clinical skill has an equivalent proposition. This is then mentally grasped by the actor and leads to the relevant step in the series of acts, which completes the larger act. So on this model, giving an injection will involve the assumption that the task as a whole is composed of smaller, discrete steps for each of which there will be an equivalent mental proposition. What distinguishes the person who can perform the task (the expert) from one who cannot (the novice) is that the former has the internal manual and the latter does not. This model suggests that there is a sharp distinction between theory and practice i.e. theory is one's knowledge of the mental propositions and the practical tasks are those

which one is engaged in therefore theory precedes practice. When one administers an injection it is necessary to first learn how to prepare for and perform the skill. However, what we should remember is that levels of theory and depth of knowledge will vary between participants.

The students believed that the knowledge base they required was simply to understand the practicalities of preparing the injection and administering it. What they failed to appreciate is that they also needed to be aware of the anatomy and physiology of the skin; pharmacology; technical knowledge of the syringe and needle and drawing up of the injection in a safe manner.

Samantha, a mentor claimed that:

*'As mentors our role is to supervise the students performing the clinical skills. I think that it is up to the lecturers to teach them why they are performing them and to give them the theory before they come to us. We don't have the time in practice to do all the teaching'. (Samantha; staff nurse and mentor)*

Ryle (1949) disputes this model and suggests that considering mental propositions is itself an activity, although Ryle's work is not specific to nursing his concepts can be applied to a caring environment. The supposed relationship between activities and propositions cannot go on forever; at some point we must simply act without actions and being prompted by consideration of an 'inner' mental proposition. There is a clear sense in which practice is given priority to theory, many theories of nursing follow from the practice of nursing therefore, such actions cannot be theory driven. For example, concurrence of best practice states that one of the nursing actions that must be taken to prevent a pressure ulcer developing is to relieve pressure (Norton *et al*, 1962). Therefore, as Walker and Avant (1985) claim, the essence of practice theory is a desired goal and prescription for action to meet that goal.

Jacox (1974) described practice theory, as being the actions a nurse has to take in the clinical areas to produce a change or to affect the condition of the patient.

### **3.1.4 Knowing how**

The final component, that of a nurse's judgement, may be related to the work of Benner (1984) in her discussions regarding 'knowing how' to perform a particular task and the work of Schön (1983), who described reflection-in-action, where problems are solved for practice through informal theories that are constantly being tested, modified and retested in the clinical areas.

This assumes that any set of mental propositions which generated nursing actions constituted a theory, therefore, mere knowledge of a relevant set of propositions (a theory) is not sufficient for knowing how to perform a particular activity, for example, the student may be able to discuss all the steps required to administer an injection but physically cannot carry out the task. This clearly demonstrates that 'knowing how' does not necessarily precede successful carrying out of the task. It is difficult to directly relate Ryle's work to nursing, although some areas are practice based, there is also the concept of accountability for all registered practitioners that suggest each registered nurse must understand the theory prior to engaging in nursing care.

Furthermore the Nursing and Midwifery Council (2004, p.16) state that:

*'You must keep your knowledge and skills up-to-date throughout your working life. In particular, you should take part regularly in learning activities that develop your competence and performance. You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional. You have a duty of care to your patients and clients, who are entitled to receive safe and competent care.'*



### 3.1.5 Preparation for clinical skills

I asked the students how well they felt they had been prepared within the school to undertake their role in the clinical environment. They all discussed the issue of clinical skills and believed that they should be taught a wide range of them prior to going into practice rather than being taught areas such as biology, sociology and psychology. Louise a first year student described how she felt:

*'To be honest, I don't think we have learnt a lot from the lectures like some of the biology ones.. .....I need the really basic stuff and things that we are going to see on the wards, you know practical things. We need to know how to do blood pressures and things like that'. (Louise; year 1; semester 1)*

This was a rather interesting observation from Louise, as she appreciated that the theory she was learning was correct but she believed she required the practical skills to allow her to 'fit into' the team. The students wanted to fit into the team and wanted to learn how to become a registered practitioner and as such were reluctant to question practitioners on how they performed certain duties. This phenomenon may be related to the concept of a rite of passage for the students. Their practice in the clinical areas mimics that of their role models, the permanent staff, the students want their own knowledge and skills base to develop as a result of attending the practice placement areas. They also want to be accepted as a valued member of the team who will become an asset to the clinical areas when registered. They understand their own social standing in this group and the boundaries associated with it, so despite the fact that they may have a more developed knowledge base of theory they are unwilling in their student role to upset the status quo in their placement areas.

Julie, a second year student, echoed the views of Louise in her interview stating that:

*'Well I thought the first year for teaching [in school] was not very good because we did not learn how to do blood pressures, injections or anything like that before we went onto the wards. I usually end up doing a load of auxiliary work, like the washes and giving out drinks when there are other things you would rather be doing and learning, you tend to miss out because you are doing the basic care rather than expanding your knowledge as a student should'. (Julie; year 2; semester 2)*

### **3.1.5 Auxiliary work**

I asked the registered practitioners what they thought was the role of a student nurse while on placement. On the whole they said that it was to learn and for the student to be able to apply theory to practice while becoming competent in performing clinical skills.

Claire, a ward sister and student mentor explained:

*'I feel that our role [mentors and registered staff] is to give the students practical experience and skills, like supervising them changing an I.V. bag of fluid. They know the principles but have never done it to a real person, a patient in a bed. That's our role to provide the link for them and to develop their practical skills'. (Claire; ward sister and mentor).*

Marion, also a ward sister and mentor believed that while the students were on placement they were: *'A valuable asset who can help us [permanent staff] when the ward is busy and can go and do the obs for us when we are busy with other things'.*

Interestingly, both students and registered staff distinguished certain clinical skills as auxiliary work, for example, washing patients; generally the students stated that:

*'We are here to learn and not just do the auxiliary job, I mean I know the washing is important but you have to develop clinical skills like*

*wound dressings, recording of vital signs and drugs rounds to be able to do a staff nurse job'. (Students; Years 1 and 2; semester 1 and 2)*

Marion was the only mentor who highlighted the value of learning and undertaking 'basic nursing care skills' and she identified that it was important that the students understood the role of each member of staff while they were on placement because:

*'When the students have completed their training the care assistants will be able to do the basics but you have to know how to do everything, they have to learn from the bottom up and learn to give holistic care by looking at all the people from the auxiliary nurse through to the ward manager'. (Marion; ward sister and mentor).*

### **3.1.6 Acquiring knowledge**

It would seem that the acquisition of practical knowledge and the ability to be able to put it into practice makes the students feel as though they are undertaking their role effectively and that they are becoming a valued member of the team. The need to understand the underpinning theory is seen as secondary to the ability to be able to perform the task unsupervised. They have all perceived nursing to be a practical discipline that does require some evidence of knowledge to underpin the execution of the skill effectively, but the actual 'doing' of the skill is seen to develop them into efficient nurses. Rather than the 'knowing why', they are performing the skill. The students have obviously developed an insight into what they perceive will be the role of the registered practitioner. This urgency to acquire clinical skills would appear to be the catalyst that makes a 'real nurse' in the clinical environment. Yet the students understood the importance of possessing the underpinning knowledge as their comments have demonstrated. It is apparent that the students themselves have developed their own perceptions of which

boundaries exist in the clinical areas and have identified that one is the ability to be able to perform clinical skills.

### **3.2 Learning to be a student**

When the students enter their clinical placement areas they anticipate that they will be offered the opportunity to develop and enhance their knowledge and skills base to prepare them for their registered role of the future. At the same time they understand that they must also learn how to be a student and to become an accepted member of the ward team. The issue of the students' ability to be able to competently undertake clinical skills assists them in being able to socialise into this role and to overcome boundaries.

Adele, a third year student explained:

*'When I was a first year I was shown how to do the obs and other skills by the auxiliary and that was good because I could talk to her and ask questions, without feeling daft. Now I am a third year I can teach the junior students and the auxiliaries how to do those things, but the difference is I understand why we do them `cos I am training to be a staff nurse'. (Adele; Year 3; semester 1).*

The students believed that as they became more experienced they would naturally develop the underpinning knowledge base. It was interesting to note, that as the students progressed through their training the importance of the types of clinical skills to be undertaken changed. For example, as the students advanced through their third year, they wanted to undertake enhanced clinical skills that included the recording of electro-cardiograms (ECGs), venepuncture, cannulation and male catheterisation. These skills had been taught to the students in semester 1, year 3 in the school and the students were eager to practice them in the clinical areas. Both the unregistered and registered staff on the wards performs these skills provided that they have

undertaken the appropriate training. The registered practitioners, during the interviews, did not particularly believe that it was necessary for the students to undertake these skills during their placements. Instead, they felt that they could develop these skills when they had registered.

Marion, a ward sister, explained:

*'I know the students are taught these enhanced skills in school, but we have staff that have been specially trained to do them on the wards..... Some of these people are health care assistants who could not assess the student doing them. It's better that they wait until they are registered then they can do the Trusts training programme and be assessed properly'. (Marion; ward sister and mentor).*

This exemplifies that the ward staff are aware of the skills that the students are learning. However, as some of these skills have been delegated to the unregistered staff it is difficult for the mentors to assess the students' competency levels in undertaking them. Some of the registered practitioners on the wards had not undertaken the training programmes to enhance their skills and, therefore, they relied on the medical staff to perform certain skills, for example, cannulation and male catheterisation. Samantha, one of the mentors informed me:

*'I think it is a good idea that they [the students] learn these skills but it is difficult for some of the mentors to help and advise them as we cannot do them ourselves'. (Samantha; staff nurse and mentor).*

The availability of mentors trained to perform these enhanced skills was an issue for the students who wanted to undertake them. The Intensive Care and Coronary Care units had encouraged their staff to undertake the training and perform these skills. It was the general medical and surgical wards where the majority of staff had not undertaken the requisite training. The students themselves found this to be a problem when attempting to develop their skills

base. They were disappointed that they could not use the skills they had been taught and develop their practical knowledge in the clinical areas.

Adele, a third year student explained:

*'When we were in school we got taught how to take blood, record ECGs and perform male catheterisation, but when we get on the wards they won't let us do it' (Adele; year 3; semester 1)*

This is a valid point if the school is teaching the students certain clinical skills should the clinical staff then not be ensuring they can perform these skills as well? It would appear that the students have a more in-depth knowledge base of enhanced skills, at this stage of their training than some of the registered practitioners. It may be fair to say that their social status has risen in this area and they could, in fact, teach the registered practitioners how to perform these skills. This would then lead us to believe that the students are becoming more equal and powerful in the clinical areas. These concepts will be discussed in more detail in the next chapter.

### **3.2.1 Knowing About Nursing**

We have to question whether nursing is a purely practical profession or would it be more correct to say it is in fact a science with practical aspects? There are a variety of descriptions for the concept of science; there are some who see it as an end in itself, science as contemplation. Science does what it does for the sake of science, i.e., to increase knowledge about the world. Others take a less pure view and see the purpose of science as being about the way in which scientific facts can be applied to problems in the world. When we compare this to nursing we can note that nurses spend a lot of time 'nursing' and therefore when we talk about nursing science we mean one theory that

can be applied to nursing (Reed and Ground, 1997). What we need to do is distinguish between '*knowing about nursing*' and '*nursing knowledge*'.

Nursing knowledge may be defined as the knowledge, information, or understanding that nurses need to do the job e.g. how to perform a wound dressing or record a blood pressure. *Knowledge about nursing* is knowledge about the job itself. The way nurses manage their tasks, the way they are constrained or enabled by various factors and their aims and aspirations. Both types of knowledge are important and to a point interrelated (Reed and Ground, 1997). Through the interviews, observations and data analysis I have seen that this is evident. Students believe that they possess *nursing knowledge* if they are able to perform the clinical skills effectively, they are not as concerned about *knowledge about nursing* when they are within their placement area, this they believe will be shown to them when they register and become a permanent team member.

During the interviewing of the students I asked them what action they would take if they were asked to carry out a task that they were unsure about or that they had not witnessed before. The replies were interesting:

Joanna, a second year student, explained that:

*'They [the registered staff] expect you to just get on with it, sometimes when you ask how to do something or why you are doing it, they say "I'll do it myself" because it is quicker than having to explain it to me. They don't really have time to show you how to do things so I just do whatever it is because it's a task and then read up on it when I get home or ask when we are in Uni'. (Joanna; year 2; semester 1).*

### **3.2.2 'I'll do it myself!'**

This concept of '*I'll do it myself*' was rationalised as acceptable by Joanna as she believed that the staff were too busy to spend time explaining procedures

to her when the clinical areas were busy. However this contravenes the NMC's (2004, 4.3) Code of Professional Conduct which clearly states:

*'You must communicate effectively and share your knowledge, skills and expertise with other members of the team as required for both the benefit of patients and clients'.*

The Code of Professional Conduct is referring to all members of the team that includes student nurses. So despite the fact that practice areas may be busy due to clinical commitments it is an integral and professional aspect of each registered practitioners duty to share their knowledge with the students. Arguably we could assume that PBL has promoted the abilities of the students to seek out information and identify their own learning needs to such an established degree that they no longer require the knowledge or expertise of the registered practitioners to explain procedures to them. I would contend this and believe that the staff feel the teaching of student nurses, while the clinical areas are busy, is a task that they do not have the time to undertake and as such they do it themselves to ensure that the procedure or task is carried out in the fastest time possible.

The notion of *'I'll do it myself'* has been studied by Johnson *et al* (2004) in a research project exploring the role and accountability of Senior Health Care Support Workers (SHCSWs) in intensive care units. They discussed that the reluctance to delegate may in part be due to the issues of responsibility and accountability. The registered practitioners' perceptions of the SHCSWs were that they were there to assist the registered nurses. The registered nurses felt that they would be accountable personally for any errors that were made by the SHCSWs, both to their employer and the Nursing and Midwifery Council. The issues of responsibility and accountability may well be one of the reasons



why registered practitioners are reluctant at times to delegate certain duties to the students. The *Code of Conduct* (NMC, 2004) makes explicit that the registered practitioner may delegate to other members of the team but that they will remain accountable for the appropriateness of that delegation.

Although the students do not always feel that they are being taught the underpinning knowledge in the clinical areas, there is a clear sense from them that they feel well supported by the University. They do not worry too much if they have to seek out the knowledge themselves; they are becoming quite self-directed in developing their own knowledge and then discussing it with their facilitators in the school or with the practice development co-ordinator.

Sarah, a first year student stated that:

*'The practice development co-ordinator is really good. She teaches us how to do things, like blood pressures and giving oxygen, you can ask her questions and she will explain things that then help to make sense of the skills you have done on the wards. You don't feel daft asking her!'* (Sarah; year 1; semester 1).

In respect of being taught the rationale behind performing certain procedures and developing their confidence they believed that it was the practice development co-ordinator who delivered the information. Julie, a third year student explained:

*'She [the Practice development co-ordinator] holds skills teaching sessions that we [the students] all enjoy because she teaches us the reasons why we do things. The ward staff just expect us to do it and do not explain why we are doing it.'* (Julie; year 3; semester 1).

The students perceived the practice development co-ordinator to be a person who they could confide in, as she was not directly related to the clinical areas where they were working. They believed that they could openly ask her questions and it would not affect the successful completion of their practice documentation.

### **3.3 The role of the practice development co-ordinator**

The Practice development co-ordinator was a role developed in line with the recommendations laid down from the *Making a Difference* (DoH, 1999a) and *Fitness for Practice* (UKCC, 1999) documents. The approach developed at this Trust has been to employ a practice development co-ordinator to oversee the learning environment and to support the mentors in practice. She has provided a strong link between practice and the university to discuss various student-based issues. Her role has allowed for an effective collaboration between the two sectors. For example, the practice development co-ordinator and a member of the academic staff, who has responsibility for liaising with this group of staff, meet on a monthly basis. They discuss student and strategic issues. These meetings provide a forum, through which both the practice and educational sectors can discuss any problems and new ideas, thus producing a collaboration of both areas for future developments. Prior to this post being implemented the academic area relied heavily on feedback from students and practitioners regarding any practice issues. The feedback was collected after the students had completed their placement areas, whereas, these problems can often be dealt with at an earlier stage thanks to the input of the co-ordinator.

Criticisms of the old curriculum had included that students and staff did not feel well supported in the clinical areas. They claimed that while in the school of nursing they had support from their personal teacher but in practice they did not feel that they, apart from their mentor, had anyone they could approach regarding questions about education and placement allocations. There was also an apparent void of communication between the school and

practice areas as there was no named individual who could be contacted to discuss various student issues. The whole philosophy of the new curriculum was to strengthen the partnership between the key stakeholders.

### **3.3.1 Development of the role**

The post was intended as a support for the student nurses on placements, for practitioners and to aid in the development of the clinical learning environment. The person was employed in the post in January 2001 and the current post holder has been working in the Trust since that time. The model used to progress this role is one that focussed upon practice. It should be highlighted here that various Trusts around the country have adopted different models for this post and my discussions focus specifically upon the chosen one for this Trust and may not be directly related to others.

Senior staff from the Trust explained that:

*'We wanted a model that focussed upon practice, it was about taking education back into practice and not out of the university or the education department but about nurses on the shop floor.'* (Senior nurse for practice development).

There was a realisation that there would be significant challenges during the first twelve/eighteen months of the implementation of the new curriculum particularly in supporting the registered practitioners with the transition from the old to the new curriculum.

The senior nurse for practice development rationalized that the Trust saw the practice development co-ordinator as being someone:

*'Who would have two primary focuses, one was to work with the registered staff in clinical areas and develop them as mentors, working with them around the curriculum, supporting them as clinical guides, helping them to understand the concept, supporting the wards with issues around placement allocations, trouble shooting and delivering the mentorship programmes. Equally the role was to support students*

*and to be a key link so that when the students required any questions answering or needed clarification of any issues they had an identified person to liaise with based on their own home Trust site'. (Senior nurse for practice development).*

The development of the role is currently under discussion by members of the Strategic Health Authority (Commissioners), who themselves have just taken over the employment of these people rather than NHS Trusts employing them individually. The role in its current form has been accepted and viewed as a positive addition to the support of the students from both the practitioners and the students alike. During the interviews the participants discussed the role of the practice development co-ordinator and how has the role affected the education of student nurses in the clinical areas and how it had developed since she came into post. All the interviewees were aware of the role of practice development co-ordinator; however there were different conceptions of what the role entailed and how this person should function. All of the interviewees believed that the role was beneficial to the students and the registered practitioners. The following section will discuss the data collected from the interviews and observations regarding this role.

### **3.3.2 Promoting clinical support**

On the whole, the students perceived this role to be one of support for them in developing their own clinical skills and someone who they could approach for help and guidance in a confidential manner.

Jane, a third year student nurse explained:

*'She [the practice development co-ordinator] has encouraged and initiated a lot of training sessions and has taught me more than other people have. I think she is more like a clinical guide; she is there when you need her she is a support for us [the students]. I have found her approachable and a resource for us'. (Jane; year 3; semester 1).*

Maria, a second year student, echoed these views stating that:

*'She (the practice development co-ordinator) has helped me to develop my confidence through the teaching sessions she has held in the clinical skills lab, because I can learn the skill and then go straight back to my placement area and practice them She is also someone that I can go and talk to about things that are happening on the ward and I know that she will try and sort them out for me'. (Maria; year 2; semester 1).*

The mentors and ward managers also felt that this role was beneficial to them as it created a link between the practice areas and the university, which in the past they felt they had not had. One of the ward managers interviewed commented that:

*'We now have a link with the university, before this post there had been a gap and we had no-one to go to, she can help us to sort out problems and knows who to contact in the school'. (Christine; ward manager).*

Another of the ward managers believed that the role had positively impacted upon her own role when planning for the students' placements as the practice development co-ordinator ensured that the clinical areas received prior notice of the students' arrival and this, therefore, allowed them the opportunity to allocate mentors and to plan induction programmes.

She stated that:

*'I think that before she was in post things were a bit haphazard, students would turn up and we did not know that they were coming. Our student evaluations have improved because of her [the practice development co-ordinator], and everything is more structured for the students'. (Susan; ward manager).*

It would appear that this role has helped the clinical areas to be able to plan for the student's arrival and has offered support to the students, mentors and ward managers in dealing with problems. The practice development co-

ordinator herself has seen the role develop in the twelve months that she has been in post. She explained that the verbal feedback she has received has shown that there has been an increase in registered staffs awareness of student issues and that staff on the ward have taken an active role in developing orientation and teaching and learning packages for the students allocated to their areas.

The practice development co-ordinator has also introduced monthly 'drop in' sessions for the students, where they have the opportunity to discuss clinical issues with her and with their own peers. The students' written evaluations of these sessions were positive, stating that they were given the chance to *'share experiences and feelings in a safe environment and reflect on situations they had been involved in'*. Many of the students stated that they felt they could discuss sensitive issues in these sessions, as the practice development co-ordinator was not involved in evaluating their clinical practice or completing their practice assessment document.

Margaret a first year student stated that:

*'I don't like to keep pestering the staff as they are all really. The practice development co-ordinator is useful because I can ask her questions when we meet and she has the time to explain things to me'.  
(Margaret; year 1; semester 2).*

The notion that the clinical staff were always busy and that the students did not want to be constantly asking them questions was a theme described by all the students at some point during their interviews with me. The students often referred to the support that they received from the university and their own abilities to be able to self-direct their learning helped them to meet and develop their learning needs. The students were aware that they were

'visitors' to each of the wards they were allocated to and as such were aware that there were boundaries that they had to appreciate and overcome. The role of the practice development co-ordinator has been one vehicle that the students have been able to access and that has helped them with the passage through their education and training period.

### **3.4 Fitting into the team**

#### **3.4.1 Meeting expectations**

What became apparent during the data analysis was that the students wanted to be viewed as a valuable member of the ward team and wanted to 'fit in'. Therefore if they undertook the tasks allotted to them without question they believed that the staff would accept them. The students were striving to meet the expectations of their mentors and the ward staff while struggling to cope with how to develop their own learning needs, to fit in with the team and provide care that was evidence based. Marshall (1986) sought to understand stress from an ecological point of view and focussed one aspect of his work on the occupational stress of nurses. He found that stress arose around role expectations, especially with regard to the public and the patients. Coping mechanisms for dealing with stress were also studied and it was suggested that nurses manage within an organisation by seeing patients as illnesses and nursing as tasks that have to be done. This was exemplified during the interviews with the students who felt that were part of the team and 'fitted in' when they understood the ward routine. Furthermore, when the students and indeed the registered staff discussed teaching in the clinical environment they focussed on illnesses as the main area that they needed to learn and understand.

### 3.4.2 'Hands on' students!

Many of the staff interviewed thought that the students were now more practical as Liz, a mentor, explained:

*'They [the students] seem to have a totally different remit, they expect to get involved and want to be involved, they seem to have been given a different brief to come in and learn and to be able to do things under supervision that they feel they are able to do. There is such a big difference from previous students the school seems to be better preparing them for practice, it's wonderful!' (Liz; staff nurse and mentor).*

This was echoed by Rebecca another mentor who stated:

*'They [(the students)] seem to be more hands on, even though they are supernumerary, they want to do more and get more involved. Their attitudes are different.'* (Rebecca; staff nurse and mentor).

The inference that it is the attitudes of students that is changing is interesting. Rebecca is quite clear in her comments that these students are more 'hands on'. This change in attitudes has helped the students cross the boundary of being a student nurse who is on placement to a student nurse who is a valued member of the team. It is the notion that they are more involved in nursing care activities and are caring that has helped this transition. Leininger (1981) states that the central theme that nursing knowledge and nursing practice is based upon is that of caring. Indeed, Benner (1984) argues that nursing as a discipline has disregarded the knowledge that can be and is gained from the practice of nursing. She maintains that the main function of a nurse is to care, although she does not deny that cure is also foremost. Therefore, because the students want to care they are accepted and the staff choose to help them develop by sharing their knowledge and power allowing them an insight into the role of the registered practitioner.



### **3.4.3 Ever changing boundaries for student nurses**

It was as the students progressed through their training that they felt they were not learning if they were working alongside the unregistered staff. They believed that the knowledge and skills they now required surpassed the knowledge base of the health care assistants and that they had reached a higher social standing in the clinical environments. Indeed, what they were demonstrating was their own rite of passage from junior to a more senior student and moving their own professional boundaries. A part of this phenomenon may be the teaching in school. As the students progress through their studies they are expected to be able to discuss planning, management and evaluation issues of nursing care and to offer rationales for the choice of care. This is quite different to the first year where the students are taught the fundamentals of basic nursing care.

They had recognised that in their first year they needed to develop relationships with all grades of staff, especially those students who had had no prior caring experience. They witnessed the unregistered staff administering the basic nursing care duties and to a point managing the workload for a particular shift, i.e. the unregistered staff were ensuring that the physical needs of the patients were being met. If the unregistered staff accepted the students they were in essence becoming a part of a group whose skills were respected on the wards. In effect, the students were attempting to emulate the peer support in the clinical areas that they received in school from their base groups. Liberatore *et al* (1988) explain that in a small group each person is able to relate to every other group member and

that this helps in the problem solving process as each member of the group would be attempting to reach the same goal.

I asked the students if they felt they had developed their skills and knowledge base while they had been on their placement. The students on the whole felt that they had, especially in the high technical areas where they had worked with a registered practitioner for the duration of their placement. During my observation periods I noted that the students who were allocated to the high technical units, i.e. intensive care and coronary care units, worked on a one-to-one basis with their mentor and cared for one or two patients with the staff teaching at the bedside encouraging the student to link theory to practice. Whereas, on the general wards the registered staff numbers did not allow for this to happen and although the students did work alongside a registered practitioner for a period of their placement time, the registered practitioner was often called away to answer the telephone, answer queries, perform ward rounds etc. this prevented the staff from teaching at the bedside. However, Liz, a mentor stated that:

*'I try and teach the students as we go around the ward, looking after the patients or doing the drugs..... They will go away and look things up and then ask me questions, it makes me want to share my knowledge with them. They get 'stuck in' with the ward routine and seem like they want to be here.'* (Liz; staff nurse and mentor).

The registered practitioners felt the students did learn while on placement yet many of them stated that you never really learn until you qualify and that is why:

*'They [the newly registered staff nurses] all have a preceptorship period so that they know how we do things in our area'.* (Rebecca; staff nurse and mentor).

I can only conclude that the registered practitioners felt that students were to some degree apprentices and that they learnt by watching how things were done and then went away and did it themselves. Again we can see the split between the academic and clinical settings, as discussed by the staff in their interviews. The university is where the students learn and the clinical areas are where the students practice. The gap between theory and practice has not been bridged, but then I question should it be? If we did not have this gap then practices would not be questioned or new developments implemented leaving a status quo. The changes in the curriculum, promoting problem-based learning, must be viewed as positive. It should provide the student with the necessary skills to be able to question while in practice and in the academic area, but they should also possess the abilities to be able to solve problems for themselves rather than becoming reliant on academic and clinical staff to provide the solutions for them.

#### **3.4.4 Who should teach?**

The teaching of students was perceived to be a time consuming activity that only took place off the ward with a member of staff formally teaching the student. The concept of problem-based learning was seen to be a teaching and learning technique used in the school of nursing and not in the clinical areas.

All the students I spoke to explained that they did learn in the clinical areas, they learnt how things were performed in practice and they realised that there was often a difference between the idealism of nursing theory and the realities of practice. This was interesting because throughout my observations and interviews it had become apparent that although the registered practitioners

had stated that a part of their role was to teach and develop the students ensuring that they were fit to practice at the end of their training period. There was still a strong feeling that the school of nursing should be teaching the students all the underpinning knowledge to support their practice and that the school should also be teaching the students clinical skills prior to them arriving in the clinical areas.

The concept of a '*good student*' was someone who could undertake clinical skills without supervision and who would report any abnormalities to the registered practitioners, not a student who would ask to be taught a skill or who would say that they did not know how to undertake a certain skill.

This was intriguing as many of the mentors and ward managers had commented that '*we do not have enough time to teach*', which was seen in the discussions regarding '*I'll do it myself*'. Yet in the observation periods it was apparent that teaching was happening. The practitioners were explaining to students how to perform procedures or explaining why they were doing what they did. This was happening at the bedside rather than in a formalised teaching area, such as the resource room.

*Field Note: Intensive Care Unit; Wednesday 2pm. I have been observing the students now for just over an hour and it is interesting to note that they have remained with their mentor for that period. Mike (the mentor) has been constantly questioning the student regarding the patients care. He has asked her what the blood results stated yesterday and how they compare with today's results. The student has answered him and has made an excellent effort to plan his care using the information she has about the patient. She is motivated to learn and not relying on her mentor to direct her.*

However, the students and to some degree, the registered practitioners did not recognise this sharing of knowledge at the bedside as a legitimate form of teaching. It would appear that teaching is still perceived to be the domain of

the classroom and not the clinical areas. Staff and students struggle to recognise that practical teaching and establishing the students' knowledge base through linking the theory learnt to the practice is as equal as classroom teaching in developing the skills and understanding of the students. Benner (1984) recommended that it was the role of the experienced nurses in the clinical environment to facilitate the transition from novice to competent practitioner. Indeed Burnard (1990) referred to the mentor as an experienced practitioner whose role is was to guide and look after the student.

