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Exploring the potential of the pre-registration programme for developing student nurses as future clinical leaders within contemporary healthcare

by

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ABSTRACT

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This thesis describes a project using a qualitative study approach. It explores the utilization of the pre-registration period as preparation for clinical nurse leadership relevant to work in contemporary health care. The empirical focus of this study was to fundamentally address only the perceptions of senior student nurses about to qualify, of their own leadership development during their programme.

Using focus groups with a total of 35 third year pre-registration students about to qualify as nurses provided a rich and detailed description of what inhibited and enhanced the development of their leadership skills. Alongside this, the students' perceptions of qualities and competencies required specifically for contemporary nurse leader roles were identified. No substantive studies exist in the United Kingdom exploring the experiences and perceptions of student nurses regarding nurse leadership during their training.

It is distinctive as it challenges the state of nurse leadership in healthcare and the expected developmental needs for it. Students recognised the need to be prepared for leadership during their pre-registration programme and questioned the use of the standard theoretical approach for its development. They asked instead for skills to deal with difficult conversations, unexpected power struggles, challenging and dealing with inappropriate behaviour and introducing evidence into practice in areas of resistance. The study makes an important contribution to education as the findings can inform leadership development throughout the pre-registration nursing programmes within England. It also raises the question as to whether nursing needs more leaders, or just for nurses to take the professional responsibility for their own practice.

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I, Stephanie Caroline Meakin declare that the thesis entitled

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and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

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Date:……

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My husband Andrew and my sons Alexander and Edward have lovingly encouraged me throughout this journey. I will always be grateful.

1. Introduction

1.1 Introduction

The primary aim of this study was to explore the value of the pre-registration programme for developing student nurses as future clinical leaders within contemporary healthcare. The topic is important as evidence identifies clear links between leadership and effective clinical outcomes for patients (Shipton et al 2008). Leadership in nursing is recognised as central to ensure quality care and safety for service users. Yet nursing itself limits the increase in its influence and authority due to the public and medical perceptions of it, and how nurses position themselves in health care. Public inquiries and media reports in the first 13 years of the millennium illustrated unsafe and inadequate standards of nursing care, directly attributable to poor leadership (Willis 2012; Francis 2013). In addition, these inquiries raised issues of bullying, intimidation and abuse by and between nurses, even towards patients, impacting on the reputation of the whole nursing profession.

There has been an abundance of leadership development programmes for qualified nurses over several decades. Nevertheless, the public inquiries highlighted a lack of nurse leadership thereby raising questions regarding the effectiveness of some of this development provision. Nursing itself has been lamenting the weakened state of its leadership for decades (Sorenson et al 2008). Perhaps leadership development alone is not enough to change habits, and a reliance on this to train clinicians is insufficient to change skills, attitudes or behaviours (Coomarasamy et al 2004). Waiting until after qualification may be too late to embed the values, behaviours and courage required to lead on healthcare. Interestingly, little attention has been paid to the pre-registration period which should be the optimum time to develop the leadership skills and competencies relevant for contemporary challenges in healthcare. Considering this, the following thesis set out to explore leadership development in the student nurse pre-registration programme.

1.2 Nursing Leadership

Drivers to enhance the leadership role, specifically within the nursing profession, have been varied and supported at national level by the Department of Health (DoH) (DoH 2006). High Quality Care for All; The Next Stage Review (DoH 2008), made quality the organising principle of the NHS. It was led by Parliamentary Under Secretary of the State for Health, and set out a clinically-based vision to revolutionise the NHS to be fit for the future. To implement the changes required appropriate and effective nursing leadership. Inspiring Leaders; leadership for quality was then published (DoH 2009), the purpose of which was to provide guidance for Strategic Health Authorities (SHAs) on talent and leadership planning. The Operating Framework for the NHS in England (DoH 2009) announced the Department of Health's plans to introduce improvements in leadership capacity and capability. In addition, High Quality Care for All (DOH 2008) made clear the leadership challenge to deliver the visions for clinical improvements. Inspiring Leaders: leadership for quality (DoH 2009) highlighted the vision of a talent and leadership plan and the need to attract, retain and develop leaders to serve the community at all levels.

Even with the political drivers for leadership, the quality of nursing itself has been raised as a concern. This thesis was undertaken in the political and social context of inquiries into poor levels of care provided in a number of healthcare environments. In June 2010, the Secretary of State launched a full public inquiry into Mid Staffordshire Foundation NHS Trust in response to considerable concerns regarding its quality of care and patient safety. The inquiry was chaired by Robert Francis QC and resulted in a 3 volume report containing oral evidence from 164 witnesses. On 6th February 2013, the final report was published with 290 recommendations for health care providers to take account of, many of which are the focus of nursing and nursing leadership (Francis 2013).

Within the report, Francis emphasised that the inquiry had received requests to review a number of other healthcare environments with comparable issues. Concerns were that the findings from the inquiry may be typical of elsewhere and evidences "a culture of habituation and passivity" (Francis 2013:26). Autonomy and personal responsibility enters the picture and whilst leadership was held responsible by Francis (2013), individual nurses could not be allowed

to stand apart from the ultimate catastrophe that occurred. In the light of the recent Francis report (2013), there has been no better time to consider and address this issue.

Perceptions of nursing itself are associated with powerful and often contradictory discourses of professional standing and autonomy alongside oppression and subservience (Hargreaves 2008). An understanding of how nursing was crafted in the past may help to illuminate the present and the origins of the contradictions. Preparation for future leaders requires a realistic understanding of historical and potential barriers to be able to manage the change effectively, and reduce and adapt approaches to them. Reviewing the historical perspective is an appropriate first step to see where the oppression and opinions actually arise from. The historical image of women caring for the sick and the suggestion of a calling or duty sanctified work is a resilient picture for some. This does not depict an autonomous practitioner leading on patient care, but more of the subordinate, oppressed, obedient domestic described by Oakley (Oakley 1993).

The rather clichéd reasons for the continuing oppression of the nursing profession includes gender issues, and the continued dominance and patriarchy of medicine (Corner 2001). Nursing may need to take increasing responsibility and review what can be done positively to move the profession on, rather than maintaining the status quo due to tradition, custom and practice. There may be lessons to be learned from the USA. Stein et al (1990) revealed changes within American nursing from a study he had undertaken in 1967 (Stein 1967). The previous model was what he described as the doctor-nurse game where this relationship had to be maintained at all costs, the nurse seemingly negotiating around the doctors at all times. In 1990, he observed advances in nurses' professional autonomy and ability due to the changes to an academic education, alongside a growing professional maturity and a desire to make its own decisions (Stein 1990).

Nevertheless in England, there remains suspicion of the increasing academic education. Even though a significant number of both student and qualified nurses have undertaken this academic education from diploma up to doctoral level over the last thirty years, there appears to be limited advance in nurses' professional autonomy and ability. An announcement by the Nursing and

Midwifery Council (NMC) in November 2009 declaring that nursing would become an all graduate profession by 2013 was followed by patronising and demeaning responses from journalists, doctors, members of the public and even nurses themselves. The response from the nursing regulatory bodies and senior nursing professionals was ineffective. It was insufficient to influence opinions towards the need for academic input and level to improve patient care and to strengthen nursing careers whilst still remaining at the patient's bedside.

There were suggestions that nurses do not need "a degree to care" and being too qualified to undertake personal care. To illustrate this dilemma, one article written by Simon Heffer in the Daily Telegraph on Saturday November 14th 2009, included the statement that the result from this "silly and wastefully expensive decision is that many girls who are not academic but who would make brilliant nurses will now be deterred from joining the profession." The leadership required becomes confusing for a professional group who are unable to be identified by the public and their peers for their roles and professional standing, and is still viewed by some as a career for "girls who are not academic". Hence, whilst policy makers drive forward the plans, public and professional perceptions may inhibit progression. These perceptions are worthy of enquiry if nursing leadership is to continue to develop. Whilst comparing the changes brought about by academic education in the United States, with the limited response in England, a question emerges as to the adequacy of the content within the preparation of student nurses.

1.3 Education for leadership

To prepare student nurses for leadership in contemporary practice requires an understanding of what is required. At first this may appear a simple task yet leadership itself is difficult to define and inspires strong debates around styles. The impact of it is also disputed (Kings Fund 2011). Leadership is seen from multiple perspectives and theoretical concepts further complicating what is appropriate for nursing and the complexity of the healthcare environments in which they work. The Kings Fund Commission on Leadership and Management in the NHS defines leadership "as the art of motivating a group of people to achieve a common goal" (Kings Fund 2011:12). To justify this definition, they

added that leadership requires other skills such as being analytical and being able to communicate direction and balancing resourcing and conflicts as they arise. Nevertheless, nurse leadership seems to require more than this. Nurse leaders need to be able to lead others to provide quality, evidence based care for individual patients as well as tackling unacceptable practices and challenging inappropriate behaviour. Nurse leaders need to provide a culture in which care giving is possible.

Responding to that complexity, a working definition which would appear to be more suitable is offered by Rafferty (1993;3-4). Leaders "inspire you and whom others will follow, but who will trust you. They will trust in your integrity…Leaders care for the people they are leading/serving. Leaders try to strengthen and promote these people… They facilitate and help and encourage and praise". The reason that Rafferty's definition has been chosen for this work is because of its emphasis on leading and serving, the importance of trust and integrity and the need for encouragement and praise.

There is recognition that leaders need to be nurtured from the very beginning of their professional journey (Andrew 2012). Rippon (2001) put forward the idea of growth cultures in order to develop leaders with the necessary skills and intelligence for leadership. The most appropriate growth culture for nurse leaders would potentially be the pre-registration training to cultivate sufficient leadership attributes and competencies**.** It is when the student nurse is immersed in learning in both theory and practice environments and is the opportunity to positively influence their future practice and beliefs. Nurturing and strengthening them as they develop attitudes and behaviours would seem more effective than trying to change these during post qualifying courses.

Whilst there is an element of leadership and management theory within the pre-registration curriculum, there is no formal recognition of its potential or evaluation of its purpose and suitability. Indeed there is minimal reference to this period as being an optimal time for preparation for leadership. Nurse educationalists are well placed to be able to improve, or develop self-esteem in student nurses, and by careful selection and development of effective and appropriate mentors in practice. Creative and resourceful innovations in teaching leadership could be realised, not usually termed as leadership and management, but are key to future leadership. Examples of these could be

negotiation skills, self-confidence, tenacity, self-belief, assertiveness along with the more traditional decision making and problem solving instilled throughout the training.

Conversely, the comparison to leadership in practice is limited. There is also the danger of emphasising the teaching of leadership skills to the detriment of clinical skills and to lead in clinical practice requires clinical expertise. Indeed nurse educationalists in Britain face the charge that the system is no longer producing nurses who are competent when they qualify (Hargreaves 2008). Much that is written covers theories and models of leadership but little offers an insight into overcoming the inhibiting and discriminatory factors. It is not about a power struggle but about being able to work with, and adapt, to offer the patient the best care whilst supporting other nurses rather than trying to oppress the opposition.

Perceptions for when nurses become leaders are confusing and frequently reliant on a title. It is no longer lying solely with those carrying senior positions in a hierarchical structure. All individual nurses are now considered to be the leader of their own practice, taking full responsibility for it (NMC 2010). When references are made to nurse leaders, it is confusing therefore as to whom are being referred too, a nurse in a distinct senior leadership role or every nurse.

The Nursing and Midwifery Council (NMC) are quite clear in their Standards for Pre-registration Nursing (2010) by prescribing the essential competencies and standards relating to leadership. All nursing students must achieve these throughout the practice placements and prior to registration, as leadership is an integral feature of the work of every nurse (Bach et al 2011). From this, nurses lead from the moment of registration, coordinating, delegating and supervising care safely, managing risk and remaining accountable for the care given (NMC 2010). Skills and competencies learned should underpin those required for leading on teams and services if their roles dictate this. However, a literature search highlighted only a small number of publications regarding student leadership development. All were unique projects for a limited number of students.

1.4 Overview of the study

This research project focused on the utilization of the pre-registration period as preparation for clinical nurse leadership relevant to work in current and contemporary health care. The empirical focus of this study addressed the perceptions of senior student nurses about to qualify of nurse leadership within contemporary healthcare, and what inhibited and what enhanced their own leadership development. There were no studies which asked students for their perceptions of leadership or how to be prepared for it.

It was believed that understanding their perceptions was the most relevant to this topic. Senior student nurses had experienced all the theoretical and practical aspects of the curriculum including leadership. Perceptions were sought rather than just their experiences. Making sense of the experience through a person's own senses equated with their reality rather than just their experiences. It was the making sense of the experience to the person which was more important to this study. It was hoped that findings from this study would influence changes to leadership development in the curriculum.

The actual value of the pre-registration period as preparation for clinical nurse leadership relevant to work in contemporary health care was assumed, but not confirmed. The study design was developed as a first step to investigate this by exploring the perceptions of pre-registration student nurses regarding the value of their leadership development. It explored how the culture, nature and nuances of the Higher Education and clinical environment influenced the students' perceptions. It considered how their experiences inhibited or enhanced leadership development, and identified lessons learned from the findings regarding developing leadership skills in student nurses.

Section two reviews the relevant literature to establish what is known about leadership development in the pre-registration period, and what new knowledge is needed to contribute to the arena. It explores historical perspectives of nursing, nursing leadership and nursing education to throw light on enduring images, not all of them helpful for nursing to move forward.

Section three explains and justifies the methodology chosen for the study. An in-depth qualitative research study was employed to enable the individual

students' perspectives to be recognised and assign value to their personal experiences and knowledge. It explored in depth the inconsistencies, ambiguities and uncertainties that this subject provided. Section four presents the data analysis in the themes that emerged by using Versus Coding. Versus coding acknowledged conflict and the codes identified which individuals, groups or systems were struggling for power (Saldana 2013). Section five is a discussion of the findings from the study whilst section six concludes the study by recommendations for education and for future research.

1.5 Summary of section one

This section highlighted the drive to strengthen nurse leadership within clinical practice due to political and public expectations. Even with the leadership development opportunities provided for qualified nurses, examples of poor quality healthcare continued to be presented. Whilst the need to improve care fits firmly in nurses remit, examples of bullying, poor patient care and weak presentations reduced their impact. Raising the academic standard entry onto the nursing register had been met with ridicule and derision. It was timely to review the value of the pre-registration programme for leadership preparation appropriate for contemporary nursing. As a first step, the proposed study asked the students for their perceptions of what inhibited and what enhanced their leadership development, and how they perceived nurse leadership in contemporary practice. There were no studies which asked students for their perceptions of leadership or how to be prepared for it. Reviewing the literature, students' perceptions were not sought on any subject, only their experiences or evaluation. It was unclear why that may be so. Perhaps it was believed that students were too inexperienced to have valuable insights, but perceptions can uncover insights with a personal intelligence and fewer preconceived ideas than qualified staff.

2. Background literature

2.1 Introduction

In preparation for the study, literature published in the United Kingdom (UK) was reviewed to establish what was known already and what new knowledge was needed to contribute to the arena. The NMC is the regulatory body for nursing and nursing students in the United Kingdom only and has responsibility for the quality of their curriculum. The majority of the literature reviewed was therefore relevant to UK healthcare systems.

However, there was no literature pertaining to perceptions of student nurses regarding nurse leadership or about their own leadership development. No relevant systematic reviews were identified. There was no literature investigating the impact that any leadership development experienced during the pre-registration programme has had on the future practice of professionally qualified nurses. Only articles describing small projects for a limited number of students had some relevance to developing any leadership skills during pre-registration nurse programmes in the United Kingdom. This is also reflected in leadership development in students from the wider international context.

In section one, potential limits upon the increase in influence and authority which may impact on nurses' ability to lead due to the public and medical perceptions of nursing was raised as an issue. To positively influence pre-registration nurse training as an effective culture in which to develop leaders, an understanding of how nursing was crafted in the past was thought may gain an understanding of the background to some of these perceptions. Preparation for students as future leaders to work within contemporary health care systems requires a realistic understanding of any historical and potential barriers to be able to manage the change effectively and adapt approaches to them. This section therefore, briefly reviews the history of nursing to gain an understanding of any entrenched perceptions of nurses' public standing which may impact on students' transition to leadership.

Likewise, a brief history of nursing leadership is included to understand its political impact and influence from patients' bedside to the Executive Board. There is also a broad overview of leadership literature itself within the discussion. Changes within the pre-registration nursing programmes leading to the all graduate status of the profession is included due to the controversy that it has raised, and its potential impact on students' experience in practice. The literature review therefore, sought perspectives that may negatively and positively impact on the image of nurses as professionals who can lead contemporary practice, and to identify issues that could inhibit or enhance student leadership development.

2.2 A brief history of Nursing

Historical research can be useful when it is possible that something in the past can assist an understanding of something in the present (Streubert et al 1999). The value of reviewing the history of nursing, its previous status and identity, was to provide an understanding as to why there may be this complex and confused appearance in contemporary practice. Challenging the proposition that history represents the accumulation of objective facts, Carr (1987) contends that history is the product of the people and the context that produces it. There is a wealth of historical references to nursing and its history and, agreeing with Carr, whilst some of it is fact, much of it is from living memories of nurses. These are open to personal interpretation and values and may inspire a more romantic image, depending on the perspective and the experience of the author (Hargreaves 2008). Political and sociological environments influenced some authors and their histories were often driven by their own aspirations (Rafferty 1997).

Although largely undocumented, some form of nursing has been carried out for thousands of years. Nursing has been described as the oldest of the arts and the youngest of the professions (Donahue 1985). Its historical image was of a subordinate, obedient domestic caring for the sick with a suggestion of a calling or duty sanctified work (Oakley 1993). This image appears to remain for some confirmed by the media report in section one. The majority of nurses were married women doing mostly domestic work for patients reflecting what they did at home for their families (Miller 1976). These women had only just

been freed from either the cloisters or their homes and therefore, were strong and independent within the constraints of society at that time (Oakley 1993).

Florence Nightingale attempted to establish nursing as a profession and away from these cruder aspects of domestic work (Oakley 1993). She saw nurses as a kind of hospital housekeeper whose job it was to supervise the health of the patient's environment. This required them to be members of a highly disciplined occupation with its own code of conduct and behavioural and ethical standards (Oakley 1993). The early image of the doctor's handmaiden was in part, derived from the position of women in society at the time. Nightingale's legacy, rather than challenge authority as her experiences in the Crimea might suggest, reinforced submission to authority and maintained class bound divisions of labour determined by gender (Corner 2001).

Early history textbooks were written by nurse reformers, many of whom promoted the idea of nurse registration (Rafferty 1997). Registration was seen as a method to distinguish the trained nurse from the women who had claimed the title prior to the nursing reforms of the nineteenth century (Nelson 1992). During the first half of the 20th century, nurses accepted the duty to care without thought for their own autonomy (Mason 2011). Definitions at the time implied that nurses operated under the supervision of a physician failing to identify any independent work. With nursing's historical circumstances, serving others without being subservient was difficult to achieve. In 1972, the Briggs report recommended that nurses must be a professional among equals and not a handmaiden to any others (Department of Health and Social Security 1972). Nevertheless, examples of nurses continuing as handmaidens to medical colleagues remain in some environments, despite a period of forty years to the time of this study.

One such example was illustrated in a paper by Pollard et al (2005), who reported findings from a recent research study investigating opportunities for students to learn and work inter-professionally. The original drive to develop inter-professional learning into the pre-registration programme was to prevent the development of stereo types and professional barriers. Seven events of inter-professional working across three NHS Trusts were observed by the researchers. These were all meetings which involved a range of health professionals and students reviewing their clinical work together. The results

highlighted behaviours crucial to effective inter-professional work such as sharing decisions, showing clear communication channels and a mutual respect between each member. Yet also in the results it would appear that at each event, medical agendas and models determined proceedings. It was clear that senior medical staff influenced how others related to each other and appeared to only confirm the continuity of medical dominance.

The increase in medical technology and scientific breakthrough in health care has maintained a level of medical power over nurses. Meanwhile nursing still struggles to define its sources of knowledge on which to base practice on. Historically, the science, spirit and skill of nursing did not begin to develop until it became apparent that love and caring alone could not ensure health or overcome disease (Donahue 1985). Nursing theory really started in the 1970s and 1980s in the United States. Henderson (1966), Roger's (1976) and Orem (1980) theorised that the nurse's role was to maintain and promote health, prevent illness and care for and rehabilitate the sick and the disabled. Unfortunately this does not appear to show any ground breaking effects or scientific discoveries. These theorists did not therefore produce any knowledge that Nightingale, in the previous century, had not already identified.

This humanistic and holistic side is difficult to put into scientific terms and in an age of technological advances, is not always measurable (Corner 2001). In addition, nursing is described in terms of science and art and is therefore not considered within traditional reductionist scientific methodology (Watson 1999). Nursing research itself has developed only over the last 30 years. Nurses have traditionally based their own practice on their own experiences because it has always been done that way. In a study by Thompson et al (2004) looking for the accessibility of research-based knowledge for nurses in the United Kingdom, found the most common source of information was their colleague's experience. Whilst personal experience and those of others is invaluable, relying on this solely for knowledge is detrimental to nursing practice and can perpetuate the risks of unsafe practice. The status of nursing as a profession can only be enhanced by the public and by medical colleagues when it is recognised that nursing is not just common sense and tradition, but is based on knowledge derived from research (Parahoo 2006).

2.3 Contemporary Nursing Identity

The duty to care organised within the political and economic context of nursing's development has made it difficult for nurses to obtain the moral and ultimately political standing. Whilst nurses are searching for a way to forge a link between altruism and autonomy (Reverby 2011), some have lost their duty to care. Increasing media attention since the beginning of the 21st century illustrates nurses behaving without values or compassion, as seen so clearly in the Mid Staffordshire Inquiry (Francis 2013), and losing the very identity of nursing.

The increasing concerns that nursing had lost its way were so serious that in 2008, the Chief Nursing Officer commissioned the report A Vision of Tomorrow's Nurse, to support work informing the Next Stage Review (DoH 2008). The report set out to restore confidence in the nursing profession. Its recommendations defined what patients and nurses wanted in good quality care and identified measures to implement a step change in the quality of care (Maben et al 2008). The report illustrated a vision of the professional identity of nurses. It confirmed that nurses practice individually, in partnership and as leaders providing high quality healthcare across a range of settings. The report also reinforced that all nurses should be confident and effective leaders, championing care quality at all levels of the healthcare system, whilst taking personal responsibility for delivering personalised care. For a Chief Nursing Officer to need a report to reinforce and confirm only what was already an established understanding of the nurses' role and identity goes some way to illustrating the weak image of the profession. This portrayal of nursing identifies the struggle for the recognition of nurses as leaders of care.

2.4 A brief history of nurse leadership

Wildman et al (2009) undertook a study examining distinct periods in the development of nursing to rediscover a history of nursing management in England. The paper explored the impact of social factors on the development of nursing leadership and two distinct periods emerge. The first is from the end of the 19th century and the other is from the creation of the NHS. Prior to this period, Nightingale had believed that the success of nursing was

dependent on a trained lady superintendent who was to have the authority and discipline to lead all the nurses in the hospital. The outcome was the enhancement of the managerial role of the matron, which established a female chain of command securing a sphere of authority for women in an occupational hierarchy (Witz 1992).

There is a particular dearth of information about nursing between this period and the establishment of the NHS in 1948. Much that is written has its emphasis on the changing direction of policy due to governmental changes. Successive governments managed and reorganised the NHS, strategic decisions being made at governmental levels to which nurses did not have access (Ministry of Health 1966; Department of Health and Social Security 1972). One result was that the 1970s saw the removal of the matrons and the introduction of an industrial model of management. Nurses were put into pure administrative roles for which they were largely untrained and were away from the patient's bedside. This was resented by medical and nursing staff and the control over nursing practice became less. The 1980s saw further reorganisation by Roy Griffiths who introduced general managers into the NHS and ensured doctors, not nurses, became more involved in management (Department of Health and Social Security 1983). An internal market structure emerged (DoH 1989). A further dismantling of nursing management occurred as general managers took over and any nurses wishing to progress, could only go into non-professional specific general manager roles. Of concern was that these roles were away from the bedside and were often based on pure administrative duties.

In the 1990s, Making a Difference (DoH 1999) announced a career structure for nurses up to and including Consultant Nurses to regain leadership at the bedside. In the NHS Plan (DoH 2000), the labour government decided to instate the role of the Modern Matron. These roles recognised the importance of nurse leadership to improve patient care but have been limited in numbers undermining their potential impact.

The NHS Next Stage Review in 2008 (DoH 2008) placed renewed emphasis on clinical leadership. Francis (2013) recommended an increase in the presence of leaders and was concerned of the overall lack of nursing leadership. He also drew attention to other Trusts which have been found to have the same levels

of completely inadequate standards of nursing directly attributable to poor leadership portraying this as widespread (Francis 2013). What sort of leadership is not explored, just the term is recommended. How nurse leaders should effectively be prepared for contemporary practice is lacking. There have been countless leadership development programmes for decades but with recent events uncovering poor quality nursing care, not all can have been successful.

2.5 Leadership

Little space is available in this literature review to rehearse the many and contested conceptualisations of leadership. There is a vast literature on leadership with many definitions which are frequently contested. Leadership raises debates and discussions around styles, characteristics and impact (The Kings Fund 2011). It is one of the most observed and least understood phenomena (Daft 2005). Within the plethora of literature on leadership, there are more than 350 definitions (Daft 2005). Bass (1990) identified that the key purpose of defining leadership was to provide a framework and a value orientation, within which leadership could be interpreted and used. With more than 350 however, there seems little value or necessity for definitions as they tend to be subjective and therefore not helpful (Yukl 2002).

Complexity around leadership is not just in the defining of it. Theorists put forward conflicting opinions about what leadership is, arguing that it is a character trait, a quality, a process, a power relationship or a position (Walker et al 1994). Leadership occurs across a whole range of styles and is dependent on the person's characteristics (Daly et al 2004). One certain model of leadership does not appear to fit the dynamic and complex nature of healthcare and there appears little challenging or evaluating this.

2.6 Nurse leadership

Many different models of leadership are taught as part of the theoretical aspect of the pre-registration curriculum. Theoretical learning around models of leadership is thought to enable student nurses to understand and be able to utilise the best leadership approach in different situations. The actual value of

identifying suitable models is questionable as all nurses are expected to lead on, and in practice as soon as they are qualified.

However, identifying leadership theories and models appropriate for nursing is frequently contested in the literature, even distributed leadership, most seemingly suited to nursing has its limits. Distributed leadership focuses on a workplace group rather than the individual, encouraging collaboration to achieve mutually understood goals (Cleary et al 2011). For the success of such a model, the nurses would want the well-being of patients to be central to their practice and understand collaborative and close team working relationships. Yet Cleary et al (2011) brought to their paper that many nurses are more concerned with maintaining power rather than taking opportunities for collaboration and team working. A model such as distributed leadership will not be effective with nurses who do not identify with nursing.

The worrying trends of behaviour in nurses referred to so far raises the question as to whether they should learn the skills, attitudes and behaviours fitting for nurse leadership rather than learn the theories. Identifying leadership skills relevant for nursing is complex and inspires frequently conflicting opinions. Reviewing the literature, ethics and morals should be inseparable to any leadership model (Jones 1995) but more especially for nursing. Courage is identified as vital to nurse leadership due to the hostile nature highlighted in many healthcare environments (Edmondson 2010; Clancy 2003; Corley 2002). Instances of bullying between nurses are in the literature dating back over many years, illustrating a lack of self-assessment and ethical behaviour (Leap 1997; Pringle 1998; Farrell 2001; Randle 2003; Radcliffe 2009; Edmondson 2010; Francis 2013).

Edmondson (2010) reviewed sources of moral distress amongst nurse leaders. He wrote of the complex environments that nurse leaders work in and their need for moral courage as they may be shamed and ridiculed. From their literature review however, Hutchinson et al (2006) found that nursing leadership can both mitigate against, but also allow bullying to occur. Indeed back in 1999, Bezyack (1999) wrote of being fearful for the lack of good role models in healthcare. In 2000, Clarke et al (2000) maintained this fear and thirteen years on, was justified when reviewing the examples of patient neglect raised in 2013 (Francis 2013).

This study is about leadership development. The literature review raised the question as to whether leadership can be taught and developed at all. In 2003, the Centre for Leadership Studies at the University of Exeter undertook a review of leadership theory and competency frameworks. They found that there were as many leadership traits identified as studies (Bolden et al 2003). No consistent traits were found and results as to effectiveness were inconclusive, especially as certain traits such as honesty and loyalty are difficult to measure. Bolden et al (2003) concluded that whilst some leaders might possess certain traits that they were born with, if people did not have them, it did not mean that they could not be a leader.

The vast majority of leadership development literature reviewed for this study was reliant on gaining prescribed competencies and standards. Back in 2003, the Centre for Leadership Studies at the University of Exeter sensed an emerging dissent and a distinct move away from competency and standards frameworks by Schools of Leadership. The move was due to a growing body of evidence that they have done little to improve quality of leadership in many organisations (Bolden et al 2003). The Centre put forward new views which included more of ethically and socially acceptable behaviours, ideal for nursing leadership. They promoted mind sets that leaders needed to master, rather than the behaviours to exhibit (Bolden et al 2003). Additionally, the Centre recommended focusing on leadership development to explore what does and does not help improve organisational performance, rather than providing a post-hoc description of leadership qualities. Storr et al (2010) focused on the group orientation of leadership development, emphasising the relationship between the person and those around them involving everyone within the organisation. Improving healthcare organisations' performance may begin with leadership development, but the serious concerns raised earlier regarding patient care goes to the heart and essence of actual nursing.

The pre-registration period therefore would seem to be the most appropriate time to adopt attitudes and behaviours, and learn about the responsibility of being a nurse rather than having to change poor practice after qualification. Nursing scholarship encourages nurses to use evidence and to question practice constantly to improve patient outcomes, research competence being seen as no longer being an optional extra (Willis 2012). Nevertheless, as

nursing's graduate status remains a contested area, a brief review of the history of pre-registration training was thought in order.

2.7 A brief history of pre-registration nursing education

In section one there was an example of the anti-intellectualism that remains for the nursing profession published by a journalist in the media in 2009. This illustrated that for some, nursing is for "girls" who do not need any higher educational qualification. A newspaper article written by Phillips (1999:13) ten years previously in the Sunday Times was comparable, stating that "When nurse training became a University course it was invaded by the nihilistic postmodern gibberish that has disfigured social sciences". Meerabeau (2001) provided other examples of derogatory, journalistic reports which questioned the need for nurses to gain academic qualification as they deal with "bottoms" and "bedpans". Even more surprising to Meerabeau, was that the journalists in question were all female graduates and they were arguing that nurses, who were predominantly women, had risen above their station of nurturing. Reflecting this back in 1976, Jean Baker Miller in her book Toward a New Psychology of Women, wrote that this type of nurturing work was perceived to be low level and not for successful people (Miller, 1976).

It is worthy of briefly reviewing the history of pre-registration education to understand where this resistance may have come from. The education provision for nursing changed from the Middle of the 19th Century when the growth in numbers of nurses and training schools grew with the hospital movement linked with the industrial revolution (Abel-Smith 1960). The history of nursing education shows power struggles and conflicts between various groups with little action (Davies 1999).The apprenticeship model of nurse training contracted to a hospital training school continued to the late 1980s within the NHS in a "vast and complex patchwork of provision" (Davies 1999:108).

In 1960, the University of Edinburgh launched the first nursing degree in the UK followed by a Master's degree in 1973 (Willis 2012). English Universities have been including graduate nursing programmes since the first one introduced at Manchester University in 1974, yet the resistance to it remains. There was a transfer of all nurse training to Higher Education in the early

1990s at a time of other subjects usually viewed as vocational. This was for a shift to a more academic nursing workforce who it was thought could then prove their academic ability more formally (Harmer 2010). The drive came from the recognition that patients and their families would benefit from a suitably qualified workforce who would be fit to practice in a dynamic health care system (Willis 2012). Indeed the drive to the professionalization of nursing had been on nursing's agenda for some time but seemed to lack a critical exploration of limitations that may be put upon it.

The term Project 2000 was used for the pre-registration programmes which were newly transferred to Higher Education institutions in the 1990s. Project 2000 was focused on preparing practitioners to be "knowledgeable doers" who would be "fit for practice" and have "the necessary skills to reflect in and on their practice within the context of learning throughout the life of their professional practice" (Davies 2003;121). It was believed that this new educational level would deliver nurses who would be more adaptable and able to respond to rapid and continuous change (Hargreaves 2008). Implemented strictly as an educational programme, the government unfortunately dismissed the opportunity to develop a new form of nursing practice as unworkable.

There has been continual change since then, but a lack of progress in England was attributed to the professionals and the public who maintained that nursing was a practical occupation. There have been debates continuing between the proponents that nurses should have parity with other health care professional groups and opponents that nursing is fundamentally a vocation (Basford 2003). This was not reflected in Scotland or Wales. By 2004, all nursing programmes in Wales were provided at graduate level and by 2011 in Scotland (Willis 2012).

As graduate education and status for nursing in England remained contentious, the Royal College of Nursing commissioned Lord Willis of Knaresborough to examine pre-registration nursing education in the UK. The brief was to review the essential features and types of support that pre-registration nursing students need to be compassionate and competent nurses who are fit for practice (Willis 2012:4). The findings were that moving to an all graduate nursing profession and gaining the intellectual requirements needed for the profession was essential. This conclusion was supported by the realisation that

nursing scholarship supports nurses to have the "even greater reserves of self-determination and leadership" as healthcare moves into a myriad of settings outside hospital" (Willis 2012:4). They found that the accusations made that graduate nurses were less compassionate and caring were unfounded and not made against any other graduate professions (Willis 2012).

Along with the changes to pre-registration education and the move to Higher Education, concerns were raised about nurses having a licence to practice unchallenged without evidence of a currency of knowledge and an assessment of their competence to practice (Davies 2003). The United Kingdom Central Council for Nurses Midwives and Health Visitors (UKCC 1994), the regulatory body prior to the Nursing and Midwifery Council, therefore set out regulations through which professional competence could be verified. The framework for this operates through the mechanisms laid down for the Continuing Professional Development standard and the Continuing Professional Practice standard (Davies 2003). Since then, each nurse must adhere to the legal requirements of meeting the post registration education and practice (PREP) standards laid down by the UKCC and maintained by the NMC. The PREP standards are to protect the public and ensure that all nurses are registered with the professional regulatory body (Basford 2003). PREP requires all nurses to undertake continuous professional development of at least (35 hours) of learning activity prior to the renewal of their registration and that this must be documented (UKCC 2000). The PREP practice standard is that all nurses need to have completed a minimum of 750 hours practice before their renewal of registration. The value of the PREP standards is still unclear.

Overview of section two

This section set out to explore literature relevant to developing leadership skills in student nurses. There was little in either United Kingdom or international papers except some small projects dedicated to a very limited number of students with inconclusive results. A wider literature search was undertaken to review general literature on leadership and on nursing leadership development. It became clear that there was a multitude of definitions, theories, models and opinions about leadership with little convincing evaluation associated with them. Choices and appropriateness of each were subjective.

Currently there is no literature pertaining to perceptions of student nurses regarding nurse leadership or about their own leadership development. There was no literature investigating the impact that any leadership development experienced during the pre-registration programme has had on qualified nurses, and no evaluation of the leadership skills taught. For clinical leadership, the majority of literature focused on leadership roles and therefore was linked with seniority. Yet the NMC (2010) state that all nurses are expected to provide "linchpin" clinical leadership from the moment of qualification (Willis 2012;19). The search raised questions regarding the term leadership for nursing and Francis (2013) asked for more nurse leaders. Nurses however, should all perform to the level that they are trained to work at, be compassionate and lead on clinical practice (NMC 2010).

The resistance to lead has seemingly caused increasing stories of appalling care and mismanagement. This resistance instigated a historical review to identify past perspectives to inform appropriate educational interventions into the pre-registration programme. The image of being good women and the history behind the oppression of nursing was explored and may explain some remaining contemporary perceptions of the profession. At the end of the literature review, it was clear that all nurses require specific skills and behaviours that are termed under leadership.

The conundrum here is whether there should be just more good nurses to lead, or does it need a small number of effective managers for teams of nurses who lead on their own practice. Or going further, do all nurses require specific leadership skills. Nurses who behave and use skills recognised as leadership skills and behaviours could be perceived as nurses who have a strong professional identity and take responsibility for their practice. A conclusion that has emerged, but not apparent in the literature, was that nurses may not need to align with the definitions of leadership. Nurses may just need to understand what nursing is and take professional responsibility for their practice.

3 Study design, methods and analysis

3.1 Introduction

The substantial search and review of available published literature established that there were no studies exploring senior student nurses' perceptions of nurse leadership, and the potential of their pre-registration programme to develop them as future clinical leaders within contemporary healthcare. Section one justified that it was a valuable area for research. Such an exploratory investigation required a methodology sensitive to uncovering detail. This section begins by setting out the focus of the investigation with the research aims and study question. Justification for choosing a qualitative methodology follows by investigating the beliefs and values inherent in qualitative research. To uncover themes from the data, coding was used and the choice and efficacy will be reviewed. An exploration of the researcher's role highlights their responsibilities, followed by a discussion around validity and reliability in a qualitative study. The section concludes with a summary of the main points.

3.2 Research aims

Whilst there are leadership competencies required by the nursing professional regulatory body, the Nursing and Midwifery Council (NMC 2010), for successful completion of the programme and entry to the nursing register, the actual value of the pre-registration period as preparation for clinical nurse leadership is assumed but not confirmed. The aim of this research was to explore the potential of the pre-registration programme for developing student nurses as future clinical leaders for contemporary practice. The study design was developed as a first step in reviewing the value and to answer the following research questions

- What are the perceptions of pre-registration student nurses regarding nurse leadership in contemporary healthcare practice?
- What are the perceptions of pre-registration student nurses regarding the value of their leadership development during their programme?

- What are the perceptions of pre-registration student nurses regarding the inhibiting and enhancing factors for leadership development during their programme?

To meet the aim and answer the research questions, the programme of investigation was designed to:

1. Illuminate the experiences of undergraduate nursing students in one Higher Education Institute (HEI) in England

2. Explore how the culture, nature and nuances of the HE and clinical environments influenced the students' perceptions

3. Consider how their experiences inhibited or enhanced leadership development

4. Identify lessons learned from the findings regarding developing leadership skills in the students

The empirical focus of this study therefore was to explore the students' perceptions of their pre-registration nurse training programme as preparation for future clinical nurse leadership. The findings from this study will formulate relevant changes required within a student nurse programme at one HEI with the potential for others throughout England.

3.3 Overarching approach to the research

The research project aimed to explore the perceptions of leadership development throughout the three year pre-registration programme for students about to qualify as nurses in one Higher Education Institute. Studying leadership development within a complex environment such as healthcare necessitates its contextual information. Students come from multiple, social and educational backgrounds with differing life experiences. Even taking into account their varying learning styles, the theoretical learning around leadership on their programme had been consistent. Nevertheless, they had all experienced at least six different clinical practice environments. The learning in practice was with, and provided by, a multiplicity of practitioners all with

their own unique leadership styles and experiences. An in-depth qualitative study was therefore chosen and discussed further below.

3.4 Qualitative approach

The term qualitative research is an umbrella term covering a number of approaches that seek to understand human experience and the meaning of social phenomena (Parahoo 2006; Denzin et al 2005; Merriam 1998). No attempt is made to manipulate the naturally unfolding phenomena and no prior constraints are placed on the outcomes of the research. Change within natural contexts is considered normal and an inevitable aspect of human experience. It is therefore expected and accommodated rather than controlled or considered a confounding variable within the research process (Patton 2002).

Employing an in-depth qualitative research study was what enabled the individual students' perspectives to be recognised. Value was assigned to their personal experiences and knowledge, along with the unique interpretations of their real life situations. What was real to the students was a construction in their own minds of their individual experiences. Qualitative researchers are actually interested in understanding the construction that people make in their own minds, how they make sense of their world and the experiences they have within it (Merriam 1998). Indeed, fundamental to the underlying philosophy of qualitative approaches is a constructivist paradigm which supports the contention that human behaviour can only be understood through the interpretation of events by the people being studied (Denzin et al 2005).

Constructivist researchers wish to understand the world in which their participants live in order to enable them to interpret their cultural and social context (Cresswell 2007). To get at that, qualitative research uses unreconstructed logic, or an image of reality in what people actually do or do not do and what they say they do (Denzin et al 2005). Clinical leadership and student nurse training were individually complex subjects and became even more complex when put into the practice milieu. The students had experienced both the theoretical and practical events of nursing and had worked within diverse clinical placements conceptualising these differently as a result of external conditions that they had encountered. For this research, a method was

needed to explore in depth the inconsistencies, ambiguities and uncertainties that this subject provided.

Constructivism is referred to by terms such as theory, knowledge, world view beliefs and is seen as a way of making sense of all aspects of human experience (White 2004). It gains meaning from human interaction and understands that individuals experience their world, construct their own knowledge and is guided by interpretivist beliefs (Schwandt 2001). Interpretivism tries to understand and explain human experience in life context. Qualitative approaches are committed to explore, describe and explain phenomena in their natural settings, acknowledging the contextualised nature of experience and the interpretative understanding of human experience (Denzin et al 1994; Bogdan et al 2007). The students in this study had different experiences which shaped their ideas and beliefs therefore the research design was interpretative. From a constructionist perspective, it is not usual to adopt a theoretical framework prior to the data collection as the whole aim of the research is to allow the theory to emerge (Appleton 2002). It was therefore important to generate knowledge and understanding from the perspective of the participants rather than start with a theory to be proved or disproved.

According to Bateson (1972:320) all qualitative researchers are philosophers in that "universal sense in which all human beings ...are guided by highly abstract principles". The combination of ontology, epistemology and methodology shape how the qualitative researcher interprets the world and becomes their interpretive framework or paradigm (Guba 1990). Choices regarding which interpretive practices to employ are not necessarily made in advance and will depend upon the questions that are asked on their context (Nelson et al 1992;2). Skills necessary therefore for qualitative researchers include being able to deploy appropriate strategies and methods as necessary even inventing practices at times, all which could be described as a form of bricolage (Denzin et al 2005).

Levi-Strauss (1966) first clarified the term bricolage and bricoleur as a Jack of all trades, a kind of do it yourself professional adapting the

bricoles of the world. The qualitative researcher as a bricoleur is comparable to a quilt maker crafting an original design from an assortment of materials, a jazz musician who improvises whilst playing to form a new creation or a filmmaker who edits various cinematic images to produce a completed film (Denzin et al 2005). He or she interprets how the individuals see their world, observing and interpreting this human experience to construct knowledge. There was an appropriateness of the term bricoleur to describe the assembling of the research process for this study. The qualitative strategies and methods were assembled as the process progressed and as issues and findings emerged as the students perspectives were explored.

3.4.1 Critics of qualitative methods

Critics of qualitative approaches tend to favour exclusionary designs which increase theoretical rigour of a study, but can often lose the contextual situation. One of the criticisms of qualitative methodology is the difficulty in replicating the precise detail which is central to scientific enquiry so that the study outcomes can be refuted or confirmed. Allan (1991) went so far as to say that the approaches were impressionistic and non-verifiable. To illustrate this further, one common method of qualitative data collection is the interview. The exact situation of an interview would be difficult to replicate due to the changing nature of humans affecting their responses. The degree to which others can follow the exact procedure is more important. The primary motivation for conducting qualitative research is the need to understand the essence of an experience. It is a process of discovery not whether the study can be replicated.

Merriam (1998:20) writes that the qualitative researcher must have an enormous “tolerance for ambiguity”. According to her, qualitative research has no procedures or processes and has a lack of obvious structure. A distinction between qualitative and quantitative is not always clear (Denscombe 2003). One of the philosophical assumptions underlying qualitative research is that there are multiple interpretations of reality and that reality is not an objective entity (Merriam 1998). The key concern is to understand the phenomenon of interest from the participant’s perspectives, not the researcher’s. Whether the

participant speaks truthfully and what they truly believe is an issue for any research method.

There was a lack of theory, or existing theory, to implement or assess the need for effective changes or input into the student nurse pre-registration programme to develop leadership. No hypotheses could therefore be deduced to guide the investigation. By using a qualitative approach, researchers seek a theory to explain their data, in contrast to deductive researchers who hope to find data to match a theory (Goetz et al 1984).

3.5 Sampling

Sampling is the selection of a section of the whole population to gain knowledge and information (Holloway et al 2010). Decisions about which sampling method to choose are influenced by the methodology of the study, what is already known about the topic and in response to findings which emerge during the study. The researcher identifies participants who are willing to talk and possess special knowledge of the phenomena under study and who will increase understanding of the case.

Sampling in qualitative research is less concerned with how representative the sample is as the discovery of findings that generalise beyond the sample. The researcher takes into consideration the voice and the perspective of the sample but includes that of the relevant groups and interaction between them. Two methods of sampling in qualitative research are purposive and convenience (Parahoo 2006). Purposive tends to require some form of judgement and choice by the researcher which provides a degree of control over the sample. Kitzinger (2006) and Cresswell (2007) advise the use of purposive sampling to target key informants. The purposive sampling utilised in this research was designed to identify participants who had the most information to offer, and whose characteristics and inclusion would illuminate the research question (Mason, 2002; Patton, 2002). Nevertheless, there was an aspect of convenience sampling as attendance at the focus groups was according to who was available and interested enough to participate. Convenience sampling chooses the nearest individuals and captive audiences according to who is available (Coyne 1997) and can continue to be chosen until the required sample size has been reached (Cohen et al 2000). Indeed an invitation was sent out to all the

students who fitted the inclusion criteria and it was unknown how many of those would volunteer to attend the focus groups. The distinction between purposive and convenience sampling can be blurred as the choice of samples may involve both judgement and convenience (Parahoo 2006).

3.5.1 Inclusion criteria

Initially, the total population was assumed to be all the pre-registration student nurses studying at the one HEI in 2010. It was decided to exclude all students except for those in their last six weeks of the programme, and therefore near to completion of the third year for two reasons. The first reason was because these students would have experienced the whole of the theoretical programme and nearly all their practice learning. The study was exploring perceptions of leadership development during the pre-registration programme, and therefore it was felt that third year students about to qualify were the participants who possessed special knowledge of the phenomena.

It was estimated that the original sample needed to be drawn from approximately 450 pre-registration nursing students in the final 6 weeks of their three year programme. On successful completion of the both the theoretical and practical aspects of the programme, all students are entered on to the Nursing and Midwifery register. Up until 2011, students could read nursing at three different levels of academic award in the Faculty, Diploma in Nursing Studies, Diploma with Advanced Studies and Bachelor of Nursing (Hons). From 2011, nursing programmes provided in the Faculty would all be at undergraduate and post graduate level. This reflects the government drive to an all graduate profession therefore findings from this study have the potential to impact on future undergraduate curricula. It was therefore fitting to interview only the student nurses on the degree programme. This means that only third year students reading nursing at undergraduate level would be interviewed. Many of those reading nursing at Masters Level were mature, have held leadership positions in other jobs or professions and had already experienced University learning and were therefore excluded.

The pre-registration programmes prepared student nurses for adult, mental health, child and learning disability fields. Each field had a partly generic and partly unique curriculum but still had identical leadership skills taught to them

as part of their programme. The only field to be excluded was Learning Disability. The HEI was no longer commissioned from 2010 to train students for this field of nursing and therefore any specific information in the data would not be used. Out of the 450 third year students, approximately 200 had commenced either on the programme at the undergraduate level or had transferred to it during their programme. It is possible that through conscious selection of a convenient population of informants, there is unconscious selection of people on the basis of a certain set of personal attributes. The selection had the potential for producing certain types of responses from the informants. The key issue of the choice of informants therefore is whether they are credible representatives of their population and are appropriately knowledgeable (Field 1985). All the third year student nurses were credible representatives as they had all experienced the same undergraduate pre-registration programme (Table 1).

Table 1 Overall inclusion in the study

Each participant needed to be
• A pre-registration student nurse at the one Faculty central to this study • Studying at undergraduate level only • In the final 6 weeks of their programme having successfully completed all theoretical parts of the programme • In the final placement experience of the programme

3.5.2 Recruitment

The invitation was sent by a third party to all third year Bachelor of Nursing (BN) pre-registration students, who would be in their final 6 weeks of the programme at the time of the focus groups. It was essential to avoid any form of coercion or bias towards certain individuals and therefore the invitation was not associated with the researcher. The third party was the programme lead responsible for the BN programme who sent out an invitation via e-mail to all

3rd year BN student nurses to attend a focus group. She was not involved in the research and ensured that this was made clear to the students. The invitation expressly asked for help with reviewing the development of leadership skills in the future curriculum by utilising their personal experiences. The onus was placed on individuals expressing their interest in participating and reassuring them that they would not be contacted if they did not respond. Once they had contacted the programme lead to express their interest in taking part, a follow up letter was sent. It included a participant information letter which emphasized that they would need to consent to take part and could withdraw from the study at any time without detriment (Appendix 1). They were sent a final letter of confirmation to give details of the time and date of their discussion and the venue.

It was explicit in the invitation that the research was about their perceptions of developing leadership skills during the pre-registration nursing programme. Volunteers may have been the most focused and energised about developing leadership skills or those who may have had the most concerns. This had the potential to miss out the experiences and perceptions of less focused and pro-active students who may have had other requirements for leadership development. Nevertheless, each one had undertaken the leadership and management module in the 3rd year, the content of which focuses on relevant theories and models and all had experienced 2,300 hours of clinical practice. They had all studied the pre-registration nursing curriculum validated in 2007.

3.5.3 Research participants

48 volunteer participants were recruited from a potential group of 200 BN students from a single cohort of the full-time pre-registration nursing programme. Twelve were unable to attend the focus groups due to difficulties with getting the time away from placement and two had interviews to attend on the focus group date. It can be seen in Appendix 10 that there were 35 participants.

3.6 Data Collection

Data was collected through the use of six focus groups during August and September 2010. The Higher Education Institute (HEI) had five campuses, one on the main University site, and four satellites close to related hospitals and community areas where clinical placements were undertaken. All theory was taught on the main University site. The satellite campuses offered library resources and venues to meet for small learning group activities and for tutorial support. Each locality had its own unique community of size, population, social and health issues. One focus group in each area was a pragmatic decision, and may have highlighted a difference in experience of leadership and was convenient for the students experiencing clinical practice based there. The main campus supports a much larger number of students therefore two were held in that campus and one in each of the others.

The use of focus group interviews had been chosen to collect research data for this study instead of one to one interviews. It is a form of group interview that capitalises on communication between research participants in order to generate data (Kitzinger 1995).

3.6.1 The focus group

A focus group can be described as collective conversations, or as an interaction between one or more researchers and more than one respondent for the purpose of generating research data for analysis (Stewart et al 2007). They can be directed or non-directed (Kamberelis et al 2005). There is a broad agreement on the basic form and function of focus groups, typically consisting of between 6 and 12 members (Stewart 2007). One of the reasons for choosing focus groups as the data collection method for this study was that they are strongly associated with qualitative approaches to social research. It was felt that they would provide more opportunity for a rich understanding of people's lived experiences and perspectives situated within the context of their particular circumstances (Murphy et al 1998). In addition, there was minimal evidence for the subject available prior to this study and focus groups are advocated by some as a method to gather data in such circumstances (Morgan 1997).

Ages ranged from 21 to more mature, some with families. There was a male student in each group and two males in one of the groups. In the HEI where this study took place, 10% of nursing students are male. For many years it remained at 8% and in 2008, increased to 10% but remains a much lower figure than female students. During this study, 35 students attended the focus groups and 7 of these were male which may have been significant but it would appear that both male and female students had similar experiences. All the students studied the same programme yet there were many differences in personalities and outlooks. Pope et al (2006) claims that focus groups are typically based on homogeneous samples but the differences between members of a group can be just as illuminating as the similarities.

Everyday forms of communication may tell more about what people know or experience. In this sense, focus groups can reveal understanding that often remains unheard by conventional data collection techniques. This type of interpersonal communication can highlight cultural values and group norms, and there is potential for discussions to develop further thus yielding a wide range of responses (Cohen et al 2000). Holloway et al (2010) recognised the stimulus that participants gain from each other in the group helps identify both their unique and shared perceptions and experiences thus shedding light on the reality of their lives and experiences.

Group discussions were particularly appropriate as there were a series of broad questions prepared for the discussion (Table 2). The participants were encouraged to explore the issues of importance to them as well in their own vocabulary, generate their own questions and pursue their own priorities within leadership. Participants also had the opportunity to validate or refute information given by others during the interview. Focus groups are not to offer conclusions but "to highlight productive potentials, both oppressive and emancipator of particular social contexts (with their historically produced and durable power relations) within which such prescriptions typically unfold" (Kamberelis et al 2005:897).

Focus groups are frequently used in evaluation research because different stakeholders can be brought together to give their views and to clarify conflicting perceptions (Parahoo 2006). Participants can bring forward collective memories which may remain untapped without a group recall and

this can be attractive in some research contexts for example when studying an established group such as in nursing (Cohen et al 2000). Indeed according to some, the interaction between participants may reveal information that would be difficult to obtain in an individual interview (Stewart 2007)

Groups have been found to be less anxiety provoking and constitute a culturally sensitive methodology (Gray-Vickery 1993). Although group interviews are often used simply as a quick and convenient way to collect data from several people simultaneously, focus groups explicitly use group interaction as part of the method (Kitzinger 1995). The group dynamics often promote self-disclosure among participants by using the group discussion which in turn produces richer data (Freeman 2006). They can create multiple lines of communication that help create safe places to speak freely. The study was evaluating aspects of the students' programme which raises the potential for disclosure of sensitive issues about nurses within the University or clinical practice environments. Gaining access to such a variety of communication is useful because people's knowledge and attitudes are not entirely encapsulated in reasoned responses to direct questions.

3.6.2 Disadvantages of focus groups

Some subjects are not suitable for group style interviews due to the sensitive and personal issues that do not conform to the norm (Parahoo 2006). Quieter members of the group may lose the courage to speak at all and may feel inhibited with some of the attendees. There are personalities that can dominate group dynamics and show power hierarchies. This occurred in only two of the focus groups. In the freer atmosphere, some dominant members did speak for longer and tried to monopolise the discussion, expressing their views at the expense of others.

Discussions can then be dominated by a small number of participants and this may inhibit equal participation. In one, a mature female who had worked in a business environment talked over other members of the group and they had to be asked directly for their opinion to put balance back in the room. In another, a mature male tried to monopolise the group but was managed quite appropriately by the members. Keats (2000) warns of the difficulty in trying to prevent many participants from speaking at once on an issue in which they are

emotionally involved. Whilst this did occur several times in the groups, the contributions they made, especially on emotional subjects proved all the more rich for the occasional passionate discussions. In essence, the moderator has less control than is the case of one to one interviews (Keats 2000). In fact the researcher has less control over the data generated than other methods and the data may be more difficult to analyse.

Another disadvantage could have been that members of the group who, without realising it prior to attending, knew each other, and may then be inhibited from speaking because of this. Participants can choose this type of forum to complain about personal aspects or issues around the subject, but without bringing other information to add richness to the discussion. Finally, focus groups have not been the object of systematic research even though there are many books explaining how they should be undertaken (Stewart et al 2007).

For this study, the advantages of focus groups outweighed the disadvantages. The idea behind the focus group method for this study was that group processes would help the students to explore and clarify their views in ways that would be less easily accessible in a one to one interview (Kitzinger 1995). Most pertinent to the subject was that focus groups can be especially useful for studying dominant cultural values and for examining work place cultures (Barker et al 1992). Indeed the power culture within health care environments and nursing itself was revealed during the focus groups and emerged as a key issue. Groups such as those in this study can actively facilitate the discussion of such taboo topics (Kitzinger 1995) because there is communication between the participants rather than the participant and the researcher (Holloway et al 2010). This went some way to reduce the power that can emerge from the researcher.