The aspect of teaching the students was not viewed to be an essential priority, but in fact many of the staff believed that staff from the university should come into the clinical environments and teach the students. Four of the mentors' interviewed reminisced about the previous role of clinical tutor. This post involved a member of the academic staff visiting the clinical areas, at a pre-arranged time spending a proportion of time with the students. During this time they would discuss various issues, practice clinical skills and spend the time with students caring for a caseload of patients. The mentors stated:

*'The clinical tutor was really helpful, we knew they were coming to the ward and that we could leave the students with them knowing that they were going to be taught how to do things. If there were any problems with the students abilities we could discuss with the tutor how to sort them out'. (Liz; staff nurse and mentor).*

They found that the post of practice development co-ordinator had been beneficial for the teaching and learning needs of the students as she offered formalised teaching sessions for all students to attend regarding clinical skills. The staff, perhaps, viewed the practice development co-ordinator role as a substitute for the clinical tutor role. Indeed, the senior nurse for practice development also believed that the academics should spend a percentage of

their time in the clinical areas not only teaching the students but also ensuring that their own clinical skills and knowledge were up-to-date.

*Field Note: Surgical ward, Monday morning: I have been sat observing in the bay for nearly 3 hours and the students have been busy making beds and chatting to the patients and between themselves. I think they have forgotten I am here! As the morning has progressed the 'tasks' have been completed and the ward is relatively quiet. The staff and the students are all having a coffee at the nursing station. What is most noticeable is that the ward is quiet and yet the staff have not taken this opportunity to teach the students, I thought they may have used this quiet period to perhaps explain common conditions etc to the students. I have to say that the notion of always being busy and being too busy to teach is not being fully supported during this observation period.*

### **3.4.5 Successful practice assessments.**

It was important to the students that they received a positive practice placement assessment and they worried that if they questioned practices too much their assessment documentation would not be successfully completed.

For example, Joanna, a second year, stated that:

*'I don't like to question the staff too much or they might think that I think I know more than them. At the end of the day I am only here for 11 weeks and it is important that I pass my assessment. I will be able to change things when I am a staff nurse and I will explain things to my students'. (Joanna; year 2; semester 1).*

Once again the students are describing the safe environment of the University. They perceive that they can instigate changes in practice through their facilitators and as such the student remains anonymous, thereby not disrupting the power relations in the clinical areas. Therefore, they rely on lecturing staff, who they see as being from the 'higher status' group to communicate with the ward staff regarding areas of practice that may require some development.

### 3.4.6 The routine

The 'ward routine' has become an important aspect for the students being accepted into the ward team and learning how to undertake their clinical role. The notion that they will get 'stuck in' helps the students to alleviate some of the problems of being a visitor to a ward. The questioning abilities of the students and the fact they will go and seek out knowledge for themselves reflect that the students are using some of the principles of PBL in clinical practice. They are clarifying their understanding by asking the registered practitioners questions and are attempting to link theory to practice. The need for students to become accepted as a part of team through learning the ward routine is by no means a new phenomenon (Melia, 1987, 1997, Olesen and Whittaker, 1963) but the fact that the students in this study are actively using the principles of PBL to link theory to practice establishes that they understand the importance of questioning issues while in clinical practice to further develop their own knowledge base. The students considered that PBL had provided them with the skills to be able to work through issues themselves and find solutions.

Jayne, a third year gives this account:

*'I try to break the problem down and address or work through the issues and see how they can be overcome...I don't think that the staff really understand PBL, like when they face a problem if they don't know what to do they pass it on to someone else rather than to try and work through it in a logical way.'* (Jayne; year 3; semester 1).

It could be argued that PBL has given some of the students the ability to be able to work through issues in the clinical area in a logical fashion, but this notion is one that will require larger scale systematic study in the future.

### 3.4.7 Making a difference

The students discussed that when they move into the 'higher status' group of a registered practitioner they will be able to make a difference but as students they are in the lower status group.

Carrie, a third year student, echoed this view:

*'I was introduced to my mentor on the first day and she showed me around the ward and explained what needed to be done before the late staff came on duty. I worked with her all morning and by the end I had a good idea of what needed to be done..... Halfway through my placement I knew I was working as a member of the team 'cos I didn't have to keep asking what needs to be done now'. (Carrie; year 3; semester 1).*

From the comments that Carrie made it was clear that once she had learnt the ward routine she felt as though she had 'fitted into' the team. Her knowledge base had changed by the fact that she was now comfortable with the routine and this made her feel a member of the team. It could be assumed that the ward routine affords a feeling of safety for the students, in that; they can plan their workload according to the routine and appear to be busy. This notion of always looking busy will be discussed in more detail later.

Carrie explained that she if she were asked to do something she had not undertaken before and her mentor was busy elsewhere she would ask another member of staff who would probably show her what to do, but sometimes the registered staff would do it themselves because it was quicker.. She said that if this happened she would read about it at home when she had finished that day or would ask her facilitator when she was in school. I pursued this line of inquiry and asked her if there were many occasions when the staff did not explain the reasons for carrying out certain procedures and why she thought this happened. She answered:



*'Well they are often very busy and do not always have the time to explain things to us. Some of the staff have said to me that I am here to learn what really happens in practice and that the theory is to be learnt in school..... You are sometimes better just keeping quiet and discussing it when we go back into school.'* (Carrie; year 3; semester 1).

From Carrie's comments I can presume that the notion of 'fitting in' with the team and being accepted is high on the student's agenda.

### **3.4.8 Developing an identity**

We can now assume that students believe acceptance and developing an identity within an already established team is a major part of their role. Stewart (1976) states that when people work together in organised contexts they form a social relationship within the group and develop their own distinctive ways of getting the work done. Indeed, Homans (1961) claims that there may be several social groups within one work group with some individuals who do not belong to a group. The social group is likely to have a sense of like-mindedness among the members who will agree upon many subjects of immediate importance to them. This theory may be related to the role of the students within the clinical area, they are part of a group yet are not an integral part of the already established group who are permanently in that clinical area. Homans observes that as the groups become more socially cohesive they develop norms that may restrict or enhance productivity. This may be related to the behaviour of the students, who believe that their ability to perform clinical skills will enable them to become a part of the ward team.

In fact, Adair (1986, p. 95) argues that:

*'A team can be distinguished from a group. Or rather, in the words of Bernard Babington Smith, a team is a group in which the individuals have a common aim and in which the jobs and skills of each member fit in with those of others, as – in a jigsaw puzzle pieces fit together*

*without distortion and together produce some overall pattern. The two strands of this definition – a common task and complementary contributions – are essential to the concept of a team. An effective team may be defined as one that achieves its aim in the most effective way and is then ready to take on more challenging tasks if required’.*

During the student interviews Kate, a third year student nurse explained how she felt she fitted into the clinical team:

*‘When I am on placement I work alongside a staff nurse and try to help them with their job, like I will do the drugs with her, admit patients, do the care plans and of course the obs. I try to do the things that the staff nurse would do so that they know I am able to do the things that need doing that day.’ (Kate; year 3; semester 1).*

However, Vanessa a first year student did not feel as though she were part of the ward team, she said that:

*‘I am left working with the auxiliaries and am more or less left to my own devices! I have to push myself forward all the time to find things out and although they do answer my questions I feel as though I am just making numbers up and the staff don’t really know what my role is’. (Vanessa; year 1; semester 2).*

I asked her then what she thought was her role. She stated:

*‘Obviously being new in this role I have to observe a lot and gain confidence so that I can achieve some goals while I am on the ward. This is the second part of my placement and I am feeling more confident and am achieving some goals so I can do a bit more which helps the staff, because when you look round you can see they are busy and would rather do the skills themselves because they do not have the time to show me.’ (Vanessa; year 1; semester 2).*

When the registered staff were asked the question of what was the role of the student nurse on placement the answers were varied, fitting into the team was perceived to be an important aspect.

Liz the practice development co-ordinator explained:

*‘I think it depends on what stage of their training they are at. I think that for the first years it is mainly observation but it is important for all of them to get involved in the ward team and try to relate the theory they have learnt into their practice on the wards.’ (Liz; practice placement development co-ordinator).*

Liz one of the mentors stated that she believed:

*'The students have to help out all the team members so that they know the role of every member of the team, if they don't then how can they be part of the team..... I think they sometimes get too attached to their mentor and can't then function as an effective team member when she is not there. They need to work with everyone.'* (Liz; staff nurse and mentor).

The senior nurse for practice development explained that the role of the student nurse was to learn how to nurse at that point in time. As nursing was changing all the time and that the students had a role to play in contributing to patient care by delivering care, linking theory to practice and working alongside the clinical team.

*'I guess that their role is to develop an understanding of what nursing is all about today and being responsive to patient needs and delivering care that is pro-active. It is about teamwork. They [the students] need to experience working with the Health Care Assistants to gain basic nursing care skills otherwise we will build a culture that nursing is about being a manager and not delivering patient care, it must be a culture of teamwork.'* (Senior nurse for practice development).

It is important that all members of the team are valued and that the team works together to support one another to achieve their objectives. The registered practitioners believed that it was important that the students worked alongside, and understood the role of the unregistered staff. Whereas, the students, as they progressed through their training programme, believed that they had learnt the skills possessed by the unregistered staff in their first year and now needed to progress to understanding a staff nurse role. This may be attributed to the theory of social development that stresses society is composed of social groups that stand in power and status relations to one another: people need to assess the value of their own group in relation to that of similar ones.

### **3.4.9 Social development**

Turner (1991) claims that subgroups are by nature stereotypic and that they mark out agreed boundaries of group membership. He has linked the process of inter group and interpersonal comparison to two essentially distinct aspects of the self which fall into two different sub-systems: one of them is made up of social identifications derived for the in-group – out-group categorization (such as sex, race, occupation and class); the other consists of personal identifications, idiosyncratic descriptions of self which derive from differentiation of self as a unique individual from other individuals. We can relate this to many of the students' comments in which they do not perceive their role to be one of undertaking the role of the unregistered staff. The registered practitioners, however, can appreciate the roles of all members of staff, regardless of grade or class, and can formulate that into the development of an effective team.

### **3.4.10 Developing Effective Communication Skills**

Prior to interviewing the students I observed them in practice for half a shift. During this time the staff were busy but there were times when they appeared to be stood chatting to each other around the nurses' station. The nurse's station in all but one area, critical care, was the meeting point for the staff where they would go to when the work was completed. The students would sit and chat to one another rather than sitting and chatting with the patients. Communication on an informal level with the patients was rare. In fact, the students would say to me that:

*'This is a quiet day we are normally much busier than this and don't have time to sit down' (Maria: year 2, semester 1).*

The students did not always seem to appreciate the importance of communication with the patient, unless they were asking them specific questions about their condition or regarding their planned care for that shift. This was despite the fact that they had identified communication as an essential clinical skill they needed to learn. This may have been because when the students observed the permanent staff members during these quiet periods they themselves did not sit and talk to the patients. Sitting, talking to patients was often viewed as the student as trying to avoid administering other aspects of care to the patients, for example, assisting with hygiene needs.

While talking with one of the second year students following the observation period I asked her why she did not sit and chat to the patients and she informed me that:

*If you sit down and talk to the patients the staff think that you are lazy and you are trying to avoid doing other things like the bed baths you always need to look busy and sitting down isn't being busy'. (Maria; year 2; semester 1).*

During these quiet periods in the clinical areas I had expected to observe the students either studying patients' case notes or questioning staff about issues relevant to their patients. This was not apparent during the observation periods, neither were the registered staff approaching the students and offering informal teaching sessions, this was despite staff informing me that they did not have the time to undertake teaching sessions with the students. It must be remembered that the observation periods I undertook only provided a snapshot of the ward's normal routines and what I observed cannot be attributed to every situation.

Interestingly, the concept of looking busy with physical activities rather than sitting and talking to patients was not particularly portrayed in the critical care areas of Intensive Care and Coronary Care. Here the students were actively 'encouraged' to talk to the patients, to discuss how the patient felt and to talk about their life away from the care environment. On these units the students informed me that that they felt a part of the ward team because the staff allowed them to sit down and talk to the patients and trusted them to discover how the patient felt helping to formulate the care plan to reflect their conversations with the patients. What is noticeable here is that the permanent staff encouraged the students to talk yet the students viewed this as being 'allowed' to talk to patients. This may be due to their own experiences from other clinical areas where sitting and talking had been viewed in a negative fashion. Students believed that the critical care areas were excellent learning environments as they stated that:

*'We have learnt loads here; the staff are always willing to teach us even though they are busy. They ask us questions about why we are doing things and ask us why we think they have done something. When we talk to a patient they ask us what we have learnt from them and if the plan of care needs revising'. Debbie and Marjorie; year 2; semester 2).*

This observation from the students may well be due to the staff/patient ratios in the critical care areas. I observed that there would be one registered member of staff per patient on each shift. In addition there was one health care assistant and a ward clerk.

The students understood the need and value of effective communication skills while recognising that they were as important as attending to the physical needs of the patients. The fact that the staff were encouraging the students to

develop their own knowledge base, through asking the patients questions and reassessing their needs on a regular basis, was not only encouraging the students to be an active member of the team but was also fundamentally problem based learning. It was apparent that this strategy of learning was being employed in these areas and was helping the students to fit into the team thus developing their communication skills.

The students appeared to feel as though they 'fitted in' when the staff involved them in the care being planned and delivered and when the students worked closely with the registered practitioners. This maybe is an aspect of power and status relations between the student and registered practitioner, whereby the student clearly understands which social group they belong to.

#### **3.4.11 Looking Busy**

The students identified communication as a clinical skill that they should be competent in, yet in the reality of the clinical areas there were many boundaries created that prevented them from always successfully developing this skill. Perhaps this is an area that as educationalists we need to study in more depth and teach to both pre and post registration practitioners, that of the importance of communication with the patients. This idea of nurses always having to look busy is not a new phenomenon, indeed Melia (1987) discussed the students' perceptions of sitting and talking to patients and that many of the permanent staff viewed it as staff '*not pulling their weight*'. She comments that the whole issue of talking versus working can cause problems for students as some ward sisters 'encouraged' the students to talk to patients while others 'allowed' the students to talk to patients that promotes the idea that physical work is what nursing is about (Melia, 1997, pg.21). We can argue that this

situation has arisen from nursing's need to be recognised as a profession. Nurses are supposed to be caring and able to show empathy to their patients without becoming too involved. Whereas, professionals have the power to distance themselves from the emotional distress and retreat behind the 'cloak of detachment' (Davies, 1996). It is here that the problems begin; nurses tend to become attached to their patient, particularly if they have been an in-patient for a long period of time with an important aspect of nursing being that of developing a therapeutic relationship that is gained by communicating with the patient. If nursing is to become professionalized do we really want to lose the understanding aspect of the job or is it already happening?

#### **3.4.12 Nursing practice – what is it?**

The changing role of the registered practitioner has produced a predicament for the students in clinical areas. They leave the school understanding that they need to integrate the theory they have learnt into practice and are aware that they are learning to become competent registered nurses who are *fit for practice* and *fit for purpose*. However, when they reach their placement area they are confronted by registered practitioners, who in the main appear to be managers at varying levels, planners and organisers of care, whereas, the unregistered staff are seen to be administering the basic nursing care. Benner and Wrubel (1989) have described nursing practice as that of caring whereas, Curzer (1993) argues that nursing is not about caring but is a professional relationship between the nurse and patient. This may be where the dilemma arises for student nurses when they are attempting to understand the role of the registered practitioner. The students then struggle to understand where they fit into the scheme. The students must decide whom it is they follow, to



develop the skills and knowledge to become competent and professional upon registration.

The integration of new roles such as Trainee Assistant Practitioners (TAP) has allowed the registered practitioner to move away from the bedside role and take on roles that were traditionally performed by the junior medical staff, for example, venepuncture, cannulation and nurse prescribing activities.

#### **3.4.13 Trainee assistant practitioner (TAP)**

The TAP role is an initiative that has been developed in the North-West of England. Other similar training schemes are available in the remainder of the country but may be referred to under different terms.

The TAP is a relatively new role to health care and was introduced in September 2002 and the first students from the courses registered in September 2004. They leave their chosen universities with a Certificate in Health Care and are paid as a 'C' grade practitioner. Their pay structure will change with the inception of '*Agenda for Change*', which is in progress across the country. The role is as the title suggests assisting the nurse practitioners in the clinical areas. They are expected to assess, plan, implement and evaluate patient care and perform clinical skills. They have not been trained to undertake the medicine rounds or to take charge of the ward. Their role has been envisaged to fill the void between unregistered and registered nurses. That is to say, that they will be responsible for administering the 'hands on' care while supervising the unregistered staff to undertake the same. These practitioners are educated to a higher level than the unregistered staff who have completed the NVQ three in health care.

The TAP role may well cause more confusion for the student nurse when they are trying to understand the role of the registered nurse and indeed where they, as a student, fit into the team. Again, they are witnessing a change in role boundaries and social status of staff members. If the students were to read the job descriptions of the unregistered staff and the Trainee Assistant Practitioners, they would probably assume that the reason they are undertaking their student nurse training, and the differences between their skills and those of the unregistered and Trainee Assistant Practitioners is that they will be allowed to administer medication when they register. These roles need strict clarification if the students are to effectively socialise in the health care culture.

#### **3.4.14 Using PBL to understand and overcome clinical boundaries**

Throughout my interviews with the students and registered practitioners we discussed the teaching and learning strategy of PBL. The students felt comfortable discussing their experiences of PBL, whether or not it was used and how they applied its principles in clinical practice. The registered practitioner's interviews concerning this subject were somewhat different. I wanted to know whether or not this strategy of learning was helping the students to develop their problem solving and questioning skills and if it was actually making a difference to the student's performance while in clinical practice. I was also interested to know what knowledge base the registered practitioners possessed regarding the new curriculum and PBL.

#### **3.4.15 Sharing of knowledge**

Power and knowledge are strong analytical concepts that have a long history with nursing. Street (1992) argues that clinical nursing is embedded in

traditions, historical constructions and a specific nursing culture. The culture shapes nurses and is reciprocally shaped by them. She further argues that nurses recognise the value of their clinical skills, knowledge, experiences and relationships and this aids them in being able to help a patient transform from a person of illness to health or from illness to death. The students on the wards are attempting to develop their knowledge base and in doing so they are trying to understand why they and registered practitioners do what they do. When they arrive on the wards the students do feel powerless and have to constantly ask staff, which they perceive, hold the power to instruct them. This is why the role of the mentor is so important. It is the person the student can liaise with at all times and some one who they can turn to, ask questions and reflect with in a relatively safe manner as the mentor is there for support.

One of the mentors undertaking the Level 3, Preparation for Mentorship Module discussed the concept of PBL in her interview. She was the only practitioner fully to understand this concept, probably due to the module she was taking. She believed that PBL had contributed to the changes in the students while they were on placement because:

*'...As far as PBL is concerned it makes them look at the whole picture and pull theory and practice together. It makes them realise that they have to work together as a group when in school and if one of them does not get the information they need then they ruin it for everyone else. This is helping them to problem solve when they are on the wards'. (Pat; staff nurse and mentor).*

The strategy of PBL was viewed to be a concept used in the school and not in the clinical environments; it was seen as a purely academic strategy for teaching and learning. This may be due to the fact that the school of nursing had embraced the concept and while practitioners had participated in the curricula planning stage these staff members had been of a senior level. It is

therefore questionable as to how effectively these staff members had explained the concept to ward staff. Academic staff had run road shows explaining the new curriculum to staff and had explained it at mentorship study days but the focus had not been on the teaching and learning strategy of PBL but rather changes in the length of student placements, role of the mentor and role of the practice placement co-ordinator.

The practitioners did believe that the students were being better prepared for their clinical experiences as they did appear to be more questioning and more 'hands on' as they felt the students were receiving more clinical skills training prior to going into practice. In reality, the students undertaking the new curriculum do not have extra instruction in the performance of clinical skills prior to going to their clinical placements than previous students.

#### **3.4.16 *Belonging***

This led me to reflect on the concept of PBL and how the students now 'belong' to their own base group while in school. From the commencement of their studies the peer support they have seems to be facilitating them to become more confident in their abilities while in the clinical areas. Although the students worry about questioning practitioners too often, they have demonstrated that they possess the skills to direct their own learning, attain the relevant information and then discuss it with their mentor in practice or their base group facilitator.

Indeed, Price (2003) argues that the small study groups assists the students to manage the emotional work and to manage their anxieties, as the process of collaboration and challenge within the group is believed to be educationally beneficial. He continues to discuss that within the practice areas there are

often no right answers, only better solutions and that working within a small group helps to develop the ability to construct meanings from the available information. This group working in school is providing the students with the ability to work effectively in a group in the clinical areas. Despite their limited knowledge of the changes the new curriculum was welcomed and thought to be beneficial for the training of the students. It is difficult to ascertain exactly why the clinical staff believe the students are more effective. It may be that the post of practice development co-ordinator has provided the staff with a named person who they can contact if they have any questions relating to the students. It may also be due to the fact that the students are now working in small groups, the base groups, when in school and through this they are learning how to work in a group and understand the needs of their peers. They then transfer this group working into the clinical areas and learn how to work as a part of the ward team.

Students were eager to learn in the clinical areas. They wanted to become proficient in performing their clinical skills and to understand and participate in the role of staff nurse. The students believed that the strategy of PBL in the school of nursing had prepared them for working in the clinical environments.

Debbie, a second year student explained that:

*'When we are looking at triggers in university and then you come out into placement you can see how it all fits around the patient, like your care management and care delivery domains and you can relate it to your patient. You are able to help the patient and know how to find out information for them if they ask you a question'. (Debbie; year 2; semester 2).*

### **3.4.17 Integrating theory and practice using triggers**

Debbie believed that the use of triggers had enabled her to be able to put the theory she had learnt into practice. During her trigger work in school, she and her group had sought out information to answer the triggers and to feedback to her facilitator. This skill was now being used in her placement areas where she was able to find information for the patients on her own rather than having to ask the registered staff. She also stated that the staff on the Coronary Care Unit where she was placed were also using PBL when they were teaching her. She described to me how this happened:

*'When I am working with the staff they ask me questions about the patient and the care that is being given. They also ask me why I have decided to do things in a certain way; I suppose this is a form of PBL. I then have to explain why the care is being delivered if I don't know I have to go away and find out why. They then ask me again.'* (Debbie; year 2; semester 2).

All the students I interviewed told me that they wanted to learn how to be safe practitioners and that they would either question the staff if they did not understand something or they would seek out the information themselves. They considered that PBL had improved their abilities and knowledge regarding how to find evidence to support their care interventions.

## **3.5 Effective mentors**

### **3.5.1 Mentorship – being a support for the students?**

The registered practitioners saw the role of the mentor as one of an advisor, a teacher and a support for the students. It is important to explain here that not all registered practitioners are mentors. To become a mentor the staff must either possess the English National Board's 998, teaching and assessing certificate or the Level 3 Preparation for Mentorship module. They must also

attend yearly mentorship update sessions to ensure they are aware of any changes. In addition, to the mentor role there is the associate mentor. Registered staff that undertake this role are a support for the mentor and can only mentor students under their supervision. They must attend a day's study session that explains what is expected of them and issues relevant to the curriculum. Furthermore, they must have completed their preceptorship period and if they sign any of the students' documentation it must be counter signed by the mentor. Students had highlighted that sometimes their mentors were on night duty, annual leave or on sick leave during their placements and they, therefore, found it difficult to work alongside them. The associate mentor role was developed to ensure that the students were able to access some form of mentor support during their clinical placements.

Benner (1984) claims that the professional expertise of a mentor should take a number of years and they should be experts and professionals within their role. The students themselves saw the role of their mentor as someone in whom they could confide, who could teach them clinical skills and who they saw as an expert in practice who had a degree of authority within the ward team, therefore, they tended to expect their mentor to be an 'E' grade or above. On the whole the students did not appreciate having the ward manager as their mentor as they felt they were too busy with paperwork to be able to mentor them effectively.

### **3.5.2 Awareness of the curriculum**

All the wards I visited held a copy of the *Making a Difference* (DoH, 1999a) document in their ward office. During the interviews I asked the staff if they were aware of the changes in nurse training and what they thought had been

the main changes. All the staff, bar one, were aware that nurse training had undergone changes but they had not read, in detail, the relevant documents, however, some of the staff had attended mentorship study days, which had given them an overview of the curriculum and the relevant changes. All the staff stated that they believed the main change had been the supernumerary status of the students. This was interesting, as the Project 2000 students had held supernumerary status as well during their period of training. One mentor had been unaware that there had been any changes in nurse education and was under the impression that students were still undertaking the Project 2000 form of training. Following this particular interview I arranged for the practice development co-ordinator to visit her and update her on the changes, which she accepted. Following the interview this practitioner talked to me for a long period of time (I made field notes of these following our discussion) and explained that she had been on permanent night duty for a large proportion of her career. This night duty, she believed, had left her feeling '*ignored and forgotten about*' by senior staff when educational opportunities arose. She said that she had asked on numerous occasions if she could attend study sessions but they were always during the day and she could not attend. She had also asked if she could undertake a teaching course, so that she could help assess the students when they were on night duty. However, her requests had been refused. She said that she felt '*pushed out*' and had decided to '*just get on with the job*'. She also explained that as the students registered with a diploma or a degree, they were '*far more qualified than me*' and as such she did not believe that her general nursing qualification was sufficient to be teaching or mentoring these students.



### **3.5.3 Intra-occupational tensions**

It was quite apparent that this mentor believed there was a boundary between her and educational opportunities as she worked nights and that there was a boundary between her and the students, due to the level of academic qualification that the students would leave university with on registration. Allen (2001) has discussed the notion of boundaries in health care in detail. She describes the intra-occupational tensions that can be seen on a ward and the concept of 'new nursing' that were affecting the professional identity of practitioners. She argues that because nursing work relies on staff working together it becomes too easy for nurses to blame one another for contradictions. These observations clearly match how this sister was feeling and that her role was being blurred with the inception of students who would eventually register with a higher academic qualification than herself.

### **3.5.4 Being an effective mentor**

I asked the mentors what they thought their role as a mentor was and what preparation they had undertaken to perform it. In addition I asked the students what they thought the role of their mentor was. The replies for the role of the mentor were similar in that the majority of the mentors stated that it was someone who was able to teach and who could be there to offer the students help and advice as necessary. However, the preparation they had received for this role varied greatly and the feelings of the staff were often strong and somewhat defiant towards the implementation of this role. It is important to note that the job descriptions for all registered practitioners include that of actively teaching the students and those staff of 'E' grade and above are expected to act as a student mentor. The students themselves saw the role of

their mentor being someone who they could talk to, discuss professional issues with and who would guide them through their allocation on the ward and perhaps most importantly to them it was the person who would complete their practice placement assessment documentation.

Indeed, Donna a first year student stated:

*'I have worked with my mentor for nearly every shift and she has shown me what to do and the right way of doing it I have been lucky, some students never see their mentors and have to make do with who ever is on duty that day. I mean how will the staff be able to complete their placement report properly or how will the student know they are doing things properly?'* (Donna; year 1; semester 2).

### **3.5.5 Worker versus student**

Donna's statement exemplifies the students' view of themselves as workers while on the wards and to a degree how they model their own behaviour upon the mentor with whom they are working. It is not until they reach the summative assessment stage of their allocation that they revert back into the student nurse role.

The *Making a Difference* document (DoH, 1999a) appeared unclear about whether nurses were to be trained by apprenticeship or educated in the liberal arts tradition. Training was used in the document to refer to the preparation of student nurses and stated that all nurses would be trained to broadly the same standard and would have the same skills wherever they were trained. The priorities included an increased emphasis on practice within the nursing programme and a nurse education system that was responsive to the needs of the NHS. The document maintained that basic personal care should remain a part of the registered nurse's training including; helping patients to eat and drink, access and use toilet facilities, maintain personal hygiene, be

comfortable, mobilise as planned as well as performing basic cardio-pulmonary resuscitation; contributing to raising an awareness of health issues and understanding the ethical and moral dimensions of care. Bradshaw (2001) argues that as nursing has become more professionalized, and caring has become commodified, the vocational ideal has withered. Under the vocational model of nursing the nurse did not aim for status, but in the public mind was accorded the highest possible esteem because of their altruism. Some kind of status rested in the value accorded to the nurse as a bedside carer. As the nursing role has changed to meet the requirements of status and professionalisation, so the boundaries between the medical and nursing professions blurred and it is now probable the unregistered staff rather than the registered nurses will perform that personal care for the patient. If this idea is followed to its conclusion then we must surmise that the unregistered staff will become nurses in all but name, while nurses will not nurse.

This judgement has in part been realised through my observations of the roles of the registered and unregistered staff in the clinical areas. The RCN congress in April 2004 saw a resolution tabled and debated regarding the role of the registered nurse. It stated; *'that this meeting of the RCN Congress believes that the caring component of nursing should be devolved to health care assistants to enable nurses to concentrate on treatment and technical nursing'*. The resolution was resoundingly defeated with 95% against and 5% for. It would seem that registered nurses do want to be involved in the 'hands on' caring activities but pressures of the ward and the ever changing role of their post does not always allow for it to come to fruition. However, this resolution was not based on a scientific survey therefore we have to question

the validity and authenticity of the results. Jo, a mentor described her mentor role as being:

*'My role is to make them feel part of the team and to show them how the ward works and what needs to be done when they are on duty. I am also there to be an advocate for them because if they have certain educational needs hopefully I will be in a position to facilitate them.'*  
(Jo; staff nurse and mentor).

This served to reiterate that students and practitioners believed that theory was taught within the classroom and that clinical skills and becoming part of a team were taught in the clinical areas. The students believed that an effective mentor was one that had shown them around the ward and explained to them the routine within the first week of their allocation. Once the students had mastered the ward routine they believed that they then understood the individual roles of each member of the staff.

The distinction between theory and practice has arisen with the mentors believing that theory is taught in the academic sector and the students accepting this idea. The culture of each clinical area is important, many students have commented that the wards are busy and therefore accept that staff will not always be able to explain rationales behind certain procedures or will not have the time to teach the students skills or to aid in the development of their knowledge base.

### **3.5.6 Preparing the mentors**

Mentors themselves have stated that they recognise a part of their role is to teach the students and to help in their quest towards registration, however, they too perceive the teaching role as secondary to completing the ward work and that they are not allowed sufficient time to perform the mentor role. Many

of the mentors saw this role as an added burden to their already busy life in the clinical areas of which they had had insufficient training.

In fact one of the mentors stated that in relation to the training she had undertaken for the mentor role:

*'I don't think I have had any [training]. I have done my 998 [a course in teaching and learning of students], which I suppose comes in handy for the mentor role, but at the end of the day I'm only here to show them what's done on the ward I can only give them basic knowledge and they do not start to learn until they qualify when they could be on any ward.'* (Andrea; ward sister and mentor).

This is interesting as the 998 was a formal teaching and learning qualification which was one of the pre-requisites required to undertake the mentorship role. Andrea did not appear to understand fully that she possessed the necessary qualifications to support the students and indeed did not believe that her role was actually one of teaching the students the underpinning knowledge. She strongly believed that she was there to show the students what work needed to be performed on the ward. During my observations I noted that there were many posters in the clinical areas advertising educational and mentorship study days for all staff involved with student nurses. I asked the mentors what actions they would take if they were unsure as to how to complete the documentation. Those who had not attended the study days said they would ask the students which they thought was perhaps wrong, as they should be au-fait with the paperwork. What was extremely interesting were the comments from a couple of the mentors who recognised that they should be competent with the paperwork.

However they did not see why they should have to attend study sessions to up-date their knowledge they stated:

*'I know we should really know what we are doing with the assessment documents but why should I have to go in my own time to learn about it? The lecturers from the school should come down the ward and tell us what to do. In fact, I think the lecturers should come onto the wards more often and teach the students'. (Andrea; ward sister and mentor).*

Again I sensed from this remark that registered staff believed that their role was to teach the students how to behave in the clinical environment, which rules they had to follow to 'fit in' with the philosophy of the ward. The comments relating to the mentors having to attend study sessions in their own time is significant, as the registered staff understood the need to keep themselves updated with mentorship issues but believed that their workplace should provide them with the time to attend. They did not believe that they should have to go to the study sessions in their own time; they believed that being a mentor was part of their role and therefore the Trust should allow them the time to develop into it. However, the study sessions delivered by the Trust and University were during a morning or an afternoon, which is in 'works' time but staff did not attend as they stated that the wards were too busy to allow them to leave. This is a difficult situation to overcome and perhaps the only solution would be to offer staff financial payment to attend or to offer them 'time back'.

All but one of the staff nurses had attended the relevant study days prior to undertaking the role but they still felt ill prepared for the role. They worried about completing the students' documentation in case they 'got it wrong'. I attempted to relieve their anxieties by explaining that they could not "get it wrong" as they were assessing the student's competence while on their placement. All the mentors believed that their knowledge base was developed sufficiently to be able to assess the students that because they

had been registered for a number of years they possessed experience that could be transferred to the students.

### **3.5.7 Student/mentor bond**

The students developed an affinity with their named mentor when they arrived on their clinical placements and sometimes found it difficult to form strong relationships with other registered members of staff when their mentors were not on duty. In addition, they worried that if their mentor did not closely guide and explain how to undertake procedures they would not develop the skills required of a staff nurse. This was echoed earlier in the interviews by one of the ward managers who had expressed a concern that the students were a little too reliant upon their mentor and often felt 'lost' if they were on a shift without them. Maintaining a close relationship with the mentor was beneficial to the students as they felt that they had an advisor, confidant and someone to who they can turn if they had any questions. However, this may at times be to the detriment of them developing their skills as a team player and being able to integrate effectively in the clinical teams. The next theme that emerged from the data is that of what is a real nurse?

## **3.6 Being a real nurse**

The students wanted to learn how to be a 'real nurse' when they were in clinical practice. They wanted to understand the role of the registered nurse and how they could gain the necessary skills to become a safe and competent registered practitioner. Both the registered practitioners and the students appreciated that the clinical areas allowed the students the opportunities to witness the 'real' world of nursing, rather than the 'ideal', which they alleged was being taught in the academic area. The registered practitioners

understood the need to ensure that the students worked as part of a team and learnt how to prioritise the workloads on a daily basis ensuring that the wards were functioning effectively.

Rebecca explained:

*'We need to give the students the opportunity to be a part of the team. We also need to let them know of the policies and procedures so that they understand how to do things. While they are on placement they need to know how to be a real nurse and see what really happens on the wards, they can learn the ideal in school'. (Rebecca; staff nurse and mentor).*

During my interviews with the registered practitioners they were all positive about the learning opportunities they afforded their students when they were on placement.

One of the students echoed this view of being encouraged to see different procedures as long as it did not affect the running of the ward even though the students were meant to be supernumerary:

*'This is the first time I have been allowed to observe a procedure that happens off the ward. I have arranged to see a couple before but the staff have told me I am not allowed to go because the ward is too busy and they need me to help with the washes and getting the patients up.'* (Debbie; year 2; semester 2).

Students valued the time they spent with their mentors as they classed this as 'learning about real nursing'. They believed that they needed to become proficient in learning how to undertake ward rounds, the paper work and liaise with other members of the multi-disciplinary team. What interested me about this was that the students did not appear to always appreciate the importance of acquiring and being proficient in 'basic nursing care skills.' However, during my observations I noted that the registered staff rarely performed these tasks and the students were witnessing a quite marked demarcation of roles.



Shils (1961) identifies and discusses the issue of society and how this relates to institutions and the cultivation of cultural values. He argues that these institutions, that can include hospitals, have an authority, 'an élite', which might be either an individual or a group of individuals, loosely or closely organised. Each of these élites makes decisions, sometimes in conjunction with other élites and sometimes on their own initiative, with the intention of maintaining the organisation, controlling the conduct of its members and fulfilling its goals. The decisions made by these élites contain as major elements certain general standards of judgment and action, and certain concrete values, of which the system as a whole, the society, is one of the most pre-eminent. He refers to these values as the 'central value system' of the society. They are central because of their intimate connexion with what the society holds to be sacred; it is also central because it is espoused by the ruling authorities of the society.

He continues to explain that the central value belief system is constituted by the values which are pursued and affirmed by the élites of the subsystems and of the organisations which are comprised of the subsystems. By their very possession of authority, they attribute to themselves an essential affinity with the sacred elements of their society, of which they regard themselves as the custodians. In relation to the university system he argues that the élites practice certain values that that govern intellectual activities.

With regard to the students valuing the support of their mentors and attempting to emulate how they practice as registered practitioners. We could argue that this is the students central value system in so far as the clinical areas are viewed, by the students, as the society and that the registered

practitioners possess the authority to not only ensure the clinical areas are safe and efficient but also that the learning needs of the students are identified and met. The unregistered staff are a part of the society's sub-system who play an important role in maintaining the delivery of nursing care but are also working to the authority of the registered practitioners.

### **3.6.1 Understanding the staff nurse role**

One of the mentors during my interview with her she stated that:

*'The students need to work with their mentors to understand the role of the staff nurse, it is no good that they work with the auxiliary and do all the washes and stuff because that is not what they are here to learn. We have a resource room here that I encourage the students to go into when I am busy or when the ward is quiet but many of them don't want to and would rather be on the ward'. (Claire; ward sister and mentor).*

I asked her why she thought the students would rather be on the ward than in the resource room. She answered that she thought it was because the students valued their time in the clinical areas, observing practices and being with the patients and that they felt they miss out on something interesting if they were in the resource room. This exemplifies the importance the students place on being able to observe practices while in the clinical areas and being offered the opportunity to 'do real nursing'.

### **3.6.2 Kinship**

The importance the students place on working alongside the staff rather than spending time in the resource room relates to the notion of kinship. Greenhalgh (2000) claims that this sense of kinship is supported by the group's evolution of particular attitudes and behavioural patterns, or norms and beliefs systems. The kinds of beliefs system on which a group operates are of critical importance and can make a difference between a sterile or even

destructive group and a useful one. The evolution of group norms can serve as a means of helping some members feel safe. Some norms and belief systems have the effect of widening the boundaries of the group. She further discusses that these systems help students to discuss problems they may have and produces an environment that provides co-operative learning methods that enriches the exchange of ideas and experiences and increases the motivation for learning.

Marjorie, a second year student explained to me that:

*'Working in ICU has been great; I have learnt such a lot and feel a valued member of their team. It is a bit like being in our base group. They all want to help me learn and they make me work through problems and treat all the patients needs, not just the diagnosis'. (Marjorie; year 2; semester 2).*

The senior nurse for practice development stated that:

*'The students should be learning by mirroring the registered staff, but it is not the registered staff who are delivering the direct basic care, it's the unregistered staff, so there is a dilemma there, if the student works alongside the staff nurse they learn about how to co-ordinate a ward, run an office, risk management, management and man management etc. so to gain the experience of basic nursing care they need to work with the support worker who does have the experience to link the theory at the bedside with the student. The students themselves begin to think that they are being used as a pair of hands because they want to be a staff nurse and they see the staff nurse doing something different than delivering patient care. I think we are at risk of building a culture where nursing is not seen as delivering patient care but is seen as being a manager.'* (Senior nurse for practice development).

### **3.6.3 Transferring skills**

Barrows (1994) argues skills learnt should be transferable and equip the students well for the varied clinical situations that may arise in the practice element of their courses. Furthermore, Savin-Baden (2000) states that PBL should mimic practice in so far as it reflects the collegiate way in which

practitioners need to operate, identifying their own and others' expertise and working coherently to solve a problem. We could argue from this that students are indeed using the principles of PBL in the clinical areas as they are asking the registered practitioners, who they see as the experts, for answers to their questions.

In relation to what they saw as their role, the students stated that when they worked with their mentors they learnt how to do the drugs rounds, bleep doctors, discontinue intra-venous infusions and other clinical skills but when their mentor was not on duty with them they were:

*'Treated as an auxiliary when my mentor was on nights, I had to help with the washes or help to feed patients, I wasn't doing what nurses do, like the dressings and the paperwork, but I've stuck with it and now my mentor is back things are much better.'* (Jayne; year 3; semester 1).

## **3.7 Being professional**

### **3.7.1 Social relations in the clinical areas**

Hogg and Abrahms (1988) demonstrated how the power and status relations between groups bear on social identity; the dominant groups in society have the power and the status to impose the dominant value system and ideology, which serves to legitimate and perpetrate the status quo. Individuals are born into this structure, and simply because of their sex, social class or "race", fall into one social group rather than others. By internalisation of the social categorizations that define these group memberships, they acquire particular social identities that may have positive or negative value. Members of dominant and higher status groups gain a positive social identity and high self-esteem from group memberships; members of lower status or subordinate groups have a less positive social identity and lower self-esteem.. If a

proportion of individuals believe that membership of the higher status group is achievable by individual effort, they will attempt to move upwards into the dominant group by these means. However, if individual upward social mobility is impossible and members of the low status social groups see boundaries between groups as impenetrable, they may adopt collective strategies to create a more positive social identity for their group. Tajfel (1978) calls these strategies social change.

### **3.7.2 Social change**

Tajfel (1978) uses the term social change to include three kinds of activity. The first of these is assimilation or merger, which involves the adoption of the positive features of the high status group by the low status group who wish to join them. The second type is social creativity, whereby the subordinate group seeks to create a new and positive image for itself thereby reducing the need for comparisons. Finally, rather than seek to compare themselves with the superior group, low status groups may seek comparisons with equivalent or more subordinate groups to themselves in order to enhance their social identity.

Attempts to exert social influence can take on a number of forms. *Conformity* occurs in situations where individuals yield to group pressure without direct requests to do so. *Compliance* is a more direct form of social influence. It occurs in circumstances where people will alter their behaviour in response to a direct request to do so. *Obedience* involves commands, rather than requests and *modelling* takes place in situations where behaviour is changed through the observation of the actions of some one else (Niven, 2000).

This theory of social identity can be related to the performance of students in clinical practice who want to manifest and learn the skills of registered practitioners and not those of the unregistered staff. The students perceive the registered group of staff to be the 'higher status group' which they wish to emulate and the unregistered staff to be the 'lower status group' that is not their role during their training period in clinical practice. This can be linked to conformity where the students are changing their behaviour despite not having been asked to. There are two explanations for conforming to group pressure. The first is normative social influence and states that one reason why individuals conform is because they do not want to cause problems by openly disagreeing. The second explanation is that of informational social influence. Niven (2000) offers the example that if all the people in front of you have answered in a way that disconfirms your opinion, you start to question your ability to make correct responses.

The concept of obedience in social influence relates to the role of the student nurse in clinical practice. The students 'obey' the commands from the authoritarian figures of their mentors and the registered practitioners in order to successfully complete their placement. If they 'disobey' then they believe they will be punished through an unsuccessful practice placement assessment.

In fact, during the interviews, the students actively challenged the merits and advantages of them working alongside the unregistered staff. Joanna stated that:

*Different members of staff expect different things.....I'm here to learn and not just to do tasks Some people expect you just to act like you are an NA rather than a student learning to become a nurse and sometimes when you are doing nursing things you get other people*

*thinking you should go and clean that patient. (Joanna; year2; semester 1).*

This may be referred to as social competition. The students are challenging the basis of the status hierarchy and are seeking to change the relative power and status of the groups by active or passive resistance. In addition, the paradox of professionalism within nursing has seen the concept of 'higher status' work being highlighted as a recruitment initiative rather than promoting the values of administering basic nursing care. This may be exemplified from registered practitioner's job descriptions that states they will be expected to 'enhance' their roles, i.e. perform cannulation and venepuncture. Indeed, the students observe the registered practitioners enhancing their roles and through their individual efforts, of undertaking clinical skills effectively, they are attempting to move up into this higher status group.

### **3.7.3 Developing professionalism**

The students mentioned, when interviewed, how they taught and helped more junior students; this may be viewed as the students attempting to compare themselves with equivalent or more subordinate groups in order to enhance their own social identity. Julie was discussing her role as a student and how her role had changed over the last two years. She explained that

*'Well now I'm in the third year I feel that I can teach the first years and share with them what I know.....it makes me realise that I have learnt things over the past two years.....I am a senior student now and the first years really don't know anything!'* (Julie; year 3; semester1).

The vision of the bedside nurse who cares for all the basic needs of the frail and elderly person has been replaced by a 'professional,' whose role it is to define, plan and evaluate patient needs while the unregistered member of

staff implements the care required. This has to some degree been promoted by the changes in nurse education and the move from 'traditional' hospital based schools of nursing into universities. As the students progress through their nurse training they perceive themselves to be developing into the registered nurse role and therefore becoming a 'real nurse' and becoming professional.

Throughout the interviews and observation periods the students had viewed the administration of 'basic nursing care' as an unregistered member of staff's role. In fact, when they had been asked to undertake these roles they believed that the registered practitioners were using them as 'a pair of hands' rather than treating them as learners. Some of the registered practitioners, during the interviews also stated that they did not believe the students should be carrying out this role because they were not learning anything from it.

During my discussions with Claire she explained:

*We have to be careful not to use the students its easy to say can you just go and do the obs.....we should be teaching them why they are doing things and questioning them (the students).....not just using them as a pair of hands and to work with the N/A's when we are busy'. (Claire; ward sister and mentor).*

#### **3.7.4 Observing professionalism**

My observations took place on eight different wards. On duty each day were varying numbers of registered and unregistered staff as well as students. All the wards except Intensive Care and the Coronary Care Unit were split into bays, with a registered and unregistered member of staff in each bay and the student working alongside their mentor, if they were on duty. Intensive Care and Coronary Care were open plan units and the staff were allocated individual patients, up to a maximum of two each, again the student was



working alongside their mentor (during this stage of the analysis these will be referred to as units not wards). In the two units the student was always working with a registered member of staff, probably as the ratio of registered staff was relatively higher than on the general wards. My first observation, from the early shift (commencing at 7:30am), on all the wards was that the unregistered member of staff assisted the patients to either sit up or out of bed for their meals and served the meals to the patients. The registered nurse undertook the medicine round. The student in all cases assisted in helping the patients with their personal hygiene and nutritional needs. Following the medicine round the registered nurses spent a proportion of the morning answering telephone calls, making telephone calls and carrying out the doctor's ward round.

Noticeably, on three of the wards there were two students on the same shift and inevitably they worked together. It was heartening to note that when they approached any patient they wished them good morning and explained what they were going to do and attained the patient's permission for the nursing care intervention prior to proceeding with anything. I do not believe that they did this because I was observing them as this was maintained when the students were behind the curtains with the patient.

The staff nurses did communicate with the students on all the wards normally asking them how well they were progressing with the hygiene needs of the patients, however, on all but one of the wards the students were not invited to assist with the medicine rounds or join the medical ward rounds.

I asked one of the second year students what she thought her role was during the shift I had been observing and she replied:

*'Well for me to work alongside the staff nurse and do their role. So I try and do the drugs, take bloods, give I.V.s, but obviously I have to have them checked because I am not registered. I normally do the same as my mentor like admissions, discharges, assessing the patients, doing the care plans and the obs. This morning, though it's been busy so I've had to help with the auxiliary work'. (Joanna; year 2; semester 1).*

*Field note: I have noticed that Joanna's mentor has been asking her to assist with the medicine round. Joanna has been reading from the prescription sheet, placing the medicines in pots and administering them to the patients. The staff nurse has been nodding approval and has been congratulating Joanna on carrying out the procedure. The staff nurse has not asked Joanna any questions so I presume that she understands the medication she is administering. I must ask later how the students learn about the drugs, contra-indications etc.*

Registered practitioners on the ophthalmic ward approached the students quite differently and they were invited to observe a number of procedures, assist with the medicine round and they were actively encouraged to contact the medical staff and other members of the multi-disciplinary team to ask them to visit patients. This may have been because the majority of the patients were self-caring and the priority of the ward was not to ensure that all patients had been assisted with their hygiene needs and helped out of bed as appropriate but to administer specific ophthalmic care. The first year students described their role on the ophthalmic ward as:

*'We help the nurses do all the admitting and discharging. The auxiliaries here are really good and don't leave everything to you to do. The staff here are very student orientated and make sure we see all aspects of the patients care. They are interested in students and they know about the forms we have to fill in for Uni.' (Sarah and Margaret; year 1; semester 1).*

What is probably the most noticeable feature about her comments is that she has drawn quite a distinction between the roles of the registered nurses and the unregistered staff, in that she was impressed that the unregistered staff did not expect the students to undertake what they viewed was their own

roles. Therefore, even as early as the first year of training the students are formulating very definite views of what the various roles are of the ward team and that the role of the student is to learn to be a staff nurse and not an unregistered member of staff.

### **3.7.5 Changing boundaries of being professional**

The students had been challenged by their perceptions of the roles of the registered and unregistered staff and indeed their own role while in clinical practice. The role of the registered practitioner continues to change with the changing needs of the health service. Registered staff 'take on' the traditional roles of medical staff and enhance their own roles in an attempt to offer holistic care to the patient, but in doing so blur the boundaries of their own profession. This division of labour is by no means new to this study.

### **3.7.6 Division of labour**

During the interviews and observation periods I noticed a marked division of labour between the registered and unregistered staff. Allen and Hughes (2002) studied this division of labour and remarked that, even when the nurses and support staff worked together washing patients and preparing breakfasts they tended to different patients. Nurses would stay in the ward areas, from where their skills could be utilised if needed, whereas the support staff would work in the bathrooms. These arrangements, she argues, afford the support workers considerable freedom in the performance of patient care. Although the unregistered staff do not possess a formal qualification to undertake mentoring duties, they do appreciate the principles of administering basic care needs. They have learnt this either from undertaking the NVQ courses or being instructed by the registered staff. This would lead us to

believe that they are the most appropriate group of staff to teach the students these skills. We should also remember that there is always a registered practitioner on duty and, in principle the unregistered staff are always supervised, albeit from a distance.

The more senior students, normally third years, felt that they were being used as 'a pair of hands' when they worked with these staff members. Indeed, Donna, a first year student stated that:

*'I have learnt loads from the health care assistants. I have never worked in a hospital before and did not know anything. They [the health care assistants] have taught me how to bed bath and get patients up in the morning'. (Donna; year 1; semester 1).*

Whereas, Julie, a third year student, explained:

*'I don't mind helping the health care assistants but I should not be working with them every day, I don't learn anything from them. How am I meant to know how to admit and discharge people and things like the paperwork if I am with them all day?' (Julie; year 3; semester 1).*

Freidson (1970, p.63) discussed '*the dilemmas of nursing*' and argued that leaders of nursing had become concerned that nursing should not be a dilution of medicine nor an accreditation of the functions medicine had sloughed off. He maintained that in order to gain autonomy and professionalism, occupations had to be able to operate outside the walls of organisations especially organised institutions such as clinics and hospitals. The nurse, he believed, seemed fated to remain subject to doctor's orders in part because of the fact their work is largely carried out within a hospital environment. He continues that nursing is required to become a part of an organisation, within the hospital or out in the community, and as such

depends upon doctor's orders and requirements to delineate which tasks belong to nursing and which do not.

Interestingly Freidson (1970, p.57) asserted that in order for nurses to obtain semi-professional status, they need to become a part of the subordinate paramedical division of labour, and so handicap their chance for subsequent professional status. He concluded that *'legally and otherwise the physician's right to diagnose, cut and prescribe is the centre around which the work of many other occupations swings, and the physician's authority and responsibility in that constellation of work are primary'*. This remains true today of the medical profession. The consultants lead the patients care and nurses and other professions allied to medicine are required to follow the medical orders when delivering their aspects of care. Nursing will therefore find it extremely difficult to ever attain total autonomy. It is this dichotomy that the students have witnessed while in clinical practice and what makes it so difficult for them to understand not only the role of the registered practitioner but also how they are to become true professionals when registered. The question that needs to be addressed is can nursing ever be a profession in its own right or is all it can truly try to achieve is that of being a 'semi-profession?' These questions led to all the participants discussing how they reflect upon their own roles and experiences from the clinical areas.

## **3.7 Reflecting In Practice**

### **3.7.1 Students reflecting**

When the students are in school they are encouraged to reflect upon their experiences from the clinical areas, with an integral part of the practical assessment process, being the development of a learning diary through

reflection. Boud *et al* (1985) suggest that the outcomes of reflection may be both cognitive and affective in nature, and that reflective learning may also lead to changes in attitudes, values and behaviour. This is an important concept for the students in the practice areas. They attend their placements to learn how to link theory to practice, develop their own knowledge base and how to integrate into a ward team. The effective use of reflection helps them to link together all the pieces of the jigsaw. Duke and Appleton (2000) agree that the use of reflective practice can assist practitioners to share knowledge they have gained and connect the theory to practice.

When questioned about the use of reflection in the clinical areas the students, on the whole, agreed that there was someone on the wards they could reflect with if required. The people who they approached for their reflective activities were both registered and unregistered staff. This was interesting, as the students were happy to reflect with an unregistered member of staff, but at times felt quite aggrieved when asked to work alongside them for a period of time. This demonstrated to me that the students appreciated and respected the experiences of the unregistered staff; it was the lower academic level of the unregistered staff that the students felt did not benefit the development of their own academic capabilities.

I asked the students with whom they reflected while they were on their placements. The students explained that, on the whole, the person whom they been working alongside when an incident occurred. For example, following the death of a patient one of the students had talked to the unregistered staff member about the situation, as she had performed last offices with her. I asked her why she had not discussed it with her mentor she said:

*'Because I was with the health care assistant at the time .....  
She made me feel better so I didn't need to talk to my mentor about it'.  
(Maria; year 2; semester 1).*

If an event happened that related to performing certain nursing procedures the students would wait until they returned to the school of nursing and discuss the event with their personal tutor. This would normally be in the form of a significant event or as a discussion surrounding their learning diary entries. This usually regarded an incident involving clinical skills for example, the changing of a wound dressing.

### **3.7.2 Reality of reflecting in practice**

Karen, a third year student, reflected upon an event when she had been asked to change a wound dressing with a staff nurse. They had approached the patient with the dressing pack and the procedure was carried out at the patient's bedside, without a dressing trolley. Karen explained that when she had undergone the same procedure with the ward sister previously they had set up a dressing trolley and performed the procedure 'properly'. The staff nurse had informed her that her way was the quickest way but when she had been working with the sister she had in fact carried it out following the written guidelines. A dressing trolley is accepted to be the cleanest way to undertake a dressing change at the bedside as it provides a clean area onto which the staff may place the necessary equipment to perform the procedure. However, if the nurse were to clean, for example, the bed table prior to commencing the procedure then this would be acceptable, this is supported by Jamieson, McCall and Whyte (2003). She did not feel that she could reflect on this situation with the ward staff, as she did not want to get any one in trouble. Indeed she did not believe that she possessed the authority to question the

staff nurse or to discuss the situation with the ward sister; therefore, she said that she told her personal tutor who would then inform the link tutor for the ward. This portrays that the students do not feel they are regarded as equals nor have the power to fully question in practice. These concepts will be discussed in more detail in the next chapter.

### **3.7.3 With whom should I reflect?**

Reflection in practice is ongoing for the students and they all appreciate the importance of reflecting to improve their own practice however the problem they face is with whom they should reflect. Schön (1983) claims that to nurse, reflective practice is essential and describes three aspects: knowing-in-action, reflecting-in-action and reflection-in-practice. Knowing-in-action relates to nurses recognising a certain phenomena but not being able to give a complete description of them. Reflection-in-action and reflection-in-practice tend to occur together where the process of reflection-in-practice is not time limited and may happen immediately or a few hours or days later. Reflection-in-action requires the nurse to listen and communicate and to create openness to know and receive. Students must feel comfortable to reflect in practice with their mentor or another member of the ward team if they are to develop their skills and confidence. Being able to reflect critically upon their own actions and indeed actions of others will allow them the opportunity to be able to question practices and to make a difference to the care that they plan, implement and evaluate both as a student and as registered practitioner.

### **3.7.4 Learning through reflection**

Eraut (1994) discusses the concept of process knowledge defining it as knowing how to conduct various processes that contribute to professional



action. Including knowing how to access and make good use of propositional knowledge. He claims that when people are asked to describe what professionals do or to examine the nature of professional action, the result will be a list of processes. Indeed, the quality of professional performance largely depends on the manner in which such processes are conducted and that all professional processes make use of propositional knowledge. He does clarify that the *knowing how* cannot be reduced to *knowing that* as described by Ryle (1949).

What is interesting here though is that many of the students when interviewed based their knowledge upon the actions they have observed within the clinical areas and what actions the practitioners have undertaken to deal with a variety of situations. The students themselves when questioned about their knowledge base would describe a list of processes they witnessed.

Mary, a first year student, stated:

*'Whenever I am not sure of how to do a clinical skill I ask one of the staff nurses to show me what to do and then I watch what they do. After that I can do it on my own because I know that they have done it right'. (Mary; year 1; semester 2).*

When I asked her what evidence they based their actions on and whether or not she questioned their actions during the procedure she answered:

*'They have been doing these things for years so they know what to do, they have the experience that I don't have at the moment, but if I need to know anything technical I will look it up in a book when I get home or ask my tutor when I get back into school'. (Mary; year 1; semester 2).*

This clearly highlights that the students consider that experience forms a sound knowledge base of how to undertake procedures. They do realise that

practitioners may not always be able to offer the rationale underpinning the procedure and that they may need to seek out this information for themselves.

### **3.7.5 Developing knowledge using reflection**

The students often found difficulty explaining what they understood by the term caring. Many felt that the basic nursing care skills delivered by the unregistered staff were indicative of caring. Whereas, the registered practitioners were perceived to be less caring, as their role was not primarily to undertake these skills but also to assess, plan and evaluate the care administered while liaising with other members of the multi-disciplinary team. Karen, a second year student, reflected with me regarding her knowledge and experiences of caring in the clinical areas:

*'When I was in my first year I learnt how to care for a patient 'cos I worked with the NA's. Now I am in my second year I am learning how to do ward rounds, the medicine rounds and referrals like the staff nurses do'. (Karen; year 2; semester 2).*

I asked her if she thought the registered staff were caring she replied:

*'Yes, but they do not have the time to do all the hands on care so they have to delegate these duties to the NA's. They need to make sure the ward is running safely'. (Karen; year 2; semester 2).*

She believed, on reflection, that the registered staff were as caring as the unregistered but due to the priorities on the ward they had to delegate the 'basic caring aspect' of nursing to the unregistered staff members.

### **3.7.6 Acquiring information**

Eraut (1994, pg.108) argues that an efficient and effective approach to the acquisition of information requires at least four types of knowledge, those being:

1. An existing knowledge base in the area concerned.

2. Some kind of conceptual framework to guide one's inquiry.
3. Skills in collecting information.
4. Skills in interpreting information.

He claims that these may be characterized as a combination of appropriate propositional knowledge and the ability to select and implement appropriate methods of inquiry. However none of these methods of inquiry may be learned from propositional knowledge alone and the knowing how is as important as the knowing that. The student nurses are all taught a variety of skills in collecting and interpreting information in addition to being given the underpinning theory prior to going on their placements. The conceptual framework that they are using at the moment is that of problem based learning. This encourages them to question when in practice but also if they come across a problem to attempt to find the answer themselves through a process of identifying the problem and attaining the knowledge and information they require to solve the problem effectively.