3.6.3 Environment

Promoting a safe environment was important for such self-disclosure and for the potential discussions to develop thus yielding a wide range of responses. Each focus group took place in rooms within each locality to reduce travelling time for the students, and to enable participants to be familiar with their surroundings. The rooms were chosen to be in a quiet area, seemingly

protected from passers-by in an area with little or no potential disruptions or distractions. Privacy was an important consideration as the free flow of information might have been limited by either the physical presence of others, or the possibility that they may be heard. The informal structure of the focus groups seemed to give the students freedom to explore issues. All groups were recorded by an unobtrusive tape recorder suitable for recording groups. The groups naturally lasted between one to one and a half hours. Refreshments were available to provide a more relaxed environment.

3.7 Researcher's role

Foucault (1972:9) warns that in the final analysis, the concepts that are present from the discourse maybe be something that the historian "secretly supposes to be present" and therefore it is his own history not fact. The data collection and the analysis was being undertaken by a nurse who had both clinical and educational experience of thirty years and had worked in areas of power struggles within healthcare environments thereby bringing a personal history. Foucault's warning requires a confrontation with the interpreter's prejudices and how this may impact on the research process and findings.

A critical step therefore was to reflect on the researcher's role and identity in preparation for the focus groups to take care that it was not one that took a coercive stance. This became even more critical as power relationships were increasingly revealed in the focus groups. Rice et al (1999) offered a broad definition of reflexivity which suggested that it is an acknowledgement of the role and influence of the researcher on the research project. They believe that the role of the researcher is subject to the same critical analysis and scrutiny as the research itself. Reflexivity itself helps to understand "the particular lens through which the researcher views that phenomenon, the lens of one's own philosophy" (Carolan 2003:13).

It would be naive to suggest that the interviewer exerts no personal influence on the nature of data gathered as there is a considerable investment of themselves in the interview method (Smith 1992). Whilst interviewers should consciously be aware of their potential to produce bias throughout the focus group, the social context of the research study calls for personal judgement (Webb 1992). Getting close to people and settings is valuable for gaining an

insight into the totality of a particular experience. Paradoxically, the closeness of the researcher to the participants both enhances and threatens the truth value of the research. Seemingly both distance and detachment can distort investigation (Stiles 1993) but the participants themselves do limit the control of the researcher over the research process.

The recognised status of the interviewer may have had some impact on the informants' responses particularly as the interviewer was regarded as an expert. At the time of the focus groups, the interviewer was the Head of Pre-Registration Nursing and Midwifery. The added complication was that the interviewees may have viewed the researcher as the University gatekeeper, having a professional influence relationship with the local Trusts who were likely to be their future employer. Informants may have responded in the "right" way by saying the right thing because they wanted to be perceived in a favourable light. As such there can be a tendency to misrepresent true thoughts and perhaps avoid contentious issues or understate negative feelings (Polit et al 2010). The participants could have feared that any negative comments may impact on marks, reports or references for future jobs so the timings of the focus groups was crucial. It is possible that informants could lie, omit relevant data or misrepresent whatever the timing (Lecompte et al 1982). To reduce this fear, late August, early September was decided upon as the timing for the focus groups as all assessments were completed, most clinical hours had been fulfilled and the majority of students were about to take up their first staff nurse post, references already having been sent out.

The skill of the facilitator can considerably influence the outcome of the focus group as the potential degree of control and direction exerted on the process may affect the way in which the conversation flows. The interviewer's job was to produce an account of how the participants experienced leadership development whilst avoiding the temptation to overtly influence the conversation. Personal views were identified but it was decided not to disclose these as there may have been a tendency by the students to use them as a basis of the responses and may have tended to bias them.

There was careful planning as to how the topic would be introduced as this would set the scene appropriately (Keats 2000). Whilst information was sent out prior to the focus group, the reasons for the research were reiterated and

the potential for the results were again clarified at the beginning. The sort of information determined precisely what information was wanted but care was taken to ensure questions were reasonably vague and carefully phrased without directive or bias (Keats 2000). However, they were generated by the researcher and therefore were inevitably shaped by personal knowledge and experience to some extent. Table 2 shows the questions that were planned for the focus group. They were not quoted verbatum but provide the general sense of what was asked.

Table 2 Questions planned for the focus group

What do you think is meant by nurse leadership?
Did you work with nurses who you perceived to be clinical leaders?
What aspects of your programme helped develop your leadership potential?
Did you experience anything that you feel inhibited your leadership potential?
What else do you feel you needed to develop your leadership potential?

3.8 Data Analysis

The purpose of data analysis regardless of the type of data, and regardless of the tradition that has driven its collection, is to impose some order on a large body of information so that some general conclusions can be reached and communicated in a research report. There is no systematic universally accepted rule for analysing and presenting any qualitative data (Polit et al 2010). Each textbook or guideline has its own steps or procedures to follow, the purpose of analysing qualitative data is the same. Researchers have to unravel and make sense of the phenomena they are investigating (Parahoo 2006). There are many possibilities for fusing theoretical and methodological positions but it requires careful consideration and justification and with seemingly more room for error. This art of analysis has been described as craftsmanship or as detective work but there remains a hunt for concepts and themes to explain what is going on in the inquiry (Patton 2002). Data analysis was defined by Stake (1995:71) as "giving meaning to first impressions as well as final compilations ".

Data needs to be organised in a way so that they can be analysed to find what the findings tell them about the phenomenon of interest or the case (Patton 2002). Data analysis for this study was undertaken using thematic analysis. The process of thematic analysis involves sustained engagement with and immersion in the dataset enabling an appreciation of the depth and breadth of its content and to look for significant features that contribute to developing meanings (Braun et al, 2006; Patton, 2002). Episodes of data analysis were undertaken following each phase of face-to-face data collection. Devising categories was largely intuitive, but it was also systematic by using coding and informed by the study's purposes, the researcher's knowledge and experience.

Undertaking the actual process of transcription which included continually reflecting upon, reading and rereading the data went some way towards familiarisation with it. For the research project, this happened during the first stage of analysis, looking at the data as a descriptive account which included thinking about what would be included and what could be left out (Merriam 1998). The researcher had to take steps though to undertake critical rationalism which was discarding themes that had been anticipated (Silverman 2010).

3.8.1 Coding

Braun et al (2006) suggest that although thematic analysis is widely used in qualitative research, there is no clear agreement about what it is or how it should be undertaken. They do highlight that its flexibility and freedom from pre-existing theoretical frameworks means that it has the potential to provide a detailed and complex account of the data. The investigation was structured to generate texts that would address the initial study aims and questions. An early task in the process of analysing the data was for the researcher to develop a coding scheme that related to the major topic under investigation (Polit 2010). Coding is a symbol applied to a group of words to classify or categorise them (Robson 2011). Once a coding system is developed, the data are reviewed for content and coded according to the topic that is being addressed. The method of coding then relates more to the theoretical perspective as it will seek to organise the data into themes to be sorted appropriate to the theory.

3.8.2 Sequence of analysis

From a constructionist perspective, it is not usual to adopt a theoretical framework prior to the data collection as the whole aim of the research is to allow the theory to emerge (Appleton 2002). The data collection method of a focus group was specifically used to promote societal discourse amongst third year students, surmising that this would foster more comprehensive data as the students responded to each other.

It was acknowledged that due to the complexities involved in moderating a group, a second facilitator would have been effective as a scribe, and to provide a quality check, leaving the first free to concentrate on the participants or for at least a small number of the focus groups. Unfortunately, due to ill health, the second facilitator was unwell and no time was available to organise a suitable substitute. It seemed though, that the brief notes jotted during the focus groups along with the tape recording and post group notes captured most of the rich data.

With the participants' permission, the data from the audio tapes was transcribed verbatim, brief field notes had been taken throughout each one and added to as soon as possible after each focus group. Transcribing verbatim ensured that all data were recorded preventing issues from being excluded that may have proved important and reduced the risk of any preconceived ideas influencing the analysis. This reduced the risk of any potential bias and preconceived ideas influencing what was included and what was not as humans can have natural biases and natural deficiencies when acting as observers (Robson 2011).

The transcription was undertaken as soon as convenient following each focus group and provided an opportunity for some form of preliminary analysis as soon as the data was collected (Robson 2011). It is possible, to first develop a case description by looking for a set of themes or areas linked to the research questions. By starting at a relatively early stage and in the absence of a theoretical framework, the scrutiny of the data assisted in identifying several emerging issues as the transcripts were read and reread. During the task of transcribing the tapes, first impressions were noted and categories were

developed which were returned to following the transcribing of all the focus group data. Undertaking this process ensured familiarisation with the data.

The analysis was led by an inductive approach (Strauss et al 1998). Inductive analysis means that themes and patterns emerge out of the data without imposing any categories on them prior to the data collection (Patton 2002). Srivastava et al (2009) believed that to some extent, themes and patterns are driven from the data by what the inquirer wants to know. The data analysis and interpretation were interactive and iterative processes across the data which meant returning and revisiting the data and connecting them to emerging insights. There was however a great deal of raw data produced and it was decided that a system of coding should be used to organise and manage it.

3.8.3 Coding the data

The amount of data led to a concern of missing key issues and it was therefore felt that coding would focus on aspects of the data and assist with bringing themes forward. Saldana (2013) writes that the choice to code is purely dependent on the researcher's belief systems about qualitative enquiry. A code can be a word or a phrase that allocates an attribute to a portion of data for later purposes of categorization and potential theory building (Saldana 2013). Whilst there are legitimate critiques against coding, for others, coding is whatever the researcher wishes it to be and is the best person to assess how it should be used. A code in qualitative data analysis is "researcher generated that purposes of pattern detection, categorization, theory building and other analytical processes" (Saldana 2013:4). There is a breadth of opinions regarding the use of coding for qualitative analysis ranging from strong objections to questions about researcher proficiency (Packer 2011; Strauss et al 1998). Saldana (2013) cautions against either extreme suggesting that coding should be determined individually for each research project. It is not a precise science and the individual interpretation becomes through what Saldana (2013:7) calls the "researcher's analytical lens". In other words the coding you apply is open to individual interpretation and perceptions of the world and can easily be disagreed with by others viewing the data through their "lens".

If coding is believed to be appropriate then the choice is complex. Reviewing the literature for methods of organising data revealed a vast array of types of coding. During the data collection itself, the researcher's involvement may affect the way the way the data is coded and categorized (Adler et al 1987). Their own subjectivities and personalities are brought to the research along with their own interpretations of society (Sipe et al 2004). Involvement with the data collection by being with the participants and how they presented themselves may also alter the coding mechanism.

Reflecting on researcher subjectivity in this instance is complicated due to experience and personal perspectives. To truly read the conversations of the interviewees without personal bias was not possible. A person who was external to the HEI and the study, also a nurse, a midwife and an educationalist, was therefore asked to review the scripts, the choice of coding and the final analysis to observe potential for bias towards previous knowledge and experience.

3.8.4 Initial coding

Charmaz (2006) describes Initial Coding as breaking down qualitative data into discrete parts to be able to closely examine them. This is very similar to Open Coding, one of the recognised steps in grounded theory (Strauss et al 2008). Initial coding is the opportunity to reflect deeply on the data and be open to the many theoretical possibilities (Charmaz 2006). It can be a part of a first cycle approach employing an array of coding methods.

The decision during the initial review of the data was to use In Vivo coding which requires developing codes directly taken from what the participant says, using the actual terms or words. Appropriate for all qualitative studies, it was chosen due to its versatility but it was also recommended for those researchers with little experience of coding. This was undertaken by putting In Vivo codes in a margin next to the relevant data (Examples of data and In Vivo codes are in Appendix 2). By using this well-known style of coding encouraged an in-depth yet simple review of the data, line by line, sometimes word by word looking for phrases and statements that needed highlighting or were believed to merit a code.

Eatough et al (2006) recommend consideration of the participants actual language to code data due to the meaning of the emotions used. During the focus groups, participants displayed some strong emotions which, whilst a little surprising, raised the profile of certain issues pertinent to the subject that may have seemed less of an issue without the actual amount of emotion used. The code then is more real and has more impact by using emotion loaded statements. Undertaking this offered time for immersion in the data, getting to know it, opportunity for a crucial check on what was significant and helping towards ensuring that codes were participant inspired, not researcher generated. There are no rules around the number of codes or ratio which was liberating, but also gave opportunities for over coding. It can be seen in the examples in the appendix that the temptation was to use all the quotes which became quite a simplistic exercise, limiting a more theoretical analysis. Another coding method was therefore desired. It is quite acceptable to employ In Vivo codes during the first cycle of coding and then to use other codes during the next cycle (Saldana 2013).

3.8.5 Versus Coding

During the initial reading of the transcripts, and indeed in the field notes, elements of power became apparent. The focus groups brought forward conflict, power seemingly struggled for, struggled against, sometimes used wisely benefitting patients and staff but also used carelessly for more selfish reasons. The students recognised how its use inhibited and enhanced nurse leadership and disclosed conflicts and competing goals within, between and among healthcare workers.

Wolcott (2003) described a moiety as one of two mutually exclusive divisions within a group, existing in many facets of life. Moiety is a French word meaning “Half”. “Versus coding acknowledges that humans are frequently in conflict and the codes identify which individuals, groups or systems are struggling for power” (Saldana 2013:105). It then explores how they fit into the concept of moieties as one of two divisions within a group. Nurse leadership seemed to bring two sides into view for each concept. There were historical divisions, gender issues, conflicts with health professionals, other healthcare workers and even between themselves. Power inequalities between mentors and students, conflicting beliefs about knowledge and policies were all raised

as relevant to leadership development. The students recognised that good leaders were consistent, used power wisely and dealt with conflict, not engaged in it. In Vivo Coding brought these conflicts to attention and Versus Coding helped to categorise them. See Appendix 3 to review examples of first cycle versus coding within the document. In all, 104 Versus codes were listed from the data (Appendix 4). These were too numerous and again too simplistic but was from the first attempt and provided little analysis. A second selection provided a simple list of 50 versus codes (Appendix 5).

Table 3 Second iteration of the 50 versus codes – The themes that emerged from the data

1. Identifying nurse leadership
2. Identifying nursing
3. Personal accountability
4. Role models
5. Creating an effective culture
6. Organisational behaviour
7. Always done it that way
8. Theory of leadership

Saldana (2013) then offers the next step for the second iteration of code mapping which is categorizing the initial versus codes. To do this, the 50 codes were organised into fifteen categories by physically comparing and sorting them into similar groups together. A simple cutting and pasting exercise on screen was undertaken to do this and the results can be seen in Appendix 6. With further reading and moving backwards and forwards across the data and the codes, eight versus sub categories emerged. These sub categories were used as the themes for this study. They can be viewed in table

3 and can be seen with the relevant codes chosen to go together in Appendix 7.

Saldana (2013) now describes the third iteration of code mapping, categorising the eight sub categories or themes even further into the final categories. These three final categories can be seen in Table 4 and again in Appendix 8 with their relevant sub categories.

Table 4 Third iteration of versus coding. Recategorising the eight categories

1 Professional identity – conflicting images of nursing
2 Creating a culture in which care giving is possible - Organisational conflicts
3 Knowledge for nursing - Conflicting sources of knowledge

The fourth iteration of versus coding explores how the categories fit into the concept of moieties in other words transforming the categories into an X VS Y format (Saldana 2013). One of the categories can be conceptual, not directly quoted in the data but able to capture the central theme of conflict (Table 5).

Table 5 Fourth iteration of versus coding - Moiety codes

1. Professional nurses VS self-enmity (confused identity of nursing resulting in behaviour unbecoming)
2. Nurses autonomy VS oppression (by HCSWs, doctors, each other)
3. Nursing knowledge VS the sciences (struggling to define its sources of knowledge)

3.8.6 Themes

A theme is an outcome of coding, categorisation and analytical reflection yet the definition varies between authors. After reviewing several definitions, there is agreement that a theme is a way of organising data into a group of

"repeating ideas" (Auerbach et al 2003;38). Themes are also made up of extended phrases rather than short codes. Braun et al (2006;82) define "a theme" as a concept that captures an important aspect of the data in relation to the research question and represents a level of patterned response or meaning within the data. The themes for this study were the eight, what Saldana (2013) called sub-categories, in which the data from the study were organised and then sorted into the final three categories. The final moiety codes will go towards informing any education changes or interventions following this study (Table 5).

3.9 Validity and reliability

This study did not set out to be generalizable as it was for one Faculty within one University. The findings however have the potential to impact on students within other HEIs who, at any point in time, are reading nursing during their three year programme. Indeed Miles et al (1994) acknowledged that qualitative researchers have some understanding that their findings may have implications for larger numbers of people. This could be thought to be generalizable but the term transferable seems preferable in this instance (Lincoln et al 1985).

Terms such as credibility, transferability, dependability and confirmability replace the usual positivist criteria of validity, reliability and objectivity in qualitative research (Denzin et al 2005). In traditional social research, validity refers to the measures aimed at guaranteeing truthfulness of research (Saukko 2005). Although the issues of validity and reliability have been thoroughly explored in relation to the collection of quantitative data, their naturalistic counterparts are less well defined but are nevertheless just as important (LeCompte et al 1982). The credibility of naturalistic research depends on its ability to present the truth. Empirical problems arise for qualitative researchers due to the difficulties of using humans as narrators. An account is a representation of life at a given moment and is not a static product, rather a developing process which reflects the changing perspectives through ongoing experiences (Sandelowski 2000). These representations are reconstructed in every telling and the idea of validating narratives for consistency or stability is completely alien to the concept of narrative truth.

The major strength of naturalistic research is high validity because it employs methods of data collection and data analysis which remain true to the participants' perspective. It is important to note that issues of validity and reliability are not congruent with naturalistic enquiry which is more concerned with construction of meaning (Mishler 1986). They are terms which are used in relation to naturalistic research by both Field et al (1985) and Lincoln et al (1985). This highlights a paradigm conflict which has yet to be resolved. How well a research study represents reality and how little the research method distorts reality is described by validity (Field et al 1985).

Focus groups are not replicable. The reliability and validity of the findings from focus groups are difficult to ascertain on their own and the researcher may have to reflect on the motives or reasons for what was said and by whom realising the potential effect of group pressure on the type of data collected. Mishler (1986) suggests that attention should be shifted to an emphasis on the informants' efforts to construct coherent and reasonable words of meaning and to make sense of their experiences. In the context of the research interview, the aim should be to facilitate an interview which enables the informant to articulate meaning, what Mishler (1986) describes as the joint construction of meaning.

To try to ensure validity for this study was complex. The plan for a second facilitator to attend some of the focus groups as a method to validate the discussion and findings did not occur due to an unexpected and long term sickness. The students were leaving the University within a short time from the focus groups and would therefore be more difficult to access to validate the findings. Triangulation by another method did not seem necessary due to the sheer volume and richness of the data from the focus groups alone. It was therefore decided to ask another healthcare professional, who is also a nurse educationalist at another HEI in England, to review the tape recordings and read the transcripts to agree accuracy. She was then asked to review the coding and themes to validate or challenge the findings from the data. To be challenged, to defend and justify was a confirming exercise and she felt that the analysis process and findings were justifiable, unbiased and appropriate.

3.10 Ethical considerations

Protection of the dignity, right, safety and well-being of participants is paramount (Holloway et al 2010). During the focus groups, it was recognised that there was potential for the participants to be upset due to power differentials within the groups. The researcher had the responsibility to ensure that all the participants respected each other by allowing each the time to speak and to air their views. At the beginning of each focus group each member in turn agreed ground rules and were also offered the opportunity during the focus group to stop the discussion if they felt uncomfortable. This was all in the participant information sent prior to the focus groups. Stake (1995) reminds researchers that they have ethical obligations to minimise misrepresentation and misunderstanding as well as to protect the participants from any harm.

To avoid coercion, participants were invited to take part by those who were not part of the study and had no conflicting interests in it.

Appendix 1 is the participant information leaflet which published that the

- Potential participants were free to withdraw from the study at any point without question
- Any aspect of their participation to the study could be could be retracted or removed at their request without question
- The participants could withdraw during the focus groups at any point
- Potential participants who did not respond to the invitation were not approached by any means again
- The researcher could be approached by the participants at any time for further information on a mobile telephone number that was not University related
- The participants could approach the programme lead for advice or guidance if it was felt that the researcher would be biased.

Table 6 Process of analysis

Specific process	**Description / Purpose**
In Vivo Coding (Charmaz 2006)	Simple coding line by line, word by word, power and conflict emerged strongly as a theme
Versus Coding (Saldana 2013)	Used to analyse the strong conflicts of some nurses with their leadership behaviours
First iteration of Versus Coding	Initial coding and identification of 104 conflicts to 50 specific conflicts
Second iteration	15 codes sorted to 8 coding undertaken by organising into themes which relate directly to both nurse and nurse leadership behaviours
Third iteration	Remaining codes were organised into 3 major conflicts resulting in a lack of leadership behaviours. Nurses poor alignment with their professional identity and impacting negatively on the care giving culture and learning environment which they are responsible for
Fourth iteration	Moiety codes highlight 3 distinct conflicts for nurses and their identity with professional leadership

3.10.1 Informed consent

A sample consent form was sent to them with the invitation letter and they were advised that these would be signed at the start of the focus groups and the group could then be the witnesses for the signatures which would include the researcher's. The consent form also included that the students agreed to be recorded and that the data could be transcribed but would be removed if the consent was subsequently withdrawn.

So that the informants felt safe and therefore able to divulge information freely, they required assurance that the data would not be attributed to them or disclosed in a way that might be recognised. Thus it was important to assure the informants that their identity would be protected in subsequent publications. This would include the need to not refer to their names as the University will be known on publications.

3.10.2 Confidentiality and anonymity

All participants were reassured that their contribution was confidential and:

- That it was locked in a secure place away from the University
- That any criticism of the University or Trust placements would not be attributed to them and result in any retribution from either future employers or tutors who may be assessing their work at post graduate level or indeed future employment in the University
- That if a safeguarding issue was raised that it would require disclosing to an appropriate third party
- That all participants were asked not to discuss the contents of the discussion with anyone outside of the group
- Were reassured that audio tapes were transcribed quickly after the focus group onto hard copies. They were advised that some of the tapes would be listened to by a third party, not from the HEI or local Trusts, and checked against the hard copy for accuracy. They were then advised that the audio tape machines would be passed back to the University and wiped clean of all data.

- Each student had a code for validity, ease of access and for cross checking purposes only. The code was the number of the focus group, 1G - 6G, the membership number, 1- 8, and whether they were male (M) or female (F).

- The names of all students were not kept anywhere except on consent forms which were kept in a locked cabinet in the University, the researcher only having the key. The transcripts were kept away from the consent forms and therefore could not be linked so only anonymous data and demographic information had been stored on a computer and on a USB stick, both were password protected

This was stated at the start of each focus group and recorded.

3.10.3 Protection from harm

Previously in this section, the researcher's involvement with their study participants is not always impartial and is interactive. Researchers must be prepared to support participants as they reveal their experiences and thoughts (Holloway et al 2010). From such a subject it was surprising that intensity and passion was revealed. Incidents of potential safeguarding were questioned. One ward had been closed due to the incidents raised. One had been in the first year and was felt to be too long ago. Others refused to provide any further information and others had already reported and had been dealt with. Further help was offered but none of them requested it. All participants were encouraged to ask questions at the beginning of each group and at the end to clarify any areas or issues of concern.

Ethical approval was received in July 2010.

3.11 Summary of section three

This section began by revisiting the aim of the study and then justified the use of qualitative research to undertake it. An overview of the case study approach was provided. The sample was identified and the use of focus groups to collect the data was reviewed for its appropriateness for such a study. A substantial discussion was included regarding the data analysis and the choice of codes. The themes and categories emerged from the data by initially using In Vivo

coding, then using Versus Coding from which emerged the power and conflicts in healthcare environments that can impact on the ability for nurses to lead. Three categories were constructed with the 8 sub categories or themes which emerged from the data. Versus coding sets out to uncover “moieties” which make clear the two distinct sides of a topic or an issue. It is hoped that the moieties will assist in the development of appropriate changes to the pre-registration programme. A brief discussion on reliability and validity in qualitative research and ethical considerations concluded the section.

4 Findings

4.1 Introduction

The following section describes the perceptions of 35 senior student nurses about to qualify of nursing leadership in contemporary practice and the potential for their pre-registration training programme as a method of preparing them for future clinical leadership. The background literature in section two highlighted a paucity of information with regard to student nurses' perceptions of clinical leadership development in practice and theory. Contemporary healthcare is broad and multifaceted with multiple drivers and stakeholders.

Developing nurse leadership skills within this environment is complex, students experiencing different healthcare settings and cultures. An in depth qualitative study was therefore required for such an exploration to be able to take into account multiple contexts. Focus groups were identified as the appropriate method to gather such qualitative data. Themes emerged which had impacted both positively and negatively on the potential for leadership development and these needed to be reported on rather than according to each focus group findings or research questions.

The section attempts to analyse some of the statements that the students made related to their perceptions of nurse leadership and how this influenced their leadership development. It became clear as the analysis progressed, that the students recognised effective nursing leadership was necessary for high quality patient care and understood it was to key to contemporary practice. Students varied significantly in the extent to which they both recognised and valued the theoretical input. They consistently cited the practice placement experience as having the greatest inhibiting or enhancing impact on the learning and development of their leadership potential and skills during the programme. The greatest inhibiting factor to their development was the consistent lack of nurse leadership witnessed. Nurse leaders were identified in single figures or frequently by none at all. Another consistent theme throughout all the focus groups was the lack of actual nurses who were behaving and practising as professional nurses. To develop as a nurse leader,

the students believed that an understanding and an enthusiasm for nursing itself and having a clear professional identity as a nurse was critical. Levels of care and knowledge provided by some of the nurses who the students worked alongside were inconsistent to such an extent, that some students believed that nurse leadership was not possible.

The perceptions of the use of power experienced during their programme appeared to inhibit or enhance the students' understanding and development of their leadership skills. The power discussed in the focus groups emerged from discrete sources and materialized in differing ways. Students' reflections on their actions when faced with power usage varied widely. Some realised their own power to impact on the environment and had either used it, or reflected on how they should have used it, or why they felt they could not. Others were less reflective on the situations and focused on others' behaviour. Nurse leaders were recognised to impact both positively and negatively on service user experience by utilising their power. Some of the students recognised that they had the ability to create an environment in which care giving was possible even within complex and hierarchical healthcare organisations. They acknowledged the power of role models and the impact that this had on their development.

In Vivo coding was used initially to explore in depth what the students said, but elements of power usage and conflicts directed the analysis towards the use of versus coding. Versus coding is one way to recognise and identify individuals, groups, organisations and processes in direct conflict with each other. The students recognised conflict and exclusive divisions between people and other professionals within healthcare organisations impacting on the power of the nurse to lead. It was not always apparent as to who would profit from these divisions but where students recognised effective leadership, both service users and healthcare workers benefited. Three categories were constructed with eight subcategories or themes and the analysis is displayed under each in the section and discussed in the previous section.

Versus coding sets out to uncover "moieties" which make clear the two halves of a topic or an issue. By recognising the moieties assists in the development of appropriate changes to the pre-registration programme. Understanding the power sources which conflicted with nurses and their potential to lead

provided significant information for programme developments central to learning needs required for contemporary healthcare challenges. Students should be able to position or reposition themselves and to recognise what is required to lead in areas of conflict. Due to the word constraints of this thesis, it is not possible to describe the entire experience of all the students in extensive separate detail, only the discourses recognised as relevant to the subject are reviewed.

Originally, all statements and quotes had a code which is explained fully in section 3. The code denoted the number of the focus group, 1G - 6G, the membership number and whether they were male (M) or female (F). Gender may have had an impact on perceptions or experiences. Originally this included whether the student had come from further education or sixth form or from previous employment or higher education to denote age and previous experience. During the analysis, there appeared no relevance to either this or gender as impacting on perceptions. The code was therefore removed from this data analysis. Appendix 10 contains the original codes and is left in there for interest and if needed for further studies.

4.2 Professional identity - Conflicting images of nursing

4.2.1 Identifying nurse leadership

To open the discussion in each focus group, the students were asked for their understanding of nurse leadership. There was a distinct inability to provide a consistency in definition, description or understanding of nurse leadership. Leadership roles were put forward including “leading on patient care” and “leading teams”, but there was an inability to articulate what constituted a leadership role and an actual definition of leadership. There were conflicting views about who should be and who should not be a leader.