There are times that the students may not be allowed the time to seek out the appropriate information on which to reflect, for example, in the case of a cardiac arrest. Here they will have to reflect following the incident with someone who experienced the situation with them. This is known as 'deliberative interpretation' where there is time for thought and discussion. Benner (1984) suggests that experienced professionals learn to detect changes in a familiar person or situation. This is particularly important in nursing where intuitive detection of a change in a patient's condition often precedes more dramatic events or alerts nurses to the need for other sources of information. This capability, she claims, appears to be experientially

developed and that there may be a significant role for tutors in accelerating the learning process. It depends upon the continuity of contact with the patient on how the nursing care is organised and not just the recorded evidence and research that suggests this is the correct way to deliver care. Students reflected upon this phenomenon and hoped that when they became registered practitioners they would be able to make instantaneous decisions regarding a patient's condition, as they would possess the experience to guide them in their decision-making. The importance placed upon experiential learning by the students exemplifies how they are attempting to integrate theory into practice and to develop their own understanding of the rationales for undertaking certain procedures.

### **3.7.7 Experiential learning**

The discussions of experiential learning highlighted the different thought patterns of those students who had been working as unregistered staff members prior to the training programme and those who had entered nurse training with little or no health care experience. The students who possessed prior knowledge had pre-conceived ideas of what they should be learning on their clinical placements and during their reflections they felt that they were being '*treated as a health care assistant rather than as a student*'.

Julie, a second year student, who had been an unregistered staff member prior to undertaking her training, stated:

*'I feel that I am being treated as an auxiliary. I know how to do the basic cares. I should be being taught how to do real nursing, like the drugs and ward rounds'. (Julie; year 2; semester 2).*

The first year students who possessed little or no health care experience felt that being involved in planning and administering the 'basic care' was learning

how to be a nurse and that they could learn a lot about interpersonal and communication skills from performing the 'basic' care such as bed bathing a patient. The students with some prior knowledge did not seem to appreciate the importance of this and saw the procedure of bed bathing as a task rather than an opportunity to communicate with the patient.

### **3.7.8 Propositional, practical and experiential knowledge**

Brew (2002) describes two conceptions of knowledge that may be applied to this situation. That of '*propositional knowledge*', which is knowing as a quantity and could be claims to facts or truths that are added to the store of knowledge. The second being, '*practical and experiential knowledge*', where the students know the event or thing from prior experiences. These two types of knowledge are also described by Benner (1984, p.97) and have been discussed earlier in this chapter. Therefore, they already have a process of learning from their previous jobs. She further claims that there is an assumption that the accumulation of experiences leads to or parallels with the accumulation of knowledge. This in itself may cause problems for the learner as they may use this prior knowledge as an avoidance to further develop their knowledge and that they may use inadequate criteria for checking the accuracy of their own knowledge base. She continues to discuss that the process of learning is a continual journey and the highest point of knowing is not knowing, in which lies the paradox of learning from experience. Students who did have health care experience often reflected that practitioners did not appreciate what they already knew and often did not help them develop their established knowledge base.

Donna explained:

*'The staff know that I used to be an auxiliary and they tend to leave me to do that role ..... Perhaps it is my own fault sometimes because I can see what needs doing on the ward and just do it forgetting that I am a student now'. (Donna; year 1; semester 2).*

So prior experience may sometimes be detrimental to the learning needs of the student. Some of the students found it particularly difficult to make the transition from an unregistered member of staff to a student nurse especially if they had been seconded onto the Diploma programme from the Trust in which they were undertaking their training. From my observations and interview data, encouraging all students to reflect, regardless of their backgrounds, is vitally important if these people are to be able to fulfil their student nurse role and to enable them to become effective registered practitioners in the future.

### **3.8 Conclusion**

The data collection and data analysis processes were both interesting and illuminating. I had entered the fieldwork stage believing that everyone would know about the new curriculum and the strategy of PBL and that there would be an air of excitement amongst the staff in having the opportunity to share their experiences. What actually transpired was that many registered staff were aware of the changes but did not fully understand how nurse education had changed. The students were willing to share their experiences and wanted their voices and opinions to be heard and shared.

The only interviewee that 'gave me' the answers I had been expecting was the senior nurse for practice development. This may have been for a variety of reasons. He had been part of the curriculum planning team and been involved with the development and implementation of the new curriculum from its inception. The staff in the clinical areas had been informed of the changes,

via, briefing sessions and study sessions but many of them had not attended, due to pressures of work. Many of the staff had stated that they did not see the relevance of attending for their own practice.

The second aspect that was interesting from the analysis is that the students are still being judged on their level of competency by the amount of clinical skills they can undertake successfully without supervision. Melia (1987) in her work, discussed learning and working in the clinical areas and this thesis supports many of her findings, suggesting that clinical staffs' attitudes have changed very little over the last 25 years.

The overwhelming conclusions are those of the importance placed on clinical skills acquisition and the role of the registered practitioner. Many students alluded to the issue that they felt they were being trained to become health care assistants when they had been asked to carry out 'basic nursing care' duties. They had perceived these tasks to be the role of unregistered staff and not of a registered practitioner that they were expecting to become at the end of their programme

Nurses need to be aware of all aspects of the patients care but also need to understand how to make decisions, how to solve problems and the underpinning rationales for performing their care needs. There appears to a blurring of the boundaries of each role at the moment. Health care assistants are now undertaking training for their own roles i.e. National Vocational Qualifications that allows them to take more of an active role in the implementation of patient care and to some degree a role in the planning and evaluation of the care as well.

The main discussion throughout this chapter has surrounded the experiences of students in undertaking their clinical role. I have argued that students find it difficult to understand what is expected of them when they enter the clinical areas and as such they rely upon their mentor to direct them. In addition the students observe practices in the clinical areas and watch who is undertaking various care interventions. As such they become confused as to the role of the registered practitioner when they see the unregistered staff implementing the basic nursing care skills which leads them to believe that this is not one of their roles as a student. Yet the teaching and learning strategy of PBL should be promoting critical thinking and problem solving skills in the students, thus allowing them the opportunity to understand the division of labour in the clinical areas. The research questions that I had set out to answer in this thesis were about the effect of PBL on students in relation to the theory – practice gap and how it might have helped them to learn differently in practice. In part these issues have both been explored with the importance of clinical skills development being identified as the underlying factor that enables students to socialise into their clinical role. However the importance of students learning to be a ‘real nurse’ has become the focus of the discussions and there’s no denying that the realities of qualitative research led to me, as others before me, to refocus my analysis on the students’ experiences of preparing to adapt to ‘real nursing’ on qualification. The analysis of the data has examined and established the boundaries that the students have to overcome to facilitate them to achieve this goal.



I found some limited, but encouraging evidence of my hunch that the the use of PBL as the main teaching and learning strategy used within the school of nursing has encouraged the students to become more questioning while in clinical practice but has also given them the confidence to seek out information for themselves from books, journals and the internet as well as discussing issues with their mentors and other members of the ward team. This has helped them to be able to link the theory learnt to the practices they are involved with. Yet it must be remembered that there is still reluctance for students to question excessively as they believe that the staff will look on them unfavourably and think that they are not progressing in line with the curricula outcomes. The importance of receiving a positive and successful practice placement assessment prevents the students from questioning practices that may be out dated or ritualistic. The students would rather wait and ask questions in the safe environment of the school where their assessment will not be affected.

The art of reflection also allows them an opportunity to link theory to practice but as I discussed this is an area that is not utilised to its full potential and some students did not feel comfortable engaging in reflective practice with staff from the clinical areas. The fact that students are now taught in small groups while in school appears to develop their interpersonal and communication skills that they can transfer into the clinical areas.

Positively though, the registered staff all commented how much better prepared the students were for their clinical experiences stating how well they fitted into the ward team and that the students wanted to learn and be

involved in 'hands on' work. On the whole the students interviewed were all positive regarding their experiences.

The introduction of the practice development co-ordinator was perceived to be a positive addition to the team. She was viewed to be the link between theory and practice that had, at times, been missing from previous curricula and she provided additional impartial support to the students. The continued importance of developing the mentor role as stated in the *Making A Difference* (DoH, 1999a) and *Fitness for Practice* (UKCC, 1999) documents were viewed as positive developments by the students who relied upon mentor support to guide and develop them throughout their training programme.

Socialisation issues of has been highlighted as an important factor in students learning to be a real nurse and being able to fit into the team. Registered staff and the students use the ability to undertake clinical skills in an effective and efficient manner while on clinical placement as a level of their competency. I would therefore argue that to a point the various teaching and learning strategies used within schools of nursing makes little impact on the registered practitioners' assessment of students' competencies in the clinical areas. The registered practitioners do not always value the importance of students understanding the underpinning knowledge to support their interventions, but rather, they value the students' abilities to be able to undertake wound dressings, observations of the patients, medicine rounds and caring for IVI's. The next chapter will discuss and explore the boundaries of professionalism, culture, power and equality concepts that have arisen during the data analysis.

## **Chapter Four**

### **Exploring the boundaries of professionalism, culture, power and equality**

The implementation of the *Making a Difference* recommendations (DoH, 1999a) and the strategy of PBL were designed to enhance the students' questioning abilities; their ability to be able to link theory to practice; the ability to understand and apply research and evidence into their own practice and to become independent life long learners. Integral to these are the concepts of professionalism, culture, power and equality that impinge upon the students' abilities to be able to develop into their clinical role. The ensuing chapter will investigate the perceived power relations, inequalities, issues of culture and the notion that nursing is a profession. The discussion will examine the new curriculum and the strategy of PBL to establish if it assists students to overcome these inequalities and to illuminate the power relations in the clinical areas. It will progress to examine the strategy of PBL ascertaining the extent to which it has actually achieved its aims, which are to improve the students' understanding of their role and to aid in their development towards professionally registered practitioners. Furthermore, as nursing continues to strive to be recognised as a profession within its own right the concept of professionalism and how this impacts on the student nurse role will be investigated.

#### **4.1 Professionalism**

As discussed in the previous chapter the students were confused as to the role of the registered practitioner. The changing role of the nurse had led to discussions surrounding how they 'fitted into' the team and how they perceived their role. The changes implemented through the new curriculum

had attempted to prepare them for their careers yet an element of confusion still remained.

Through the educational programmes, nursing needs to be promoted as a discipline that possesses a body of knowledge making it distinct from other health care groups. The concept of a discipline maybe defined as: *'a field of study with a distinct theoretical body of knowledge within defined boundaries whose purpose is to guide the pursuit, development and dissemination of knowledge'* (Johnson and Webber, 2001, p.222). In fact Deans *et al* (2003) undertook a study of nurse education and the expectations of nurse academics for the year 2008. They concluded, from analysis of the data generated from their study, that nursing was unlikely to be considered as a discipline by the year 2008 and that the status of nursing as a profession would not be recognised by that time either. Furthermore, they predicted that the research assessment exercises would cause nurse academics to prioritise their research above teaching; curricula would be driven by national workforce priorities rather than academic standards and that universities would find it difficult to recruit suitably registered and experienced nurse academics. This in turn could lead to negative implications for the disciplinary development of nursing.

Prospective students who wish to undertake a nursing programme now attend university and will exit following a three-year programme with either a degree or diploma in nursing, dependent on which course they apply to, and are successfully accepted for. The move from hospital to university-based education may well be one of the reasons for the changing role of the registered practitioner as discussed in chapter one.

Henderson (1966) described nursing as being primarily to assist an individual in the performance of those activities contributing to health, or its necessary recovery that they would perform unaided if they had the necessary strength, will or knowledge. It is noteworthy that Henderson in this description states the word 'nursing', rather than specifically saying the role of the registered nurse.

The role of the registered practitioner has been constantly changing since the British nurse education system commenced at St. Thomas's Hospital in 1860. This in turn has led to a change in the skills and knowledge base required by student nurses to become practitioners that are '*fit for practice*' and '*fit for purpose*.' However, these changes have at times caused a degree of confusion for students in fully understanding their role and what will be expected of them on registration. Indeed, this wish for nursing to be recognised as a profession has led to an expansion of boundaries for the registered nurse in the clinical areas, with at times, these boundaries becoming a blur as to what their role is and what the role of the junior medical staff is.

Over the years nurses have taken on roles that were previously undertaken by the medical staff and following appraisals of job roles these duties have changed. Indeed, Hughes (1984) recognised the division of labour and argued that it was due to changes in macro-sociological and micro-sociological factors stating that one of the ways an occupation could attempt to increase its status was by taking on work that was accorded a higher social value. This would appear to be what nursing has been attempting to achieve in its bid to be recognised as a profession by taking on the work of junior medical staff.

The importance of developing nursing into a profession has led to a greater emphasis on the issues of power, equality and culture in the clinical areas. Prior to discussing these issues the elements that constitute a profession will be considered.

#### **4.1.1 Issues of professionalism**

The definition of a profession and the wish for nursing to be recognised as one has been a source of great debate. Johnson and Webber (2001, p.217) offer the following as a definition:

*'A profession is a vocation or occupation that requires specialised knowledge, skill, and methods based on research and is taught in an institution of higher education. A profession advocates high ethical standards of its members and engages in expanding its body of knowledge. Members of a profession function autonomously, are committed to advanced study and are motivated by service to society.'*

They have based their definition on Pavalko's (1971) dimensions of a profession that stated a profession would have:

- An educational period
- Elements of self motivation
- A theoretical framework
- Professional practice based on a theoretical framework
- Training
- A code of ethics
- Commitment to life long learning
- Relevance to social values
- Members in control of the profession

In this section I will discuss in detail the concept of a profession and argue that nursing is striving to be recognised as one but has not ultimately

achieved that aim as yet. It is important to note here that whether or not nursing ever becomes a profession will make little difference to the public, as they will still receive the same type of care they have always received. Although nursing has moved into higher education and is eager to expand its body of knowledge, it may be argued that it has not yet reached total professionalism. Indeed Kloss (1988) argued that nurses as a profession place considerable emphasis on formal training and hold that a nurse is not competent to perform a task which they have not been specifically trained to do, unlike most other professions, which recognise training acquired through practical experience.

Nurses themselves do not reach complete autonomy in their practices as they often rely on policies, procedures, medical orders and direction from the managerial hierarchy.

#### **4.1.2 Boundaries**

Witz (1992) believed that in relation to nursing, medicine was the dominant group and nursing was the subordinate group, with the medical staff possessing the power to demarcate responsibilities. She further argues that this demarcation is present between nurses themselves, who exclude more subordinate groups than themselves, for example, the lower status that was afforded to the State Enrolled Nurse (SEN). However, the SEN is now afforded the title of Registered Nurse but is on a separate part of professional register to the first level registered nurses who undertook a three-year training and education period. This could signify that nursing is attempting to remove this boundary and valuing the skills of all registered practitioners. Nevertheless, there is a demarcation in status attributed to unregistered

nurses and to students despite the fact that students are indeed unregistered practitioners. The demarcation in this case refers to the fact the students are undertaking a formal qualification that will ultimately allow them to become registered practitioners. Indeed, there is another demarcation line drawn between those students who are undertaking a degree programme and those undertaking the diploma.

Furthermore, we see a difference between those students who were trained using the Project 2000 method and those who are, and have undertaken the *Making a Difference* programme. There were comments made by the registered staff in the interviews that I held referring to the differences between students who had been trained using various curricula. Many of the registered staff commented that the old curricula focussed on the academic aspect of nursing rather than the practical side and, as such the students did not understand how they should behave when they were on the wards. Whereas, students who had undertaken the *Making a Difference* curriculum appeared to be better equipped to take on the student role.

Luker (1984) in her study examined the differences between student nurses who undertook their training as university undergraduates and those in a school of nursing, based within a hospital. She likened the differences to the position of the disabled in society arguing that the '*differentness*' of the undergraduates was identifiable through its visibility. This meant that there was no immediate opportunity for the concealment of information about them, as undergraduates wore different uniforms from the other students and this led to other members of the team stereotyping them. She alleges that the white uniform did at times provide a cover for rule breaking in so far as the



students became aware that if they deviated from the usual ward routine it would, on occasions, be tolerated as it would be interpreted in the light of their label 'university nurse'. Indeed, the demarcation lines drawn between the diploma and degree student nurses and the students who have undertaken various curricula are similar today. They may not wear different uniforms but they are categorised by their identity of which programme of study they embarked on.

#### **4.1.3 Nursing and medicine**

Taylor and Field (2001) have claimed that nursing adopted many of the structures and philosophies of the medical profession in their quest to become recognised as a profession. These included the move to replace training with education; the establishment of a career structure in the form of a progressive ladder for promotion, which is based on the male model of a working life and does not allow for career breaks and the emphasis on quantitative and scientific research and clinical effectiveness that are based on medical terms. Indeed Freire (1972) noted that the education process could act as a tool for conformity or an instrument for liberation and promotes an education based on liberation. Individuals are empowered through critical examination of their reality via the vehicle of reflection. The students and staff discussed the use of reflection during their interviews and identified that it did aid in their development and understanding of issues, yet many staff did not use reflection in depth. However Paley (2002, p.31) argues that the possibility that a culture of deference which originally characterised by nursing's relationship with medicine, has been introjected into the community of academic nurses. He further argues that the passive, unquestioning demeanour historically

required of nurses by the medical profession has been transferred to a number of high-profile nursing academics. Furthermore, Paley (2002, p.31) maintains that nursing's attempts to outdo medicine in the 'fantasy competition for status', has gone to ridiculously self-congratulatory attempts. Davies (1996) argues that nursing should create a new and genderless approach to professionalism by challenging the assumption that caring and empathy are female characteristics whilst authority and scientific logic are said to be masculine ones. This could be achieved by an approach based on collective responsibility; with egalitarian working between doctors and nurses and that the secrecy and exclusiveness that has been adopted by professionals should be discarded. The role of the educator is one of critical intervention (Monette, 1979) with the educator contributing to the students' ability to be able to think for themselves and empowering them to realise their own role. Freire (2000) proposes that by engaging in critical enquiry and reflection students will become responsible, accountable and ethical practitioners who wish to advance the discipline and practice of nursing. Nurses have developed their clinical skills to take on roles traditionally undertaken by medical staff for example, venepuncture and cannulation, they need to be equipped with the education base to undertake these tasks while possessing the ability to be able to critique and question the appropriateness of undertaking them. The roles of Specialist and Advanced Practitioners (DoH, 2003) provide a valid example of nurses preparing themselves for this. The reduction of junior doctors' hours although not a new initiative, the *Calman Report* (DoH, 1991) had previously called for a reduction in junior doctors' hours, was an impetus for nurses to change their roles.. Indeed

Greenhalgh (1994) and the NHS Executive (1991) had also reviewed junior doctors' hours suggesting that the impetus for many of the proposed advances in nursing practices originated from government and management's aim for a more cost-effective use of available resources. This had resulted in senior nurses being required to assume a proportion of clinical activities that had previously been undertaken by junior doctors.

By 1994 the UKCC had announced a recordable entry on the professional register of 'Specialist Practitioner'. The UKCC guidelines (1995) for advanced practitioners were concerned with the acquisition of academic qualifications, empowering nurses to develop and deliver high quality nursing care. However they did not define the role of the advanced practitioner in the acute sector, evading this by suggesting that this might stifle potential development of individuals (Neenan, 1997). Neenan (1997) further argues that nurses most likely to seek advanced practitioner status were interested in the technical aspects of the role, particularly when combined with the possibility of clinical decision making regarding medical treatments that had been traditionally led by doctors.

The UKCC (1997) stated that this type of nurse would be clinically focussed, educated to degree level and have specialist knowledge who was required to work autonomously and to exercise higher levels of decision making. Additionally they stated that this person should be concerned with advancing clinical practice, research and education, developing new roles in response to the changing needs of the health service and therefore extending the boundaries for future nursing practice. It was envisaged that this role would

serve to empower the nursing profession enabling nurses to influence future plans and decisions regarding health care provision (Neenan, 1997).

Following this the UKCC (2001) produced the Higher Level of Practice descriptors of the activities and competencies that would be used to assess whether a practitioner was working at an advanced level. The UKCC identified seven areas as being central to the advanced practice role. These were providing effective health care; improving quality and health outcomes; evaluation and research; leading and developing practice; innovation and changing practice; developing self and others; working across professional boundaries and organisational boundaries. The *Making a difference* document (DoH, 1999a) announced that those practitioners who were practicing as nurse consultants would be educated to at least Masters Level and would practice autonomously possessing the same authority as medical consultants. Various Government policies have been instrumental in developing the roles of specialist and advanced practitioners to meet the needs of reducing junior doctors' hours in the NHS workforce. These include the *New Deal* (NHSME, 1991); *Calman Report* (DoH, 1993); *A Vision for the Future* (DoH, 1993); *The Heathrow Debate* (DoH, 1994); *Scope of Professional Practice* (UKCC, 1993); *NHS Plan* (DoH, 2000); *Making A Difference* (DoH, 1999a) and reports by the Audit Commission (1999). We should also consider the impact these reports have had on the developing role of the unregistered staff. As the registered role develops in line with these policies and white papers then the role of the unregistered staff member also develops to encapsulate the traditional roles of the registered practitioners. Caines (1993) suggested that nursing duties not considered essential for registered nurses to undertake could be

delegated to unregistered staff in order to free up registered nurses for greater cost-effective use of their time and expertise. Castledine (1994) further suggested that the increased level of education that was meant to enhance the quality of nursing care appeared to have distanced the registered nurses from basic care, with these roles being delegated to the support staff. Indeed Gaines (1993) acknowledged that the higher level of education amongst registered nurses only served to advocate the use of support workers to perform 'simple care' duties. With Glen (1996) arguing that competence is not achieved by education alone, but through a combined experiential, attitudinal and educational attainment. Moreover, Castledine (1995) asserted that if nurses were primarily occupied with invasive high technical procedures there would be no opportunity for them to use the essential skills of assessment, planning and evaluation for which their knowledge base had specifically equipped them and without which there would be no nursing function. He continued that there would be a risk of nurses evolving into technicians or sub-doctors. Interestingly these comments by Castledine were echoed in the student interviews where they discussed the confusion they felt in understanding the role of the registered practitioner and often questioned why they, as students, were asked to undertake the role of the unregistered staff when this would not be a part of their role when they registered.

We could argue that many of changes that have occurred in the education of practitioners to a higher level are not as a direct result of the development of nursing practices and meeting the needs of the patients, but as a result of having to meet the changes in junior doctors hours and Government policies.

The relationship between nurses and medical staff has been studied in the literature (Mackay, 1993; Allen, 1997; Wicks, 1998). They argue that medical staff retain dominance whilst enabling the nurse to participate covertly in decision-making. Allen (1997) further argues that the changing boundaries between medical and nursing work, as nurses move into areas of medical work that were traditionally the domain of doctors, causes a social structure based on a 'negotiated order' as described by Strauss *et al* (1963).

Allen (1997) continues to discuss the social mechanisms that she believes are in place which retain the order of health care delivery. This allows for nurses to participate in medical decision making to a degree that belies their position in the formal organisational hierarchy. Wicks (1998) states that there is a need to question the divisions of labour in healthcare that she claims are based on a 'nineteenth century conception of master/servant gender appropriateness'. She suggests that the result of these divisions is that the medical problem dominates all other aspects of the patients' life.

Hurst (1999) has suggested a model of health practice that may aid in the blurring of these boundaries between the professionals. The model proposes that health carers should not be restricted by function, traditional compartmentalisation or overspecialisation, but rather should be equipped to provide the service required by the patient. I would argue that nurse education is attempting to achieve this aim by teaching the students to care for the patient in a holistic manner using a problem solving approach to the assessment, planning, implementation and evaluation of their needs. However, what probably needs to be developed is some form of shared learning for a time in the educational programme. That is to say that all the

professions allied to medicine would be taught together for subjects such as communication, clinical skills and working as a team. This may help to reduce the boundaries and for each member of the health care team to appreciate the different roles.

Interestingly the Department of Health (2004a, 2004b, 2004c) has published key policy documents displaying the Government's continuing drive towards an agenda for modernisation and improvement in health and social care services. They aim to promote and implement interprofessional learning ensuring that the professions allied to medicine will learn together and therefore work better together. They believe that this will develop teams who can work collaboratively across organisations and agencies who will communicate using a common language that aids effective team working.

#### **4.2 Nursing knowledge**

Porter (1992) stresses that while nursing is striving to develop a unique body of knowledge; this detracts from patients possessing knowledge and disempowers them. This he suggests, is that the development of nursing knowledge is for the benefit of the nurses rather than for the patient and, therefore, detracts from the service ideal. He believes that there is an alternative route for nursing to gain professional status and that is through clinical professionalism that is independent of medical supervision, for example the expanding of nurses' roles and nurse specialist/consultant posts. Nevertheless, Walsh (2000) argues that although nursing has a specialised body of knowledge it has drawn heavily on the social and biomedical sciences for its theoretical base, and as such does not possess its own unique knowledge. However, the move to a university based education and with the

curriculum having a more in-depth focus on the application of research in practice suggests that nursing is endeavouring to develop its theoretical base. Walsh (2000) further argues that although nurse education is now in higher education, the majority of nurses register at diploma level, rather than graduate level; conveying that many nurses are hostile to the notion of nursing becoming an all graduate profession and, therefore, not all nurses aspire to professional status.

There is indeed a continuing debate between the NMC, the RCN and nurses regarding the move to an all-graduate method of education with the RCN recommending the move. However, it may be argued that this would alienate a percentage of people from entering the profession, who would feel that they were not academic enough to complete degree level studies, for example those people who do not hold recognised academic qualifications, but rather possess vocational qualifications. This would suggest that there is a social divide inherent in nursing, where those who are deemed to be academically competent are the managers of the future, whereas, those who maybe are less academically gifted are the 'givers' of care.

#### **4.2.1 Financial concerns**

Financial concerns are not confined to registered nurses but also to those wishing to enter nursing. The reluctance for people to enter at degree level is not confined to standards of academia. Those who apply for the diploma will be given a fixed non-means tested bursary every month for the three-year training programme. Those who enter at degree level will receive a means tested bursary and as such many people cannot financially afford to undertake these studies. On completion of the two programmes the students



will both register with the same professional qualification, that of a Registered Nurse, it is only the academic qualification that differs. In the clinical areas this will make no difference to the level at which the student enters and many would rather undertake a post-qualification degree in the area they are specialising in on registration. The RCN are discussing the discrepancies in students' bursaries and attempting to find a more equitable solution, however, the debate continues. If bursaries were to be paid at the same rate for diploma and degree nurses we may well see an upsurge in applications for the degree course.

The *Making a Difference* curriculum offers students the opportunity to transfer to Level 3 studies in the final six months of the programme, providing the academic institution has included this in their curriculum. This is known as 'Advanced Standing', if students choose this path they will exit with a diploma in advanced standing and will have accrued 60 Credit Accumulation Transfer points at level 3. This suggests that although diploma courses are offered to students the NMC is attempting to encourage an all-graduate profession.

#### **4.2.2 The Nursing and Midwifery Council**

Included in the characteristics of a profession described by Taylor *et al* (1995) was that of having a high degree of autonomy and self-regulation.

Nursing is governed by the NMC so in this respect it achieves that criterion of a profession. Their membership is not entirely made up of nurses, but has representation from nursing, midwifery, health visiting, education, employers and consumers. In total there are 36 members. The rationale to include lay members was that the NMC believed there needed to be a balance of professionals and general public to ensure that the public were protected and

they, the NMC, were robust in protecting the good names of the nursing and midwifery professions (Asbridge, 2002). Admission to the NMC is by the election of people, by nurses, who have shown an interest in participating in the work of the council. However, Johnson (2004) considers that the NMC should also develop, with other relevant bodies, a national framework of standards for education and training in safeguarding vulnerable people. In addition, it should commission work to learn from good practice elsewhere, and on the model of its predecessors (the UKCC) should begin to invest in the systematic investigation of educational preparation, maintenance of professional standards and professional regulation.

The NMC also provide the regulation of nurses through competencies and guidance on ethical practice. They have the power to be able to remove registered nurses from the register if they are deemed as unfit to practice. It is also the nurses' responsibility, as individuals, to ensure that they maintain their own education and competency levels. As discussed earlier nursing is not totally autonomous but is guided by external forces that include the medical staff, Government agenda, national guidelines and local management issues. Indeed, Wilkinson (1997) proposes that to be truly independent is idealistic and undesirable. He suggests that it would be more appropriate for nurses to be aware of the external factors that control their practice and to challenge these when it affects their ability to care for their patients in the way they would wish. Macdonald (1997) concurs with this, stating that we should view nurses' and other health care workers' autonomy as relational, as they are not only dependent on working in an institutional culture that is supportive

of their capacity for independent judgement, but also upon supportive social relations.

#### **4.2.3 Nursing as a vocation**

Nursing is perceived by many to be a vocation that has the welfare of people as its purpose. Yet with the rising expectations of women in the workforce and an increase in men entering nursing there has been a rising dissatisfaction with the low financial rewards. The percentage of men entering nurse training has been 10% for some years; in 2004 it was 17% within the University used in this study. We should consider that midwifery is now all graduate and prospective nurses undertaking their training in Scotland and Wales also undertake a Degree programme. The debate surrounding the move to an all-graduate programme is in England.

Arguably what nursing should be interested in is the care of the patients, with nurse training identifying how the students care for patients while applying the best available research and evidence to their planned care and working in unison with relevant members of the multi-disciplinary team. In fact, Wade (1999) suggests that nurses should be concerned about doing the right thing for the patient at the right time, while engaging in collective enterprise with other health care professionals. The notion of caring as being a pivotal factor in becoming a nurse is an issue that requires some discussion. The debate regarding what is caring and who actually cares are causing power and equality boundaries in the clinical areas. Before we discuss the concepts of power and equality the term caring requires clarification.