Students talked of the different qualifications that they believed were necessary or not for nurses to be leaders. During their programme in various contexts and for different reasons, healthcare staff and patients had seemingly given their opinions to the students, even if not asked for, on the level of academic qualification required to become a nurse. Some of the nurses and the public remained ambivalent or disagreed about the need for graduate level study.

There had also been views aired in the recent media suggesting that the academic training of students caused the uncaring attitude of nurses and this was raised as a concern in the focus groups. One mature student said that

> *I think nurses can be leaders but some are and some are not. I do think though that some could be very academically qualified but do not have the people skills for leadership. Some people just do not have the people skills. They may be managers but they are not leaders. Some leaders tend to be shut off from what is going on in the real environment*

The student expressed the view that some are leaders and some are not and then used "*people skills*" as an overarching requirement. She also included issues around academic qualifications needed for nurses and for nurse leadership. Linking academic qualifications with the term "*people skills for leadership*," reflects some of the media concerns about nurses' qualifications but their lack of caring skills. "*People skills*" would seem to be pre-requisite for being a nurse with or without leadership skills as the job itself is predominantly about helping people. All nurses require exceptional communication skills suitable for providing healthcare in countless circumstances. It was interesting to note the inclusion of the leader versus manager debate, and the assertion that nurses could be managers without people skills but could not be leaders. If a nurse requires exceptional communication skills, then whatever nursing role they undertake would seem to require the same.

A further question she included was who should be a leader. During the pre-registration programme, leadership skills and competencies are assessed and require successful completion to be entered onto the NMC register. The assumption from that dictate would be that all nurses should be or will be leaders clarified by a mature male student in the focus group:

> *But leadership is part of every nurse's role*

As leadership is part of every nurse's role and all nurses are academically qualified then an anticipated outcome from their programme would be that they all have the leadership qualities expected. If it is that all nurses are leaders they still may take on roles that require leading on a particular

environment or aspect of care then that requires additional skills. Conversely some practising nurses undertook their training before the move to Higher Education establishments and may not have chosen to undertake further academic qualifications. Their perception of leadership may again be different to others and expectations of therefore may not be the same.

Yet there was an acknowledgement in one group that the status of nursing had to change by someone giving nurses the authority suggesting other powers that would do this.

> *The responsibilities are increasing and these are increasing. You cannot heap the responsibilities and not expect people to have some ownership of it. They need to have some authority.....and they don't*

Which responsibilities were increasing was not identified but this concern was again raised by some practitioners themselves to students. Implications that any nurse was not aware of their authority or levels of responsibility conferred a sense of unease within the groups. It was not revealed who should, could or would give them the authority. To others it was clear that nurses are responsible for their own practice and have the power and authority already. A young female student stated:

> *But all nurses, they are all responsible and accountable*

It was deemed that nurses needed to earn that authority and not just have it due to their position, especially when there were examples of inappropriate power usage. Nurses traditionally were respected for their role in society. Just being a nurse was no longer enough to gain respect from service users, students and other health professionals as explained by this student.

> *You have to earn it. Just because you are wearing a staff nurses' uniform you uumm does not give you the right to push people about. It is how you do that and it is how your subordinates kinda how they react to you. You see the staff nurses who think oh I will just get the HCSW to do it, like the doctor I can get the nurses to do it, that is not leadership.*

The student had been a HCSW for many years previous to undertaking her training and therefore explained that she was speaking from experience.

One mature male student said:

> *But you need to respect your leaders. You are going to have to pay managers but you need to respect a leader. You respect someone who leads your team you will work harder making their job easier.*

A common occurrence throughout the focus groups was that any perceptions of excellence raised by the students were illustrated by one practitioner only. The majority of the students spoke of good experiences in terms of "one mentor" or "one leader" or "one team". During the programme each student undertakes six placements. Each placement will have had at least one mentor and many nurses. Examples of good leadership and mentoring were rarely spoken of in multiples.

> *The final placement included me in the team. They bolstered my confidence and let me work autonomously*

This quote refers to the final placement only. Whilst students may be randomly recalling incidents thereby leaving out other examples of good practice, only recalling one raised the concern that there may be fewer than expected. Concerns regarding not only a lack of nursing leadership but also a lack of understanding of what nurses do and where they belong.

4.2.2 Identifying nursing

Students were confident that the quality of the nurse leadership impacted on the quality of the care provided, on the environment and its culture. Examples given by the students illustrated nurse leadership enabling an environment where the giving of high quality care was possible, and where all nurses were willing and able to advocate for others. This was not a consistent picture illustrated across their clinical practice experiences. Indeed the actual status of nursing itself remained of concern to some. Examples of disempowered nurses and uncaring treatment of patients was frequently linked to the poor clinical leadership by nurses in the related environments. Throughout their

programme, these students had been taught that care and compassion are central to nursing (NMC 2010). Students talked of isolation and helplessness in the face of weak clinical leadership and distanced themselves from this sort of behaviour. Some of the students expressed their disappointment one stating that:

> *The University push values and compassion. Then you go out into practice and there they are bad habits and poor practice*

Not only did some students witness poor care, they did not seem to be able to identify the expertise required to lead on the changes to care. They had not all witnessed such expertise but some believed that to lead on nursing care requires compassion and a set of ethical values but to others, these alone were not enough. The students debated the skills required which included complex decision making utilising expert knowledge, whilst ensuring professional levels of communication skills, to not only engage with, but also lead and direct on all aspects patient care.

Other very powerful discourses took place in the focus groups which highlighted a lack of any of these abilities, let alone compassion. One of a number of examples follows in which a student emotionally described an experience she had.

> *There was one place I worked. The patient cried. Middle aged bloke. He had cancer and was frightened and hungry. He had been asleep a lot and sometimes missed filling out his menu. He was hungry, can you believe that! I asked for food for him and was brushed off by the nurse "should have filled in his card". I went and bought him some sandwiches when I got my lunch. He said it was the nicest sandwich he had ever eaten. Leadership my 'arse, a good leader would never let someone go hungry! I looked after him all the time after that. He was so grateful. I will make sure that never happens again on my wards*

Interestingly, the student herself did not challenge the staff. Instead she went and bought the patient a sandwich from her own money. She did not see any other option and her priority was to care for the patient but not challenge an environment in which that was allowed to happen. She did not express any

other responsibility and her statement was one of resignation to this situation. Whilst she believed that she would behave differently when she is the leader, she did not put forward what she would do or how she may have challenged this. There was no thought as to what skills are needed to deal with similar situations.

In response, another student listened and firmly put the responsibility of the level of care with the nurses but acknowledged that fear may have played a part.

> *That is wicked. You see there does not seem anyone to manage that sort of thing. But as nurses, it should be automatic. You care for people the way you want to be cared for. To be frightened is dreadful. You would reflect on the care and you would know how to challenge it. The nurses must have been very frightened to not challenge.*

When asked to expand on the aspect of fear that had been raised, none of the students could or wished too. It was important enough to bring into the discussion but its source could not be identified or the consequences of it clarified in any way.

A young student believed that to fully understand the service user experience of healthcare required a form of experiential learning as a way forward:

> *Students should experience what patients go through. Maybe they see those nurses who don't care that someone's food is cold every time and actually just needs someone to find out what they like or that their teeth fit and they can't chew and so on or…or that they are cold or frightened because everyone is busy and forget why they are there and do not have the time to actually care so someone lies frightened on their own or hungry or in pain and…and…and nurses think sexy technology is..is much more important than "bed 3" who just needs a cuddle or an extra blanket… the power they wield… and maybe I should have left. Nurses who lead properly ensure that every single patient is heard and not alone. So what if certain tasks are not done on*

time, Mrs Brown is warm and safe…that is leadership. It is not doctors who control nurses, it is nurses.

Issues raised within this emotional quote highlight a frustration with healthcare environments that were led by nurses, but did not provide the essential levels of care central to nursing. The student's perception of the situation she identified as lacking in care was rather simplified for such complexity. Her belief was that student nurses would develop into caring nurses by experiencing all that the service users go through. Another student stressed the importance of a leader showing just "

Humanity

Needing to develop a basic instinct of caring with humanity in nurses has worrying connotations for recruitment of and the future for nursing. Whilst there are many challenges in providing contemporary healthcare such as funding, governance and technology, the experience for service users as people remains fundamental, nurses being the central professional with that responsibility. The values these students highlighted were sound and should underpin all that nurses do. What some of the participants seemingly witnessed in practice was being reflected in the media and showing a direct conflict with traditional nursing.

4.2.3 Role models

In the three years of a pre-registration nurse programme, the students will have worked with, observed and been taught by a goodly number of nurses, many of whom would act as role models for them. Throughout the focus groups, students referred to attributes of good role models for them.

See someone who is a good model is that they are that way all the time, they never deviate, they are always the same and consistent.

and

I had implicit trust in her

Following a question regarding being signposted to these positive attributes, a student said

> *You work with that person one time, it does not take that long, we just know*

Within that same focus group, another member followed with

> *The whole team is happy and willing to help, the leader manages and encourages does not control, does not wield power because she or he does not need to, everyone just knows*

Consistency in personality and practice was a key character and skill identified by several students as a key leadership quality as stated by this student:

> *Inconsistency is the major thing. See someone who is a good model is that they are that way all the time. They never deviate, they are always the same and consistent.*

Nurses are role models for students and the power to mould future practitioners and leaders of nursing practice may be underestimated. Not so for these students who fully appreciated accomplished nurses and identified with them wishing to model themselves on them.

> *This is how I want to be, this is how I do not want to be and I do not want to adopt the poor practices and the bad habits that others adopt*

4.2.4 Mentorship for nursing

High quality clinical placements are essential for learning as part of pre-registration nursing programmes. Fulfilling the role of mentor to nursing students is both challenging and rewarding. Mentors are positioned to be role models and enable students to grow in confidence and competence in their development towards the safe and valued professional required for entering the Nursing and Midwifery register. Their role of assessing these students provides invaluable gate keeping to the profession. To become a mentor, a nurse has to attend a validated educational programme and successfully complete the associated assessment. They then require annual updates to

remain active on the register of mentors. Challenges arise as the mentors who undertake this role do so in addition to their work demands.

Students expressed concerns as not all mentors fulfil the role as expected of them.

> *Not sure any of the mentors thought of partnership, more control. I have to say I do not feel ready to lead because I suppose I have not worked with any leaders. It was all a bit nurses being handmaidens. Saw usually old school mentors mostly did not agree with degree nurses and started using the old arguments, you know, too posh to wash etc*

Examples were raised of the mentors who do not wish to remain in the role. Students sometimes perceived that they were an additional stress and that the mentors had been recruited to that role under duress or as a management dictate, rather than for enthusiasm to undertake it. One student said:

> *But there are great mentors out there and really good staff but they are not all enthusiastic about taking students. One told me she did not want a student and did not have time to look after them on her ward. She told me either things got done her way or she would not sign off my AOP. Need to know how not to get sucked into the poor practices just to pass the placement*

The AOP is the Assessment of Practice and is the necessary document for each student in which skills, competencies and achievements are signed off as completed successfully confirming that the placement has been passed at the recommended level. Indeed the mentor must sign off the placement for the students to progress in his/her programme illustrating how powerful the above statements are. This situation was questioned by other students stating that the she should have challenged this at the time whilst others felt pressure to not complain or to step out of line as this example demonstrates:

> *They have to sign off your AOPs so do you want to fall out with them?*

Findings

This discourse illustrated a bleak situation where mentors could seemingly blackmail students and were in direct conflict with the aims of their role giving them the power to perpetuate poor practice. Students said that in these sorts of situations they felt helpless to challenge. A rather disheartening picture emerged when this mature male student explained with

> *I had so many problems on placement, I would say right let us do that then and they would say oh I don't know if you can do that as a first year and I would say I can*

There seemed confusion over the role of the mentor. Rather than developing students as effective nurses, the perpetuation of a student being used as just another pair of hands remained in some areas. Whilst it is understood that all will provide hands on caring, to treat students as a HCSW highlights a lack of understanding of the nurses' role and the students' development as expressed by this student.

> *They did not see why I needed to do anything and treated me like a Health Care Support Worker but then a mentor could make or break your experience*

Some mentors did not always recognise the students' limit or how far their limit should be pushed causing frustration. The students found this unacceptable due to the plethora of information and advice available to mentors including information in the AOP, on line and from the academic tutors who link to each placement area.

> *The mentors do not know their boundaries. I found it quite a lot. Especially in my third year and the mentors really gave quite a lot of resistance*

Concerns were expressed over mentors who did not encourage them and seemed to be fearful of students who challenge and who wished to take control of their learning. One participant's realisation was that:

> *But you are threat. If you are a competent student and some mentors would worry that you are better than them. Better keep you down as you are so good and they feel threatened.*

A mature student presented the following experience*:*

> *I have a real problem and it was the assertiveness problem. They blocked me out I sorted my own experiences to gain experiences. They ignored me most of the time and would say oh just read those notes. They gave a look to each other when they were deciding who would take me with them. They used to roll their eyes and snigger when I spoke. They ignored me but when I kept going and getting other experiences and demanding to be part of things, they then let me in a bit. It was like the mentors, the team as a whole they would stop me going in to group works or case conferences. They said that they could not let me in anything as I was only a student. I therefore continued phoning round to find someone somewhere else. It was horrible and the whole team were in on it. No-one ever welcomed me, said hello or said goodbye. I used to cry every day. I am a grown woman for god's sake !*

Students were challenged as to why they did not report such instances. To find out how mentors perform requires evaluation and feedback from students. Accurate feedback was inhibited as students needed the mentor to sign off the Assessment of Practice document (AOP) to progress in their programme. Students' priority was overwhelmingly to progress and some did not want to upset the mentors or make claims that would ultimately impact on them. Mentorship is part of every nurses' role but some may be better than others. Why mentors respond in such a way is worthy of further exploration.

Identifying good mentors brought the attributes that they recognised into the focus groups. They seemed to instinctively know who the good nurse leaders were

> *When you work with someone well, your mentor, and you just feel calm and if there is something wrong, you just talk about it*

Exemplary mentors seemed to know how to position themselves with the students, patients and to use power wisely. Again the following statement was from a student recalling only one which stood out in her mind.

> *I had a mentor who always credited me with things that I had done to other staff, never took the credit for herself. She also ensured I knew if I was doing well or not. So easy when you know where you stand.*

4.2.5 Personal accountability

Not all of the students articulated their responsibility in situations around patient care. Their needs for their own development were not always clear. Others knew of their own responsibility, that they should be part of their own development but also what was required to help this development in the pre-registration programme.

> *The first year should be self awareness. You have to know what you are thinking with difficult situations you need to be aware of yourself and what I am feeling and be very aware of yourself so you can act appropriately. It is about you are not feeling comfortable with this situation. I do not know what you are trying to tell me, can we rephrase it*

Developing independence and preparing for autonomous practice was reflected by this student

> *You are better working on your own otherwise you will keep asking people but you will ask yourself*

The long arm supervision needed to allow students to work independently requires mentors who are confident, and are able to assess the level of competence to allow students to practice on their own. One participant explained that students should observe nurses and recognise good practice for themselves

> *Picking out those best things from other people those things that you use those and I will use those but I definitely will not use those*

Students also advised showing levels of independence themselves to their mentors. It was crucial to them to develop an individual style and take personal responsibility for their own development

Properly act out, properly develop your own style

Taking their own responsibility for developing skills by witnessing practice and assessing and deciding on what is the most appropriate was also recommended by this student

Picking out those best things from other people those things that you use and I will use those but I definitely will not use those

The following statement is an example of one student who was aware of her own development needs

You need diplomacy skills. If you are not comfortable with what the consultant is saying or whoever you need to diplomatically ask, question etc. It is the way you ask for example, the consultant. It is appropriately asking. It is diplomacy.

Taking personal responsibility for own learning was in evidence in such statements as

I had skills already so I wanted them to help me to develop them

Students participating in the focus groups have, like many students throughout the UK, been supported within one smaller distinct tutor group of students which tends to remain unchanged throughout the 3 years of the programme. The group is to provide a learning environment suitable for more reflective activities and the tutor facilitates these groups. The students are expected to contribute to the group, to support the other members and to be part of the learning activities within. Difficult situations encountered in practice are reflected upon in these groups and therefore there needs to be an element of trust. Confidentiality is assumed. The activities should ultimately assist leadership development. Yet examples of behaviour that is not dissimilar to the control, power and conflict in the analysis about practice seems to be mirrored within the student body.

During the second focus group, a mature male student sought ways of recognising and developing potential leaders from within the student body and put forward the idea of targeted projects for potential leaders who are recognised during their training. Whilst this was realised as a positive way

forward to enhance leadership skills during their programme, others were not so enthusiastic due to the conflict illustrated by student against student in the group.

> *But this is going to cause tension in the group in that others will be frustrated that some are getting more attention. But in our small group of 10, there has been tensions if there is something extra for one. I have had this turned towards me. It has been tense at times. Some progressing, some not. It has been very tense. Small groups can have such problems with jealousy. If you are identified, and you are picked out and singled out, you will be bullied. This stops you going the extra mile as you have to worry about how your group will accept you. The group will have power over your performance and how you get on with your assignments*

Whilst it is expected that in all groups there may be disagreements, this behaviour was all the more perplexing as these students are in a profession renowned for its caring and support of others. It reflected the behaviour unbecoming in practice highlighted previously. Several of the students talked about tensions within the groups. References were made to “cliques” and being “left out”. One stated that she did not dare to ask questions in because

> *I was worried about being laughed at by the other students.*

Particularly painful to a number of mature students in the focus groups was the generational nature of abuse, that of younger student against mature female students particularly those who have children. One mature student explained about her concerns due to the exclusion she had experienced from younger learning group members

> *As a student who does not live in, I am already excluded when I go to the University and because I have children. I already suffer because of that if you picked me out, the group would be difficult towards me. The younger ones already think that I am too old to be part of their gang*

There was also the opposite to discrimination of mature students, that of students believing that some students were too young. Particularly pertinent to this were the rather belittling comments regarding other students for their age and maturity an example being from a mature student who had been a manager prior to nursing

> *But, I felt as a mature student, and I have been around the block a bit, I felt that it was possibly useful for the younger ones but I do not know, because they may not have had any experience or had to think about the progression of a group before*

Interestingly dominance was observed by gender issues within the groups. Each had one or two male students which was a statistically high response rate in comparison to females to attend considering that there are only ever 10 - 12% male student nurses commencing each year. Ages ranged more towards the mature range. The men were more outspoken than the women and would frequently talk over the women and interestingly the women often fell silent and allowed the male member to speak. Yet the male students had the same experiences in practice.

4.3 Creating a culture in which care giving is possible

4.3.1 Creating an effective culture

Some of the students identified a nurse leader as someone who can change the environment to one which has a positive impact on staff, service users and students. These leaders had an understanding of how they personally impacted on the culture. Their appearance, demeanour and character significantly altered the culture in which service users and staff experienced healthcare.

> *I have got one role model and he was absolutely inspirational. I felt like you did until I worked with him. He made me realise that I had to take responsibility and to look at myself as part of the care package that patients get so that care package needs to be evidence based, humanely given etc etc. And he always said know who you are and what your biases are so that you can deal with*

> *them and know how you come over to patients and staff. He also taught me the power of smiling and I realised that so many nurses do not smile. The culture on his ward was busy but always lovely and cheerful. The smile can change a culture*

Whilst the students were concerned about some of the care being provided, they observed a distinct lack of leadership from the nursing staff in such environments which to them perpetuated substandard care. It highlighted cultures that lack care or compassion but again not all the students recognised their responsibility to change or to challenge within them. Some of the students did not respond to examples of poor care. When challenged within the group, they either trusted that the leaders would act, that as students it was not their responsibility or that they were just too scared to inform anyone. During one focus group a student stated

> *You are a team aren't you. I mean I think you work in some areas and the whole feeling of the place is scary and the oppressive uumm culture pervades the place. The top dogs change the culture and staff work differently. Oppressed, controlled, bullied even. It is in the hands of the nurses to challenge that to encourage not control.*

Even the demeanour of the lead nurse was mentioned in several focus groups, this was given as an example:

> *But if you are working in that environment and the leader/manager is disillusioned then she will not take to inspiring practice. In fact she will block it. She has the power to completely ruin patient and nurse experience by her miserable attitude. I mean, let's face it, it is the nurses with the miserable face that is..... that is the problem. That look has the power to spoil the shift and disturb patients and relatives. Certainly not going to worry about student's experience are they. Community team was lovely. Hospital aggressive and frightening.*

A young female student challenged the position of being intimidated by other nurses as her view was that a student

should be the nurse she or he wants to be.

This strongly spoke of leadership even as a student, with little sympathy for any student who was not prepared to stand up and speak out. Whilst this is laudable and what is hoped for, one student aired why this may not happen by using the term *"frightened"* again to illustrate that sometimes nurses are *"fearful"* which may impact on their ability to lead. Students expressed that they had entered nursing motivated by idealism and the desire to help others. Their concerns highlight nurses who appear to have lost that nurturing and compassion and instead have gained "*cynicism"* and "*disillusionment*". Others could identify nurses who were "*strong advocates*" for their patients and used their power to create a care giving environment.

Concerns were expressed around staff morale, how that may impact on the culture of a healthcare environment and especially the skills needed to lead such a team.

> *Well if nurses are low and unhappy, they tend to be less caring of the patients and less compassionate. Miserable staff make a miserable culture which makes the patients sad too*

A debate emerged in the focus groups of the impact that nurses' disillusionment can have on patient care. There was recognition that the nurses who were seen to be disillusioned were actually disempowering other nurses and putting themselves in a position of being done to. Students remarked about how the miserable culture goes against the typifying or representing picture of nursing that has an ideological image of people who are dedicated and caring, enjoying the job due to the satisfaction it offers. Yet it was not clear to them as to why nurses are disillusioned as during their training. Clinical placement would have made up 50% of the assessed programme and they would have gained hands on experience and clarity as to the nature of the role. The students not only spoke of working with nurses who were disillusioned but also patients who were disillusioned with nurses.

One young female student felt strongly that this disillusionment is in the nurses' hands.

> *But surely if you are disillusioned then you should not let others know about it? Surely you should change the practice not moan about it. If nurses are disillusioned then change practice not moan about it.*

Another student strongly believed that if a nurse is disillusioned with practice

> *He or she should change their attitude, change their job*

The nurse has the power to change practice by effective leadership yet one participant spoke of how disillusionment can instil a certain culture in a practice environment which increasingly may even discourage students from continuing with their programme;

> *But I have also worked with so many nurses who are disillusioned and even patients disillusioned with nurses so not sure if I want to be a nurse at the moment.*

The culture in the hospital environment can be stressful and busy but students agreed that leadership in the community was different

> *Well I think going into people homes means they have no power, the patient does invite them in really and you cannot tell anyone what to do in their own home.*

Many of the students agreed leadership in the community seemed to be more about sharing power with the patient, a concept that some argued was equally important within any healthcare organisation.

4.3.2 Organisational Behaviour

There were also perceptions that others may take advantage of environment which was full of disappointment. Students consistently raised the issue of weak leadership around nurses behaving as subordinates to other healthcare professionals. The majority of the students had witnessed nurses behaving in subordinate roles to Health Care Support Workers (HCSWS).

Health Care Support Workers (HCSWS) are employed to support the work of nurses providing direct patient care and undertaking tasks that they have been

specifically trained to undertake but always under the instruction of the nurse. There are an increasing number of HCSWs undertaking whole patient care and not just tasks (Gainsborough 2009). Recently there have been opportunities to train and increase their responsibilities, and scope of practice enhancing the skill mix in teams caring for patients within acute settings and in the community by staff working together. An increasing number are taking up the opportunities to become Assistant or Associate practitioners requiring academic qualifications such as a Foundation Degree.

Some HCSWs have worked in the same environment for many years, and have remained none registered. These HCSWs are normally an excellent source of information and provide valued unique insight and support to the team that they work within. Nevertheless, students cited examples of power and control coming from HCSWs which resulted in a detrimental effect on both the atmosphere on the wards and on the actual care that patients received. These created sources of conflict for some of the students by the ambiguous nature of these manifestations of power which were against their understanding of roles and nurse leadership. The power of HCSWs identifies a disparity in an understanding of the nurse leadership role.

One young female student explained:

> *Well I worked in one area where the HCSWs ran the ward. They virtually bullied the patients and the nurses and no-one stopped them. Care was dreadful. They were lazy. The patients were not cared for properly. They need a really good leader to go in there and shake everything up. I think it has been closed to students since. I nearly left. It was my first year.*

When asked whether she had reported this situation to anyone, she disclosed that she was

> *too scared*

The term scared related to telling anyone, including telling those in a leadership position but could not clarify what she was scared may happen. The undercurrent of fear may be the cause for the lack of assertiveness and advocacy as suggested in the previous section. The fear of what again is a

concern that requires exploration. The word "*bullied*" was also used and is a compelling term especially when it is in connection with patient care. Comparable situations were referred to by a number of participants who were students of varying ages and experiences. The students did not offer any form of management strategy, just spoke of it.

One of the mature female students stated that

> *Well, not sure if I have ever seen a nurse who is a leader. Mostly it is them being told what to do or the HCSWs run the ward. Maybe out in the community but not in hospital.*

In principle, HCSWs have the position of supporting, not leading. Students gave examples where the HCSW was able to exercise some form of unexplainable power and in direct conflict with nurses. A participant stated that after witnessing poor delegation, poor leadership that

> *someone should stand out of the crowd here and say this is wrong*

The students were clear on the aspects of practice that they were unhappy about but did not include in their discussion what skills may be required. It seemed that "*someone should*" but not themselves.

There was a pattern that emerged from the examples but the students could not identify what holds these patterns of behaviour in place. They identified that the most common incidents seemed to be where HCSWs had been in the organisation for a long time and usually had not progressed and developed themselves any further. The personality or age did not seem to be a common factor but there always seemed to be a few HCSWs together producing a "type of respect" which one student insinuated was a seeming clique instigated and maintained by them.

> *There are groups that just glare at you, talk to each other but completely blank you and the patients and the nurses who try to manage them. The other nurses run around being nice to them not asking them to do much, just like a gang culture*

> *But you can be a leader in the health service but it does depend on which area you work in. Some areas have strong bases that*

> *are difficult to break. You are either in or you are out and frequently it is the HCSWs who have the power.*

This student found it difficult to explain what she meant by power but it was deemed by her to control the atmosphere on the ward and the level of care. Some HCSWs have been working in the same environment for many years and opportunities to review and enhance their practice may have been missed. The term "you are in or you are out" does not fit within a culture of caring and compassion or indeed within a professional environment and students likened it to "a school playground" or a "gang culture".

One student had been a HCSW for several years and had then started a Foundation degree (FD) as a pathway onto the pre-registration nursing programme which she was just completing.

> *As soon as they knew that I was planning a career in nursing and started studying for the FD programme they shunned me. Completely pushed me out. Treated me as an outsider. Horrible, people who I have worked with for years just cut me dead. Not pleased for me just clear I had left them even though I was still working with them whilst I studied.*

This example illustrates behaviour by HCSWs who believed that once she had decided to become a nurse and begin the studying necessary, she was no longer suitable to talk to or be friendly with. She had left them and going to join another group. This extreme alienation may offer a picture of cultures that exist within healthcare. You are with them or not going against what should be team work.

In this study, the instances quoted were always in hospital environments. Whilst there were nursing staff within these environments, a certain level of power had been given to the HCSWs as they did not seem to be managed by anyone. The next exemplar from a mature female student depicts the simultaneous positioning and power of HCSWs

> *Real problems seem to come from HCSWs especially when they have been working there for years. Sometimes find students a good thing to have power over. Make them feel really small.*

> *Actually sometimes nurses find it quite difficult to manage them. HCSWs can sometimes have absolute power over the culture on a ward. They can make or break the atmosphere. Never had a problem with HCSWs on the community.*

One mature male student put in a further layer of some HCSWs' negative attitude towards students.

> *Now delegation. That is so interesting. UUMM, I am just doing my management placement. The HCSWs do not want to do anything I ask them to do. Power you see. I will be a staff nurse soon and either they are thinking that they can get away with it before I become one or they are frightened that I will become one soon and they want to make sure that I know my place before that happens.*

Students in this focus group recognised how the power was circulating and the HCSWs were perhaps fearful for when the student would be qualified. He asked the lead nurse to explain to the HCSWs that he was acting as the lead nurse for his experience and they then responded positively to him. Nevertheless, once the nurse was unable to witness them, the HCSWs reverted to ignoring his directions, only conforming when she was around. The power circulated in this circumstance, no-one having ultimate leadership.

The realisation in this situation is one of disempowerment. One of the tasks of being a nurse who is leading a team is to delegate tasks as a means of dividing up the workload, allocating work to the most appropriate member and utilising the mix of skills to produce the best care. It is a skill recognised by the student below.

> *They are leaders because they have to delegate and she or he has to check that everything is done and the delegate has done everything, the job to the standard that she wants it to be. They may be small things but have to be done to a high standard. But they are leadership skills. Happy to delegate*

4.3.3 Professional nurses VS handmaidens

The relationship between doctors and nurses has attracted debate and discussion for many years. Advances in professional autonomy for nurses have taken place in some areas of healthcare recently and students gave examples of co-operation and team working between doctors and nurses which they experienced as increasing. Subordination to medicine remains established in other areas but surprisingly was referred to in a dismissive fashion by the students as if it rated quite low on concerns of ability to lead. It was disregarded by some but illustrated clearly in this short response

> *Doctors still tell nurses what to do because it is the natural order of things*

Whilst the training sets out to encourage and develop team working and leadership, examples such as this continues the history of nursing which was of being the handmaiden to the doctor in some environments as seen by examples chosen below.

> *There are pressures like the doctor knows best. Some real problems with the power system, doctors run it nurses run after them*

"Nurses run after them" demonstrates an unequal power relationship and an overt hierarchy in absolute conflict of nurses' autonomy and professional standing. Another equally demeaning statement

> *Doctors say jump, nurses say how high. Status quo. Reinforced this again and again*

These examples were from across the focus groups and not isolated incidents. One student expressed a logical view which she did not seem to question

> *Doctors tell nurses what to do. I know it is not just that but ultimately a doctor at the moment is making a lot of decisions the nurses can't. I know it is going to change quite rightly ….. But again a doctor at the moment is making a lot of decisions*

Findings

A number of students spoke of the power relationships between doctors VS nurses and HCSWs VS nurses and seemed resigned to it. Students did not offer examples of nurses changing the balance only examples of where nurses are already working in partnership therefore were unable to offer any interventions that had improved this balance of power. The community was an example of patient power and partnership working but the medical model is perhaps less apparent in the community.

Worries were expressed by some of the students of a profession that was unsure of itself and its place in healthcare whilst medicine remained secure in its position and its role. Concerns were also raised regarding nurses taking on jobs previously performed by doctors. Students realised the potential and positive aspects for developing their roles for nursing whilst others had concerns about nurses

> *picking up the jobs that doctors no longer wanted to do.*

Others expressed unease over nurses perceiving the medical jobs as more important than nursing jobs

> *Nurses only seem to like doing doctor's jobs. Think they are better by doing medical tasks that the doctors have got tired of doing. Do not wish to do nursing type jobs just doctor's jobs*

> And

> *Too busy doing doctor's job's so give nursing tasks to HCSWs*.

The concept of Inter-professional learning is not new but early in 2000, the concept was formalised and driven from government and commissioning bodies for health professional training to improve respect between the professions, for team working and communication. The Higher Educational Institute working with other similar institutes introduced an Inter-professional module into each year of the programme grouped under the heading of IPLU. Groups of students from varying health care professionals worked and learned together. However, the experience in the focus groups was a key part of their discussion and the insinuations was that IPLU did not enhance the development of their leadership skills and

IPLU reinforced social structures doctors/nurses as ever

4.4 Knowledge for nursing - conflicting knowledge sources

4.4.1 Always done it that way

The students referred to different types, characters and aspects of knowledge in the context of nurse leadership development. References were made to the impact of academic study, the use of evidence in practice and how knowledge itself is viewed in the context of clinical leadership. Students considered that leadership included the sharing, learning together and the identification of knowledge for the wellbeing of service users. The need for successful nurse leaders to reflect and respond on and in action on their own behaviour and reactions in practice using knowledge produced a theme of reflexivity.

Power struggles were illustrated in examples of nurses withholding information and knowledge from the students. In section two it can be seen that that there were criticisms regarding student nurses being educated at undergraduate level highlighting a belief that nursing knowledge did not require any level of critical analysis and synthesis. Students in this study had continued to experience this seeing nurses holding back the profession by not accepting the need for graduate status.

> *It is the ones who think they are always right and who probably never changed their practice, still moaning about not needing a degree.*

4.4.2 Using an evidence base for practice

Students expressed appreciation of the mentors who had positively influenced them and had helped in their development. Using evidence to base practice on was agreed as fundamental in providing quality health care. The emergence of evidence based practice focuses on best practice based on best available evidence (Pearson 2003). The nurses who emphasised the importance of this were reviewed so positively by the students and they included it as one of the

key skills required for leadership. One mature female student provided this statement but yet again only used one example.

> *The ones who I remember, they did develop me because they are enthusiastic about this stuff so I want to know more about it or I want to do this. They have a motivational responsibility. But to develop my leadership skills relates to one mentor in Placement 3. And she was absolutely brilliant. She taught me about managing my own learning. I did not get this from the University. And I did not get this from any other mentor. And it was about how to evidence everything in my AOP, I write reflections after work. She made me write things down and linked it to my AOP. In terms of delegation, she directed my development. She would give me articles to read and would then challenge me as to how I could use the content into developing my practice. I have never met anyone as good as that ever again. I nominated her as mentor of the year. She shaped everything. I wanted to know why no-one else had ever told me to evidence all my own stuff, it is about managing your own work and leading yourself. As a nurse, she was very good. I had implicit trust in her. And she helped develop me and she was very professional.*

This mentor facilitated the student to lead her own learning and development. There was no one else able to take that responsibility and to do this she must have the ability to evidence everything she does and be reflective upon it. For students to learn to lead and develop practice, the use of evidence was seen as a reason to have confidence in their skills and judgement as explained by this student:

> *It made a huge difference to have staff that enabled and trusted. If you can always evidence your care you should be trusted.*

Another student put forward that

> *I felt supported and I could evidence everything and I could measure before and after. And that made a massive difference to me. Measure the severity of the case and then measuring at a later point*

The use of evidence based practice is agreed policy and one of the quality measures in healthcare. Whilst many nurses utilise evidence to base their practice on, the focus groups raised the concerns of nurses not using such skills. A student, again in the last placement recalled

> *I wanted to know why no-one else had ever told me to evidence all my own stuff it is about managing your own work and leading yourself*

He cast doubt over competencies and comprehension of not only his previous mentors but the nurse educationalists providing theory. Within the same focus group there was an agreement between the other members one saying.

> *I met nurses who I could aspire to be like who could evidence everything that they do*

The ability to articulate the knowledge and evidence to service users and other professionals demonstrated nurse's knowledge and professionalism. Evidence to use for practice includes the role and understanding of policies, rules and regulations but also helps in building expertise. For one student, this was logical.

> *The training policies, procedures and governance help you decide what is right and wrong. This is why I have done it this way. I was able to evidence everything. It was always follow your policy and your evidence and away you go.*

A mature male student identified that for him, a key leadership quality was the use of evidence to base practice on do likewise. Yet he only witnessed this in his final placement.

> *So when I got to my final placement, I was very doubtful about the future, and I met people who I could aspire to be like, who could evidence everything they do. They have an answer for everything or there is a reason for why things are done in a particular way. That was the key for me from a very negative experience I was seeing such positive things.*

Findings

Students talked of knowledge and the conflicts between types of knowledge used and shared or not. “Always done it that way” was a term frequently used to justify practice which was of concern to the students and did not offer consistency or quality. Nurses are required to remain current in knowledge and skills. To do this is a quite a feat in such a rapidly changing environment as healthcare. Skills necessary for nursing includes knowing what knowledge is required for particular service user needs and how and where to access the relevant knowledge. Students are learning the most up to date sources of knowledge appreciated by some of the nurses who would use this knowledge as a resource to help them in the quest to remain current. There was no conflict or power to know more but to learn together. One of the examples of this:

> *Most of the mentors say I do not know that so let us look it up together. That way they learn too. Some of them say it is so good having students because it keeps them up to date or they will ask me what is the latest on this or that.*

The students judged true leadership as being someone who is able to constantly learn, identify what their service users’ needs are and what additional knowledge is required for them, embracing the concept of learning together in a supportive environment.

> *They want to learn from me and in turn they then teach me how to translate that into practice.*

Training historically inspired an unquestioning learn by rote system. Now, students are encouraged to discover what sources of knowledge are relevant to their practice and will know the nature of knowledge that they need to seek and where to access it. What some of the students found was an irritation with this spirit of enquiry from some practitioners. Emphasis during their training had been about critical thinking to base decisions about practice on. Working in environments where nurses perpetuate outdated and unquestioned practice blocked this critical approach and they behaved as if resentful when being questioned on their practices. Two examples of this were raised by students in one of the focus groups.

> *Practice say I always ask too many questions. Some nurses have said you do not need to know why you just do it. This makes me wonder if they do not know themselves. They feel threatened by us knowing what they know. Knowledge is power or as the saying goes. They may be worried that it will make them look bad.*

It was agreed that leaders role model the way that they do not know everything, wish to continue their learning and embrace others' opinions and perspectives including the patients.

> *Some just get away with it. They probably don't know much and do not want you to find out, some nurses hide that. They probably don't know much and hide it by being bossy and dismissive.*

One other mature female student agreed with this and recognised leaders encourage team work between themselves and students so that they learn with the students but in turn push the students.

> *Maybe they don't know it either and therefore are not going to show you they do not know. Knowledge is power and all that but to be a good nurse you need to know when to ask for help or advice. The mentors need to know that they should be pushing the student and have confidence to tell them to do something and trust that the mentors are involved. Get the mentors to push the students. Do not let the student sit there and absorb get them to get stuck in.*

One mature male student asserted that

> *Doctors were the only ones who have ever bothered to teach me. I ask and they teach. I ask nurses and they refuse for all sorts of reasons, too busy, don't need to know that, look it up, yourself*

Part of every nurses' role is to teach and support others especially students and they commented on how the resentment to teach made them feel.

4.4.3 Recognition of limitations

The students realised that leadership skills included the recognition of limitations. It could be linked to the theme above where nurses are not seeking new knowledge or are so worried about being seen as not knowing something leaving the potential for mistakes to be made and limitations to not be realised.

> *Some may be superb at technology but others may not. But if they know their limitations that is more important. And also they teach you to ask if you do not know and make you feel comfortable with that. It is the scary ones who look down on you if you ask for help*

The realisation of the danger when limitations are not recognised was explained by one student:

> *Our biggest concern are the not so good leaders I have worked with who are complacent and they have thought they know it all*

This troubled the students.

> *Well we have seen so much go wrong because of people who have not had the ability and not asked for help or recognised that they needed advice. Or could not say they did not know.*

One student clearly knew about her limits as seen by this statement:

> *Yeah I am as ready as much as I can be, I know my limitations and I know I will have to ask. I am happy to delegate, bits that I do know and I do understand I am happy with and happy delegating to people and things like that but I am happy to ask if I do not know something.*

4.4.4 Reflection

Students acknowledged the importance of reflection and by using it in practice how it has implications for deeper learning. A number of the students spoke of the importance of reflection and reflective practice for nurse leaders. They felt that it was a crucial skill for developing leadership skills and for being a leader.

Yet the concept of reflection was contested in some quarters and its use dismissed by others.

> *Not sure if all nurses know about real reflection. Maybe superficial or about maybe bitching about other nurses or carers or even patients but certainly not to develop practice. I was told by one nurse she was too busy to reflect. How about that?*

Students are taught reflection using formal theories and then practised within small learning group situations to review clinical situations that they may have come across. A number of nurses had seemingly through that reflection was just an academic endeavour whilst studying only.

> *Reflection? Nurses kept telling me they have not got time for that academic twaddle*

Students were concerned about nurses who did not seem to reflect on their practice and just continued with what they had always done, not learning from their own mistakes or adapting and adopting practice in response to experience. The importance of reflection and reflexivity to some remains clear in this students' explanation.

> *Policies, procedures and governance can help you decide what is right and wrong if they are used properly but sometimes they become a stick to beat with dependent on the intelligence of the person. Through your training and through your practice you reflect and just know the right direction I do think you just know the right direction, the right skills but with reflection, you know when to adapt and interpret differently. If you are not a good leader you stick to the rules regardless of patient, illness and person. Not patient centred, rule centred.*

Reflection is a powerful tool within a nurse leader's skills set explained perfectly by one female student responding to the previous comment.

> *You adapt it to whatever situation and it is all sorts of reflection and if I did it that way what would the outcome be and I think we are taught and encouraged to reflect and it is very good but it is*

> *good to think what was good about that what was bad about that. How did that make me feel. What would have happened if I had done that. I remember in the first year I thought God I hate reflective assignments what is the point but then as you go through you do it without working on it*

Understanding self and being self-aware is important but the following highlights an implicit knowledge which is necessary to develop learning and recognising own learning needs.

> *If you are aware of yourself and where you are in the world, because you know your weaknesses and you know your strengths. You then reflect automatically. How would that have happened if I had done so and so. I then think if I had done that with person A but it would have worked with patient B but not patient C.*

Anecdotal evidence highlighted pockets of practice in healthcare that had neither the evidence to support it but continued due to "personal preference", "intuition", or lack of guidance or change. There were role models and this included staff who were inspirational and showed this student to aspire to be like them.

> *You adapt it to whatever situation and it is all sorts of reflection and if I did it that way what would the outcome be and I think we are taught and encouraged to reflect and it is very good but it is good to think what was good about that what was bad about that. How did that make me feel. What would have happened if I had done that.*

One focus group where it was discussed in some depth there was an emphasis on academic learning. During this discussion, one female student stated that:

> *Academic work helps you think differently you look it up and then think why is it like that and think what if and why it is critical refection*

4.4.5 Curriculum conflicts/ The theory of leadership

Formal knowledge for nursing leadership in the students' experience was provided by one module in the 3rd year entitled Leadership and Management. The teaching was provided by formal lectures and small group work. It included established and relevant theories and models and encouraged reflection on practice. During the focus groups, the conversation about leadership was predominantly about practice rather than theory. Understandable perhaps as practice provides real experiences and theory may be seen as dry and sometimes irrelevant. Leadership and management theories may provide models to base some development on but seeing leadership in action can provide a clearer picture. Nevertheless, the module taught by the academic staff was not recognised as relevant to their leadership development, an example to clarify this was by one of the students with this simple quote:

> *I cannot remember it*

Students could see the point to learning about models and theories but it required practice to make it relevant.

> *Models will help but you have to see it in practice.*

This student clearly positioned herself here as learning leadership in clinical practice but respecting a place for theory within that practice. Another mature female went as far as to disregard theory and believed it requires practice only explaining that

> *You cannot teach leadership. It cannot be taught. It is something that you develop over time. Uumm, I think you need a practical application.*

One mature male student in another focus group argued that

> *Practical experience developed my leadership skills. I was dreading the Leadership and management module and that it may be going over old ground. And it was*

Theories abound around nursing leadership but what is truly required appears flawed or inconclusive. Due to the examples related by students in this focus group nursing leadership requires more than is available or it may mean that not all nurses are able to lead.

4.4.6 Leadership theory

Aspects of leadership theory were recognised as being required much earlier on in the programme. One mature student spoke of students' own responsibility to learn.

> *I thought why did we not have this at the beginning of the first year and then we could have linked it right the way through all 3 years. It should run as a theme throughout the whole 3 years. It would have made sense. So when we were doing the introductions to nursing practice, and the principals, if linked in we could have recognised well what are the leadership aspects to this. How would you be able to lead on this situation who would you speak to how would you solve this what would you do to make an informed decision uumm, those things that would have made more sense to link in with that project really well.*

Leadership theory is usually introduced in the final year to senior students which for this student was too late. There was a feeling of frustration due to the inadequate and poorly timed curriculum. The leadership and management module itself was not felt to be enabling or helpful

> *The leadership and management module, I found it informing but nothing else*

It was felt to be idealistic and task orientated and seemingly more geared to management skills.

> *It did not develop skills, it just gave us more information. And gave us distinct ideas of leadership being distinct, idealistic kind of way, management being tasks, meeting deadlines and things like that, and for me, that is not it. You can have as much theory in the world but...*

Subjects required to be taught for leadership are difficult to quantify and some of the students felt that they had the theory to prepare them but it was the practice that was key.

> *I think one thing that would really benefit a lot of people is a real effort on assertiveness. Teaching assertiveness to students because it can be so difficult. Some of us are mature and some of us have got a health service background. And we struggle! I think it is just hard to speak up. Need some sort of self-awareness so that you know what to work on.*

Following the theme assertiveness and "speaking up" the students unanimously wished for guidance and help with dealing with the situations discussed within the groups. The concern over HCSWs was revisited and the skills required to tackle such situations

> *Having difficult conversations, tackling the bullies would really benefit us*

This was also recognised as not just being in the clinical areas over the care provided did not seem to be the only area as the concept of bullying within students groups emerged.

> *I think what has helped me is being a mature student. I think if I was younger I would not have had the gumption to be assertive.*

4.5 Summary of section four

This section provided the descriptions of experiences that the students believed illustrated their own leadership development throughout their programme. They were not guided as to what was expected to be discussed, it was what they perceived enhanced or inhibited their leadership development. The students' major concern raised in all the focus groups was around nursing itself. The lack of professional identity and the provision of substandard care by some nurses reduced any ability to lead effectively and challenged the ability of nurses to lead in contemporary. An inconsistency of standards of role models was observed.

Findings

Themes or categories emerged following Versus Coding of the data. Conflicting power struggles were recognised by the students to impact on the ability of some nurses to lead in healthcare practice. They recognised the nurses and educationalists with leadership qualities and what was required for contemporary practice. Their perceptions went some way to understand developments and interventions that may be effective for leadership skills appropriate for contemporary healthcare. The next section will critically discuss the findings and the implications from this study for their programme.

5. Discussion

5.1 Introduction

Section four provided a detailed description of the perceptions of third year student nurses regarding contemporary nurse leadership. It also explored the inhibiting and enhancing factors to their own leadership development during their pre-registration programme. Within the discussions about leadership, critical issues emerged around the nature of nursing itself in contemporary healthcare. These were raised as the students recognised that they impacted on leadership development, both negatively and positively. The following section will review their perceptions, bringing relevant literature to them. It will recognise the importance of their concerns regarding these issues and the impact that they have on recommendations for developing leadership in future students. The section will also demonstrate how this study has enriched existing knowledge of contemporary nurse leadership and provided additional educational direction for development of it.

The section is organised in four areas which follow on from a brief overview of the data. By undertaking the steps of analysis described by Saldana (2013), three distinct categories of conflict related to nursing leadership emerged from the data. The first three sections of this section are set out as the three categories. The fourth section concludes the section with the recognition by the students of their own responsibility to learn, challenge and adopt leadership potential. It also provides an insight into curriculum changes recognised through the findings for pre-registration student nurse programmes.

Prior to the discussion, it is important to assess how many nurse leaders were encountered in practice. Each of the students in the study would have worked with, and been assessed by, many nurses whilst undertaking a minimum of six different placements, fulfilling the required 2,300 clinical hours to enter the NMC register. Nevertheless, their experiences of working with, or being mentored by a nurse leader was usually expressed in single figures, often only as one. There may have been nurses who were in more formal leadership roles

present in the clinical areas that the students worked in, but the study was exploring their own perceptions of leadership.

There was consistency in examples or experiences provided by the students. Students discussed their leadership development in the clinical practice environment more frequently and with more emotion than their theoretical time. Puzzling through how and why the particular examples from the student perceptions stood apart, or caught the attention more than others was part of interpretation. A number of the themes that were raised from the data could have been expected due to published literature and media coverage. Other instances were when examples questioned some taken for granted grasp of how nurses were involved in their work.

There was recognition by the students of why leadership was really important to nursing to ensure cultures supported high quality, compassionate care giving. Attempts to define nurse leadership were more complex and the observations that they made in practice of the standards for nurse leadership were inconsistent. Indeed a presence of any nurse leaders in contemporary practice was questioned by some and the possibility of it ever being a real part of the nurses' role by others. These opinions were also found in a study undertaken by Horton-Deutsch et al (2001) in North Carolina exploring student nurses' evaluations of their clinical experiences in hospital environments. They found that nursing students' unfavourable opinions of their profession was directly attributable to an absence of nurse leadership. The negative influence of an anti-intellectual stance amongst members of the nursing profession was recognised as part of the fading of nurse leadership (Horton-Deutsch et al 2001).

5.2 Professional nurses VS self-enmity (confused identity of nursing resulting in behaviour unbecoming)

This section discusses the students' perceptions of how some nurses had lost their professional identity, which negatively impacted on leadership credibility and inhibited leadership development for both nurses and students. The students recognised that there was a conflict between the professional identity

which they had been taught about and the behaviour of some of the nurses that conflicted with this professional identity. Credibility for nurse leadership was in jeopardy for the students because of this confused identity which in turn, affects the whole community of nursing.

Students' concerns regarding weak or absent nurse leadership was because of its negative impact on the quality of care. One of the students had worked in a clinical environment where nursing care was poor and she realised that it needed "*a really good leader to go in there and shake everything up*". Of even greater concern was that the students identified practices and behaviours that indicated a lack of what they believed were even basic nursing traits. Examples were given where there was confusion and conflicting opinions of what nursing itself was reflected in this quote, "*a good leader would never let someone go hungry*". The behaviour highlighted nurses with poor values and little compassion, one student concerned about patients who "*are cold or frightened because everyone is busy and forget why they are there*". There seemed to be a loss of what a nurse stands for and what the profession identifies with, increasing bewilderment around leadership. Observing and working with effective role models is part of a student's development into becoming a professional nurse. Students in this study did not always experience effective role models, but of more concern was that they worked with nurses who seemed confused about their role and identity.

The students could not understand why or how some of the nurses were confused. Notorious nursing theorists such as Orem (1980) and Henderson (1966) in the twentieth century demonstrated that the theory of nursing was effective management of patient care. Their emphasis was leading on patient care. Henderson (1966) was under no illusion as to the unique function of the nurse leading on people's health and their recovery from ill health. The other well-known nurse theorists maintained this function as illustrated by Rogers (1976) believing that nurses led on promoting health, preventing ill health, caring for and rehabilitating the sick and the disabled. In the past, nursing had a clear identity, the public and other health professionals knowing what they did and who they were (Maben et al 2008).

Loss of nurses' identity in the United Kingdom was deemed serious enough for the Chief Nursing Officer, Professor Dame Christine Beasley, to commission

research in 2008 to explore where nurses now stand in society (Maben et al 2008, Harmer 2010). The stimulus for the report Nurses in Society, Starting the Debate, was due to a sense that nursing had lost its way “whilst navigating the complexity of the increasingly technical environment that is contemporary healthcare” (Maben et al 2008:5). Recommendations proposed in the report set out to restore public confidence in the nursing profession and to define good quality care. The report recommended that nurses professionalism needed to be underpinned by “a reinvigorated sense of service, one which is responsive to what patients want from nurses: empathy, compassion, keeping them informed, doing the right things at the right time, being with and available to patients and their loved ones. These are the constants of care and nurses its custodians” (Maben et al 2008:4). A false polarity has emerged between the art of caring and humanity and advanced and technical tasks and roles that nurses are undertaking. Its conclusion was to recast the role of the nurse suggesting that nursing was not achieving its aims.

Reviewing the theorists' understanding of nursing would question why the nurses’ role should be recast. The recognition of the importance of the business of caring and its contribution to quality healthcare raises the need for nurses to do nursing, not waste time recasting the role. Despite this, examples of unsafe, uncaring and inhumane care provided by nurses are, with increasing frequency, being heard in the media raising questions as to where the leaders are (Francis 2013).

Fagermoen (1997) investigated the values underlying nurses’ professional identity. From her study, Fagermoen (1997) concluded that the common core of nurses’ identity is ensuring the values of dignity and personhood. Nursing is being a fellow human with a moral practice concerned with providing personalised care and enabling reciprocal trust. One student in this study said that nurses just needed to show "*humanity*". Human dignity stood out as the core value and all values appeared to be linked to this basic value either by arising from it or being aimed at preserving it.

For the continued quality of care, Fagermoen recommended that it was essential for students to be mentored by excellent nurses who have strong professional identity to develop their own required knowledge, skills and ethical grounding (Fagermoen 1997). In reality, the students witnessed both

nurses who had this identity, but also those who did not and witnessed behaviour and practices that were in conflict with it. "*Well we have seen so much go wrong because of people who have not had the ability and not asked for help or recognised that they needed advice. Or could not say they did not know*". Terms used in the data to describe the nurses who had strong professional identities were being a "*good model*", nurses "*who never deviate*" always "*consistent*" and students had "*implicit trust*" in them. One student said "*you can recognise it, just working with that person one time*" and another quote was "*you just know*" when you work with them.

Worries expressed by the students reflected a profession that was unsure of itself and its place in healthcare. Identity theory was formulated by the psychologist Stryker (1980), who proposed that individuals take on different identities depending on the role that they are undertaking. Identity theory sets out to explain an individual's role related behaviours. It demonstrates that society affects social behaviour through its influence on the self which is all part of the makeup of an individual (Hogg et 1995). The psychologists Hogg et al (1995) recognised in their theoretical paper exploring identity theory, that people tend to interact in groups and often adopt the persona of the group in which they are a member. It gives structure to the lives of the participants and aids cohesion by creating a hidden understanding and a sense of belonging to certain groups within their community such as nursing.

Lave et al (1991:29) undertook an analysis of apprenticeship learning "in communities of practitioners", and showed learning to be a situated social process which is developed through interactions with others. They found that it was through interactions with others that learning was developed from rather than the isolated learning assumed in the classroom. This supports the findings in the data as students discussed their learning of leadership in practice as much more relevant than the theory. Reviewing the Lave and Wenger analysis, Le May (2009:5) talked of the social learning experienced through the "master-apprenticeship relationship in which master and apprentice learned from, and through each other, and the apprentices' interactions with each other and their wider community enabled successful learners to move from the edge of the community to full participation in its socio cultural practices". This in turn resulted in apprentices forming an identity with the community then becoming new masters thereby working with

new comers. Students found few “Masters” in their experiences and if weak mentors work with students who are struggling with their own self-esteem, the potential for a perpetuation of a weak community occurs. Adopting the persona of the group as suggested by Hogg (1995) may explain the perpetuation of unacceptable practices.

Community provides the language in which individual’s understand themselves and interpret their world (Henkel 2005). This enables the community to craft an identity that maintains a relationship with the wider society (Gobbi 2009). According to the data, crafting an identity to maintain relationships with the society of service users and their families is complex as the community of nursing appears divided and conflicted. Examples include one student who commented that patients were disillusioned with nurses at present whilst another spoke of "*miserable staff make a miserable culture which makes the patients sad too*"*.*

MacIntyre (1981;206) underlines the idea of the individual bearer of community tradition. “What I am is in key part what I inherit. I find myself part of a history and one of the bearers of a tradition”. Students questioned the long held tradition of nurses being responsible for leading on patient care considering what they were seeing in practice. They recognised the small number of nurse leaders as those who concentrated on providing and improving patient care and influencing others to do so.

Students realised there were those who did not want to be the individual bearer of the tradition of nursing and who seemed to wish to be a doctor instead, one stating that “*Nurses only seem to like doing doctor’s jobs”*. This could be because the value of nursing is rarely recognised as medicine is valued more highly and is believed to be the dominant group in control of all domains of healthcare (Corner 2001). In the data, concerns were about nurses actually taking on jobs previously performed by doctors. Its reinvention to become an associate science to medicine instead of achieving credibility and leading on its core strengths and expertise may be part of this loss, nurses driving to be ever more like doctors (Radcliffe 2000). Students voiced concerns about nurses “*picking up the jobs that doctors no longer wanted to do”.*

Others expressed concerns over nurses perceiving the medical jobs as more important than nursing jobs. Radcliffe (2000:1085) acknowledged the "jostling" for position between nurses and doctors but believed that little had changed and there was a mistaken sense of equality which in fact was uniformity. Quotes in the data reflected this as "*Nurses run after them*" demonstrating conflict of nurses' autonomy and professional standing. It was rather demeaning but it seemed their choice to do so, "*Too busy doing doctor's job's so give nursing tasks to HCSWs".*

Harmer (2010) was concerned that whilst nursing was busily extending, expanding and delegating traditional nursing duties, it lost its way. The extension of roles may have allowed a blurring of boundaries between professions further blurring the professional identity of the nurse. For those who view claims to professional status as resting on the provision of holistic nursing care, the casting-off of the apparently routine becomes more problematic. Students recognised that technology and medical practices were perceived as "*sexy*", whilst the direct patient care was of less importance.