### **4.3 Caring – A registered nurses role?**

During the interviews the concept of caring was discussed by the students. They believed that the role of the unregistered staff displayed the conventional definition of caring. However they did think that the registered staff were also caring as they ensured the effective planning, assessment and evaluation of patient care. Mackintosh (2000) and Stockdale and Warelow (2000) claim that caring as a concept is admirable in itself but is just one ideal among others arguing that there are other values and virtues, and as such caring cannot be held to over-ride them. In fact Kuhse (1997) and Koehn (1998) believe that caring should be regarded as a vice as it encourages favouritism; creates injustice; provokes inefficiency and tends to paternalism. Bowden (1997) proposed that the ethics of caring underestimates the powerful organisational, professional and social structures that conspire to subvert nursing, and which may even find in the caring ideology a source of legitimisation.

Morse *et al* (1990) claim that caring as a concept remains elusive and that there is no consensus regarding the definition of caring. With Savage (1997) observing that caring was a subjective concept and was difficult to define objectively and therefore to measure. Paley (2001) argues that nurses' *knowledge* about caring is almost exclusively knowledge of what is *said* about caring. He continues that the vast majority of empirical studies report the views and perceptions of nurses, and make no attempt to describe what nurses actually do. This is an interesting insight into the definition of caring and relates well to the student nurse role. During this study the difficulties that the students were having when undertaking their role were understanding the

registered practitioner's role and what they should be doing to develop into their future registered role. The students witnessed the unregistered staff administering the 'basic' nursing care duties or the 'hands on' care, whereas, they perceived the registered practitioners to be planners of care, managers, and at times, office workers. These responsibilities would appear to lack a sense of caring. Are we, therefore, to assume that professional barriers hinder nurses' caring and is this why the students feel vexed when they are asked to undertake tasks such as, bed bathing and feeding patients?

#### **4.3.1 Perceptions of caring**

The participants in my interviews had various perceptions of what caring actually entailed. To the general population nursing and caring are synonymous, they perceive the nurse as being the person who will look after their physical needs, talk to them and hold their hand if they are in hospital. The student nurses did not view their role or the role of the registered practitioner, as caring for the physical needs of the patient, but rather saw this as primarily the unregistered role.

Caring is central to nursing and each nurse would, no doubt, claim that they are a caring person. Perhaps then we need to redefine our own ideas of what caring is. The concept is diverse and in the clinical areas it would be foolish to say that registered nurses do not care as much as the unregistered staff, because they perform less 'hands on' care. The planning and evaluation of a patients stay in a health care environment also equates to caring. Without effective and efficient planning and evaluation of care interventions, the patients would not receive the appropriate attention. This is, therefore, a form of caring. Indeed, Arthur *et al* (2001) differentiates between 'caring as an

activity' and 'what is said about caring'. We could use these to explain the views of the students in their attitudes towards caring; in that, they believed the unregistered staff perform the act of caring whereas, the registered staff know about caring and are able to direct the care interventions.

#### **4.3.2 Role of the nurse**

Watson (1997) encapsulates why the students have found difficulties in understanding their roles and development needs while in clinical areas. She describes modern health care as being very high technical, losing the human element in the process and that the nature of caring has become impersonal. The idea that caring is about a therapeutic nurse-patient relationship is lost if the human element has gone in health care environments. Whereas, Benner and Wrubel (1989) claim that caring is not simply about being physically present in the same room as the patient, but it is about being able to understand the verbal and non-verbal communication signs from the patient. This would, therefore, seem to explain that although the registered staff may perform less 'hands on' care interventions, they do listen to patients, understand body language and can relate these verbal and non-verbal cues to the effective planning of patient care.

The issues of culture, power and equality relate to the differences between the registered and unregistered staff with the notion of caring being one of the boundaries. The students perceive that the registered staff retain the power base and authority in the clinical areas with their ability to be able to plan and delegate care activities. The importance of the ward team working as a part of the multi-disciplinary team is important, yet in terms of equality, there is little to be observed with a very definite social status attributed to registered and

unregistered roles. Before the students can become an accepted member of the ward team they need to understand the culture of the area they are allocated.

#### **4.4 Culture**

Within the clinical area there is a quite definite cultural pattern that in itself leads to levels of social status and power. The ward managers hold the authority, with this grade planning and controlling the ward environment. The unregistered staff hold the least formal authority in the grading system, yet in reality they can in fact wield considerable informal authority. The students hold relatively little authority and their social status can be difficult to define. They are not permanent members of the staffing team, but are in fact, visitors to the ward or unit, for a pre-defined period of time. This makes it difficult for the staff to understand where the students fit in. They are neither registered nor unregistered members of staff. They are in the clinical areas to learn to become registered practitioners and will in the future hold some limited power and authority, but as students they have to learn the culture of that ward and understand how they will fit in.

##### **4.4.1 Culture in the clinical areas**

Mangena and Chabeli (2005) state that culture plays an important role for the students in that it provides the basis for language acquisition and comprehension as reasoning is empowered through language and culture. Culture can either facilitate or hinder the thinking process, since different groups react differently to group interaction.

Kendall and Wickham (2001, p.14) comment that 'culture' refers to the way of life of a group, including the meanings, the transmission, communication and

alteration to those meanings, and the circuits of power by which the meanings are valorised or derogated. By analogy, culture involves the group's way of life, particularly its meanings; with the emphasis on the politics of the ways those meanings are communicated. Culture must concern itself with the study of meanings and their dissemination, that is, with circuits of power and with forms of resistance. The students, while in clinical placement, are having to learn and understand the cultural patterns of each ward or unit they visit and attempt to immerse themselves in a seamless fashion. In addition, they need to understand the language of that culture to be able to cross the boundaries and feel a welcome member of the team. Language is an integral part of how the culture operates as a social force. It reflects the cultural norms, assumptions and patterns and contributes to their maintenance (Thompson, 2003a).

#### **4.4.2 Culture as a boundary**

This process of language and culture helps the ward team to communicate and convey messages between themselves; sometimes without them being aware the process is taking place. The students need to become members of this group and it is these processes that can hinder them. It is difficult for them to fit in with the culture if the staff do not realise their own values. Culture can cause a boundary for the students, it can be used to exclude or marginalize the student group and create a '*them and us*' situation. This is why the effective use of clinical skills and understanding the ward routine is so important. It helps the students to 'fit into' the culture as they are using the same language as the clinical staff and integrating into their cultural pattern. Indeed, Thompson (2003b) explains that a significant feature of culture is the



way in which its members become so immersed in its patterns, assumptions and values they do not notice they are there. He believes that this may be both positive and negative.

The positive aspect is that it can contribute to an '*ontological security*', a sense of psychological integration allowing people to be able to pursue everyday activities without having to question everything they do. The negative aspect is that they see the world from within the narrow confines of one culture and fail to recognise cultural differences and their importance for the people concerned. This is relevant to the students. As mentioned the students want to fit in and do not want to ask too many questions, they want to be a part of the culture. During the fieldwork the registered practitioners had identified the 'good students' as being those who understood the ward routine and who could undertake clinical skills unsupervised.

These students fitted into the cultural base whereas the students who asked questions and had to be taught how to undertake the clinical skills did not fit in as straightforwardly. However, they were still perceived to be 'good students' but were thought to require more guidance while in the clinical areas from the staff. This was due to the registered and unregistered practitioners not understanding that the students had a culture different to themselves. The strategy of PBL should, to a degree aid in the crossing of these boundaries, however many of the registered practitioners believed that PBL belonged to the academic arena and as such did not cross over the boundary into clinical practice.

#### **4.4.3 Ordering**

Kendall and Wickham (2001) forge links between culture and what they call '*ordering*'. Culture, they claim, is one of the names given to the different ways the world goes about ordering people and refers to how social structures intertwine with cultural patterns and formulations. They continue that the cultural factors rely on the social structural level that underpins and envelops them. These include the constraints of social, political and economic issues. The clinical environments are very much governed by these constraints, in that, they need to adhere to Government policies, local and national guidelines and medical instructions that create their cultures and thus can make it difficult for others to enter and attempt to change the culture.

The concept of culture does not stand alone as a boundary. Power plays an enormous part in the development and maintenance of a culture, while at the same time causing inequalities.

#### **4.5 Social inequalities**

These inequalities were experienced by the students, who believed that they were not treated as student nurses when being asked to work alongside the unregistered staff, and therefore, were not treated as an equal in status to the registered practitioners. Grabb (1993) explained that the study of social inequality is really the study of human differences. Structured inequality involves a process in which groups or individuals with particular attributes are better able than those who lack or are denied these attributes to control or shape rights and attributes for their own ends. This structured inequality can be directly associated with the issue of the difficulties the students experience in defining their own role.

#### **4.5.1 Social structure**

The students enter their placement areas with little knowledge of what is expected from them or the culture on the ward and as such they do not possess any prior experiences in that area. They are instantly disadvantaged from being able to gain an understanding of the prevailing social structure. Again, the importance of being able to undertake clinical skills without supervision or having to question how to perform them, allows the students the opportunity to become involved in the social structure.

When discussing the social structure of the clinical areas it is useful to look at Giddens (1984). He discusses the '*structuration theory*' that can be applied to the health care setting. A key element of the theory is the attempt to understand social reality in terms of both the structure, that is, the significance of social divisions, and other aspects of the social organisation, the exercise of choice. The students enter their practice placement areas with some underpinning knowledge that they have received from their academic studies. They have been encouraged to question when they are in clinical practice and informed that they will receive support from their mentors and other members of clinical staff. When they arrive on the wards they are confronted with an unfamiliar culture, where all the staff appear to know how and when to perform the daily rituals.

The students are then confronted by a choice of either following what is expected of them and 'getting on with it', or questioning and observing the practices. They have to interact with the external world of the structure and other people to understand the social reality. As they learn how to interact with others they manage to find their own identity and can then begin to exert

their own social influences. The more senior students are able to use their developed identities to exert their influence over the junior students and the unregistered staff, as their developed knowledge base allows them the opportunity to offer rationales for the administration of care and the performing of clinical skills. In essence they are moving up in the social status and as such they become aggrieved at being asked to undertake and participate in what they perceive is the work of the unregistered staff.

They are becoming empowered and feel they are in a position to be able to support others. Their identities in the clinical areas are also changing. The registered and unregistered staff, view the more senior students as someone who has a developed knowledge base and is ready to work alongside the registered member of staff to learn about their role. The students now have a degree of power and authority that enables them to be viewed more as an equal, than the junior students by staff in the clinical areas.

#### **4.5.2 Socialisation**

We could argue that the students are now socialised into the clinical areas. Thompson, Melia and Boyd (2003) discuss this socialisation process. They state that the speed with which the nursing recruits adopt the prevailing mode of nursing has both advantages and disadvantages. On the positive side it affords the learners some immediate ways of coming to terms with what they see, and of finding a way of functioning. The newcomer learns how to carry out nursing work with more confidence and competence and so the socialisation process enables the student to cope with crises and emotionally stressful situations. However, the disadvantage is that this socialisation may

put at risk the students' initial sensitivity to situations and they may compromise their own moral values in an attempt to be treated as an equal.

#### **4.6 Power**

The concept of power is dominant within nursing. The ward managers possess some degree of authority and not only manage the day-to-day running of the ward but also manage the resources and can influence the quality of the learning environment.

Thompson (2003b) offers examples of terms when power can manifest itself.

- Control or influence over the allocation of resources;
- Knowledge, expertise and skills;
- Professional discourse and legitimation;
- Statutory powers;
- Hierarchical power by virtue of status or position within an organisation.

##### **4.6.1 The multi-disciplinary team and teaching**

These five examples can be transferred into the roles of the registered practitioners in the clinical areas. The students view the registered practitioners as possessing the knowledge and expertise required to perform the nursing role, and it is to them to whom they look for guidance. They believe the registered practitioners are the professionals who they need to emulate to prepare them for their future roles as professional registered practitioners. To a point, the registered practitioners have statutory powers, in that they are able to discipline staff if they fail to adhere to the accepted policies and procedures. In contrast, the students do not view the unregistered staff as being professionals with power, but rather the 'hands on' care givers who follow the instructions of the registered practitioners.

Thompson, Melia and Boyd (2003) reason that many of the tensions and sources of conflict in hospitals may well be due to the lack of clarity about the scope of responsibilities attached to the roles performed by various members of the team. They identify that the multi-disciplinary team has been ill prepared to work in a team as they are segregated from one another during their basic training.

They suggest that boundaries and roles associated with the multi-disciplinary team need to be carefully and explicitly negotiated, clarifying the scope of each player's responsibility or accountability to other members of the team. This they argue will aid in the prevention of misunderstandings, tension and conflict in the teams. Furthermore, they state that many ethical problems, interprofessional tensions and interpersonal conflicts could have their origin both in the traditional structure of power relations, between nursing, medical and other staff, and in the actual way that power is exercised and shared between the team.

#### **4.6.2 Identity**

Weber (1968) asserted that power contained certain characteristics. These he argues include; that power is exercised by individuals and therefore involves choice, agency and intention; it involves the notion that an individual can achieve or bring about goals that are desirable; it is exercised over individuals and may involve resistance or conflict; there are differences in interests between the powerful and the powerless and that power is negative that involves restrictions and deprivations for those subjected to domination. These features of power can be visualised in the clinical practice settings that the students are exposed to during their training period.

The students are expected to understand and engage in the ward routines, if they are to be accepted. Many do not question that routine but fit in with it, if the routine is changed again this is accepted without question, exemplifying the perceived power base and authority exerted by the staff in the clinical areas. Thompson, Melia and Boyd (2003, p.33) liken the student nurse role to that of a patient. The loss of a certain amount of identity, taking on a generalised role and behaving accordingly are experiences common to nurses and patients. The student has a uniform, the patient has nightwear; decisions about day to day living have been taken from the person and placed in the hands of the organisation, e.g. meal times and off duty rotas for the nurses. New nurses often feel that they are in a rigid hierarchy, which relies on rank rather than rationality and reason. Their freedom to act and question what they see is sometimes restricted.

Conversely, when a member of staff or a student would like to implement a change in the ward areas, resistance is often noted. The authority required to make this change is a powerful struggle for those wishing to initiate the change. People who do not want the change to happen may use their power base and level of authority to resist, block, sabotage or counteract the attempts. This is the key element in Foucault's (1982) theory that power is not a one-way phenomenon. The exercise of power by one person or a group can be viewed by others as domination and, therefore, contains the potential for abuse and oppression.

However, power is also positive and can assist in people developing and attaining additional resources. Foucault (1982) argues that power is not an absolute entity that people do or do not have. Rather it is a property of the

interactions between individuals, groups and institutions. He recognises power as being positive, but that we should be aware that it could be present in a multitude of disguises that include; state organisations, internal bureaucracies and institutional arrangements. These aspects of power are all present in the culture of the NHS and the students are subjected to them on a daily basis. They have to abide by the rules of the ward, the governing body, the university and their own moral standing.

#### **4.6.3 Resources and authority**

Interestingly, the concept of power base has been likened to the availability of resources. The NHS has a finite amount of resources that can prevent change occurring and lead people to become disillusioned. Change often requires different and more resources to make it a success, for example, further training for staff. If the monies are unavailable for this to happen then the change process is hindered. The resource managers, rather than the staff in the clinical areas, hold the authority in these situations, leading to boundaries between those who practice in the placement areas and those who allocate the resources.

Whenever a student enters a ward for the first day of their placement they will recognise the seniority levels of each grade of staff, from the uniforms they wear. The wearing of the different uniforms symbolises the levels of authority present in the clinical areas. Those staff that wear the most senior uniforms, the ward managers and staff nurses, possess authority as an everyday feature of their working lives. They are the decision makers of the ward, who due to the accountability aspect of being a registered nurse live with the consequences of those decisions made. However, the authority can be and is



delegated, when these staff assign duties to more junior members of staff, including the students.

As Thompson (2003b) and Foucault (1982) argue this represents that power is not an absolute quality that a person either does or does not have. The amount of power an individual can exercise depends, upon the choices they make. They argue that power can be likened to desired outcomes to achieve particular goals. In this respect, power has a past and a future dimension, in that it represents the historical outcome of previous actions and future directions that may be successful.

#### **4.6.4 Oppression of students**

This fear of questioning in the clinical areas could be viewed as a form of oppression, but it may be due to a lack of understanding, by the registered practitioners of the learning process and obstacles to learning that can be generated. Staff should not feel threatened by the students questioning but should welcome it as a constructive process through which issues can be clarified or changed as appropriate. It is difficult for clinical staff to answer all the students' questions as the clinical areas are often busy and staff feel pressurised by the workloads. It is idealistic to suggest that the staff must be available for the students all the time. The environment should be an effective learning area, where there are resources available for the students to access if their mentors are busy with other activities.

The discussion of mentors being too busy with clinical activities has led to many Trusts employing a 'practice educator'. The role of this person is to assess the learning needs of permanent staff members and to develop an environment that is conducive to learning. The post holder is normally a senior

member of staff who has shown an interest in education. Although, they are primarily employed to assess and develop the learning needs of the permanent members of staff, they can also be used as a resource for the student nurses. The post has not been developed to replace the clinical tutor role but to enhance learning opportunities in the clinical areas. However, registered practitioners must offer some recognition to the importance of the students learning needs and allow them the opportunity to participate in and contribute to care interventions.

#### **4.6.5 Surveillance**

While in placement the students are under constant surveillance due to them being assessed in clinical practice and having to meet their competencies as required by the NMC and the university. Foucault (1977, p.171) compares surveillance with the construction and design of a military camp where the camp represents a diagram of power by means of general visibility. He states that this model of the camp or at least its underlying principle was also found in urban development, in the construction of working-class housing estates, hospitals, asylums, prisons and schools, leading to a spatial 'nesting' of hierarchized surveillance. Similarly he describes the environment created by an outbreak of a plague where the spaces become enclosed, segmented and observed at every point. Foucault (1977, p.197) continues to argue that, *'Individuals are inserted into a fixed place, in which the slightest movements are supervised and in which all events are recorded. In this situation power is exercised without division, according to a continuous hierarchical figure, in which each individual is constantly located and examined'*. This description

could be related to a hospital ward where the staff maintain constant surveillance of the patients and to a lesser extent the students.

Foucault (1977) further argues that surveillance is integrated into teaching relationships where the teachers, or with regard to student nurses, their mentors and other permanent members of staff 'observe' the students behaviour ensuring that their behaviour meets the predetermined outcomes required at that stage of their training. Although surveillance rests on individuals, its functioning is that of a network of relations from top to bottom and laterally. This network holds the whole together and traverses it in its entirety with effects of power that derive from one another. This transference of power can be witnessed in the clinical areas where the students perceive that their mentors and indeed other registered practitioners possess the power to refer them in practice if they do not successfully achieve their learning outcomes. Thus we observe a division of labour within the clinical areas where the experienced registered and unregistered staff become the supervisors of the students.

Abbott and Sapsford (1997) agree with the notion of surveillance claiming that it presents implications for the maintenance of power relations in the working environment and indeed in working with the patients. Bloor and McIntosh (1990) argue that surveillance is always something that has the potential to provoke resistance, and indeed is likely to do so, as the non-professional expresses their world view and values. However surveillance is something the students cannot avoid. Goffman (1968) described his theorizing of institutional life and argued that the hospital is a powerful institution where staff are subject to, and must learn, various formal and informal rules and regulations.

He argues that staff behaviour is shaped by the institutions and as such the students are also expected to follow the same rules or face action by the institution. Thompson (2000) contends that surveillance has implications that include:

- Individuals contribute to their own oppression through the internalisation of disciplinary practices;
- Power relations operate within systems of ideas and do not rely solely on the actions of individuals or groups;
- Those who wield power, including those of us engaged in 'people work', are also subject to disciplinary practices, that is to say, the controllers and the controlled.

These points relate to the issues of inequality, discrimination and oppression.

#### **4.6.6 The students' mentor as an oppressor?**

The role of the mentor in assessing the competency level of the students may be viewed as a form of oppression. The mentor should, in theory, work alongside their student for 50% of their clinical placement time. During the times they are not with the student, they are expected to liaise with the staff who have been working with the student and discuss their progress. The power base of the mentor is extremely strong, in that they can if necessary refer the student in practice. This would occur if the mentor believed the student were not achieving their competency level for the stage of their training. The role of the mentor is meant to be one of support and guidance and it is this role that can help the student feel a part of the team, equal and less oppressed. Spouse (2003, p.151) discusses in detail the role of the mentor in her research. She describes how students felt a '*sense of*

*membership of a clinical community*' that was central to their development of identity and enhanced their ability to learn. This had been achieved as students had gained more confidence and knowledge as they progressed through their training period, but it was also affected by the support given to them by their mentor.

The students I interviewed and observed during my fieldwork referred to the amount of support they received from their mentors in practice. Those students who perceived their mentor to be helpful and interested appeared to fit into the ward team and benefited from their clinical placement area. Those students who felt their mentors were less supportive and a little disinterested did not feel that they benefited from their clinical experience as much. Interestingly, it was these students who often commented that they felt as though they were being used as 'a pair of hands'. Wenger (1998) identifies the importance of good social support particularly when people are new to the work. Indeed, Spouse (2003) states that a human characteristic is wanting to become an integrated member of the society, and to work on its behalf and, thus gain their identity in doing so. This was certainly how the students felt during my fieldwork. They wanted to fit into the team and be a welcomed, valued member. They wanted to be recognised as student nurse and not an extra pair of hands they were all attempting to forge an identity for themselves.

#### **4.7 Problem Based Learning**

One of the largest boundaries that the students needed to overcome in practice was to be accepted as a team member. Many of the students saw the ability to be able to undertake clinical skills in an effective and often

unsupervised manner to be one of the main ways of being accepted. In addition, they saw the ability to undertake these skills as crossing the boundaries from being viewed as an unregistered staff member to being accepted as a student nurse, who was learning how to become a registered practitioner in the future. This appears to be an indirect way of proving that they, the students, are indeed professionals in the clinical area, with a higher social status, than the unregistered staff. During the fieldwork process there was a clear sense of demarcation of the students and the unregistered roles. The students believed that their clinical and problem solving skills, not only helped them become a member of the team, but also helped to enhance patient care. This was due to the fact that they could implement and evaluate the holistic care they had administered effectively as they had learnt the underpinning knowledge to support their actions through academic study.

Demarcation of boundaries proved difficult for many students in the clinical areas. Although, they had stated that they did not want to be used as a 'pair of hands' they did understand that they needed to be able to undertake and understand the unregistered role at times. However, they wanted to be able to embark on the registered nurse role effectively and efficiently. Feedback regarding the ability of students to perform in clinical practice from previous curricula had been rather poor, in that registered practitioners had commented that all the students did *'was to stand around and did not want to muck in'* (Susan; ward manager). They also claimed that now the students were being educated in university they *'thought they were too good to work with an NA'* (Susan; ward manager). The recommendations from the *Making a Difference*

document including the use of PBL were implemented to try and overcome these concerns. The question is has it achieved this?

The concept of PBL as a strategy for teaching and learning had been implemented into the school of nursing, used in this study. The degree of implementation varied dependent on lecturers; some lecturers had embraced the strategy, while others have been slightly less enthusiastic. However, each base group was assigned a number of triggers to complete during their training and each lecturer presented them to the students. The differences in the lecturers' facilitation styles varied and it may be argued that some lecturers would 'teach' the students the information they required, rather than facilitating the learning process. Nevertheless, PBL had been welcomed by the students, this can be seen through their evaluations of the modules where they stated that they *'have enjoyed working in small groups with a facilitator'* and that *'PBL has helped me to develop my knowledge and I know where to go and find the information from'* (Debbie; Year 2; semester 2).

In the clinical areas it was viewed as a purely academic concept that was not being used yet the concept has the capability to be used across both areas. This is quite a concern as we are constantly promoting the importance of linking theory to practice, to ensure that research and evidence based care is implemented and to advance nursing as a profession. In spite of this, the main teaching and learning strategy to help achieve this is not being used in the areas where the reality of nursing is happening.

#### **4.7.1 Problem solving**

Student nurses are expected to integrate into the ward team when they arrive in their practice areas and to achieve a specific set of competencies as

provided by the NMC. Furthermore, the registered practitioners expect the students to be able to assist themselves and other members of the ward team with a degree of understanding. They are expected to be able to problem-solve particularly when they are involved in nursing activities such as the nursing process. This is important as the planning, assessing, implementation and evaluation of patient care requires the nurse to be able to assess the patient by looking at non-verbal signs of communication, comparing the information provided by the patient with what is the accepted norm and to be able to refer to relevant members of the multi-disciplinary team in an appropriate manner. The students need to develop critical thinking and communication skills that will enable them to communicate and collaborate with other health care professionals. This was also an important element in previous curricula.

#### **4.7.2 Advantages of PBL**

Nonetheless Glen and Wilkie (2000) claim that PBL is considered to have several advantages over more traditional methods of education. First, student motivation tends to be high because the material presented is relevant and applicable to the clinical situation. Second, the emphasis is on encouraging the students to use their existing knowledge, a deficiency, they claim of the traditional passive teaching methods. The skills that are developed through this process are intended to facilitate lifelong learning and the ability to deal with problematic situations encountered during their professional lives. In fact the ENB (1996) reported that pre-registration students on PBL courses reported increased confidence in dealing with complex situations. In addition



to reflection in practice becoming second nature as students developed the ability to think through practice issues in a reasoned way.

#### **4.7.3 Disadvantages of PBL**

There are disadvantages as well to a curriculum using PBL as a strategy for teaching and learning. Needham and Begg (1991) were concerned that some students may find it difficult to transfer the knowledge they had learnt through undertaking the triggers, as some may not be easily transferred to clinical practice. They identified that the feedback sessions students had with their facilitator were of the up most importance in ensuring that they were able to transfer the knowledge. If there were a lack of facilitators to take these sessions then feedback could be poor from the facilitator to the student.

Andrews and Jones (1996) were concerned that facilitators might predetermine problem identification leading to students being weaker in recognising problems. This in turn may hinder the application of classroom concepts to the clinical settings. It is an issue that requires consideration yet the philosophy of PBL is that the students should be leading the sessions and the lecturers facilitating. Whether or not this occurs is debatable but the concept has its advantages over the old curricula that were often lecturer led and caused boundaries, as they did not allow for a deviation from the established timetable. Indeed, McMillan and Dwyer (1989) and Townsend (1990) argue that some students do not always want or like self-directed learning methods but would rather have direction, order and content. This is due to the fact that there are statutory and defined outcomes from the professional bodies that students have to achieve. Therefore, nursing should adopt a more limited approach of 'freedom with boundaries'.

In respect of lecturers, Townsend (1990) in her study found that some were resistant to the self-directed approach as they were used to the didactic methods and felt ill prepared for more open approaches. Yet Alavi (1995) argued that PBL encourages deep learning as it moves the locus of control from the taught (the lecturer) to the sought (the student). She suggests that this will prevent 'surface' learning where the student is able to recall information but there is little time for independent learning due to the expanse of the curriculum. PBL will, however, promote a 'deep' learning where teaching and learning methods foster active and long-term engagement with learning tasks.

Williams and Lau (2004) argue that meta-analysis shows that, PBL in a medical curriculum does not produce doctors with better factual or clinical knowledge than those from traditional curricula. They continue that there is no evidence that the new strategies will produce better doctors, and as a result, risk that students with inadequate knowledge will become poor clinicians. Furthermore, they believe that a rigorous comparison of 'traditional' versus 'new' curricula is urgently needed to determine the best strategy for training doctors. If medical schools are concerned that the strategy of PBL is producing poor clinicians then surely schools of nursing must now re-examine their use of this strategy.

The students in this study had suggested that they would seek out information for themselves if they believed they required more knowledge. Yet in the clinical environments they would still question practitioners and many felt that the practitioners did not always answer their questions fully. This would suggest that the concept of a theory practice gap remains, with the students

being self-directed in their own learning when in school, but in clinical practice they find it difficult to relate the philosophy of PBL.

#### **4.7.4 Exploring boundaries using PBL**

The advent of PBL has allowed for an exploration of these boundaries. Set lectures and seminar groups still remain, as there has to be a core content that each individual receives. The PBL sessions, however, give the students the opportunity to explore their own learning needs and to demand information that relates to the knowledge base they require to function as students. The lecturer, therefore, becomes the facilitator rather than the giver of information. This should enable the students to be able to link the theory learnt to the practice areas, thus allowing them to be able to engage in theoretical analysis related to practice that can only realistically be carried out in the workplace (Swallow and Coates, 2004).

Indeed, Spouse (2001b) discusses the complexities of practice and practice development and advocates cultures that value education as an essential and continuous process. The advocating of a culture that embraces education is one of the aims of the *Making A Difference* curriculum and PBL, in that they want the students to recognise that learning does not only occur in the classroom but also in the clinical areas. In addition, PBL is attempting to promote students who are critical thinkers and can link the theory they have learnt into their clinical practice. Nevertheless, where nursing needs to further develop, as a discipline is, in its research base. It needs to move away from the medical dominance and extend its own individual research and evidence base.

#### **4.7.5 Collection code**

Bernstein (1971) distinguishes between two types of curriculum; the '*collection code*' and the '*integrated code*'. In the collection code subjects are taught separately, and no criteria are permitted which might allow comparison of different subjects. The only source of unity in such a course of study is the timetable; this perpetuates separate areas of study. It also conveys a message that the lecturers have the power to decide what subjects should be taught and, therefore, what knowledge base is required. Treacy (1987) agrees with Bernstein's idea of a collection code. She reported that as a result of it being used in nurse education in Ireland the students felt powerless, uncertain and depersonalised. The only way they managed to complete the course was through obedience, deference and subservience by compiling and conforming to the rules and following the timetable.

Interestingly, Melia (1987) in her research found that students managed to 'fit in' with the ward team through 'compartmentalisation' and 'segmentation'. That is to say, that they were able to understand how they should behave in various situations. Throughout this study I noted that the students were in fact able to do this. They would ascertain the routine on each ward and follow that. Although they understood the importance of learning new skills and understanding the essence of nursing care, they did not want to upset the equilibrium on the wards. To achieve this they did not question excessively, as they did not want to appear to be disputing how the ward was run or the rationales for administering certain aspects of care.

Bernstein (1971) ascribes this to the notion of 'tribes and territories' where the students are associating the need to fit in with a focus on 'getting through the

work' and maintaining local loyalties, i.e. being accepted as a team member. The students, therefore, would either read about issues in their own personal time or ask their facilitator when they return to the school so as not to upset the status quo they had developed for themselves in the clinical areas.

#### **4.7.6 Integrated code**

Bernstein (1971) also identified the 'integrated code' where the emphasis is not on the autonomy and separation of subjects, but on the active connections between them. In this code knowledge is organised in themes and the timetable structured to support the exploration of these themes. This type of code or curriculum is aimed at trying to dismantle and redefine boundaries allowing for a flexible approach to teaching and learning. The strategy of PBL could be classed as an integrated code as it allowing the students to ascertain their own learning needs and encouraging them to question both in the academic and clinical sectors.

The registered staff have commented that the students were fitting into the ward team and that they were more adept at '*mucking in*' than previous students. The questioning abilities of the students were commented on with the staff claiming that the students were keen to learn while in the clinical areas. Again this relates very clearly to the notion of 'getting through the work'. On face value we could assume that PBL is indeed helping the students cross the boundaries in clinical areas, yet the analysis of the interviews presents quite a different observation.

When the students and I discussed their own roles they all discussed how they had felt like they were being used as a 'pair of hands' and were not working closely with the registered practitioners. However, they did not

complain to the staff on the ward, as they were afraid they would receive an unsuccessful practice placement assessment. They would rather discuss the issues with the lecturing staff in the school, where they felt 'safe'.

#### **4.8 Conclusion**

This discussion has centred on the issues of professionalism, culture, power and equality. I have explored how these concepts and issues may influence how the students perform in practice and how they impact on the roles of the registered and unregistered practitioners in the clinical areas.

There are boundaries in the clinical areas that students will have to face and develop strategies to overcome. Many of the students understood these boundaries and would 'fit into' the ward teams by engaging in the ward routine and not questioning the staff when they were asked to undertake certain procedures. They also found that when they understood the nursing language they were able to exert a certain amount of authority over those staff that were either junior or new to the clinical areas.

The *Making a Difference* and strategy of PBL has enabled the students to seek out information and apply it to their clinical placement areas. Yet we must remember that there are disadvantages to PBL and questions regarding its effectiveness in relation to medical education are now being asked. Perhaps, as nurses and nurse educators we should also examine its effectiveness in producing critical, problem solving practitioners.

The following chapter offers a reflexive account of the methods used and analysis of the data whilst reflecting on the research experience and proposing recommendations for future investigation. Finally the chapter identifies and discusses the contribution this study has made to nursing.

## **Chapter Five**

### **The Research Experience**

As discussed in the introduction the impetus for this study had been the implementation of the *Making a Difference* curriculum and the use of PBL as a teaching and learning strategy. However as the study progressed the issues of students socialising into clinical practice and the students' aim to learn to be a real nurse became the focal point of the study. This motivated me to investigate further and to use the information to publish papers and to present at conferences, share my early findings and to instigate discussions with other academics and practice staff who wish to improve the student experience. This chapter will reflect on the research experience, the choice of methodology, the research question and the discussions surrounding the data collection and emergent themes.

#### **5.1 Reflexivity**

I would now like to offer a reflexive account to the reader of the methods used and analysis of the data, allowing for the merits and possible implications of the study to be identified while highlighting any limitations that may be present. Spencer (2001, p.450) argues that strong reflexivity recognises that the ethnographer and his or her language are inevitably a part of the phenomenon that is being investigated. Linked to this reflexivity is a sense of responsibility for the consequences of a particular way of representing the words and practices of other people. He further argues that this sense of responsibility recognises complexities and differences rather than hiding them beneath a veil of homogeneity and generalisation. This sense of responsibility then becomes a source of liberation rather than an unwelcome burden.

Reflexivity is the process of reflecting critically on the self as researcher, the 'human as instrument' (Guba and Lincoln, 1981). It is a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the process of research itself.

Alcoff and Potter (1993) state that reflexivity forces us to come to terms not only with the choice of research problem and with those whom we engage in the research process, but with our selves and with the multiple identities that represent the fluid self in the research setting. Reinharz (1997) highlights that although we have many selves they can fall into three categories:

- Research based selves
- Brought selves (the selves that historically, socially and personally create our standpoints)
- Situationally created selves.

She argues that each of these selves comes into play in the research setting and consequently has a distinctive voice. Reflexivity demands that we integrate each of our selves regarding the ways in which research efforts are shaped and staged around the binaries, contradictions and paradoxes that form our own lives. It should be remembered that the purpose of reflexivity is not to produce an objective or value free account of the phenomenon, because qualitative research does not yield standardised results but as Ward-Schofield (1993, p.202) suggests:

*'At the heart of the qualitative approach is the assumption that a piece of qualitative research is very much influenced by the researcher's individual attributes and perspectives. The goal is not to produce a standardised set of results that any other careful researcher in the same situation or studying the same issues would have produced. Rather it is to produce a coherent and illuminating description of and*



*perspective on a situation that is based on and consistent with a detailed study of the situation'.*

Indeed this piece of work is a case study and as such will produce different results to any similar study that may be carried out with different students in different health care settings. Therefore, in order to reflect on this study and to ascertain its level of 'trustworthiness' I am using Lincoln and Guba's (1985, p. 290) suggestions for four questions that an inquirer should ask of themselves to determine the trustworthiness of a study.

They are:

1. **Truth value.** How can one establish confidence in the 'truth' of the findings of a particular inquiry for the subjects (respondents) with which and the context in which the inquiry was carried out?
2. **Applicability.** How can one determine whether the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)? Included in this category is the concept of transferability.
3. **Consistency.** How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects (respondents) in the same (or similar) context?
4. **Neutrality.** How can one establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and conditions of the inquiry and not by biases, motivations, interests, or perspectives of the inquirer?

### **5.1.1 Changing focus**

This study commenced on the premise that it would investigate and discuss whether the curriculum (*Making a Difference*) and PBL help students to make the transition into their clinical role. However during the data analysis it became apparent that the emergent themes reflected the importance of students being able to undertake clinical skills to allow them to 'fit into' the team and learn how to be a 'real nurse'. This in turn led to discussions

between me and my supervisor and the focus of the thesis changing from PBL to that of socialisation issues for student nurses and their accounts of 'learning to be a real nurse'.

## **5.2 Truth value**

Hammersley (1992) notes that the criterion of validity ultimately has its point of reference in concepts of the 'truth'. This allows for the possibility that 'truths' derived from attempts to understand and interpret the cultural processes are different from those of other phenomena. It also allows for the certainty that truths of applied research are generally more contingent and subject to varied criteria of utility than those drawn from the framework of 'pure' and discipline bound research.

Lincoln and Guba (1985) argue that the 'truth value' of a study is based on the assumption of a single, tangible reality that an investigation is intended to unearth and display. They claim that for the inquirer to ensure the truth value they need to know the nature of that ultimate tangible reality, yet if they already knew it there would be no need to mount an inquiry to determine it.

The issue of 'truth value' can be related to this study. Initially I had intended to discover whether or not the curriculum changes had had an influence on the students' performances in clinical practice, and if it facilitated them to overcome the boundaries they may have faced. The curriculum and the strategy of PBL were new and therefore I did not have any data or previous experiences as to the precise nature of the reality of the situation. I was aware that I could not prove the hypothesis as there was no data to test it against but as suggested by Popper (1959) I could '*falsify*' it. However as discussed the focus of the investigation changed and the data suggested that the issues of

the socialisation process for students, for example, the concepts of power, culture, language and inequalities became the areas for discussion. These concepts have been the focus for investigation by previous writers (Olesen & Whittaker 1968, Orton, 1981, Melia, 1987, 1997, Ogier, 1989, Castledine, 1995, Bradshaw 2001, Spouse, 2003), and therefore I was able to compare and contrast my findings with theirs.

### **5.3 Applicability**

I recognise that 'reliability' is something that I cannot achieve and believe that it would be more appropriate to use rigour and evidence trails. It would not be possible to replicate the study, as students who I studied will have completed the course and the registered practitioners interviewed may have left the Trust I visited. Indeed, Robson (2003, p.42) argues that in real world research and social science attempts to replicate are rare. Some qualitative researchers consider it an impossibility; to them each study is unique. Certainly it is just not feasible to repeat a study exactly with the same people in the same situation. I believe that it would be acceptable, in the future, to observe and interview different cohorts of students investigating how they have 'fitted into' their clinical role and discussing their experiences of learning to be a 'real nurse'. The implementation of new curricula may be used to compare differences in their experiences. Indeed the discussions surrounding the socialisation process of the students can be used as a comparison for future studies.

The main aim of this study for me has been the discussions surrounding the concepts of power, culture, language and inequalities that were identified as issues that affected the students journey to learn how to be a 'real nurse'. This

study will provide additional information for future research projects to investigate when developing curricula and preparing students for their occupational roles of the future.

### **5.3.1 Sampling**

With reference to the sample, I used the principles of purposive sampling and elements of 'convenience sampling'. The principle of 'purposive sampling' is the selection of participants by the researcher's judgement as to typicality or interest. Convenience sampling involves choosing the nearest and most convenient persons to act as respondents. Indeed Gall *et al* (1996, p. 228) argue that:

*'Researchers often need to select a convenience sample or face the possibility that they will be unable to do the study. Although a sample randomly drawn from the population is more desirable, it usually is better to do a study with a convenience sample than to do no study at all...assuming, of course, that the sample suits the purpose of the study.'*

I chose student nurses from various cohorts undertaking the *Making a Difference* curriculum training programme and their respective mentors and ward managers within the Trust where I was carrying out the study. These allowed me to gain an insight into the views of the participants. The sample choice of students relied on those students who were allocated to practice placement areas during the data collection stage.

Robson (2003) comments on the use of convenience sampling stating:

*'Convenience sampling is sometimes used as a cheap and dirty way of doing a sample survey. You do not know whether or not findings are representative'*.

While Robson's comments may be true I believe that the sample I chose was credibly 'representative' of the student population undertaking the *Making a*

*Difference* curriculum during my fieldwork period. I am confident that the work does promote discussion and identifies areas that staff and students believed were improved and areas that required development. The participants were eager to discuss their experiences with me and wanted to share their own personal feelings of boundaries they had faced when attempting to learn to be a 'real nurse' and to 'fit into' the team'. I have no reason to believe that they were not honest in their discussions regarding the issues we discussed and, therefore, I can assume that the data I collected were relevant to the issues under study.

You will recall the sampling I used met the criteria of qualitative research because in ethnography a specific number of individuals who have appropriate characteristics for the study may be contacted in order to achieve a pragmatic solution when time and financial resources are limited (Morse, 1987). Furthermore as Roper and Shapira (2000) state these participants are key informants who act as gatekeepers that enable the ethnographic researcher greater access to the study population; they are also able to reflect upon cultural practices and share this knowledge with the ethnographer. The study sample is identified both at the start of the study and during the engagement research design. During the fieldwork process various registered practitioners, whom I had not originally included in my sample, asked if they too could be involved in the interviewing process. This displayed that the practitioners had an interest in the study and believed it was worthwhile as they wanted to be involved and for their experiences and ideas to become a part of the data.

There was also an element of 'purposeful' sampling or 'theoretical' sampling.

Glaser and Strauss (1967) suggest:

*'The criteria of theoretical sampling are designed to be applied in the on-going collection and analysis of data associated with the generation of a theory. Therefore, they are continually tailored to fit the data and are applied judiciously at the right point and moment in the analysis. The analyst can continually adjust his (sic) control of data collection to ensure the data's relevance to the impersonal criteria of the merging theory.'*

The data I collected did indeed enable the evolution of the research question as the participants discussed an array of issues with me that I had not considered prior to entering the field and that then aided in the future development of the questions. This type of sampling was based on information and not statistics. Its purpose was to maximise the information I could collect from the participants in the allotted time. I believe that the responses were plausible and that the respondents could be said to be diverse as they were from a variety of cohorts undertaking their training.

### **5.3.2 Transferability**

According to Guba (1981) application or transfer of knowledge can occur across settings when one knows a great deal about both the transferring context and the receiving context. He preferred the term transferability to generalizability. In fact, LeCompte and Goetz (1982) argued that in relation to generalizability the challenge for ethnographers was to demonstrate either the typicality of a phenomenon or the extent to which it compared and contrasted with other relevant phenomena.

Lincoln and Guba (1985) state that in the classic paradigm all that is necessary to ensure transferability is to know something with high internal validity about sample A, and to know that A is representative of the population

to which the transferability is to apply. The transferability will then apply to all contexts within the same population. The process of coding that I undertook allowed for categories and themes to emerge with the underpinning theme being that of 'clinical skills'.

Participants were elicited from a particular group that of student nurses undertaking a specific curriculum. In the future the results could be used as a comparison for studies examining the role of the student nurse in clinical areas and the perceived importance of clinical skills in assessing a students competency levels. Indeed the setting would need to be in a similar situation to allow for transferability of the results.

#### **5.4 Consistency**

I recognise that nurse education and training does change over time yet the principles remain relatively constant, in that, it is attempting to produce practitioners who are '*fit for purpose*' and '*fit for practice*' on registration. In fact students who undertake the course want to learn the role of the registered practitioner to enable them to socialise into their clinical role both when they are a student and when they become registered.

With reference to the observations and interviews that I undertook in the field, the interpretations I made could be said to be consistent. Mason (2002, p.65) argues that interviews can be regarded as social interactions and as such it would be inappropriate to see social interactions as bias that can be potentially eradicated. In respect of the interviews the participants were assured that the discussions we held would be confidential so it is reasonable to assume that they understood it would only be myself who would be

scrutinising and analysing the data and as such they felt more prepared to offer truthful accounts of their experiences.

The coding was consistent yet I was aware that I might have been susceptible to 'observer drift' where I was seeing examples of category definitions that I was developing. I was aware of these possible problems and attempted not to develop a bias in my observation techniques. When analysing the data I read and re-read the information and during the observation periods I attempted to be as careful as possible by only documenting exactly what I saw and not inflicting any personal viewpoints into the data.

The fact that I had undertaken single observer techniques may be seen as a threat to the consistency and transferability of this study. Yet Dey (1995, p.224) argues that qualitative data is typically of uneven quality and if we had made all the observations ourselves, and made them repeatedly; and had the same observations confirmed by others, disinterested and unbiased and trustworthy observers, in neutral circumstances we are probably not doing qualitative research.

I have discussed the ideas generated from this study with my supervisor, academic peers and participants in addition to presenting the preliminary findings at conferences. This has allowed for an open discussion of the content. Indeed, the study was not aimed at achieving a cause and effect theory of the *Making a Difference* curriculum and the strategy of PBL, but rather was aimed at allowing the reader a theoretically informed and research based insight into the participants' views and experiences of them. It has offered an insight into the students journeys of becoming a 'real nurse' and the socialisation process they undertake with the development of clinical skills



being one of the main indicators allowing the registered practitioners to assess the competency levels of the students.

#### **5.4.1 Reflecting on the research process**

Throughout the field work and the subsequent data analysis period I continually reflected on the research process.

I examined my own criteria for judging what was moral and ethical using various questions as suggested by Mason (2002):

- 1: What were my own experiences, values and politics?
- 2: What were my own professional culture and the norms of acceptability that operate in my own professional setting?
- 3: What codes of ethical practice was I adhering to as developed by my own professional body and within nursing?
- 4: What legal framework was I adhering to, for example, data protection, rights to privacy and information?

The fourth question that Lincoln and Guba (1985) suggest the researcher should ask them is that of the level of neutrality that the researcher has achieved.

#### **5.5 Neutrality**

This study has provided many elements of neutrality as appropriate methodology of ethnographic and case study methods were used. This allowed for me to feel immersed in the culture while integrating some principles of grounded theory. As a registered practitioner and a nurse lecturer I was aware that I should not impose my own clinical values into the data. Scriven (1971) asserts that in achieving objectivity/neutrality the emphasis should be removed from the investigator and be placed on the data itself. The

issue is no longer the investigator's characteristics but the characteristic of the data, and therefore, it is the data that should be checked for conformability. This was achieved during the data collection and analysis period as themes and categories emerged that led to a discussion and exploration of the concepts identified by the participants which led to the focus of the research changing from the original aims.

## **5.6 Recommendations for future investigation**

The following section identifies some recommendations for the future and is presented under four headings:

- Research;
- Practice;
- Education
- Theory.

## **5.7 Research**

### **5.7.1 Role of the registered practitioner**

This study has identified many areas that would benefit from further research. The role of the registered practitioner led to detailed discussion during the interviews with the students expressing confusion over what they should be learning when learning to be a 'real nurse'. This therefore requires consideration and investigation into the changing role of the registered practitioner and how this impacts on the teaching and learning needs of student nurses.

The continuing changes in the NHS and the private sector lead to the roles of the unregistered and registered practitioners altering to meet health care needs. In line with these changes curricula develop and as such research will

be needed to investigate and compare curricula to ensure they are indeed meeting the needs of the service sector. When the *Making a Difference* curriculum is validated a comparative study against the newly validated curriculum might be undertaken using the information I have gathered and analysed. For any follow up studies it may be beneficial to use a research team rather than a single researcher to allow for an exploration and discussion of themes as the data is collected and analysed. Indeed work of this type evaluating '*Fitness for Practice*' is currently under way in Scotland.

It may also be beneficial to undertake a follow up study interviewing the students who were involved in this research who would be registered practitioners. This would investigate, if on reflection, the *Making a Difference* curriculum and PBL had helped them to overcome boundaries in practice and prepared them for the registered practitioner's role. In addition, they would be able to comment on students who had subsequently undertaken their nurse training and comment on their abilities to be able to undertake the student nurse role.

### **5.7.2 Assessing the competency levels of students**

Research into the competency levels of PBL trained nurses as against non-PBL trained nurses would be beneficial. This would allow for a comparative study exploring whether or not PBL trained nurses had more developed questioning abilities than those students who were not PBL trained. In addition to compare whether or not PBL trained nurses had achieved a greater understanding and ability to perform the competencies required of a registered practitioner than those who were not PBL trained.

Throughout the data analysis the theme of clinical skills was prevalent. This area requires researching as to whether or not students who can successfully undertake clinical skills in the practice areas become an accepted member of the team faster than those who require teaching of them when they arrive in placement.

### **5.7.3 Learning to be a real nurse**

As you will recall the ultimate aim of the students was to learn how to be a real nurse. I would suggest that research should be undertaken investigating the definition of a 'real nurse' and the expectations of the public and practitioners as to what their role is.

## **5.8 Practice**

### **5.8.1 Clinical skills**

The data has identified the importance of clinical skills development for the students and their importance in assessing the competency level of the students. It would be useful if the issue of who teaches clinical skills, that is to say, should they be taught within the classroom or in the clinical areas, be discussed in detail with academics and practitioners. It may be that the theory underpinning the skills should be taught in the school of nursing but the practical application of the skills should be taught and assessed in the practice areas by the mentors. This would allow for a bridging of the theory-practice gap and would allow the practitioners to be actively involved in the development of students who are *'fit for practice'* and *'fit for purpose'*. Furthermore discussions surrounding whether in fact all clinical skills should be taught in the school prior to students entering practice should be held.

### **5.8.2 PBL**

The data highlighted that although the students were aware of the concept of PBL as a teaching and learning strategy that was being implemented in the school of nursing many of the registered practitioners, although aware of the concept were not using the strategy in the practice areas. A part of PBLs philosophy is that it can be used in the clinical areas to allow the bridging of the theory-practice gap. I would recommend that academic staff present a host of seminars in the clinical areas to explain and explore the concept to the practitioners. Time restraints are factors that may prevent staff from attending therefore, the role of the link tutors or academics in practice will require development to allow a sharing of ideas and information regarding the educational needs of the students at each stage of the training process. This may include the academic and clinical staff developing 'triggers' that reflect the educational needs of the students while on clinical placement and that could be used as a part of the assessment process. The development of partnerships and collaboration between the academic staff and practitioners would also strengthen communication channels between the two sectors and ensure that changes in the curriculum and teaching and learning needs of the practitioners were shared at ward level.

### **5.9 Education**

The data collected and analysed during this study suggests that practitioners have been encouraged by the development in the students' abilities to function as effective student nurses while in the clinical areas. However it is questionable as to whether or not it has been the integration of PBL as a teaching and learning strategy that has been the major force in this, or

whether it is the fact that students have been taught their academic studies in small groups that has led to a feeling of belonging. I would recommend that small group teaching of the students is maintained within the school of nursing, with further studies being carried out to assess the effectiveness of the use of small groups in nurse training institutions.

### **5.10 Theory**

Nurse education and training has evolved from an apprentice style of training to a university-based education. Yet the ability of students to be able to effectively undertake clinical skills while on clinical placements continues to be perceived as the major indicator of the students' competency levels. The ever-changing role of the registered practitioner in light of Government policies; changing roles of unregistered staff and the introduction of new posts such as the Trainee Assistant Practitioner has seen students questioning the usefulness of them being expected to learn about how to perform the 'dirty roles' such as hygiene and toileting needs of patients.

We must therefore assume that nurse education systems need to develop to encompass the changing needs of the health service if we are to ensure that the students of the future are '*fit for practice*' and '*fit for purpose*' on registration. The continued development of clinical skills teaching would appear to be the linchpin in attaining this objective and as such I can suggest that the emergent theory is:

*'Student nurses who develop the ability to perform clinical skills effectively in the clinical areas are perceived by the clinical staff to be undertaking their role effectively and are accepted and valued team members'.*

### **5.11 What contribution has this study made to knowledge and nurse education?**

This thesis commenced with the question *'Has the Making a Difference curriculum and PBL enabled student nurses to socialise into their clinical roles and overcome boundaries?'* As the data was collected and analysed the focus changed from the impact of PBL to an investigation of students' experiences in learning to be a real nurse and the boundaries they face when attempting to socialise into their clinical role.

The study has clearly identified that the students' ultimate aim is to learn how to become a 'real nurse', this has been explored in detail and the roles of the student nurses and the mentors have been highlighted by the participants. Integral to these descriptions have been the issues of power, authority, culture, boundaries and professionalism that has led to the students explaining how they have affected their journey through their training and educational programme and which strategies they have employed to overcome them.

The issue of clinical skills development has been important to both the students and the practitioners. Although nurse education is now delivered in a university institution where it is important that students understand the underpinning evidence and research to support their care interventions, the development and effective delivery of clinical skills is seen as a major influence for practitioners when assessing the competency levels of the students. It is therefore important that during future curriculum development activities both practitioners and academics are actively involved in its inception to ensure that the needs of both institutions and the patients are

met. Effective communication channels between the two institutions must be maintained and developed if the registered practitioners of the future are to be '*fit for practice*' and '*fit for purpose*'.

The experiences of student nurses in clinical areas and their observations on learning how to be a 'real nurse' have been discussed and explored in depth. The registered practitioners interviewed commented that they believed students had developed their questioning abilities while on clinical placement and had been able to effectively 'fit into' the team. The students have viewed the teaching and learning strategy of PBL favourably but through this study it has become clear that it is an academic tool and the clinical areas are not using it as a teaching tool. In the future it may be useful to encourage its use in the clinical areas to help the students' link the theory learnt to the practice they are involved in. Arguably it is the small group teaching that has developed the team building skills of the students rather than PBL *per se*. However which ever it is clinical staff are positive in their comments towards the effectiveness of the students undertaking the new curriculum.

Both the registered practitioners and the students have viewed the newly developed and implemented role of the practice development co-ordinator as a positive change. She has provided extra support for development of the learning environments and for students and mentors undertaking their roles. The role has provided a strong link between the academic and service sectors leading to a seamless collaboration between the two institutions.

The data collected and subsequent analysis has produced a trail of evidence that has contributed to providing an exploration and discussion of the



identified themes. It may be concluded that the ability for students to become 'real nurses' are affected by the following.

There is a need for students to understand the culture and boundaries inherent in the various clinical areas that they visit. The students must develop an awareness of these issues and learn the role of the student nurse in order to acquire the skills and knowledge base that will ensure they are '*fit for practice*' and '*fit for purpose*' on registration. In order to become a 'real nurse' the students need to learn how to undertake the role of a student nurse efficiently and effectively in their clinical placement areas. Students developing their knowledge and skills base in the delivery of clinical skills help them to fit into the team and to become involved in the everyday activities of the registered practitioners. Through doing this they learn how to be professional and with the support of effective mentors and the practice development co-ordinator they learn how to reflect in practice and thus learn the skills and knowledge that will support them in their ambition to become a professional nurse when registered.

Indeed Scholes *et al* (2004, p.1) evaluated nursing education partnerships with the aims of the project being:

- To identify if the changes to nurse education made in response to *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) enhance the knowledge and practical skills of students who undergo these programmes and affect the quality of the practice experience and teaching in practice.

- To identify how the partnership has been developed and how it responds to the needs of the NHS, balancing local and national agendas for change.
- To identify if these local changes increase flexible career pathways into and within nurse education and how the alumnae of these programmes make a contribution to care (career destination).

They concluded that generally the sites involved in the study believed things had improved as a result of the partnership curriculum and that the Trusts and HEI's were collaborating well together to meet the continually changing agendas and competing demands of the health care sector. However they did identify that there was insufficient evidence of consistent challenge of the students, by the registered practitioners, to determine the students' level of knowledge and competence. This was caused by inadequate mentor knowledge that affected the type of questions and thinking to which the students were exposed. Linking higher order thinking was seen to be an unrealistic aim that was not routinely demonstrated or reinforced by mentors. In fact Scholes *et al* (2004) highlighted that some mentors were reluctant to delegate certain clinical activities or enable students to observe certain clinical interactions preferring to undertake them themselves, because they could not afford the additional time it would take a student to do this on their behalf. These points were exemplified within my study under the heading '*I'll do it myself*'.

The concepts of power and authority in the clinical areas are important issues for the students to understand. As junior student nurses they hold little or no power or authority. They perceive the ward manager to possess the power

base in the clinical areas and respect their authority. Similarly the junior students respect the more senior students as they have more experience than themselves. It is therefore fair to conclude that the concepts of power and authority as understood by students are not restricted to registered practitioners. The senior students also display elements of power and authority that they exploit when working alongside junior students and at times the unregistered staff.

This is projected through the increased confidence levels of the senior students who believe that a part of their role is to engage in the teaching of more junior students, explaining to them what their role is and sharing their experiences with them. They also believe that they now possess sufficient knowledge and skills to learn and undertake the roles of the registered practitioners, albeit under supervision of their mentor. It is at this stage that many of them become disillusioned with their student role when they are approached or expected to engage in activities that they believe are the role of the unregistered staff members. They see the registered practitioner role as being one of planning and evaluating nursing care, undertaking medical ward rounds, liaising with members of the multi-disciplinary team and administrative duties rather than engaging in hands on care activities.

Students are now developing their own understanding of the boundaries that they must either work within or overcome in their quest to become registered professional practitioners. They strongly believe that they understand the role of the registered practitioner and want to emulate this. Their ability to be able to undertake clinical skills without supervision is seen to be an indicator of

their level of competency and indeed a tool by which the registered practitioners assess the capability and competency levels of the students.

Throughout the study the registered practitioners have been positive in their assessment of the students who have followed the new curriculum and been exposed to the teaching and learning strategy of PBL. They have commented that these students have well-developed questioning abilities and are able to fit into the team. They also believe that the students are relatively self-sufficient in acquiring knowledge to underpin their clinical activities yet they do seek advice where appropriate. Perhaps one of the most interesting observations made by the clinical staff is that these students want to be more involved in the clinical activities and that they are pleased to see that the students are spending more of their training time in the clinical areas rather than in the academic setting. This is interesting as students following the old curriculum spent equally the same amount of time in the clinical areas. Yet the practitioners firmly believed that students following the new curriculum were less academically focussed and more interested in developing their clinical skills than previous students.

Overall the study has highlighted the importance of clinical skills development and delivery by the students in becoming a 'real nurse'. Through their experiences the students have learnt have to overcome boundaries and to fit in with the culture in the clinical areas. We can learn from this that the school can provide the students with the underpinning knowledge required to enter the clinical areas but learning how to become professional and a real nurse is learnt through exposure to the 'real world of nursing', it is therefore important that roles such as the practice placements co-ordinator are maintained to

provide a link between the clinical and academic areas and support for the students so that they do not feel isolated when in clinical practice.

### **5.12 Outcomes**

The study has identified the following outcomes:

1. Registered practitioners interviewed believe that the students have been able to 'fit into' the team more effectively than previous students and wish to be 'more hands on.'
2. Students believe that they can learn the skills of a 'real nurse' if they are competent in the delivery of clinical skills. This complements much of the work previously undertaken by (Olesen & Whittaker 1968, Orton, 1981, Melia, 1987, 1997, Ogier, 1989).
3. The concepts of power, culture and language and the boundaries that they create have been identified by students as issues they need to understand and overcome while in clinical placement to enable them to become valued members of the clinical team.
4. Participants in the study identified the role of the practice placement co-ordinator as being a welcome addition and provided a link between the academic and service sectors.