Some of the students believed that nurses do not want to do nursing anymore and in fact made one of them wonder if she still did. Students realised the potential and positive aspects for developing nursing roles, as many more lives are now saved by the increased medicalization of healthcare and certain nursing skills have advanced to support this. Yet these medical skills acquired by nurses are rarely critically acclaimed by patients (Corner 2001). In comparison, the extent of the lack of basic humanistic caring skills which are essential to patient care and are traditionally provided by nurses are broadly published due to the substantial impact and distress on patients' lives. Determining the professional status of the nurse is a continuing debate in many countries and it would seem from the data that it continues here to.

Melia (1987) undertook a PhD to study the occupational socialization in nursing. Its chief concern was how new student nurses were made aware of nursing activities and then investigated how nursing was actually practised on a daily basis. The student nurses in her study described nursing as a divided occupational group "whose organisation presents considerable problems for those attempting to gain acceptance into its ranks" (Melia 1987:1). Melia (1987) used the notion of segmentation to analyse and organise the data

arguing that nursing is an occupation which contains segments, each with its own version of nursing. The main segments she found were education and service, suggesting that both present different versions of nursing.

The focus groups used to collect the data for this thesis on leadership development spoke of the same dichotomy, one example "*The University push values and compassion. Then you go out into practice and there they are bad habits and poor practice*". Melia's study was undertaken more than twenty five years before this one, but the experiences of the students are comparable. She found that the students' accounts recognised an "idealised version" of nursing promoted by the college, whereas the staff on the wards practised a more "pragmatic form of nursing" (Melia 1987:161). Melia described this as the college presenting a "professional version" of nursing and practice was more of a "workload approach". A conclusion was that students in her study were learning to be student nurses rather than nurses. Nevertheless, this study raised the issues of being prepared to be a professional student nurse. Students in this study recognised the nurses who were developing them as autonomous and professional nurses, whilst others reflected Melia's study and just wanted them to get through the workload. Getting through the workload would seem to lack the professional responsibility that nursing should have. She concluded that without appropriate knowledge and identity, nursing stands without foundations and will be just handmaidens doing tasks.

The data showed that the way the curriculum had taught leadership did not prepare the student from the start, so that the student could have *"linked in, we could have recognised well what are the leadership aspects to this. How would you be able to lead on this situation".* The students felt that if they were better prepared, they could continue with being critical thinkers in practice rather than resorting to being handmaidens. This was explained by one who said *"can the curriculum be more tailored to towards supporting the student rather than being politically correct".* Brennan et al (2012) further emphasised the tensions between the identity of the student nurse being compliant in clinical practice settings and the independent critical thinker within the University. They introduced the work by Grealish et al (2005) who evidenced that students were ill equipped for their professional identity once qualified and thus required more support for this within Universities. The students in this study felt that they were ill equipped for being a student.

This section reviewed the students' perceptions of working with nurses who were identified as having lost their professional identity, and how that inhibited leadership development. The students raised concerns over nurses who seemingly wished to be doctors rather than nurses and were poor role models. They noticed the difference between the University's teaching of values and questioning practices as they worked with nurses who provided poor care and unquestioned practices. Nursing, like most professional bodies, create and sustain its own historical narrative. The students' perception of the community of nursing was one which was close to losing its traditional identity and required strong leadership.

5.3 Nurses autonomy VS oppression (by HCSWs and each other)

This section explores the concept of oppression which the students recognised impacted on the ability of some nurses to lead and how it affected their own development. Oppression can manifest itself as inappropriate behaviour about which there is a plethora of nursing literature dating back over many years. The section offers new insight into the perpetrators which the students encountered in practice, opposing the common place view of medicine as the oppressor. The data revealed nurses oppressing each other, the students and the nurses in turn were oppressed by Health Care Support Workers. The system was then maintained by rewarding those in the oppressed group who supported the dominant views and maintained the status quo. Members of the oppressed group who attempted to succeed do so by acting as much as possible like the dominant group. The students could clearly see how this impacted on nurse leadership and they put forward what they required to help them develop as leaders in such environments.

Nursing's political interaction and control of its future depends on its ability to speak with one voice. Instead, the students spoke of nurses displaying the characteristics of a subdued and oppressed group by their lack of self-esteem and passive aggressiveness. The relationship between doctors and nurses has attracted debate and discussion for many years, oppression and subordination by doctors seemingly commonplace (Corner 2001; Radcliffe 2000; May 1997,). The process of genderisation persists despite the fact that 50% of doctors who

qualify are women (Corner 2001). Men and medicine are traditionally blamed for the oppression of nurses. Due to their weak professional identity nurses were seen to be by Health Care Support Workers and other nurses.

Within the study data, students did raise the issue of medical domination but dismissed it as impacting on nurses' esteem. Instead it was the nurses who were the oppressors of themselves and of the students, one stating "*It is not doctors who control nurses, it is nurses*". Words such as "*frightened*", "*tackling the bullies*", "*oppression*" were in the data. The students emphasised the need for assertiveness training for when they were in practice. They asked for skills in managing the conflict they encountered when trying to provide appropriate care, dealing with the poor role models and "*having difficult conversations*". Students spoke of how "*hard it was to speak up*" and nurses and students were thought to have been "*very frightened to not challenge".* Fear was a term used to justify why one of the students who spoke of her distress when caring for a poorly man who had been left hungry by nursing staff did not challenge the situation.

The students gave examples of inappropriate behaviour and a lack of manners shown to them by nurses such as rolling their eyes when they spoke, sniggering and ignoring them. Students were blackmailed with threats of not passing the placement if the students did not do as they were told. "*she did not want a student and did not have time to look after them on her ward. She told me either things got done her way or she would not sign off my AOP*". (AOP is the assessment of practice document). Examples in the data were of rudeness and contempt, ignoring and dismissing the students. One student spoke of her distress and crying at the end of every shift because of the way she had been treated by the nurses, ending her statement of frustration by saying "*I am a grown woman".*

There has been a plethora of literature about inappropriate behaviour by nurses (Dellasega 2009; Levett-Jones et al 2009; Quine, 2001; Radcliffe 2000; Farrell 2001; Leap 1997). Nicky Leap (1997) is one author who described the concept of horizontal violence. This is not just a description of intergroup conflict or various forms of bullying. It embodies an understanding of how oppressed groups direct their frustrations and dissatisfaction towards each other as a response to a system that has excluded them from power.

Research continues to highlight nurses in unsupported hierarchical structures, and a constant attrition by new graduates from the nursing profession due to abusive and humiliating incidents perpetuated by registered nurses. Meissner (1986), nearly 30 years ago, termed the phrase nurses “eat our young”. Meissner (1986) recognised the bullying that occurred within healthcare organisations and alleged that nurses were guilty of "insidious cannibalism" because of the socialisation processes inflicted on students. In the last 20 years, this concept was judged from some quarters as outdated. Sadly, as recently as 2009, a study was undertaken by Sandra Thomas and Renee Burk, both nurse academics, and was conceived after Thomas heard disturbing stories depicting nurses as the major provocateurs of junior students’ anger (Thomas et al 2009). The stories were consistent with the concept of “eating our young”. Whilst there is an abundance of literature revealing comparable and disturbing levels of inappropriate behaviour in nursing arenas, there seems a lack of research into the causes.

The inappropriate use of power is linked to poor care (Ferns et al 2007; Farrell 2001; Lewis 2001; Hutchinson et al 2006; Randle 2003). Healthcare environments should conjure up a picture of healing with professionals who are trusted by patients and inspired to care for the benefit of physical and mental health well-being. All too frequently the opposite has been revealed in the media and in government reports and the demand for effective leadership to change the cultures which perpetuate aggressive behaviour.

The term "*bullying*" was used in the focus groups to describe some of the cultures but behaviour was also identified as inappropriate. Students related incidences where they were victims of inappropriate behaviour from nurses central to poor ward cultures. Terms such as "*the whole feeling of the place is scary*" and "*the oppressive culture*" were used by the students to describe their experiences. Common courtesies and good manners were lacking in some incidences such as *“No-one ever welcomed me, said hello or said goodbye”.* Farrell (2001) published a critical analysis of an extended literature review on this. He concluded that nurses act as gatekeepers to their established status quo and interpersonal interactions. Farrell writes that “once aggression arises, it is likely to be maintained unless remedial action is quickly taken” (Farrell 2001:29). Difficult relationships can continue but where aggression gets results, there is a strong likelihood for its existence to continue.

Discussion

Radcliffe (2009) strongly recommends that all staff of all levels should unite together as the incidences of bullying are legendary along with the plethora of literature on the subject. In April 2009, Sir Ian Kennedy, Chair of the Healthcare Commission, called for a renewed focus on nurse leadership and issued a warning about the corrosive nature of bullying and how it is permeating care (Santry 2009). He stated that it was even impacting on such patient care activities as not taking someone to the toilet or not feeding someone.

Randle (2002) undertook a 3 year study to explore students' self-esteem and their experiences of pre-registration education and its impact on their development. Interviews took place at the beginning and the end of their programme. The findings were that bullying by nurses was common place, not only towards the students, but also towards patients. The students began to assimilate such tactics into their nursing practice during their programme. Yearsley (1999) presents this as subservient behaviour theory, students looking for ways of being accepted within the workforce. She proposed that subservient behaviours were necessary and facilitated a form of acceptance.

Randle (2002) found that a consequence of working in the clinical environments was that students were faced with nurses who did not display caring and supportive characteristics. At first, students felt confused by the conflicting images but by the end of the programme, they had adopted ways of working and conformed to those that had initially shocked them. They then began to identify with the role models that they experienced and seemed blind to their original anxieties. From Randle's work, striving for excellent nursing role models is a priority.

Each focus group spent quite a substantial amount of time talking about the incidences of Health Care Support Workers (HCSWS) behaving in positions of power and direct conflict with nurses, one example given saying that "*the HCSWs run the ward*". They seemed to have positions of power that they exercised to the detriment of patients and the staff. Whilst there were nursing staff within these environments, the power must have been given to the HCSWs as they did not seem to be managed by anyone. A student talked of the strong power bases "*You are either in or you are out and frequently it is the HCSWs who have the power*".

HCSWs are employed to support the work of nurses providing direct patient care and undertaking tasks that they have been specifically trained to undertake but always under the direction and supervision of the nurse. There are an increasing number of healthcare support workers undertaking whole patient care and not just tasks (Gainsborough 2009). Some take up the opportunities as Assistant or Associate practitioner roles having completed a Foundation Degree in healthcare introduced by the Skills for Health organisation in 2000. HCSWs may have worked in the same environment for many years, have never progressed but are normally an excellent source of information and provide valued unique insight and support to the team that they work within.

There is no literature to explain why this oppression may happen, or indeed that it actually does. The only related literature describes abuse of HCSWs by nurses. Students spoke of the HCSWs behaviour as a "*gang culture*" or "*a school playground*", groups "*that just glare at you, talk to each other but completely blank you*". People will often form subgroups. They may help those who are uncertain about their abilities to express themselves especially in times of change. Students were distressed at the poor care provided in areas where the HCSWs had control "*They virtually bullied the patients and the nurses and no-one stopped them*" "*frequently it is the HCSWs who have the power*".

It can be hypothesized that nurses who allow this to happen have chosen to opt out of their leadership role. One difficulty for nurses with the HCSW role lies in the realm of management and accountability. A number of studies have also highlighted continued attempts by nurses to protect their occupational jurisdiction. On closer inspection, a number of potential difficulties for the nurse flow from the HCSWs role. Indeed one of the students had been a HCSW and she felt sidelined and extricated by the HCSWs who had been her colleagues. HCSWs who move on may have problems fitting in. Nurses should be leading to ensure that the atmosphere and culture are conducive to compassionate care or they should stop it happening between and towards anyone else, hospital or not. It would seem from the data that they frequently perpetuate the situation.

Discussion

When asked about the age and culture of the Health Care Support Workers who were referred to, it would seem that the majority were middle aged and had worked in the same environments for many years. Nurses and HCSWs had often worked together for a long time which can bring in personal perspectives and emotions. The relationship is then not one of leader and follower or even team working. It becomes a powerful base which is maintained and not managed. Baumeister et al (1995) undertook a theoretical review of the concept of belonging. They identified that forming groups and achieving group membership can create cohesion and social bonds especially in difficult times. Supportive relationships can provide a buffer against stress and social networks can be used to prevent or diminish threat or loss (Carver et al 2010). The need to belong can influence behaviour, emotions, cognitive processes, health and wellbeing (Baumeister et al 1995). A diminished sense of belonging can negate nurses' leadership who adopt a more conformist attitude (Tradewell 1996) which can cause a perpetuation of power by the HCSWs. From the data, the hospital environment seems to be the platform for repression of a number of people and professionals. Due to their position, nurses have the power to lead care and the staff and environments where care is provided.

The power and control of HCSWs raised by the students, provided a new picture of poor levels of leadership and emphasised the challenge to prepare students adequately to work in such cultures. Students may feel isolated when their moral courage is tested especially when taking a stand because of patient safety or well-being. With all that has been published on this subject, the students still identified aggressive and inappropriate behaviour as a key inhibiting factor in developing their leadership.

The ability to challenge is a crucial skill for student nurses to develop. It can be seen that the literature on poor workplace relationships in nursing is expanding with little attention to causes of the interpersonal conflict. Part of nursing is about being professional role models for students and without them, students flounder. Where aggression is frequently displayed by health professionals, nursing students may observe that aggressive behaviour as part of the job and perpetuate it in their practice (Farrell 2001). The data demonstrates a picture of limited numbers of professional role models further increasing the conundrum of preparing students to develop without perpetuating the poor practice that they see. It is not enough to teach graduate

nursing theory, knowledge and skills to student nurses for them to become professional nurses. What is not present is how to control fear, have the high levels of courage required to face colleagues who do not want to change and to stand alone not belonging to the majority. Emphasis in the literature on nurse leadership is on the need for nurse leaders to have courage in contemporary practice due to the hostile nature of healthcare environments (Edmondson 2010; Clancy 2003; Corley 2002).

Whilst Rafferty (1996) describes the hospital as a microcosm of society, class bound and with strict divisions of labour determined by gender the data does not indicate that gender was part of the oppression. The male students in the focus groups were victims of inappropriate behaviour as much as the female nurses. Participants recognised certain behaviour of those who they put forward as leaders regardless of gender who reflected the ideals of feminism, having humanity, a calmness, a smile, kindness. A study by Pringle in 1998 of women doctors in Britain and Australia, highlighted how the very presence of women in medicine is transforming it just simply by their presence. The most interesting aspect of her study to this project is that Pringle found that women doctors were treated more harshly by female nurses than their own medical counterparts. Many of them claimed that they felt quite threatened by nurses, especially those in their advanced practitioner roles (Pringle 1998).

Whilst there is the conundrum of preparing students to work in such threatening environments, a further addition to this was raised by the students. There were examples of inappropriate behaviour between female students against others. The students spoke of "*tension in the group*" and that certain members could be "*picked out*" *or* "*singled out*" and " *bullied* ". The rest of the group could have "*power over your performance*" and you could be *"laughed at"*. The examples given were of mature students who had children being "*excluded*" and were *"too old to be part of their gang"*. This could be the clique formation previously mentioned which is “a pervasive instrument in marginalizing those who are perceived as different or who are seen as a threat” (Farrell 2001:29). There were incidents in the lecture theatre where students were disrespectful and rude. This certainly puts the question of their behaviour as leaders.

Discussion

There was little in the literature of this except for exploratory research undertaken in the USA, prompted by "violent acts" and increased "student incivility" by nursing students (Clark et al 2007). Clark advised that students should be informed of civil norms and general codes of behaviour when learning in a professional environment. Following on from the study, Clark et al (2007) encouraged lecturers to role model by their own behaviour. Attention has been directed at student recruitment and ensuring selecting students using values based activities. Whilst recruiting students with high values to the programme is key, the data and the literature highlighted that both appropriate and inappropriate influences are more powerful from practice and practitioners. Requests from the students for educational input to enable their leadership development may go some way to reduce this classroom conflict as well. Yet the question that still remains unanswered is why there is so much potential for violence and inappropriate behaviour in nurses and nursing students considering they have chosen to be part of a caring profession.

The desire for human contact and to help others seems to have another meaning for today's students compared with what it had for the women who chose nursing a century ago when compassions and charity were important virtues. The duality of altruism and self-concern in their motivation for helping people may have changed (Rognstad et al 2004). Whilst there is emphasis on values and compassion within the nursing curricula, just teaching it is not enough. It calls for a renewed sense of pride and celebration and by developing personal and professional pride, should reverse the cycle of low self-esteem and hostility. Students recognised those nurses who were proud of their professional identity, of who they were and the quality of care they provided. For the students, the positivity should be instilled at the very beginning of the professional journey. Whilst behaviour continues the groups will remain oppressed and the impact on care will be maintained.

Giving power to the students themselves to develop the leadership skills appropriate to effect changes in practice came over strongly in the data. Nurse education and role socialisation sets out to engender within the individual the appropriate use of power. Nevertheless, nurses and student nurses are either working with or are learning behaviour unbecoming. "But it seems to me now that the notion of repression is quite inadequate for capturing what is precisely the productive aspect of power.....If power were never anything but repressive,

if it never did anything but to say no, do you really think one would be brought to obey it?" (Foucault 1972:119). Some of the students had witnessed power that was positive and produced a positive culture and a positive learning experience for the student. The nurses who were thought of as leaders seemed to have an implicit knowledge of nursing. This knowledge included the understanding of how their outward appearance and character can alter the culture of care and how patients and staff change due to it. The students recognised that when power was used appropriately, it was in partnership with high quality patient care and a congenial culture in the care environment for patients and staff.

This section reviewed the data regarding the behaviour noted or experienced by students not only in practice but in the classroom environment too. Bad manners, rudeness and inappropriate behaviour were experienced by the students from several perspectives. Fear impacted on responses to this and could have limited the desire to take the lead and challenge due to fear of repercussions such as failing the placement. Sellman (2009) observed that there remains the discovery of the right thing to do in each individual and particular case which remains unpredictable. This is what nursing is about.

The extraordinary mentors identified by the students seemed to know how to use their power appropriately and what was the right thing to do with the students, each other, the service users and other professionals. Recognition of this power and how to use it appropriately should be threaded throughout the student's education to develop their own leadership skills. Nurses' disillusionment with their role was recognised by students and caused patients to be disillusioned with nurses. Students questioned whether they wished to be part of this, and felt that nurses who were disillusioned by the job should leave as it had serious impact on the quality of patient care.

5.4 Nursing knowledge VS the sciences (nursing struggling to define its sources of knowledge)

The following section reviews the data from the perspective of the use of knowledge and an evidence base to lead nursing practice. The translation of knowledge into practice became an area of conflict for the students as they

compared the academic critical thinking and the theoretical input with what they were seeing and witnessing in practice. Students were encouraged to be autonomous critical thinkers in the University arena and once in practice some were expected to be subordinate and compliant, unable to question. They experienced an anti-intellectual stance within the profession. The following discussion will include the move to an all graduate profession, the perceptions of being inquisitive as a leader and the concerns of continued outdated and unquestioned practices. Teaching theories around leadership were not found to be helpful for students. The section concludes with a discussion of students' own responsibility to develop as leaders.

The importance for leaders to utilise knowledge and drive care by the use of an evidence base to practice is a key indicator of quality. The graduate nature of nursing should support credible leadership, yet the students experienced an anti-intellectual stance which remained ingrained in some and inhibited developing aspects of nursing practice. Graduate education was encouraged to improve the way nurses use knowledge and seek evidence to improve patient outcomes (Willis 2012). The students decided that for them, nurse leaders were inquisitive, wished to learn from students and share their knowledge too.

The comparative studies undertaken by Stein (1967;1990) discussed in section one, showed the change in the professional standing and identity of nurses in the United States resulting from the move to a graduate level pre-registration training. In comparison, the data from this study illustrates that the move from the introduction of graduate level education in the 1980s to an all graduate profession in the UK from 2013 has had little impact on the power of nurses to lead effectively on patient care. Students found their own level of education still dismissed by some nurses as just being "*too posh to wash*".

Reflecting what the students witnessed was the impediment which is “the schism between nurses with different levels of training”, efforts to gain increased recognition and status are resisted by those nurses without advanced degrees (Stein et al 1990:548). A tension remains regarding the need for a graduate status for nurses even though graduate training and post qualifying programmes for nurses have been in existence since the 1980s. Referring to the literature raised in Stein’s study in 1960 and again in 1990 in the USA, the turnaround from none graduate to graduate changed nurses

standing in American healthcare within less than 30 years. This study recognised several examples of none belief by nurses of the power and importance to their professional standing of becoming graduate. Their identity as leaders in patient care did not seem to have been understood.

For organisations to take on new cultures can take three to nine years depending on how ingrained the staff are in their own ways (Bradford et al 2003). A recent survey in the Trusts where the students experienced their placements during their programme, highlighted that over 60% of the nurses are either reading at undergraduate level or have gained both undergraduate and postgraduate academic studies, an increasing number achieving doctoral status. The change of culture experienced by Stein is not as clearly reflected and appears to be taking longer than put forward by Bradford.

The case for the need to move to an all graduate profession was because of the need for highly knowledgeable skilled autonomous registered practitioners fulfilling complex roles (DoH 2008). The students found resistance and resentment to the all graduate move. One of the students said that he only really saw "*nurses being handmaidens*" and "*old school mentors mostly did not agree with degree nurses* ". One driver for nursing to become an all graduate exit at the point of registration is the respect that such a qualification has from other professions. It was so interesting that those nurses remained trying to hold back the profession instead of trying to enjoy the opportunities that such a push could offer them. The student nurse requires an inquisitive and inquiring mind to ensure practice is appropriate for each patient. Training historically inspired an unquestioning learn by rote, and an unthinking acceptance of tradition. This may introduce the issue of their training coming to nothing as they were working within the environment of nurses who continue this acceptance.

In 2012, a report was published by Lord Willis who was commissioned to examine the health of the pre-registration nursing education. "The United Kingdom needs a nursing workforce equipped to help meet the complex healthcare challenges of today and tomorrow, to provide care and support in times and illness and distress, and to help people stay healthy. How this workforce is educated is therefore a matter of great importance" (Willis 2012:7). Concerns continue however, as the students worked with nurses that

are "*still moaning about not needing a degree*". The report found no evidence to support the view that graduate nurses are less caring, indeed published evidence to the contrary and the outdated view of nursing only shows a lack of understanding of its complexity. Frequently it was nurses themselves who were the least convinced of the need for graduate education which further supports the concerns of the confusion surrounding nurses' professional identity. Those who believed this were surely aligning themselves with the untrained HCSWs who support nurses, not the ones who need to make decisions and practice autonomously in an increasing complex environment.

Working in environments where nurses perpetuated outdated and unquestioned practice seemed to block this critical approach and they behaved as if resentful when being questioned on their practices. Unquestioned practices continued in a number of placements and completing the workload in a timely fashion took precedence over individualised evidence based compassionate care. There is a new emphasis on clinical academic roles able to facilitate and help students and nurses manage tensions between theory and practice highlighted in the research literature (Willis 2012;Maben et al 2007;Maben et al 2006). These will take some time to make a difference and teaching students about evidence and research alone are not enough to change to either support them to do this in environments where is it not encouraged and to encourage others.

The students found graduate attributes such as reflection or critical thinking relevant to underpin practice lacking in many nurses. Emphasis during the students' pre-registration training had been about critical thinking to base decisions on. They were taught to seek and appraise relevant sources of knowledge for their practice. What some of the students found was an irritation by nurses with this spirit of enquiry. Some of the nurses complained that students always asked "*too many questions*" and believed that students should just "*get on with it*".

There was a sense of some nurses feeling "*threatened*" by students who were not compliant. Students realised that some nurses did not want to look after them, viewing them only as a pair of hands. They commented on how demoralising the resentment to teach made them feel or how uncomfortable "*the scary ones who look down on you*" could be. There would seem little

doubt that improving nursing knowledge is key in the provision of effective patient care and yet nurses described by the students were only interested in getting the work done. A number of practitioners were reluctant to share their knowledge or to recommend the use of evidence. Students wondered if it may be because nurses do not have the knowledge and did not want the students to see this. The students believed that it was key to leadership "*They probably don't know much*" and do not want anyone to find out.

The students were even more worried about the nurses who were not very good but thought that they were. In the focus groups, many of the students perceived leaders as those who were able to constantly learn, identify what their service users' needs were and what additional knowledge was required for them, embracing the concept of learning together. It may be that nursing cannot be one profession anymore. One group maybe those who wish to study, take responsibility for their own practice and review instead of blaming others. The one chance that nurses have got to become the profession which has been debated over many years is the opportunity for all graduate exit programmes (Willis 2012). The two tier system may be required.

Students spoke of their frustration when told that they should complete the workload without any evidence to support the task. They talked of knowledge and the conflicts between types of knowledge used and shared or not. Melnyk (2004) in her study found that new graduates were still working in "this is the way we do it here" cultures reflected by one student who spoke of her mentor insisting "*things got done her way*" *or* "*she would not sign off my AOP*". AOP is the Assessment of Practice document in which students' skills, competencies and behaviour are assessed and the placement requires passing to progress in their programme, needing the mentor's signature to prove this. "*Always done it that way*" was a term frequently used to justify practice which was of concern to the students and did not offer consistency or quality. Newhouse (2007:21), raised concerns over students having evidence based practice in their curriculum but without the infrastructure in the clinical arena, the continuance of this in practice is not fostered. His conclusion was nurse leadership is essential to promote evidence based practice within organisations.

A key component of nursing leadership identified by the students was a strong desire to develop and share knowledge with students, continue to learn and

seek evidence to base their practice on. They had the ability to articulate the knowledge and evidence to service users and other professionals demonstrated nurse's knowledge and professionalism. Staffileno et al (2010;85) refer to this as being "professionally literate". The nurses who demonstrated professional literacy enjoyed learning from students as they recognised that the students were continually immersed in the most recent knowledge. For them, the importance of having students was that it "*keeps them up to date*" and would use this knowledge as a resource to help them in their quest to remain current. There was no conflict or power struggle to know more but an enthusiasm to learn together. Students in this study described role models who developed them using relevant knowledge and adapting it to suit individual needs. A student stated that the nurses not only wanted to learn from her but also the nurses taught her how to *"translate that into practice".*

A number of the students spoke of the power of being able to evidence their practice, remembering only a few sources of encouragement in practice to use any type of evidence. Being able to *"measure before and after"* made such a difference to one of the students. Using evidence to base practice on was seen by the students as a leadership quality. Some of them experienced this at best infrequently, one referring to only witnessing this in the final placement, a picture that unfolded throughout the focus groups. It became apparent in the study that there were few who did use evidence based practice. In several circumstances, only one nurse was mentioned.

One student talked of feeling disillusioned with negative experiences of nursing until his final placement where he met nurses *"who could evidence everything they do".* This was one placement, and therefore it shows that a culture can be established as it was described in terms of a whole placement experience. Students found that the culture did not always support the use of evidence. It was individual nurses who ensured that they explored and learned continually encouraging the students to do likewise. In this study, some nurses are using research, seeking knowledge in comparatively busy environments where others are not. Despite the same pressures, the study revealed it was individual nurses who were leading the profession on this using their own autonomy. Once again, strong personal and professional identity is central to good practice and unquestioning use of evidence to base practice on and being *"enthusiastic about this stuff".*

Evidence based practice has been recognised as the "gold standard for the provision of safe and compassionate health care" (Brown et al 2009:372) and is fundamental to continuously improving care. Nursing care outcomes are better when informed by strong evidence (Melnyk et al 2011; Malloch et al 2010; Pearson 2003). It does have resource implications but that is why evidence based practice is even more important in today's economic restrictions as methods of care require justification and is needed when reviewing staffing levels and resourcing. Brown et al (2009) reported on their study which described nurses' practices, knowledge and attitudes related to evidence based nursing, and the perceived barriers and facilitators to its use. The study was a cross sectional research study conducted in 2006 - 2007 with a convenience sample of 458 nurses. Organisational barriers such as lack of time and lack of nursing autonomy were the main perceived barriers to the use of evidence based practice. Time is one of the most commonly noted barriers to nurses employing evidence based practice. Brown et al (2009) found that culture and learning opportunities were cited as the main facilitators to using evidence to base nurses' practice on.

Findings from a study undertaken in USA at Ohio University were that it was the nurse leaders who were resistant to evidence based practice. Melynk (2004) suggested that if leaders do not role model evidence based decision making they will not provide tools or resources for clinicians it will not happen or be sustained. She found that faculties tended to emphasise research methods and critique of research rather than putting research findings into practice. The data for this study reflected this. Whilst the University taught research skills, critical reading of literature and hierarchies of evidence, none of the students were able to recall being taught how to implement research into practice. One of the students spoke of "*I wanted to know why no-one else had ever told me to evidence all my own stuff*". This statement illustrates the deficiency in the curriculum as the student believed that no-one had told him to evidence all his practice. Whilst it may be in the programme, there were failings in making this explicit enough to be remembered. There does not seem to have been any opportunity to visit this in smaller reflective groups which can offer safe environments to explore such subjects.

Olade (2004) found a number of persistent barriers to evidence based nursing practice. Inadequate knowledge of research amongst nurses was recognised

and a lack of empowerment of nurses within the healthcare culture. In fact there is compelling evidence against the existence of evidence based practice in all health care sectors and there is widespread variability in nursing practices (Pearson 2003). A study in the early 1990s by Funk et al (1991) revealed the barriers that have been continued to be reported on since. These include a lack of time, access to research information, lack of research knowledge and skills amongst nurses and lack of nurses' authority.

Consistency in reporting on the barrier of time is worthy of review. Referring back to the student who spoke of the placement where all the nurses embraced the use of evidence. This was a hospital ward, comparable to other busy environments. The studies that discuss evidence based practice speak of the barriers in whole cultures. In the data, one of the students spoke of leading on her own learning and development ""*managing my own learning*". As a nurse, there was no one else able to take that responsibility and to do this she had to have the ability to evidence everything she did and be reflective upon it. For students to learn to lead and develop judgement, students stating that they felt supported if they could evidence everything and could measure before and after. The nurses who they aspired to be like could evidence everything that they did. It was agreed that leaders role model the way that they wanted to learn and reflect on their own practice, seek others' opinions and perspectives and include patients in this. Each nurse should have the responsibility of managing their own learning and practice. They should be using evidence as they are autonomous practitioners and it seems too easy to blame the culture as in the studies by Brown (2009) and Olade (2004).

As nursing is both an academic and practice discipline, it requires not only knowing something but also knowing how and why in regard to meaning, values and intentions (Carper 1992). Nurses care for patients with not only the physical aspects but including the social, psychological and humanistic aspects rather than technological science favoured by medicine which is more visible and accords greater status. Ethics and moral knowledge in nursing requires the formal principles around the subjects and the decision making aspect. The art of nursing is around the knowing what to do in an instant and is described by Benner (1984) as the intuitive expert practitioner.

Nevertheless, if the infrastructure to foster evidence based practice in the healthcare environments that the newly qualified nurses enter, their continued growth will not be supported and continuation of outdated practices continue (Newhouse 2007). This underestimates completely the impact that practice experience may have on the students' behaviour or what interventions are required to sustain these values throughout the programme (Spouse 2000). There is an element of leadership and management theory within the pre-registration curriculum but there does not seem any formal recognition of its potential or evaluation of its purpose and suitability. Government drives are to ensure the values for compassionate care are part of the curriculum. There seems little thought as to the skills of communication and prevention needed to tackle, challenge and lead practice which was recognised by the students.

Ledlow et al (2011) recognised that studying leadership is the most important of all subjects in a graduate education, especially for health professionals. Studying leadership had a lack of relevance for these students attributed to an irrelevant curriculum which did not reflect the true picture in practice. Students recognised the power struggles and conflicts which impacted negatively on the ability for nurses to lead and did not see the relevance of theories that did not deal with these. Just using models was learning leadership in an "*idealistic kind of way"* not always helping to deal with the conflict and other realities of contemporary healthcare. Any leadership potential for them was increased by working with excellent role models in practice but there seemed to be too few to offer serious impacts considering the numbers of student nurses in training at any time. Newhouse (2007) raised concerns over students having evidence based practice in their curriculum but without the infrastructure in the clinical arena, the continuance of this in practice is not fostered.

This section reviewed the perceptions of the students regarding leadership and the use of knowledge in practice. The nature of nursing theory remains a contentious area of debate within an extensive, expanding choice of literature. Theory within nursing has been influenced by the particular philosophical underpinnings of the time and because of that, they tend to be within the paradigms of other disciplines and therefore reflect a range of perspectives and premises. There are writers who argue that nursing is a science and a profession which has its own body of knowledge that guides decisions and practice (Newhouse 2007:22).

Discussion

The leadership and management module in the 3rd year which these students had studied emphasised a critical understanding of professional and organisational cultures and their potential impact on professional practice, service delivery and improvement in contemporary health. Whilst it included leading and managing people, theories of managing conflict and change, the students wished for more input around how to introduce evidence into practice and learning in a culture resistant to change.

5.5 Personal responsibility and future educational input

This section will review the students' perceptions of their own responsibility for leadership development. Nurses are accountable for their own practice and behaviour (NMC 2010). Taking personal responsibility for their continued development should be encouraged during the pre-registration programme. The data highlighted a need for a strong professional identity to maintain their resolve whilst trying to adopt and adapt to new roles and to change other practitioners' attitudes and behaviour. The concept of phronesis will be introduced.

Evidence shows that many nurses resort to behaviours that they themselves were resistant too in their training as discussed previously. Some of the students took and found learning opportunities themselves. Some were rather in awe of mentors and whilst they recognised poor practice and behaviour, they did not take the responsibility to challenge them. Understanding self and being self-aware allows an insight spoken of by one of the students into being *"aware of yourself and where you are in the world".* Prior to challenging others, recognition of personal values and position and professional identity is important.

Sellman (2009) developed the term professional phronesis for nurses who respond appropriately in a manner that demonstrates respect for those in receipt of care. It enables a person to do the right thing, at the right time, for the right reason and guides the right action. Sellman (2009:85) based this model on Aristotle's ethics which involves the pursuit of a "flourishing life" at whatever point they are at. Learning to be a professional phronimos is not about being taught, it is about providing the students with opportunities to gain knowledge and understanding about the ethical dimensions of practice

(Sellman 2009). It was apparent in the data that some aspects of daily practice had become unnoticed to nurses, not appearing to care about pursuing a flourishing life for the service users.

Throughout the study, students recognised leaders as those nurses who appeared to be acting with professional phronesis. Nurses who demonstrated respect for service users and cared deeply about providing safe and effective care were recognised by the students as leaders and they "*ensure that every single patient is heard and not alone*". Education to develop and perpetuate this during the programme would seemingly respond to the various issues the students raised. A professional phronimos would not oppress others and would ensure that they and others around them did the right thing for the right patient.

A number of the students introduced the importance of reflection and reflective practice for nurse leaders. They felt that it was a crucial skill for developing leadership skills and for being a leader. The importance to some remains clear in this students' explanation. "*If you are not a good leader you stick to the rules regardless of patient, illness and person*". Students were concerned about nurses who did not seem to reflect on their practice and just continued with what they had always done not learning from their own mistakes or adapting and adopting practice in response to experience. Reflection was thought be "*superficial*" or an opportunity for "*bitching about other nurses or carers or even patients*" but certainly not to develop practice. Reflection is a powerful tool within a nurse leader's skills set. Students are taught reflection using formal theories and then practised within small learning group situations to review clinical situations that they may have come across. A number of nurses had seemingly thought that reflection was just an academic endeavour whilst studying only.

Nursing care requires skills to undertake clinical interventions whilst ensuring careful consideration to individual patients' situations and needs (Pearson 2003). To be such strong advocates for service users needs assertiveness, courage and intelligence to articulate clearly and professionally to hierarchical demands (Clancy 2003). Students recognised nurses who had those skills and who were intelligent and articulate. They also recognised the weak and disinterested nurses with little courage or tenacity.

Discussion

Skills of communication, assertiveness and the difficult conversations when the workload needs to be done were requested by the students as part of their leadership development. It is increasingly recognised that the assertive communication skills of all health care practitioners can be a major factor in patient safety (NMC 2010). Critical companionship and clinical supervision are two interventions with track records of success and would enhance the reflective and constructive conversations requiring professional discussions. These will be discussed further in chapter 6.

Whilst discussion in the focus groups was predominantly about practice, there were concerns raised over academic tutors' behaviour and attitudes which impacted on the leadership development. Their enthusiasm was as important to position the students' beliefs and themselves. Along with the power of clinicians to inspire and to lead, nurse educationalists can also change and develop the students and it is frequently an underestimated part of the students' development.

The leadership and management module (appendix 9) itself was not felt to be enabling or helpful and just too idealistic. Leadership content was task orientated and geared to management skills and leadership theories. Curriculum relevant to leadership was thought to be needed at the beginning of the programme and included and developed throughout the programme. Literature on leadership had recommended the content that was in their curriculum. According the NMC (2010), the students once qualified will step out into practice as leaders in care. The question which has arisen from this study is the need for nurse leaders at all. Nurses should be professionally responsible for their own practice and behave in a professional manner, both of these requiring skills and behaviours comparable to those termed leadership skills.

5.6 Summary of section five

This study has generated new knowledge of the educational requirements for students to develop their leadership skills relevant for them in contemporary practice. The students did not feel that learning leadership theories and models was enough to develop their skills for the environment that they had witnessed. Due to government led inquiries following major incidents into

poor levels of care, the need for nurse leaders to improve standards in healthcare environments was strongly recommended.

Students in this study recognised nurses who they perceived were leaders but also many who maintained poor care giving cultures which perpetuated oppressive regimes. From their experiences, the students identified skills and knowledge appropriate to support them in leading care whilst dealing with powerful HCSWs. The skills included having difficult conversations, tackling bullying behaviour, delegating to support personnel as well as colleagues and having the confidence to be advocates for patients and junior staff. Renewing the passion for nursing and understanding role identity was recognised by the students as key to leadership. Knowledge to enable implementing research and evidence findings into practice within resistant cultures was imperative. The following section will provide details of a model for leadership development devised as a result of the findings of the study to be applied into pre-registration student nurse programmes. The model would also be suited to developing all nurses as professionals.

6. Recommendations and study conclusion

6.1 Introduction

This final section draws conclusions from the study and considers the implications for nurse leadership development within the pre-registration programme. The section begins with a reaffirmation of what this study set out to achieve followed by a summary of the main findings of the study. The contributions to existing knowledge of leadership development for student nurses are highlighted along with the educational requirements. A model is introduced for developing nurse leadership appropriate for pre-registration education designed from the students' perceptions. Implications for future research evolving from the findings of this study are included. One of the conclusions drawn from the study questions whether nursing needs leadership or nurses who are all professionally responsible for their practice. This would require skills and behaviours often termed as leadership, but are in fact those of a professional nurse.

6.2 Contributions to existing knowledge

The main purpose of the study was to explore the potential of the pre-registration programme for developing student nurses as future clinical leaders within contemporary healthcare. The empirical focus of this study addressed three aspects of leadership development. The study design was developed as a first step in reviewing the value and to answer the following research questions

- What are the perceptions of pre-registration student nurses regarding nurse leadership in contemporary healthcare practice?
- What are the perceptions of pre-registration student nurses regarding the value of their leadership development during their programme?
- What are the perceptions of pre-registration student nurses regarding the inhibiting and enhancing factors for leadership development during their programme?

Recommendations and conclusion

Each of the questions was explored and addressed and highlighted in the following brief summary of the main study findings under each of the three categories that emerged from the data.

- **Professional identity - Conflicting images of nursing**

The student nurses perceived a lack of nurse leadership in contemporary practice and they raised concerns regarding the lack of nurses showing any leadership skills. Students believed that nursing and leadership were inextricably linked. They perceived nurses who did not identify with nursing, and their behaviour and values were conflicting with what was expected from professional nurses. Some did not seem to even want to be a nurse. Students' leadership development was enhanced by working with excellent role models in practice, not just as leaders but nursing role models.

- **Creating a culture in which care giving is possible**

The student nurses perceived the inappropriate behaviour and conflict witnessed in some areas highlighted a lack of leadership. Power struggles and conflicts between each other and other healthcare workers were observed. Examples of inappropriate behaviour were given and a sense of fear in some healthcare environments. The students witnessed how this inhibited nurses leading on care, whether in senior positions or not and indeed inhibited any leadership development. A number of environments where nurses were present were seemingly controlled by HCSWs to the detriment of patient care illustrating a lack of leadership.

- **Knowledge for nursing - Conflicting sources of knowledge**

The student nurses perceived the weakened value of their leadership development during their programme. Nurses did not all believe that evidence was required to underpin practice and they frequently perpetuated outdated and inappropriate practices. They maintained "the always done it that way" culture. Students recognised their own accountability to lead on practice and wanted to resist adopting behaviours unbecoming of a nurse. Students recognised that theories of leadership may be important to know about. Nevertheless, they recommended a very different educational input to enable

them to lead on their own learning. Along with the power of clinicians to inspire and to lead, nurse educationalists can also change and develop the students and it is frequently an underestimated part of the students' development.

6.3 Contributions to existing knowledge for pre-registration nurse education

In the introduction and during the literature review, the complexity of defining leadership was described. One definition perceived as suitable for nurse leadership was put forward by Rafferty (1993). It defined leaders as inspirational, trusted by others for their integrity and caring for the people they are leading/serving. Rafferty (1993) believed that leaders try to strengthen and promote people and facilitate, help, encourage and praise. The reason that this definition had been chosen for this work is because of its emphasis on leading or serving, and the concept of encouragement and praise. The students' perspectives on leadership which emerged during the study had relevance to this definition. Students spoke of leaders having humanity and integrity, being courageous and confident and whilst working in complexity and chaos. They spoke of the importance of individual leadership and taking personal responsibility. Indeed Turnbull James (2011) described leadership as reaching every individual. Good practice can be destroyed by one person who fails to see themselves as able to exercise leadership because someone else is supposed to be in charge.

The study took place in the year that the new standards for pre-registration nurse education were introduced by the NMC (2010). Within these standards are leadership and management competencies and skills which are assessed in practice. It is hoped that these will positively increase leadership development in future students. From the student perceptions of contemporary healthcare however, these skills and competencies will not be enough for effective leadership development. The students raised more pertinent perspectives to developing leadership than recognised in the NMC standards. Concerns were raised by the students regarding nursing itself. Using versus coding (Saldana 2013), the data from the students' discussions produced three categories of conflict which impacts on leadership development and can be seen to impact on nursing itself. These can be seen in Appendix 8. The conflicts were between the students' perceptions of nurse leadership in contemporary practice versus what is expected of nursing leadership and professional nursing itself.

6.4 Implications for education

The findings throw light on the gaps in leadership development for student nurses. The students did see that there was some value in learning the theories and processes of leadership such as team building, managing change and delegation. These were admirably reflected in the leadership and management module that the students in this study experienced (Appendix 9). Nonetheless, they identified other skills that they perceived as necessary to develop contemporary nurse leadership. Interestingly, these were not all unique to leadership, but what should be expected of every nurse working in the complexity of practice. The following section offers the recommendations based on the students' directions from what they perceived were important to leadership development.

The NMC (2010) qualified that all nurses lead on each individual patient's care as well as leading by example. The students' perceptions of leadership illustrated the same view. They recognised individual nurse's professional behaviour and values, their use of an evidence base to their practice, their search for and ability to share knowledge and their competence as role models.

6.4.1 Professional identity – conflicting images of nursing

In each practice placement, the students' progression and development was largely reliant on what they witnessed from the nurses acting as role models. Each student had a mentor who was expected to lead on their learning and assess their progress, signing off competencies as appropriate. The data highlighted the challenges and constraints to this. The majority of students gave examples of working with nurses and mentors who did not want to support students and did not wish to teach them. Examples were given of nurses refusing to sign the students' assessment portfolio unless they unquestioningly practiced as the mentor directed. The students recommended teaching of assertiveness skills, holding difficult conversations with staff of all grades and levels and the ability to challenge others in practice, without provoking defensiveness and undermining seniority.

6.4.2 Creating a culture in which care giving is possible – organisational conflicts

Some nurses/mentors were openly hostile or unwelcoming to students. There are many areas of weak or absent nurse leadership and the students wished to be prepared early to challenge poor practice, introduce evidence into their own practice, enthuse qualified nurses and patients and contribute more to their own development. Learning in the turbulent environments that were revealed, the students need to be the leaders themselves. Whilst students will work with and be developed by some nurse leaders, they need to be enabled to tackle those who hinder the implementation of graduate skills into practice and to lead changes. Recommendations by the students were that leadership development should begin at the start of the pre-registration programme and continue throughout. They wished for skills that tackled bullying behaviour, delegating to support personnel as well as colleagues and having the confidence to be advocates for service users.

6.4.3 Knowledge for nursing – conflicting sources of knowledge e

The students noted the limitations put on their learning by nurses who did not understand the importance of using an evidence base for their practice and perpetuating outdated practices. Students realised the importance of research skills and understanding sources of evidence. What they felt was missing was how to introduce evidence into practice especially into resistant cultures.

6.5 Students perspectives on power

The concept of power and power struggles by individuals, groups or systems was threaded throughout the students' perceptions of both leadership and their own development. Frequent examples were provided linking disempowered nurses with uncaring treatment of patients, one student stating *"the power they wield".* The data illustrated further bleak situations where mentors had the power to perpetuate poor practice by weak role modelling. Power was depicted in the language they used and how language was used to control and disable. The opposite was also discussed illustrated by the example of the nurse leader who *"does not wield power because she or he does not need to, everyone just knows"*. The students fully appreciated those

accomplished nurses who used their power to positively mould future practitioners. Exemplary mentors seemed to know how to position themselves with the students, patients and to use power wisely.

Michel Foucault was born in France in 1926 and, due to his studies, became interested in the concept of power and knowledge (Hall 2001). He was especially interested in language which depicts power over people. Foucault, during an interview about power with Pierre Boncenne in 1978, said "even if we reach the point of designating exactly all those people all those decision makers, we will still not really know how the decision was made, how it came to be accepted by everyone and how it hurts a particular category of person" (Kritzman1988:103). During the study there were examples of nurses and of Health Care Support Workers whose inappropriate behaviour was accepted by staff even though it impacted so negatively on patient care and morale. Indeed the inappropriate use of power has been linked to poor care (Ferns et al 2007; Farrell 2001; Lewis 2001; Hutchinson et al 2006; Randle 2003). The students described the simple power of the nurses to ruin patients' experience and those working with them by a miserable attitude.

Foucault put forward a concept that disagreed with the usual view of the direction of power. His concept was that power circulates but it is not centralised (Foucault 1980). All involved are caught up in its circulation including the oppressors as well as the oppressed which reflected the students' experiences. Foucault's theories on power question who exercises power, on whom and how. In this study, power certainly was not centralised and in fact was shown to materialize from different sources but briefly before moving to another. There were students who talked of the power of a positive attitude. There were mentors who had a joint power relationship with the student sharing learning and teaching. Yet with others, there was a marked distancing away from each other and a resultant power production from their own separate sources. The power of the patient seemed to be a quiet voice except when nurses ensured that the patient was central.

Foucault believed that power relations are in all areas and levels of society including within families as well as in public spheres (Hall 2001). He realised there were actual positions of power, which he refers to as the Party Leadership who "know everything" and can circulate instructions preventing people

speaking of "this or that" (Faubion 1994;113). Indeed, some of the mentors used their power to ensure that the students just did as they were told without question by simply threatening to not sign off their practice assessments. Cleary et al (2011) wrote that some nurses were more concerned with maintaining their own power rather than for collaboration or team working.

Some of the students talked of what Foucault referred to as the oppressed caught up in the circulating power. Within this concept emerges constant passing on of power, back and forth between all the parties involved. Even if someone has the power it is for a brief period only before someone else takes it. Power may circulate but within the circles, power is passed around and is never held by one person. Yet the students did not always use their own power to circulate it back. Whilst on first view the power seemed to come down directly from the mentors, the students asked for skills to be able challenge effectively and perhaps circulate the power. Interestingly Foucault argued that there are no relations of power without resistances (Gordon 1980) and indeed this is what the students asked for.

6.6 A model for leadership development

In section three, the fourth iteration of versus coding was explained and the three categories that emerged in section four provided the framework for a model of leadership development in the pre-registration programme. The categories fit into the concept of moieties, in other words, transforming the categories into X VS Y format (Saldana 2013). One of the categories can be conceptual, not directly quoted in the data but able to capture the central theme of conflict. The three categories were:

- Professional nurses VS self-enmity (confused identity of nursing resulting in behaviour unbecoming)
- Nurses autonomy VS oppression (by each other, HCSWs doctors)
- Nursing knowledge VS the sciences (struggling to define its sources of knowledge)

Reviewing the data and literature going back over many years, changing the behaviour of some nurses and mentors would appear an insurmountable

problem due to the sheer numbers. Instead, from the findings of this study, it would seem timely to change the focus to the students as the instigators of change in areas where poor patient care and behaviours remain. Students are continually sent into the practice environments, some of which provide unacceptable experiences and this may perpetuate behaviour unbecoming. Students should enter practice with new skills, able to challenge, not resorting to adopting and replicating poor practices to survive, being able and assertive enough to be advocates for patients and consistently adopting professional behaviour. This offers an upside down model of leadership, the students lead to change practice from the bottom up.

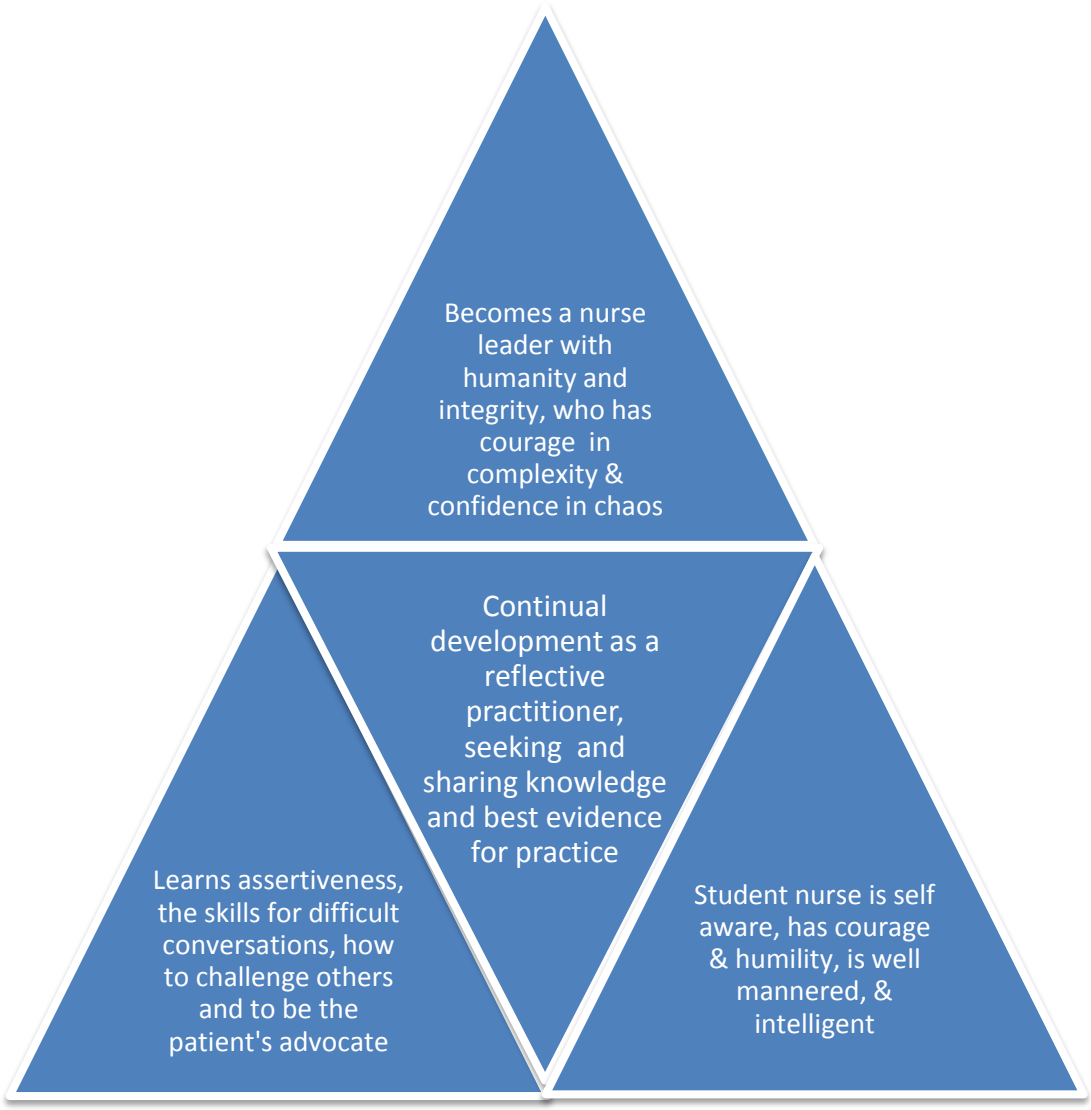

Figure 1 A model for leadership development within the pre-registration nurses' programme designed from the students' recommendations.

6.6.1 Personal attributes of the students

A model was developed from the data to develop leadership in student nurses. The model in Figure 1 shows two large sections which form the base to develop leadership from. One of the sections shows the traits that all student nurses should have to underpin their nursing practice. Good manners, self-awareness of how they come across to others, a sense of humility and intelligence and a measure of courage. These could be measured during selection and recruitment processes. These are not negotiable and an absolute requirement for the challenges ahead.

6.6.2 Skills to challenge appropriately

The left hand section, the other large stabilising section, shows what students asked for even before the first practice placement. There should be positive honesty about the potential of working in poor cultures, how to recognise and meet these situations, challenge staff appropriately and ensure they know how to access support. Concerns may be raised about providing such a negative picture for new students, those in the study believed it to be essential.

Findings from this study supported Farrell's (2001) research into poor workplace relationships in nursing. He illustrated bullying and harassment was not new in healthcare amongst nurses and was often directed at students. Where aggression is frequently displayed by health professionals, nursing students may observe that aggressive behaviour as part of the job and perpetuate the aggressive behaviour. They wanted not to be frightened, identifying courage as a key part of leadership and to alter cultures in which care giving is the most important by challenging effectively.

The students asked for assertiveness training and the ability to safely challenge in a measured way. There is a need to be explicit about bullying and inappropriate behaviour between and from nurses and HCSWs which they are likely to encounter. Exclusive preparation for tackling staff behaviour and being prepared in their first placement, developing the skills further over the programme was recognised.

The students wished to be self-aware and confident, be able to question appropriately, to have the courage to challenge, undertake critical dialogue and

be able to critically reflect on theirs and others' practice. To enable these skills in students, the following paragraphs will discuss the introduction of clinical supervision and of critical companionship. Similar methods may be helpful but these are two recommended from the study.

Clinical supervision has been described as an exchange between practising professionals to enable the development of professional skills (Butterworth et al 1992). It is a mixture of regular interaction of facilitated reflection and critical analysis of care to sustain high quality practice (Bond et al 1998; Bishop 1998; Faugier et al 1994). It is a dynamic process and a shared experience requiring high level critical conversation, challenging others, enabling deep reflection on aspects of practice whilst gaining constructive feedback (Howatson-Jones 2010). Practitioners can think about their self-concept as practitioners crucial for further development and learning.