### **5.13 Conclusion**

Overall the research experience has been both enjoyable and illuminating for me. When I first arrived in the field I had expected all the registered practitioners to have read the *Making a Difference* (DoH, 1999a) and *Fitness for Practice* (UKCC, 1999a) documents and would be able to discuss them in detail. I now appreciate that although they are important, the practitioners

were aware of them but due to clinical priorities they had a superficial knowledge of the content.

Following the research process has taught me patience and the importance of reading and re-reading information to ensure that I am objective and neutral when discussing the information gained. Most importantly I have learnt the importance of not imposing my own personal viewpoints on the information. This aids in ensuring that I am portraying a true version of the data I collected from the participants. I believe that this study is important for the staff at the school of nursing, as it allows them an insight into the experiences of students and registered staff involved with the *Making a Difference* curriculum and if nothing else, will promote discussion surrounding the issues.

Overall this study provides a focus for future research examining the role of student nurses while on clinical placement and their ability to be able to effectively integrate into the ward team. The discussion and exploration of PBL provides a basis to compare a variety of a teaching and learning strategies that identify to students and practitioners the importance of providing evidence and research based care interventions in the clinical areas. The importance of students fitting into a team and learning to be a real nurse are exciting concepts that although not new to this study do provide a focus for futures studies to explore and research. The move of nurse education into Higher Education has not removed the importance of clinical skills development and indeed competency in delivering these skills in the clinical areas for both the students and registered staff. In fact it is the competency in the delivery of clinical skills by the students that provides a benchmark for the registered practitioners to use when assessing the

capabilities of each student and to a degree the fitness of the student to become a real nurse. However, the registered practitioners in the clinical areas do still want the academic sector to provide students with the skills of 'how' to undertake skills rather than the 'why' they undertake them. This can perhaps be attributed to the concept of 'getting through the work'; where it is important that the majority of ward work is finished by the end of the morning shift. Time in the clinical areas provides a vital measure of students and registered practitioners abilities to be viewed as competent nurses. Those members of staff who question procedures or take their time completing procedures, through communicating with patients in depth are viewed to be slow or lazy. This is witnessed by the students and as such they are eager to be able to undertake the clinical skills in a 'quick' fashion. This is an area that needs to be discussed between practitioners and academics.

Overall the move into Higher Education and the implementation of the new curriculum has proved to be positive with the practitioners yet the importance of students being able to feel a valued member of the team in their quest to learn how to be a real nurse remains paramount.

# Appendix



## Appendix one

### Excerpt from interview transcript

Below is an excerpt from one of the interviews undertaken. Margaret had just commenced her second year of training. We were discussing what experiences she had had since commencing her training programme.

*'On the wards we are just given handover for the 38 beds and then go out onto the wards. We are introduced to the patients and all we are told is what we heard in handover but <sup>1</sup>no one tells us which tests they have had or what they are for, no one goes over that. I <sup>2</sup>question the staff cos a lot of the things I don't understand I'm always quizzing them but no-one tells you what the drugs are for I've had to read up on that myself at home, I've bought a drugs book so that I know everything and can learn. If I ask questions, they just say oh its heart tablet that is all. They sometimes talk you through things but some of the things they don't know themselves, oh, I shouldn't have said that. For example, one man had liver problems due to alcohol and he was bleeding from every orifice so I asked them why and they said I don't know they just do. Any way I asked someone else and she got me some books, I don't think there is a lot of knowledge here, especially the newly qualified staff.*

*Interviewer: So what do you think is the role of the student on placement?*

*Well to work alongside a staff nurse, and do their role its right difficult really cos <sup>3</sup>I've not been given a role. Fair enough, I look after pressure areas and I've been able to do assessments and care plans, evaluations and <sup>4</sup>observations. but saying that I have my own limitations because I am not registered. So I try and do the drugs but obviously, I can't do them independently, they have to be checked. The same for taking bloods and giving I.V.s because I have not been assessed but I feel that I do the same as my assessor would in terms of like doing the admissions and discharges, assessing the patients doing the care plans and the obs. And all the other patient care really. I think that the only limitations you have is that you are not registered but I do try and do the same things as a staff nurse would.*

*I've been round on drugs rounds but sometimes the trained staff feel we are an extra pair of hands we are here to work not learn just to get on with it. Yeh. I thought they would teach us how to do the skills on the ward and then I would be able to work like a real nurse, but they*

---

<sup>1</sup> No one tells us/don't know themselves/don't think there is a lot of knowledge

<sup>2</sup> Question/quizzing/at home

<sup>3</sup> Not given a role/extra pair of hands/not learn/role of a student/student role/supernumerary/needed on the ward/not being given a role/ extra pair of hands/

<sup>4</sup> Observations

don't they think that we already know how to do them. I thought I would be alright, we have done some teaching sessions at Uni but as a whole we felt that they taught us things after we had been on placement so I was quite glad that I had some knowledge prior to starting the course, because it was like how to do obs, dressings and the drugs was taught after placement it would have been better before especially the obs. I felt more prepared than others having done the job before, but I'm not an auxiliary now and I have to remember that and try and take on the role as a student. I found it hard to fit in the ward environment initially because even though you may have banked on the ward previously you now have to take on a different role; there is an overlap between a student nurse and auxiliary. You don't really have a defined role, one minute you are pulled over by the auxiliaries to help them and the next you are expected to do <sup>5</sup>staff nurse roles.

I think the school should teach all the skills cos you <sup>6</sup>wouldn't get anything here. They don't teach here they think we are here to help them get through the work. I don't think they understand what the student role is. You try and tell them you want to watch and observe things but some of them think you are being lazy. Its not as bad when my mentor is here 'cos I stick with her and she will ask me if I want to see things but when she's away then I am just a pair of hands and work with the NA's a lot. I have always tried to limit what I do with the auxiliaries so that I can learn, but some students are not as assertive and then they compromise their learning, you have certain objectives to meet and you can't do that if you are always helping the auxiliaries get people up. I had one incident when I needed to redress a patients legs the auxiliary came to me to tell me to get a patient up, but I said no I have to do this leg because at the moment it is more pressing. You have to be assertive but later on, she apologised, other students may not have stood their ground and left the patient but we have to learn so you have to stand your ground sometimes.

Although the <sup>7</sup>practice development co-ordinator has done some and they were good, brilliant, it's a smaller group and you tend to participate more, but on the wards, you wouldn't learn anything. In Uni we've done psychology but we've not done assessments or care of the patient but no-one has gone through the action plans, we have been bombarded by work and it does not flow and no-one explains things. Like we have done the history of the nurse but its not relevant, we have not done a lot of clinical skills we need more. I've done my assignment on heart disease so I have learnt a lot on that but that is cos I've read about it not that people have taught me.

---

<sup>5</sup> Staff nurse role/real nurse

<sup>6</sup> No teaching/learning opportunities

<sup>7</sup> Support

Erm, and also a **supportive role to other students** who are on the ward either those at the same stage or **first and second years**, I try to **support** and help them with their documentation, because we have all been through it and have the same concerns. You know I **also help patients** and provide good patient care.

I don't know it all yet. I've been to see a pace maker fitted today but other things I've asked to go and see I've not been allowed to because they say the ward is too busy and if I go they will be **short staffed**, I've missed three things now, but at the end of the day I am meant to be **supernumery** but when I bring that up with the staff they say well you are **needed on the ward**, so I've missed out. I think they only let me go to do because you are here!! On here I've learnt about different types of drugs because the sister **questioned me** on the drugs when **I asked her too**, I've done CPR 4 times!!!! But the staff do not always tell me why these things are happening. I feel that I **have learnt** a few things but I don't feel the school really prepared me cos they did not explain what was expected of students on the ward, no-one told us about the assessment books properly and **did not** give us the chance to **ask questions** we were just given the booklets and no-one on the ward knew what to do with them

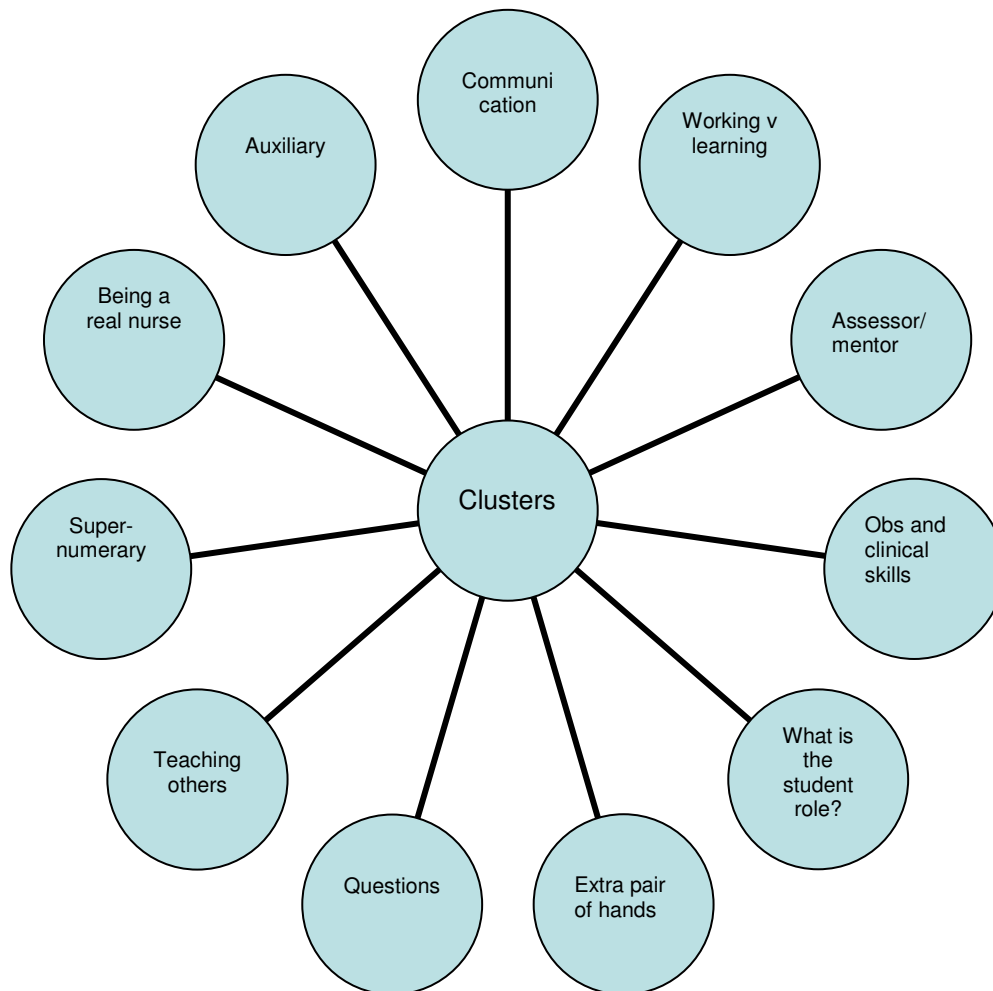
Me: Are there any more comments you would like to make?

I was thinking it would be nice if we had a visit every couple of weeks from the **practice development co-ordinator**, I've spoken to her and she has helped. You feel there is no support on the ward you are on your own, **you are not a staff nurse or an auxiliary** you feel alone. I think that, I mean the auxiliaries are great it's the trained nurses who have attitudes, they tend to look down on you like you are only a student but they don't always help or want to teach you. The whole attitude is that they want you on the **ward working not learning**. It's not all of them but I tend to find the older nurses are negative towards you just feel like you are mithering people if you ring up the Uni all the time. I think we could have more on A &P and **clinical skills** but we do have loads of support from school and we get loads of time to do the assignments, which is good. Most of the wards are very good, there has only been one ward that was not very good for **teaching** but I have worked around that. I think that's it. On the whole it's all been good!

After re-reading the interview again I re-examined the words and phrases and clustered them into headings that can be seen in appendix two.

## Appendix Two

### Examples of clustering



Information that I collected during the observation periods also helped me to develop the clusters and subsequent themes. It was interesting that as I observed the students in their clinical placement areas issues that they identify regarding questioning and communication were evident. For example, during one of the observation periods with Margaret I noted that:

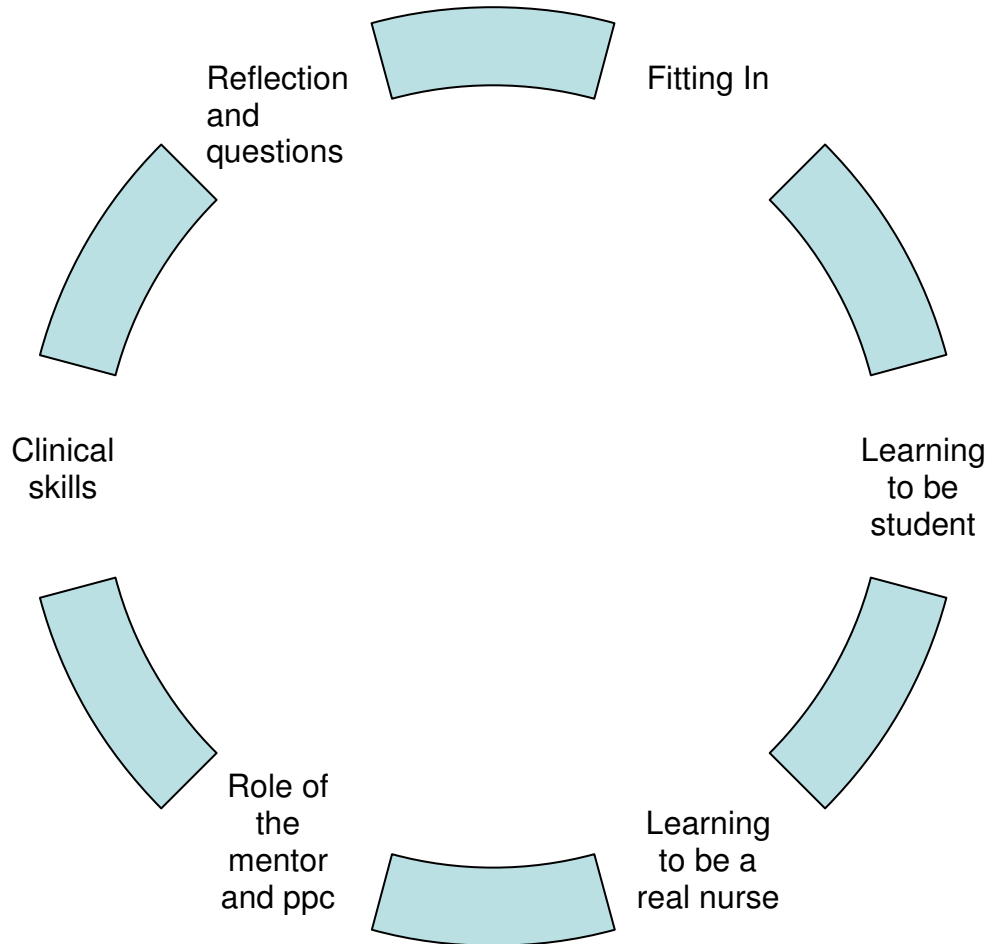
*'Although there are four qualified staff nurses on duty Margaret is working with another student nurse. One of the staff nurses has checked on Margaret and the other student asking them if they are 'OK'. Margaret has replied 'Yes, fine', but has also asked the staff nurse if she will explain the tests that the patient is due to undergo. The staff nurse informs her that she is too busy but that there are books in the resource room that she can refer to or wait for her mentor to explain.'* (Field note, observation of Margaret, 2<sup>nd</sup> year).

When I interviewed Margaret she discussed the fact that some of the staff were reluctant to answer questions and that she thought it was because they did not know the answers. What I did note in many of my field notes was that staff explained to me that they did not have enough time to 'teach' the students even though they recognised that this was a major part of their role. However during my observation periods that happened on various days and varying times there were times when the staff would stand or sit around the nurses station chatting. This would have made an ideal time to teach the students or discuss clinical issues with them. The concept of 'being too busy to teach' was not always supported by my observations.

Following the clustering I re-read the interview ensuring that I had identified all the appropriate words and phrases that had influenced the clusters. The reading and re-reading of the interviews allowed for me to understand the clusters and be able to assign them to a theme. Interestingly all the interviewees identified the acquisition of clinical skills as a major component of the students abilities to learn how to be a 'real nurse'. Following completion of all the interviews and subsequent clustering of the information themes were assigned as exemplified in appendix three.

## Appendix Three

### Themes



## **Appendix Four**

**Example of a publication based on the findings of this study**













## References

- Abbott P, Sapsford R (1997) *The Body Politic: Health, Family and Society*. Unit 11. Open University Literature, In: *Social Problems and Social Welfare*. Open University Press. Milton Keynes.
- Adair J (1986) *Effective Teambuilding*. London: Pan
- Adelman, C, Jenkins, D and Kemmis S (1980) Rethinking case study: Notes from the Second Cambridge Conference, in Simons H (ed) *Towards a Science of the Singular Centre for Applied Research in Education*, University of East Anglia.
- Alavi C. (1995) *Problem Based Learning in a Health Services Curriculum*. Routledge.
- Alcoff L, Potter E (1993) *Feminist epistemologies*. Routledge. New York.
- Allen D (1997) The nursing-medical boundary: a negotiated order? *Sociology for Health and Illness*. 19, 498-520.
- Allen D (2001) *The Changing Shape of Nursing Practice. The role of nurses in the hospital division of labour*. Routledge. London.
- Allen D, Hughes D (2002) *Nursing and the Division of Labour in Healthcare*. Palgrave Macmillan. Hampshire.
- Anderson. G. & Arsenault .N. (2001) *Fundamentals of Educational Research*. 2<sup>nd</sup> edition. The Falmer Press Teacher's Library. Routledge Falmer, London.
- Andrews M, Chilton F (2000) Student and mentor perceptions of mentoring effectiveness. *Nurse Education Today* 20, 555-562
- Andrews M, Jones P R (1996) Problem-based learning in an undergraduate nursing programme. *Journal of Advanced Nursing*. 23, 357-265.
- Andrews M, Wallis M (1999) Mentorship in nursing: a literature review. *Journal of Advanced Nursing* 29, (1), 201-207.
- Anleu S L R (1992) The professionalisation of social work? A case study of three organisational settings. *Sociology*, 26: 23-43
- Arthur D, Pang, S, Wong, T. (2001) The effect of technology on the caring attributes of an international sample of nurses. *International Journal of Nursing Studies*. 38, 37-43.
- Asbridge J (2002) NMC President. *NMC News*. Spring 2002. Number 1.

Atkinson P & Hammersley M. (1994) Ethnography and participant observation. In N.K. Denzin & Y.S. Lincoln (Eds), *Handbook of qualitative research* (pp. 248-261). Thousand Oaks C.A.: Sage.

Audit Commission (1999) *Critical to Success*. Audit Commission. London.  
Barrows H. S. and Tamblyn R. M. (1980) *Problem Based Learning, An Approach to Medical Education*. New York: Springer.

Barrows H. S. (1994) *Practice Based Learning: Problem Based Learning applied to medical education*. Springfield (IL): Southern Illinois University School of Medicine.

Becker H (1967) Whose side are we on? *Social Problems* 14 (Winter) 239-248

Begley C M (1996) Using triangulation in nursing research *Journal of Advanced Nursing*, 1996, 24, 122–128

Benedict D, Collier F, Wilkinson L (1984) *Learning a living in Canada* (Vol 1). Report to the Minister of Employment and Immigration, Canada.

Benner P (1984) *From Novice to Expert. Excellence and Power in Clinical Nursing Practice*. Prentice Hall Health. New Jersey.

Benner P, Wrubel J (1989) *The Primacy of Caring: Stress and coping with health and illness*. Addison-Wesley.

Bernstein B (1962) Linguistic codes, hesitation phenomena and intelligence. *Language and Speech*. 5 (Jan-Mar), 15-17.

Bernstein B (1971) *Class, Codes and Control*. Routledge. London.

Bettenhausen K & Murnighan J K (1986) The emergence of norms competitive decision-making groups. *Administrative Science Quarterly* 30, 350-372.

Bloor M, McIntosh J (1990) Professional autonomy and client exclusion: a study in ENT clinics. In: Wadsworth M, Robinson D, (Eds), *Studies in Everyday Medical Life*. Martin Robertson, London. Pp. 52-68.

Borgatti S (2007) *Introduction to Grounded Theory*.  
<http://www.analytictech.com/mb870/introtoGT.htm> Accessed 01/04/07

Boud D, Keogh R, Walker D (1985) *Reflection – Turning Experience into Learning*. Kogan Page, London.

Bowden P (1997) *Caring: Gender Sensitive Ethics*. Routledge. London.

Boyle J.S (1994) *Styles of ethnography*. In J.M.Morse (ed) *Critical issues in qualitative research methods*. (Pp 159-185). Thousand Oaks. C.A. Sage.

- Bradshaw A (2001) *The Project 2000 Nurse*. Whurr Publishers LTD. London.
- Brew A (2002) in *Using Experience for Learning*. Eds: Boud D, Cohen R, Walker D (2002). The Open University Press. Milton Keynes.
- Bromley D B (1986) *The Case Study Method in Psychology and Related Disciplines*. Wiley. Chichester.
- Bromley, D. B. (1990). Academic contributions to psychological counselling: In. A philosophy of science for the study of individual cases. *Counselling Psychology Quarterly*, 3(3), 299-307.
- Broom A (2006) Ethical Issues in Social Research. *Complementary Therapies in Medicine* 14, 151-156
- Burnard P (1990) The student experience: adult learning and mentorship revisited. *Nurse Education Today*. 10, 349-354.
- Caines E (1993) The impact of trusts in the management of the NHS. In Peck E, Spurgeon P (eds) *NHS Trusts in Practice*. Longman, Harlow, pp 129-138.
- Castledine G (1994) Specialist and advanced nursing and the scope of practice. In: Hunt G, Wainwright P (eds). *Expanding the Role of the Nurse*. Blackwell Science. Oxford. Pp: 101-103.
- Castledine G (1995) Will the nurse practitioner be a mini doctor or a maxi nurse? *British Journal of Nursing* 4 (16): 938-939.
- Coffey A. and Atkinson P. (1996) *Making Sense of Qualitative Data*. Sage. London.
- Cohen H A (1981) *The Nurse's Quest for Professional Identity*. Addison-Wesley, Menlo Park, California.
- Cohen H A, Jordet C P (1988) Nursing schools: students beacon to professionalism? *Nursing and Health Care* 9 (1), 39-41
- Cook J.A. (1983) *An interdisciplinary look at feminist methodology: ideas and practice in sociology, history and anthropology*. Humboldt Journal of Social Relations 10, 127–152.
- Creswell, J. W. (1997). *Qualitative inquiry and research designs: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Creswell J (1998) *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Sage Publications. London.
- Cunningham A (1999) Nursing stereotypes. *Nursing Standard* 13 (45), 46-47.

- Curzer M (1993) Is care a virtue for health care professionals? *Journal of Medicine and Philosophy*. 18, 51-69
- Cutcliffe J R and McKenna H P (2004) Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing* 45 (2): 126-135.
- Dahl R A (1986) Power as the Control of Behaviour, pp. 37-58 in S. Lukes (ed) *Power*. Blackwell. Oxford.
- Daniel A (1993) Sampling: purpose and generality, in: Colquhoun D, Kellehear, A (eds) *Health Research in Practice: Political, Ethical and Methodological Issues*. Chapman and Hall. London.
- Darling V (1984) What do nurses want in a mentor? *The Journal of Nursing Administration*. October: 42-44
- Darling V (1985) What to do about toxic mentors *The Journal of Nursing Administration*. May 1985.
- Davidson J O'C and Layder (1994) *Methods, Sex and Madness*. Routledge. London.
- Davidson A L (2002) *Grounded Theory*  
[http://az.essortment.com/groundedtheory\\_rmnf.htm](http://az.essortment.com/groundedtheory_rmnf.htm) Accessed 01/04/07
- Davies E (1993) Clinical role modelling: uncovering hidden knowledge. *Journal of Advanced Nursing* 18, 627-636.
- Davies C (1996) *Gender and the Professional Predicament in Nursing*. Open University Press. Buckingham.
- Davis F (1975) Professional socialization as subjective experience: The process of doctrinal conversion among student nurses. In: Cox C, Mead A (Eds) *A Sociology of Medical Practice*. Collier Macmillan, London. Pp: 116-131
- Davis E (1993) Clinical role modelling: uncovering hidden knowledge. *Journal of Advanced Nursing* 18, 627-636
- Day R E, Field P A, Campbell I E, Reutter L (2005) Students' evolving beliefs about nursing: From entry to graduation in a four-year baccalaureate programme. *Nurse Education Today* 25, 636-643
- Deans C, Congdon G and Sellers E T (2003) Nurse education in English universities in a period of change: expectations of nurse academics for the year 2008. *Nurse Education Today*. 23 (2). Pp 146-154
- Denzin N (1989) *Interpretive Biography*. Sage, London.



Denzin N. K & Lincoln Y. S. (2000) *Handbook of Qualitative Research*. 2<sup>nd</sup> Edition, Sage, London.

Department of Health (1991) *Calman Report- Hospital Doctors: Training for the Future*. HMSO. London.

Department of Health (1993) *A Vision for the Future: The Nursing, Midwifery and Health Visiting Contribution to Health Care*. HMSO. London.

Department of Health (1994) *The challenges for nursing and midwifery in the 21<sup>st</sup> century (The Heathrow Debate)*. Department of Health. London.

Department of Health (1999) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and health care*, DoH: London.

Department of Health (2000) *The NHS Plan*. HMSO. London.

Department of Health (2003) *Guidance on Tackling Junior Doctors Hours* Department of Health. London.

Department of Health (2004a) *The NHS Improvement Plan: putting people at the heart of public services*. Cm 6268. The Stationery Office.

Department of Health (2004b) *Choosing Health: making healthy choices easier*. The Stationery Office.

Department of Health (July 2004c) *National Standards, Local Action: health and social care standards and planning framework*. 2005/06-2007/08. The Stationery Office.

Des Marchais J.E (1993) A student centred problem-based curriculum: 5 years experience. *Canadian Medical Association Journal*. 148: 1567-72.

Dewey J (1938) *Experience and Education*. New York: Collier and Kappa Delta Pi.

Dey I (1995) *Qualitative Data Analysis. A User Friendly Guide for Social Scientists*. Routledge. New York

Doordan A.M (1998) *Research Survival Guide*. Lippincott. Philadelphia, New York.

Duke S Appleton J (2000) The use of reflection in a palliative care programme: a qualitative study of the development of reflective skills over an academic year. *Journal of Advanced Nursing* 32, 1557-1568.

Durkheim E (1957) *Professional Ethics and Civic Morals* (Translated by Cornelia Brookfield) Routledge and Kegan Paul, London

Du Toit D (1995) A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing* 21, 164-171.

Dyer W G, Wilkins A L (1991) Better stories, not better constructs to generate better theory: a rejoinder to Eisenhardt. *Academic Management Review*, 16: 613-619.

Earnshaw C (1995) Too busy studying to give patient care. *Nursing Standard (Letters)* 12 (13-15): 12.

Edwards N C, Hebert D, Moyer A, Peterson J, Sims-Jones N, Verhovset H (1998) Problem-based learning: preparing post-RN students for community based care. *Journal of Nursing Education*. 37 (3): 139-141.

Edwards S D (2001) *Philosophy of Nursing*. Palgrave. Hampshire.

Eisenhardt K M (2001) Building Theories from Case Study Research. *Academy of Management Review* 14 (4) 532-550

English National Board (1996) *Regulations and Guidelines for the Approval of Institutions and Programmes*. ENB. London.

Eraut M (1994) *Developing Professional Knowledge and Competence*. Routledge Falmer. London.

Field A P & Morse J M (1984) *Nursing Research the Application of Qualitative Approaches*. Croom Helm, London.

Fielding N. (1993) *Researching Social Life*. Sage, London.

Fielding N. & Fielding J. (1986) *Linking Data*. Sage, Beverly Hills, California.

Freidson E (1970) *Profession of Medicine. A Study of the Sociology of Applied Knowledge*. Dodd, Mead and Company. New York.

Finch J (1984) "It's Great to Have Someone to Talk To": 'Ethics and Politics of Interviewing Women' in C. Bell and H. Roberts (eds) *Social Researching: Politics, Problems, Practice*. Routledge. London.

Foucault M (1970) *The order of things*. Tavistock. London.

Foucault M (1972) *The Archaeology of Knowledge*. Tavistock. London. Www. Accessed 17<sup>th</sup> June 2004.

Foucault M (1977) *Discipline and Punish. The Birth of the Prison*. Penguin books. London.

Foucault M (1980) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. Harvester Press. London.

Foucault M (1982) *Power/Knowledge: Selected Interviews and other Writings 1972-1984*. Harvester Press. Brighton.

Foskett N H and Hemsley-Brown J V (1998) *Perceptions of nursing as a career, among young people in schools and colleges*. Department of Health. London.

Freire P (1972) *Pedagogy of the oppressed*. Sheed and Ward. London

Freire P (2000) *Pedagogy of the oppressed*. Continuum, New York.

Fretwell J (1982) *Ward Teaching and Learning: Sister and the Learning Environment*. London. Royal College of Nursing.

Gall M D, Borg W R & Gail J P (1996) *Educational Research: An introduction*. White Plains, NY: Longmann.

Garfinkel H (1967) *Studies in Ethnomethodology*. Prentice-Hall Inc. Englewood Cliffs, New Jersey.

Gilbert N (1999) *Researching Social Life*. Sage Publications; London.

Gilbert N (2001) *Researching Social Life*. 2<sup>nd</sup> Edition Sage Publications; London.

Giddens A (1984) *The Constitution of Society: Outline of a Theory of Structuration*. Polity. Cambridge.

Glaser B G & Strauss A L (1967) *The discovery of grounded theory: Strategies for qualitative research*. Aldine. Chicago.

Glaser B G (1978) *Theoretical Sensitivity*. Sociology Press. Mill Valley.

Glen S (1996) *Towards a model of competence* (Conference Paper) International Qualitative Health Research Conference. Bournemouth.

Glen S., Wilkie K (2000) *Problem Based Learning in Nursing*. Macmillan Press LTD. Hampshire.

Goffman E (1968) *Asylums: Essays on the Social Situation of Patients and Other Inmates*. Penguin; New York.

Goldenberg D and Iwasiw C (1993) Professional socialisation of nursing students as an outcome of a senior clinical preceptorship experience. *Nurse Education Today* 13, 3-15

Grabb E (1993) General Introduction. In: Curtis J., Grabb, E.Guppy. N (eds) *Social Inequality in Canada: Patterns, Problems, Policies*. 2<sup>nd</sup> Edition. Prentice-Hall. Ontario.

Gray M (1998) Introducing single case study research design: an overview. *Nurse Researcher*, 5: 15-24

Gray M A (1997) *The professional socialisation of Project 2000 student nurses: a longitudinal qualitative investigation into the effect(s) of supernumerary status and mentorship on student nurses*. Unpublished PhD thesis. Department of Nursing and Midwifery Studies, Glasgow University, Glasgow.

Gray M A, Smith L N (2000) The professional socialization of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*: 29 (3): 639-647

Greenhalgh and Company Ltd (1994) *The interface between junior doctors and nurses*. Greenhalgh, Macclesfield.

Greenhalgh P (2000) *Emotional Growth and Learning*. Routledge Press. London.

Greenhalgh T, Hurwitz B (1999) Narrative based medicine: why study narrative? *British Medical Journal* 318: 48-50

Greenwood J (1993) Reflective Practice. *Journal of Advanced Nursing* 18, 1183-7.

Guba E G (1981) Criteria for assessing the trustworthiness of naturalistic inquires. *Education, Communication and Technology*. 29 (2), 75-91.

Guba E. G, Lincoln Y S (1981) *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. Jossey-Bass. San Francisco.

Halpern E S (1983) *Auditing Naturalistic Inquires: The Development and Application of a Model*. Unpublished PhD doctoral dissertation. Indiana University, IN, USA.

Hammersley M (1985) From ethnography to theory: a programme and paradigm in the sociology of education, *Sociology*, 19: 244-259.

Hammersley M (1992) *What's Wrong with Ethnography?* Routledge: London.

Hammersley M. & Atkinson P. (1995) *Ethnography: Principles in Practice*. 2<sup>nd</sup> edition. Routledge. London.

Hansen E C (2006) *Successful Qualitative Health Research. A practical introduction*. Open University Press Berkshire, England.

- Henderson V A (1966) *The nature of nursing*. Macmillan, New York.
- Henderson V A (1991) *The Nature of Nursing. Reflections after 25 Years*. National League for Nursing. New York.
- Hogg M A, Abrahms D (1988) *Social Identifications*. London: Routledge.
- Holland K (1999) A journey to becoming: the student nurse in transition *Journal of Advanced Nursing* 29 (1); 229-236
- Holmes D (2001) From iron gaze to nursing care: mental health nursing in the era of panopticism. *Journal of Psychiatric and Mental Health Nursing*. 8, 7-15
- Homans G C (1961) *Social Behaviour: Its Elementary Forms*. London: Routledge and Kegan Paul.
- Hochschild A R (1983) *The managed heart: commercialisation of human feeling*. Berkeley, University of California Press.
- Howard D (2001) Student nurses' perceptions of Project 2000. *Nursing Standard*. 15 (48), 33-38.
- Howitt D Owusu-Bempah J (1995) *The Racism of Psychology: Time for Change*. Harvester Wheatsheaf. New York.
- Hughes E C (1984) *The Sociological Eye*. Transaction Books. New Brunswick and London.
- Hurst K (1999) Educational implications of multiskilled health carers. *Medical Teacher*. 21, 170-173.
- Hutchinson S (1986) Grounded theory: The method. In P. L. Munhall & C. O. Boyd (Eds), *Nursing Research: A qualitative perspective* (pp. 111-130). Norwalk, CT: Appleton-Century-Crofts.
- Iphofen R (2005) Ethical issues in qualitative health research In: Holloway I (ed): *Qualitative Research in Health Care*. Open University Press London
- Jacox A (1974) Theory construction in nursing: an overview. *Nursing Research*. 23 (1): 4-13.
- Jamieson E M, McCall M, Whyte L A (2003) *Clinical Nursing Practices*. 4<sup>th</sup> Edition. Churchill Livingstone. Philadelphia.
- Jarvis P (1987) Lifelong learning and its relevance to nursing. *Nurse Education Today*. 7, 49, 49-55.
- Jarvis P and Gibson S (1997) *The Teacher Practitioner and Mentor In Nursing, Midwifery, Health Visiting and The Social Services*. 2<sup>nd</sup> Edition. Stanley Thornes. Cheltenham.

Jick T. (1983) Mixing qualitative and quantitative methods: triangulation in action. In *Qualitative Methodology* (Van Maanen J. ed.), Sage, Beverly Hills, California, pp. 135–148.

Jinks A M, Bradley E (2003) Angel, handmaiden, battleaxe or whore? A study which examines changes in newly recruited student nurses' attitudes to gender and nursing stereotypes. *Nurse Education Today* (24), 121-127.

Johnson B, M, Webber P.B (2001) *An Introduction to Theory and Reasoning in Nursing*. Lippincott. Philadelphia.

Johnson M (2004) Safeguarding children and the future of the nursing and midwifery council. (Editorial) *Nurse Education Today*. 24, pp.245-247.

Johnson M, Ormandy P, Long A and Hulme C (2004) The role and accountability of senior health care support workers in intensive care units. *Intensive and Critical Care Nursing*. 20, 123-132.

Kaufman D M, Holmes D B (1998) The relationship of tutor's content expertise to interventions and perceptions in a PBL medical curriculum. *Medical Education*. 32: 255-261.

Kavaini N, Stillwell Y (2000) An evaluative study of clinical preceptorship. *Nurse Education Today*. 20, 218-226.

Kendall G, Wickham G (2001) *Understanding Culture: Cultural Studies Order, Ordering*. Sage. London.

Kenny A (1975) *Will, Freedom and Power*. Oxford, Basil Blackwell.

King N (1994) The Qualitative Research Interview. In Cassell C and Symon G Eds. *Qualitative Methods in Organizational Research*. Sage. London.

Kloss D (1988) Demarcation in medical practice; the extended role of the nurse. *Professional Negligence*. 4. pp 41-47.

Knafl K.A. & Breitmayer B.J. (1991) Triangulation in qualitative research: issues of conceptual clarity and purpose In *Qualitative Nursing Research: A Contemporary Dialogue* rev. ed (Morse J. M. ed.), Sage, Newbury Park, California, pp. 226–239.

Koehn D (1998) *Rethinking Feminist Ethics: Care, Trust and Empathy*. Routledge. London.

Kuhse H (1997) *Caring: Nurses, Women and Ethics*. Blackwell. Oxford.

Lanoë N (2002) *Ogier's Reading Research How To Make Research More Approachable*. 3<sup>rd</sup> Edition. Baillière Tindall. London.

LeCompte M D & Goetz J D (1982) Emergent Paradigms: How new? How necessary? In: E. Guba (Ed) *The paradigm dialogue*. (Pp. 246-255). Sage. Newbury Park. CA.

Leininger. M. (1970) *Nursing and anthropology: Two worlds to blend*. New York: Wiley.

Leininger. M. (1981) *Caring: An essential human need*. Thorofare. New Jersey.

Lepper M R, Drake M F, O'Donnell-Johnson T. (1997) Scaffolding techniques of expert human tutors. In: Hogan K, Pressley M, Eds. *Scaffolding Student Learning: instructional approaches and issues*. Cambridge: Brookline Books. Pp. 108-44.

Liberatore P, Brown Williams R, Brucker J, Dukes L, K, McCarthy J P, Riegler D, Shearer-Pedu K (1988) A Group Approach to Problem Solving. *Nurse Management*. Vol: 23, part 3, pp.271-280.

Lincoln Y S & Guba E G (1985) *Naturalistic Inquiry*. Sage. London.

Locke (1975) *An Essay Concerning Human Understanding*, ed. P.H. Nidditch. Oxford: Clarendon Press.

Lofland J (1971) *Analyzing social settings*. Belmont, CA: Wadsworth.

Lofland J, Lofland L (1995) *Analysing Social Settings: A Guide to Qualitative Observation and Analysis*. 3<sup>rd</sup> edition. Wadsworth. Belmont, California.

Luker, K (1984) Reading nursing: the burden of being different. *International Journal of Nursing Studies*. 21 (1), pp.1-7.

Lukes S (2005) *Power A Radical View* 2<sup>nd</sup> Edition Palgrave Macmillan: New York.

Macdonald C (1997) Nurse autonomy as relational. *Nursing Ethics*. 9 (2): 194-201.

Macintosh C (2000) Is there a place for 'care' within nursing? *International Journal of Nursing Studies* 37, 321-327.

Macintyre A (1981) *After Virtue*. 2<sup>nd</sup> Edition. Notre Dame University Press, Notre Dame.

Mackay L (1993) *Conflicts in Care: Medicine and Nursing*. Chapman and Hall. London.

Macoun A (2004) *Working paper 2. Improving the quality of research proposals*. [www.info.lut.ac.uk/depart,emts/cv/wedc/garnet/actiwp2.html](http://www.info.lut.ac.uk/depart,emts/cv/wedc/garnet/actiwp2.html) accessed 10th October 2006

Mangena A, Chabeli M M (2005) Strategies to overcome obstacles in the facilitation of critical thinking in nursing education. *Nurse Education Today* 25, pp. 291-298

Manis P T and Meltzer B N (eds) (1967) *Symbolic Interactionism: A Reader in Social Psychology*. Allyn and Bacon. Boston.

Marshall C & Rossman G B (1989) *Designing Qualitative Research*. Sage, London.

Marshall J (1986) Towards Ecological Understanding of Occupational Stress. *International Review of Applied Psychology*. 335, 271-286. Sage, London.

Marquis B and Huston C (1992) *Leadership Roles and Management Functions in Nursing: Theory and Application*. J B Lippincott. Philadelphia.

Mason J (2002) *Qualitative Researching*. 2<sup>nd</sup> Edition. Thousand Oaks. Sage.

McHaffie H (1996) Ethics and midwifery. *Modern Midwife* 6 (10); 34-35.

McMillan M, Dwyer J (1989) Changing Times, Changing Paradigm (1): The Macarthur Experience. *Nursing Education Today*, 9 (1): 151-173.

Melia K (1987) *Learning and Working. The Occupational Socialisation of Nurses*. Tavistock Publications. London.

Melia K (1997) *Learning and Working. The Occupational Socialization of Nurses*. Tavistock Publications. London.

Meltzer B N (1978) Mead's social psychology. In: Manis J G, Meltzer B N (eds), *Symbolic Interaction: A Reader in Social Psychology*, 3<sup>rd</sup> Edition. Allyn and Bacon, Boston.

Merrell J and Williams A (1994) Participant observation and informed consent: relationships and tactical decision-making in nursing research. *Nursing Ethics* 1 (3): 163-172.

Merton R K (1957) *Social Theory and Social Structure*. Glencoe: Free Press

Mertens R (1998) What is to be done? In: I. Parker (ed), *Social Constructionism, Discourse and Realism*. Sage. London.

Mifflin B M., Campbell C B, Price D A (1999) A lesson from the introduction of a problem-based, graduate entry course: the effects of different views of self-direction. *Medical Education*. Blackwell Science

Miles M and Huberman A (1994) *Qualitative data analysis*. Thousand Oaks, CA: Sage



Monette M (1979) Need assessment: a critique of philosophical assumptions. *Adult Education* 29 (2), 83- 95.

Morle K. M. F (1990) Mentorship – is it a case of the emperors new clothes or a rose by another name? *Nurse Education Today* 10 (1), 66-69.

Morriss P (2002) *Power: A Philosophical Analysis* 2<sup>nd</sup> Edition Manchester University Press. Manchester.

Morse. J M (1987) *Qualitative Research: A Contemporary Dialogue*. Thousand Oaks. Sage.

Morse. J, Solberg. S., Neander. W., Johnson. J. (1990) Concepts of caring and caring as a concept. *Advances in Nursing Science*. 13, 1-14.

Morse. J (1992) *Qualitative Health Research*. Sage Publications; London.

Morton-Cooper A & Palmer A (1993) *Mentoring and Preceptorship*. Blackwell Science, Oxford.

Muecke. M.A. (1994) On the evaluation of ethnographies. In J.M.Morse (Ed) *Critical issues in qualitative research methods*. (Pp 187-209). Thousand Oaks, CA: Sage.

Murphy E and Dingwall R (2001) The Ethics of Ethnography in P. Atkinson and Hammersley M (eds) *Handbook of Ethnography*. Sage. London,

Narcisco Throwe A and Fought S G (1987) Landmarks in the socialisation process from RN to BSN *Nurse Educator* 12, 15-18

Napthine R (1996) Clinical education: a system under pressure. *Australian Nursing Journal* 3 (9), 20-24.

Needham D R, Begg I M (1991) Problem orientated Training Promotes Spontaneous Analogical Transfer. Memory Orientated Training Promotes Memory for Training. *Memory and Cognition*. 19: 543-557.

Neenan T C (1997) Advanced Practitioners: the hidden agenda? *Intensive and Critical Care Nursing*. 13, pp. 80-86.

NHS Management Executive (1991) *Junior Doctors: The New Deal. Making the best use of skills of nurses and midwives*. NHS Management Executive, London.

Niven N (2000) *Health Psychology for Health Care Professionals*. 3<sup>rd</sup> Edition. Churchill Livingstone.

Norton D, McLaren R, Exton-Smith A N (1962) *An investigation of geriatric nursing problems in hospital*. National Corporation for the Care of Older People. London.

Nursing and Midwifery Council (2002) *Standards for the preparation of teachers of nursing and midwifery* London: NMC

Nursing and Midwifery Council (2004) *Code of Professional Conduct*. London: NMC

Ogier M E (1982) *An Ideal Sister: A Study of Leadership Style and verbal Interactions of Ward Sisters with Nurse Learners in General Hospitals*. RCN Research Series. RCN.

Ogier M E (1989) *Working and Learning*. Scutari Press. London.

Orton H D (1981) *Ward Learning and Climate. A Study of the Role of the Ward Sister in Relation to Student Nurse Learning on the Ward*. RCN Research Series. RCN. London.

Olesen V, Whittaker E (1968) *The Silent Dialogue: a Study of the Social Psychology of Professional Socialisation*. Jossey Bass: San Francisco.

Paddison J (1995) Ethical issues in qualitative studies. *Modern Midwife*. 5 (5); 23-5

Paley. J. (2001) An archaeology of caring knowledge. *Journal of Advanced Nursing*. 36 (2), 188-198.

Paley. J. (2002) Caring as a slave morality: Nietzschean themes in nursing ethics. *Journal of Advanced Nursing*, 40 (1), 25-35.

Parker I (1997) Discursive Psychology. In: *Critical Psychology An Introduction*. PP 285-298. Editors: Fox D, Prilleltensky I. Sage Publications. London.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Pavalko R (1971) *Sociology of occupations and professions*. Columbia University, Teachers College. New York.

Phillips P (1993) A deconstruction of caring. *Journal of Advanced Nursing*. 18 (10), 1554-1558.

Pinch W J (1993) Investigator as stranger. *Qualitative Health Research* 3 (4), 493-498.

Popper K (1959) *The Logic of Scientific Discovery*. Hutchinson. London.

Porter S (1992) The poverty of professionalisation: a critical analysis of strategies for the occupational advancement of nursing. *Journal of Advanced Nursing*. 17 (6): 679-684.

Price B (2003) *Studying Nursing Using Problem-Based & Enquiry-Based Learning*. Palgrave, Macmillan. Hampshire.

Pring R (1993) Liberal education and vocational preparation. In: Barrow R and White P (eds) *Beyond Liberal Education: Essays in Honour of Paul H. Hirst* E book. Mobipocket.

Redfern S.J. & Norman I.J. (1994) Validity through triangulation. *Nurse Researcher* 2(2), 41–56.

Reed J, Ground I (1997) *Philosophy for Nursing*. Arnold. London.

Reinharz S (1997) Who am I? The need for a variety of selves in the field. In R. Hertz (Ed), *Reflexivity and Voice* pp. 3-20. Sage. Thousand Oaks, CA.

Robson C (2003) *Real World Research*. 2<sup>nd</sup> Edition. Blackwell Publishing. Oxford.

Rogers C (1983) *Freedom to learn for the 80's*. Merrill, New York.

Rowe. J.H. (1965) The Renaissance foundation in anthropology. *American Anthropologist*. 67, 1-20.

Roper J M, Shapira J (2000) *Ethnography in Nursing Research*. Thousand Oaks. Sage.

Ryle G (1949) *The Concept of Mind*. Penguin Books. London.

Savage J (1997) *Nursing Intimacy*. Scutari. London.

Savin-Baden M (1997) Problem Based Learning, Part 1: an innovation whose time has come. *British Journal of Occupational Therapy*. 60 (12).

Savin-Baden M (1998) *Understanding problem based learning contexts from staff and students' perspectives*. Paper presented at Higher Education Close Up, University of Central Lancashire, Preston. [Www.leeds.ac.uk/educol/documents](http://www.leeds.ac.uk/educol/documents)

Savin-Baden M (2000) *Problem Based Learning in Higher Education: Untold Stories*. Open University Press. Bury St.Edmonds. England.

Schön D (1983) *The Reflective Practitioner. How Professionals Think in Action*. Basic Books, New York.

Scriven M (1971) Objectivity and subjectivity in educational research. In L. G. Thomas (ed) *Philosophical redirection of educational research*. University of Chicago Press. Chicago.

Seed A (1991) *Becoming a registered nurse – the students' perspective. A longitudinal qualitative analysis of the emergent views of a cohort of student*

nurses during their three year training for registration. Unpublished PhD thesis, Leeds Polytechnic, CNAA, Leeds.

Sheldon L (1998) Grounded theory: issues for research in nursing. *Nursing Standard*. 12, 52, 47-50.

Shils E (1961) Centre and periphery in *The Logic of Personal Knowledge: Essays presented to Michael Polanyi.*, Routledge & Kegan Paul, pp. 117-31. In *Modern Sociology. Introductory Readings.* (1973) Peter Worsley (Ed).

Shuval J T (1980) *Entering Medicine: The Dynamics of Transition*, Pergamon Press, Oxford.

Silverman. D. (1997) *Interpreting Qualitative Data. Methods for analysing Talk, Text and Interaction.* Sage: London.

Simon R and Dippo D (1986) On Critical Ethnographic Work *Anthropology and Education Quarterly*. Vol: 17, (4), 195-222.

Simpson I H (1979) *From Student to Nurse: A Longitudinal Study of Socialization.* Cambridge University Press, Cambridge.

Smith P (1992) *The Emotional Labour of Nursing* Macmillan. London.

Smith P (2000) *The Emotional Labour of Nursing: How Students and Qualified Nurses Learn to Care.* A Report on Nurse Education, Nursing Practice and Emotional Labour in the Contemporary NHS. South Bank University.

Spradley. J.P (1980) *Participant Observation.* New York: Holt, Rinehart & Winston.

Spencer J (2001) Ethnography after Post-Modernism in Atkinson P et al (eds) *Handbook of Ethnography.* Sage. London.

Spencer L, Ritchie J, Lewis J, Dillon L (2003) *Quality in Qualitative Evaluation: A Framework for Assessing Evidence.* Government Chief Social Researchers Office, London.

Spouse J (1996) The effective mentor: A model for student-centred learning in clinical practice. *Nursing Times Research* 1 (20), 120-33

Spouse J (1997) Issues in observing nursing students in clinical practice. *Nursing Times Research* 2, 187-196.

Spouse J (1998a) *Understanding learning in the professional context: 5 case studies of nurses from a pre-registration degree course.* Unpublished PhD Thesis. University of Bath. England.

Spouse J (1998b) Scaffolding student learning clinical practice. *Nurse Education Today* 18, 259-66

Spouse J (2000) Supervision of Clinical Practice: The Nature of Professional Development. In: *Successful Supervision in Health Care Practice* Eds Spouse J, Redfern L. (Pps 126-154). Blackwell Science. Oxford.

Spouse J (2001a) Bridging theory and practice in the supervisory relationship: a sociocultural perspective. *Journal of Advanced Nursing* 33 (4), 515-522

Spouse J (2001b) Workplace learning: pre-registration nursing students' perspectives *Nurse Education in Practice* 1, 149-156

Spouse J (2003) *Professional learning in nursing*. Blackwell Publishing. Oxford.

Stake, R. E. (1978). The case study method in social inquiry. *Educational Researcher*, 7(2), 5-8.

Stake R E (1995) *The Art of Case Study Research*. Thousand Oaks, California. Sage.

Strauss. A & Corbin. J (1990) *Basics of Qualitative Research. Grounded Theory Procedures and Techniques*. New York: Cambridge University Press.

Strauss. A & Corbin. J (1994) Grounded theory methodology: an overview. In *Handbook of Qualitative Research* Eds Denzin N and Lincoln Y Sage. London. Pps. 272-285

Strauss. A & Corbin. J (1998) *Basics of Qualitative Research. Grounded Theory Procedures and Techniques*. 2<sup>nd</sup> edition. Sage Publications; London.

Strauss. A & Corbin. J (2003) *Basics of Qualitative Research. Techniques and procedures for developing grounded theory*. New York: Cambridge University Press.

Strauss A, Schatzman L, Ehrlich D, Bucher R and Sabshin M (1963) The hospital and its negotiated order In: Worsley P Ed (1978) *Modern Sociology*. 2<sup>nd</sup> Edition, Harmondsworth, Penguin.

Stein P (1985) Using grounded theory method in nursing research. In Leninger M (Ed) *Qualitative Research Methods in Nursing*. Orlando FL, Grune and Stratton.

Stern P. N. (1980) Grounded theory methodology: Its uses and processes. *Image*, 12 (7), 20-23.

Street A F (1992) *Inside Nursing. A Critical Ethnography of Clinical Nursing Practice*. State University of New York Press, Albany.

Streubert H. J & Carpenter D.R (1999) 2<sup>nd</sup> edition *Qualitative Research in Nursing Advancing the Humanistic Imperative*. Lippincott. New York.

Stevens J, Crouch M (1995) Who care about care in nursing education? *International Journal of Nursing Studies*. 32 (3), 233-242

Stewart R M (1976) *The Reality of Management*. London: Pan.

Stockdale M, Warelow P J (2000) Is the complexity of care a paradox? *Journal of Advanced Nursing* 31, 1258-1264.

Swallow V and Coates M (2004) Flexible education for new nursing roles: reflections on two approaches. *Nurse Education in Practice*. 4 (1), p53-59.

Tajfel H (1978) Differentiation between social groups: Studies in the Social Psychology of Intergroup Relations in Brotherton C (1999) *Social Psychology and Management*. Open University Press. Buckingham.

Taylor C (1997) Problem solving in clinical nursing practice. *Journal of Advanced Nursing*. 26, 329-336.

Taylor C M (2005) Interviewing In: Holloway I (ed): *Qualitative Research in Health Care*. Open University Press London

Taylor HR, Westcott E, Bartlett H P (2001) Measuring the socialization of graduate and diplomate nurses using the Corwin Role Orientation Scale *Journal of Advanced Nursing* 33 (1), 20-28

Taylor P, Richardson J, Yeo A (1995) *Sociology in Focus*. Causeway Press. Lancashire.

Taylor S, Field D (2001) *Sociology of Health and Health Care*. 2<sup>nd</sup> Edition. Blackwell Science. Oxford.

Titchen A (1998) *A Conceptual Framework for Facilitating Learning in Clinical Practice*. Occasional Paper No: 2, Radcliffe Infirmary, Oxford. Royal College of Nursing Institute.

Thompson N (2000) *Theory and Practice in Human Services*. 2<sup>nd</sup> Edition. Open University Press. Buckingham.

Thompson N (2003a) *Communication and Language: A Handbook of Theory and Practice*. Palgrave Macmillan. Basingstoke.

Thompson N (2003b) *Promoting Equality. Challenging discrimination and oppression*. Palgrave Macmillan. Basingstoke.

Thompson I E, Melia K M & Boyd K M (2003) *Nursing Ethics*. 4<sup>th</sup> Edition. Churchill Livingstone. Elsevier Science limited.

Thorne S (1991) Methodological orthodoxy in qualitative nursing research: analysis of the issues. *Qualitative Health Research*. 1, 2, 178-199.

- Townsend J (1990) Problem-based learning. *Nursing Times*. 86, 61-62.
- Treacy M P (1987) Some aspects of the hidden curriculum. In: Allan P, Jolley M (Eds). *The Curriculum in Nursing Education*. Routledge. London.
- Treacy M, Hyde M (1999) *Nursing Research. Design and Practice*. University College Dublin Press. Dublin.
- Turner V (1982) *From Ritual to Theatre*. PAJ Publications, New York
- Turner J C (1991) *Social Influence*. Milton Keynes: Open University Press.
- United Kingdom Central Council (1993) *The Scope of Professional Practice*. UKCC. London.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1995) *Implementation of the UKCC's Standards for Post-Registration Education and Practice*. UKCC. London.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997) *Fitness for Practice-The UKCC Commission for Nursing and Midwifery Education*. UKCC. London.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Fitness for Practice*, UKCC: London.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2001) *Report of the Higher Level of Practice Pilot-The UKCC Commission for Nursing and Midwifery*. UKCC. London.
- Valsiner J (1986) *The Individual Subject and Scientific Psychology*. Plenum. New York.
- Wade G (1999) Professional nurse autonomy: concept analysis and application to nursing education. *Journal of Advanced Nursing*. 30 (2): 310-318.
- Walker L O, Avant K C (1985) *Strategies for theory construction in nursing*. Norwalk: Appleton and Lange.
- Walsh P M (1984) Planning and developing programs systematically. In: Green et al (eds) *Continuing education for the health professions*. (pp 162-178) Sage. London.
- Walshe C E, Caress A L, Chew-Graham C, Todd A J (2004) Case studies: A research strategy appropriate for palliative care? *Palliative Medicine* 18: 677-684
- Walsh M (2000) Nursing frontiers: accountability and the boundaries of care. *Nursing Standard*. 11 (52): 39-42.

Ward-Schofield J (1993) Increasing the generalisability of qualitative research. In: M. Hammersley (Ed), *Social research: Philosophy, politics and practice* (pp. 200-225). Open University/Sage. London.

Watson J (1997) The theory of human caring: retrospective and prospective. *Nursing Science Quarterly*. 10, 1, 49-52.

Weber M (1968) *Economy and Society*. Bedminster. New York.

Wenger F (1998) *Communities of Practice: Learning, meaning and identity*. Cambridge University Press. Cambridge.

White R & Ewan C (1991) *Clinical Teaching in Nursing* Chapman and Hall, London

Whyte W F (1951) Observational field work methods. In: Jahoda G ed., *Research Methods in Social Relations*. Sage. London.

Wicks D (1998) *Nurses and Doctors at Work. Rethinking Professional Boundaries*. Open University Press. Buckingham.

Wilkes L. M, Wallis M. C. (1993) The five C's of caring: the lived experiences of student nurses. *Australian Journal of Advanced Nursing* 11 (1), 19-25

Wilkinson J (1997) Developing a concept analysis of autonomy in nursing practice. *British Journal of Nursing*. 6 (12): 703-707.

Williams S (1999) *Student carers: learning to manage emotions*. Soundings 11: 180-186

Wilson A J (1998) *A Place for Learning: A Study of How Nursing Students Learn and are supported While on Clinical Placements*. Unpublished PhD Thesis, University of Aberdeen.

Williams G, Lau A (2004) Reform of undergraduate medical teaching in the United Kingdom: a triumph of evangelism over common sense. *British Medical Journal* [www.bmj.com/cgi/content/full/329/7457/92](http://www.bmj.com/cgi/content/full/329/7457/92) accessed 10th July 2004.

Windsor A (1987) Nursing students' perspectives of clinical experience. *Journal of Nursing Education* 26, 150-154

Witz A (1992) *Professions and Patriarchy*. Routledge. London.

Whyte W F (1951) Observational field work methods. In: Jahoda G ed., *Research Methods in Social Relations*. Sage. London.

Woods. M (1979) *The Divided School*. Routledge & Kegan Paul, London.



Yin, R. K. (1984). *Case study research: Design and methods* (1<sup>st</sup> ed.). Beverly Hills, CA: Sage Publications.

Yin R K (1994) *Case Study Research: Design and Methods*. 2<sup>nd</sup> Edition. Thousand Oaks. California.

Yin R K (1999) Enhancing the quality of case studies in health services research. *Health Service Research*; 34: 1209-24

Yin R K (2003) *Case Study Research Design and Methods*. 3<sup>rd</sup> Edition. Sage Publications, Thousand Oaks, California.