Within the Department of Health document A Vision for The Future (1993:3), clinical supervision was defined as "a term to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations". Whilst clinical supervision is increasingly included in the NHS strategies, implementation is and remains sparse. The United Kingdom Central Council for Nursing Midwifery and Health Visiting preceded the Nursing and Midwifery Council as the regulatory body. In1996, they produced a position statement on clinical supervision which has subsequently been adopted by The Nursing and Midwifery Council (NMC 2000). Within their position paper were six key statements, one of which was that the principles and relevance of clinical supervision should be included in pre-registration programmes. In 2006, the NMC further identified the importance of clinical supervision to develop practice and practitioners. The students in this study did not experience clinical supervision.

Nevertheless, Howatson-Jones (2010:112) wrote that “clinical supervision is only as effective as the ability of the practitioner to be self-aware and to have insights into their own feelings and behaviour”. The students in this study recommended the importance of nurses being self-aware and to be reflective. A recommendation would be therefore to introduce clinical supervision within

the first year of the programme in a safe environment such as with a group of students and peers facilitated by a skilled academic. Students could then bring in situations from both theoretical and clinical environments and review them together by critical reflection. It is hoped that clinical supervision can help the students thrive in complexity and uncertainty and be able to acknowledge their own shortcomings.

It is recommended from this study that alongside clinical supervision, a model of critical companionship should be introduced into the pre-registration programme. Critical companionship is a person centred helping relationship with a facilitator accompanying another learner to foster a culture of critical enquiry (Titchen 2000). It is another means of encouraging self-assessment, analytical and reflective skills. Students themselves would be critical companions to each other. Facilitation is about bringing hidden knowledge to the surface, highlighting problems that were previously hidden and facilitating self-reflection and critical discussion and debate around both personal and professional issues. Through the use of observing, listening and questioning techniques, practitioners are facilitated to articulate their knowledge, learn from it and to share it with others (Gribben et al 2006). The main purpose from this study is its development of holding difficult conversations, clear articulation of concerns or issues and constructively challenging others.

Critical companionship responds to the findings in the data. These concepts include partnership working, giving and receiving feedback and knowledge, knowing the uniqueness of the companionship and caring about the individual as a person. Clinical supervision and critical companionship should go some way to preventing students resorting to the poor habits as in Randle's study explored in chapter 5. The findings of that study were that students began to assimilate the bullying tactics that they witnessed into their nursing practice during their programme. They adopted ways of working and conformed to those that had initially shocked them. They then began to identify with the role models that they experienced and seemed blind to their original anxieties. This study illustrated that not all students did this but wished for support and guidance to stop it happening to them.

6.6.3 Nursing knowledge VS the sciences (struggling to define its sources of knowledge)

The central part that holds the model together and develops over the programme is shown as an upside down triangle. It illustrates a continuum from commencing on the programme through to qualification, continuing to underpin ongoing nursing practice. The sense and joy of enquiry should be engendered from the beginning of the programme to sustain the student once qualified and in practice. The study reflects the findings of Brown et al (2009) who reported the lack of evidence to underpin practice in healthcare environments. Organisational barriers such as lack of time and lack of nursing autonomy were the main perceived barriers to evidence based practice. Brown et al (2009) found that culture and learning opportunities were cited as the main facilitators. Teaching research methods and appreciating evidence is usual and essential within the nursing curriculum. Nevertheless, the students recognised that to lead in practice required more skills than just understanding research methods and knowing where to get information from. Understanding how to implement evidence into practice and inspire a learning culture as recommended is key to success. The students wanted to learn the skills to be able to lead on this in their own practice even with the lack of time so often cited.

6.6.4 Nurse leadership or a model developing all nurses

The pinnacle of the triangle was developed from the students' discussion of practice. It is clear that healthcare is complex and sometimes chaotic. The students' narratives of excellent leadership pointed to a courage and a confidence to tackle poor behaviour and practice with the patient always at the centre. They also recognised an ease with learning from and with students. One student stated that nurse leaders required humanity. This is at the top of the triangle. The model however, could also be called a model for professional nurse development for all student nurses. The pinnacle of the model can be seen to reflect how all nurses should be.

6.7 Recommendations for further research

The study raised several avenues for further research. The most important areas relating to leadership development in the pre-registration programme include:

- Long and short term evaluative research to measure effectiveness of the model of education

The recommended model, once implemented, will require short and long term evaluative research to measure effectiveness. The research needs to be from the beginning of the programme. It requires a long term study that continues to evaluate the interventions into their first years as qualified nurses.

- The study raised the issue of power and control that HCSWs appear to have over nurse leaders and cultures.

Students recognised the control that HCSWs had some in environments and talked of the power they had over the nurses, students, patients and culture. Historical contexts therefore can add to this analysis, raising the question as to how long this phenomena has been in play and how many healthcare environments are affected. The community did not seemingly provide an environment where HCSWs could position themselves into power due to the leadership from the nursing staff. This would form part of the research. Research is required as to where, why and how this occurs to provide nurse leaders with the skills and understanding to stop this continuing.

- Research into why healthcare attracts inappropriate behaviour between peers and what interventions would discourage this within students groups and impact on their future behaviour

The study raises concerns over the impact of inappropriate behaviour on leadership development. Research needs to be done as to why there are such worrying levels within nursing. Hutchinson et al (2005) found that the inner workings of organisations contribute to or perpetuate a culture of bullying suggesting that both upward and downward bullying are likely to occur in environments where unhealthy conflict flourishes.

- A national study of how mentors are recruited to the role and how they are assessed for quality following their preparation

The study highlights a significant degree of uncertainty about where professional accountability lies for mentoring students and underlines the limitations of the nature of the current mentoring system. This study raised the importance of mentorship, the data recognising how inconsistent the quality is. A national study is urgently needed to assess appropriate selection and recruitment into the most appropriate nurses to undertake this key role.

6.8 Evaluation of the study

Evaluation of this qualitative research was necessary to differentiate the findings from subjective belief statements. Difficulties arose when trying to find a suitable evaluative framework. Traditional evaluation criteria tend to lean more to quantitative analysis methods (Denzin et al 2005). For this study it was decided to evaluate three aspects of the study only. There was no evidence that any studies of student nurses' perceptions of nurse leadership and their development for it had been undertaken. There was therefore no precedent for an appropriate study design set. An in depth qualitative case study was deemed appropriate and allowed an exploration of nurse leadership in contemporary healthcare and leadership development. It facilitated the exploration of perceptions in detail within the cultural and professional contexts of the students' experiences.

6.8.1 Data collection

A potential weakness would be only using one method of data collection. The use of multiple methods of data collection is a key feature of case study. Greater insights could have been achieved through using more than one method such as one to one interviews with the participants. They could have added further depth of understanding and would be recommended for use in any future research. The decision to only use one was due to the word limit for this thesis which was submitted as part of an education doctorate. This impacted on the use of choosing any additional data collection methods once it was realised how much rich data had been accessed by the focus groups alone.

A comparable study undertaken in similar Higher Education Institutions may have added value to the study. Nevertheless, reviewing the literature around cultures and behaviour during the discussion phase of the study suggested that the same issues are comparable for many nursing students in England. The Francis Enquiry (2013) and the Willis report (2012) referred to cultures where there is inappropriate behaviour by nurses in many healthcare environments over the United Kingdom. Assumptions were therefore made that students reading nursing in other Higher Education Institutions were likely to have similar experiences.

6.8.2 Sample

It can only be hypothesized as to why some students did not volunteer to attend the focus groups. It may be that they had almost completed their programme and could therefore see little reason to attend. They may not have thought of the importance of reviewing future preparation for nurses. The timing was thought to be the most appropriate for the majority of students as they would fear less of the impact of their opinions on their future careers or assessments. Others may have been limited by this due to completing outstanding assignments or practice hours, still trying to gain employment as a staff nurse or trying to find new accommodation. It may be that the students who volunteered realised the importance of leadership. Others may believe that at the time of the study, leadership was not important to them which in itself would identify a need in the training. Obtaining other perspectives may have provided key information about developing less interested or driven students.

6.8.3 Potential for bias

The research was carried out by a nursing academic who has many years of experience working as a professional in a variety of healthcare environments. The students' perceptions of cultures and behaviour and their impact on leadership development resounded within her previous professional clinical experience. Whilst the study was a new way of exploring leadership development, it was unexpected to find that so many of the traditional barriers to implementing improvements and leading on care had been maintained. There was therefore potential for a bias within the analysis. Instead, it ensured

that certain issues raised by the students were brought forward and recognised for their continued impact on healthcare provision and provided a sense of urgency to implementing development strategies. Employing another nurse educationalist to review the data and analysis went some way to assuring that bias was limited and indeed was not identified as present.

6.9 Conclusion

This study makes an important contribution to the development of leadership skills in student nurses' pre-registration programmes. It has generated new knowledge regarding what may inhibit, or enhance the development of leadership in student nurses. The lack of effective professional role models raised serious concerns, and it was clear to the students that each nurse should be a leader for their own practice and take full responsibility for it. The study therefore also makes an important contribution into the development of all nurses.

The study could not provide a satisfactory definition for leadership or nurse leadership. The students identified qualities in those who they perceived as leaders as those expected of all professional nurses. Nurse leaders were well mannered and effective communicators. They used evidence to base practice on, regardless of the workload, creating a learning environment in which care giving was possible. They used power wisely and had the ability to critically reflect on practice and to be excellent role models for the students.

Due to the inappropriate environments that their accounts related to, the students raised the issue of changing their education to include being adequately prepared as students to develop within poor cultures. The ability to recognise and actively engage with good role models is valuable, but having the courage to act when there are none was recognised as equally important.

A model for leadership development was put forward based on the students' perceptions and beliefs. The study identified the importance to develop leadership in student nurses from the point of entry into the pre-registration programme, before they become socialised into poor workplace cultures and negative behaviours. The model began its implementation into one pre-

registration student nurse programme in September 2013. Whilst the model begins with the first year students, the development and introduction of a new leadership and management module was introduced to the senior students in 2013. The module was developed on and around the findings of the study. The module was evaluated positively. Each stage of implementation will be evaluated and reviewed from recruitment through to qualification.

The model however could be viewed as a development model for all professional nurses. Perhaps it is timely to stop using the term nurse leaders and instead expect that all nurses will take professional responsibility and be accountable for their practice. Poor healthcare workplace cultures and

negative behaviours could then become a thing of the past.

Appendix 1

Participant Information Sheet

Study Title: Exploring the potential of the pre-registration programme for developing student nurses as future clinical leaders within contemporary healthcare at one University.

Researcher: Stephanie Meakin Ethics number: RGO ref: 7328

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

The purpose of this study is to explore the perceptions of senior adult student nurses about to qualify, of the role for nurse leaders in contemporary healthcare and the utilization of their pre-registration period as preparation for leadership. A gap in the knowledge base has been demonstrated, in regards to how the pre-registration student nurse training may impact on the development of future nurse leaders within the contemporary healthcare culture. It will assess the potential of their pre-registration training programme as a method of preparing them for future clinical leadership by considering what they believe was omitted, but what they now believe to be requisite for this preparation. This study will fundamentally address only their views but will also review the curriculum content of their programme.

Why have I been chosen?

You have been chosen as you are an undergraduate senior adult student nurse in your final year of study having experienced the theoretical preparation for nurse leadership and viewing and experiencing nurse leadership in practice.

Appendix 1

What will happen to me if I take part?

The data collection will commence in August 2010. You will be invited to take part in a focus group of about 6 other undergraduate senior student nurses in their final year. There will be myself as the primary researcher, and there may be one other fellow researcher who will be there only to observe the proceedings and to verify my understanding and observations. It will last about 1 hour with refreshments. The focus will be about exploring your experiences and views of your theoretical and clinical preparation for nurse leadership in contemporary healthcare in this University. The focus group discussion will be recorded and will be analysed as part of the research study. All data will be treated confidentially and you may withdraw at any point from the study. The study will be published but all respondents will be kept anonymous.

Are there any benefits in my taking part?

The study provides the possible opportunity to influence the preparation for nurse leadership for student nurses in the future. You are unlikely to benefit directly from taking part except for the experience of being part of such research.

Are there any risks involved?

If there are elements identified as lacking in your programme during the focus group, you may feel concerned regarding your preparation for clinical practice as a qualified nurse. You can meet with me to discuss any such issue after the focus group in complete confidence. You can withdraw during the focus group at any point without question. You can approach your programme lead for advice or guidance if it you felt that I may be biased in any way.

Will my participation be confidential?

I will at all times be compliant with the Data Protection Act/University policy and all the information will be stored on a password protected computer and remain confidential. All steps will be taken to protect confidentiality and anonymity except between the other students in the focus group. However, there will be appropriate

ground rules agreed prior to every focus group regarding the confidentiality of the discussion.

What happens if I change my mind?

You have the right to withdraw at any time without question. In the unlikely case of concern or complaint, you may contact Professor John Taylor at the School of Management. Any aspect of your participation to the study will be retracted or removed at your request without question.

You can approach me at any time for further information on my mobile telephone, office number or by e-mail to discuss any aspects of your research involvement

Stephanie Meakin

Mobile number:

Office number:

E-mail address:

Appendix 2

Examples of In Vivo coding

Data to be coded	In Vivo Coding
Maybe they see those (1) nurses who don't care that someone's (2) food is cold every time and actually just (3) needs someone to find out what they like or that their teeth fit and they can't chew and so on or…or (4) that they are cold or frightened (5) because everyone is busy and forget why they are there and (6) do not have the time to actually care so (7) someone lies frightened on their own or hungry or in pain and…and…and nurses think (8) sexy technology is..is much more important than "bed 3" who just needs a cuddle or an extra blanket… (9) the power they wield… and (10) maybe I should have left.	1 "nurses who don't care" 2 "food is cold every time" 3 "needs someone to find out what they like or that their teeth fit and they can't chew" 4 "that they are cold or frightened" 5 "because everyone is busy and forget why they are there 6 "do not have the time to actually care" 7 "someone lies frightened on their own or hungry or in pain" 8 "sexy technology more important than bed 3 who just needs .... an extra blanket" (9) "the power they wield" (10) "maybe I should have left"
You are a team aren't you. I mean I think you work (2) in some areas and (3) the whole feeling of the place is scary and the oppressive uumm culture pervades the place. (4) The top dogs change the culture and staff work differently. (5) Oppressed,	1 "You are a team aren't you" 2 "in some areas" 3 "the whole feeling of the place is scary the oppressive culture pervades the

controlled, bullied even. It is (6) in the hands of the nurses to challenge to encourage not control	place" 4 "The top dogs change the culture and staff work differently" 5 "Oppressed controlled bullied even" 6 "In the hands of the nurses to challenge to encourage not control"
The ones who I remember, (1) they did develop me because they are enthusiastic about this stuff (2) so I want to know more about it or I want to do this. (3) They have a motivational responsibility. But to develop my leadership skills (4) relates to one mentor in Placement 3. And she was absolutely brilliant. (5) She taught me about managing my own learning. I did not get this from the University. And (6) I did not get this from any other mentor. And (7) it was about how to evidence everything in my AOP, I write reflections after work. She made me write things down and linked it to my AOP. In terms of delegation, (8) she directed my development. She would give me articles to read and (9) would then challenge me as to how I could use the content into developing my practice. (10) I have never met anyone as good as that	1 "They did develop me because they are enthusiastic" 2 "so I want to know more about it" 3 "they have a motivational responsibility" 4 "relates to one mentor" 5"She taught me about managing my own learning" 6 "I did not get this from any other mentor 7 "it was about how to evidence everything" 8 "she directed my development" 9 "would then challenge me as to how I could use the content into developing my practice" 10 "I have never met anyone as good as

ever again. I nominated her as mentor of the year. She shaped everything. (11) I wanted to know why no-one else had ever told me to evidence all my own stuff, (12) it is about managing your own work and leading yourself. As a nurse, she was very good. (13) I had implicit trust in her. And she helped develop me and (14) she was very professional.	that ever again" 11 "I wanted to know why no-one had ever told me to evidence all my own stuff" 12 "It is about managing your own work and leading yourself" 13 "I had implicit trust in her" 14 "She was very professional"

Appendix 3

Examples of versus coding

Data to be coded	Versus Coding
The University push values and compassion. Then you go out into practice and there they are bad habits and poor practice	**Values and compassion VS bad habits and poor practice**
Maybe they see those nurses who don't care that someone's food is cold every time and actually just needs someone to find out what they like or that their teeth fit and they can't chew and so on or…or that they are cold or frightened	**Recognition of what nurses do VS lack of identifying nurses role**
because everyone is busy and forget why they are there and do not have the time to actually care so someone lies frightened on their own or hungry or in pain and…and…	**poor leadership VS effective time management and skill mix**
and nurses think sexy technology is..is much more important than "bed 3" who just needs a cuddle or an extra blanket…	**identifying nursing care VS identifying medical roles**
the power they wield…	**nurses power to care VS power wield**
Mrs Brown is warm and safe…that is leadership. It is not doctors who control nurses, it is nurses.	**Nurses as peers VS nurses against nurses**

There was one place I worked. The patient cried. Middle aged bloke. He had cancer and was frightened and hungry. He had been asleep a lot and sometimes missed filling out his menu. He was hungry, can you believe that! I asked for food for him and was brushed off by the nurse "should have filled in his card".	**Leading on individual patient care vs lack of compassions and care**
I went and bought him some sandwiches when I got my lunch. He said it was the nicest sandwich he had ever eaten. Leadership my 'arse, a good leader would never let someone go hungry! I looked after him all the time after that. He was so grateful. I will make sure that never happens again on my wards	**Accountability and leadership VS blaming others**
That is wicked. You see there does not seem anyone to manage that sort of thing. But as nurses, it should be automatic. You care for people the way you want to be cared for. To be frightened is dreadful. You would reflect on the care and you would know how to challenge it. The nurses must have been very frightened to not challenge	**Nurses as patient advocate VS too frightened to nurse**
You are a team aren't you. I mean I think you work in some areas and the whole feeling of the place is scary and the oppressive uumm culture pervades the	**Nursing kindness VS bullying**

place. The top dogs change the culture and staff work differently. Oppressed, controlled, bullied even. It is in the hands of the nurses to challenge that to encourage not control.	
But if you are working in that environment and the leader/manager is disillusioned then she will not take to inspiring practice. In fact she will block it. She has the power to completely ruin patient and nurse experience by her miserable attitude. I mean, let's face it, it is the nurses with the miserable face that is..... that is the problem. That look has the power to spoil the shift and disturb patients and relatives. Certainly not going to worry about student's experience are they. Community team was lovely. Hospital aggressive and frightening.	**Caring environment VS uncaring culture**
Well if nurses are low and unhappy, they tend to be less caring of the patients and less compassionate. Miserable staff make a miserable culture which makes the patients sad too	**Compassionate VS less compassionate**
But surely if you are disillusioned then you should not let others know about it? Surely you should change the practice not moan about it. If nurses are disillusioned then change practice not moan about it.	**Nurses moaning VS nurses caring**

Well I think going into people homes means they have no power, the patient does invite them in really and you cannot tell anyone what to do in their own home.	**Patient disempowerment VS patient empowerment**
Well I worked in one area where the HCSWs ran the ward. They virtually bullied the patients and the nurses and no-one stopped them. Care was dreadful. They were lazy. The patients were not cared for properly. They need a really good leader to go in there and shake everything up. I think it has been closed to students since. I nearly left. It was my first year.	**Managed by HCSW VS led by nurses**
Well, not sure if I have ever seen a nurse who is a leader. Mostly it is them being told what to do or the HCSWs run the ward. Maybe out in the community but not in hospital.	**Nurse leaders VS HCSW leaders**
There are groups that just glare at you, talk to each other but completely blank you and the patients and the nurses who try to manage them . The other nurses run around being nice to them not asking them to do much like a gang culture	**Gang culture VS caring culture**
Real problems seem to come from HCSWs especially when they have been working there for years. Sometimes find students a good thing to have power over. Make them	**Gang culture VS caring culture**

feel really small. Actually sometimes nurses find it quite difficult to manage them. HCSWs can sometimes have absolute power over the culture on a ward. They can make or break the atmosphere. Never had a problem with HCSWs on the community.	
But you can be a leader in the health service but it does depend on which area you work in. Some areas have strong bases that are difficult to break. You are either in or you are out and frequently it is the HCSWs who have the power.	**In VS out**
Too busy doing doctor's job's so give nursing tasks to HCSWs. Not a good role model.	**Physicians surrogate VS nurses role**
They are leaders because they have to delegate and she or he has to check that everything is done and the delegate has done everything, the job to the standard that she wants it to be. They may be small things but have to be done to a high standard. But they are leadership skills. Happy to delegate	**Good delegation VS poor delegation**
Doctors still tell nurses what to do because it is the natural order of things.	**Doctors VS nurses**
Doctors tell nurses what to do. I know it is not just that but ultimately a doctor at the	**Doctors VS**

moment is making a lot of decisions the nurses can't. I know it is going to change quite rightly ….. But again a doctor at the moment is making a lot of decisions	**nurses**
Doctors say jump, nurses say how high. Status quo.	**Doctors VS nurses**
Nurses only seem to like doing doctor's jobs. Think they are better by doing medical tasks that the doctors have got tired of doing. Do not wish to do nursing type jobs just doctor's jobs.	**Physician's surrogate VS nurses role**
I think nurses can be leaders but some are and some are not. I do think though that some could be very academically qualified but do not have the people skills for leadership. Some people just do not have the people skills. They may be managers but they are not leaders. Some leaders tend to be shut off from what is going on in the real environment.	**Nursing leadership VS no people skills**
You have to earn it. Just because you are wearing a staff nurses' uniform you uumm does not give you the right to push people about. It is how you do that and it is how your subordinates kinda how they react to you. You see the staff nurses who think oh I	**Nurses image VS society's image**

will just get the HCA to do it like the doctor I can get the nurses to do it, that is not leadership.	
The responsibilities are increasing and these are increasing. You cannot heap the responsibilities and not expect people to have some ownership of it. They need to have some authority.....and they don't.	**Nurses authority VS nurses disempowerment**
But leadership is part of every nurse's role	**Definition of nurses leadership VS no agreed definition**
But you need to respect your leaders. You are going to have to pay managers but you need to respect a leader. You respect someone who leads your team you will work harder making their job easier.	**Respect VS lack of respect**
The whole team is happy and willing to help, the leader manages and encourages does not control, does not weald power because she or he does not need to, everyone just knows.	**Good role model VS poor role model**
Inconsistency is the major thing. See someone who is a good model is that they are that way all the time. They never deviate, they are always the same and consistent.	**Consistency VS inconsistency**

This is how I want to be, this is how I do not want to be	**How I want to be VS how I do not want to be**
Not sure any of the mentors thought of partnership, more control. I have to say I do not feel ready to lead because I suppose I have not worked with any leaders. It was all a bit nurses being handmaidens. Saw usually old school mostly did not agree with degree nurses and started using the old arguments, you know, too posh to wash etc	**Graduate nurses VS old school**
But there are great mentors out there and really good staff but they are not all enthusiastic about taking students. One told me she did not want a student and did not have time to look after them on her ward. She told me either things got done her way or she would not sign off my AOP.	**All nurses as mentors VS bad mentors**
They have to sign off your AOPs so do you want to fall out with them?	**Good mentors VS bad mentors**
I had so many problems on placement, I would say right let us do that then and they would say oh I don't know if you can do that as a first year and I would say I can	**Good mentors VS bad mentors**
They did not see why I needed to do anything and treated me like a Health Care Support Worker but then a mentor could make or break your experience.	**Good mentors VS bad mentors**

Threatened by competence VS working together

But you are threat. If you are a competent student and some mentors would worry that you are better than them. Better keep you down as you are so good and they feel threatened.

Nurses VS students

Bullying nurses VS mentorship

I have a real problem and it was the assertiveness problem. They blocked me out I sorted my own experiences to gain experiences. They ignored me most of the time and would say oh just read those notes. They gave a look to each other when they were deciding who would take me with them. They used to roll their eyes and snigger when I spoke. They ignored me but when I kept going and getting other experiences and demanding to be part of things, they then let me in a bit. It was like the mentors, the team as a whole they would stop me going in to group works or case conferences. They said that they could not let me in anything as I was only a student. I therefore continued phoning round to find someone somewhere else. It was horrible and the whole team were in on it. No-one ever welcomed me, said hello or said goodbye. I used to cry every day. I am a grown woman for god's sake !

So when I got to my final placement, I was very doubtful about the future, and I met people who I could aspire to be like, who could evidence everything they do. They have an answer for everything or there is a reason for why things are done in a particular way. That was the key for me from a very negative experience I was seeing such positive things.	**Good learning experience VS bad learning experience** **Last positive placement experience VS all other five negative placement experiences**
The ones who I remember, they did develop me because they are enthusiastic about this stuff so I want to know more about it or I want to do this. They have a motivational responsibility. But to develop my leadership skills relates to one mentor in Placement 3. And she was absolutely brilliant. She taught me about managing my own learning. I did not get this from the University. And I did not get this from any other mentor. And it was about how to evidence everything in my AOP, I write reflections after work. She made me write things down and linked it to my AOP. In terms of delegation, she directed my development. She would give me articles to read and would then challenge me as to how I could use the content into developing my practice. I have never met anyone as good as that ever again. I nominated her as	**Using evidence for practice VS using no evidence** **Relates to one mentor VS many mentor role models** **Learn to evidence everything VS not being told by any other mentor** **Good mentor VS weak mentorship** **Good teaching and role modelling VS not**

mentor of the year. She shaped everything. I wanted to know why no-one else had ever told me to evidence all my own stuff, it is about managing your own work and leading yourself. As a nurse, she was very good. I had implicit trust in her. And she helped develop me and she was very professional.	**teaching as part of the role**
I felt supported and I could evidence everything and I could measure before and after. And that made a massive difference to me. Measure the severity of the case and then measuring at a later point	**Evidence VS none**
I wanted to know why no-one else had ever told me to evidence all my own stuff it is about managing your own work and leading yourself	**Using evidence for practice VS not encouraging evidence based practice**
I met nurses who I could aspire to be like who could evidence everything that they do	**Evidence everything VS no evidence**
Most of the mentors say I do not know that so let us look it up together. That way they learn too. Some of them say it is so good having students because it keeps them up to date or they will ask me what's the latest on this or that.	**Learning together VS always being right**

It is the ones who think they are always right and who probably never changed their practice, still moaning about not needing a degree.	**Graduate education VS none graduate education**
Some just get away with it. They probably don't know much and do not want you to find out, some nurses hide that. They probably don't know much and hide it by being bossy and dismissive.	**Constantly learning VS hiding lack of knowledge**
Practice say I always ask too many questions. Some nurses have said you do not need to know why you just do it. This makes me wonder if they do not know themselves. They feel threatened by us knowing what they know. Knowledge is power or as the saying goes. They may be worried that it will make them look bad.	**Asking too many questions VS just doing it without question** **Learning together VS not showing any lack of knowledge** **Sharing knowledge VS knowledge is power**
Some may be superb at technology but others may not. But if they know their limitations that is more important. And also they teach you to ask if you do not know and make you feel comfortable with that. It is the scary ones who look down on you if you ask for help	**Ability to recognise limitations VS not recognising**

Well we have seen so much go wrong because of people who have not had the ability and not asked for help or recognised that they needed advice. Or could not say they did not know.	**Lack of recognition of limits VS ability to ask for help and advice**
Reflection? Nurses kept telling me they have not got time for that academic twaddle	**Reflection VS academic twaddle**
You adapt it to whatever situation and it is all sorts of reflection and if I did it that way what would the outcome be and I think we are taught and encouraged to reflect and it is very good but it is good to think what was good about that what was bad about that. How did that make me feel. What would have happened if I had done that. I remember in the first year I thought God I hate reflective assignments what is the point but then as you go through you do it without working on it	**Reflection VS no reflection**
If you are aware of yourself and where you are in the world, because you know your weaknesses and you know your strengths. You then reflect automatically. How would that have happened if I had done so and so. I then think if I had done that with person A but it would have worked with patient B but not patient C.	**Reflection VS none**

Academic work helps you think differently you look it up and then think why is it like that and think what if and why it is critical refection.	**Critical reflection VS none**
I have got one role model and he was absolutely inspirational. I felt like you did until I worked with him. He made me realise that I had to take responsibility and to look at myself as part of the care package that patients get so that care package needs to be evidence based, humanely given etc etc. And he always said know who you are and what your biases are so that you can deal with them and know how you come over to patients and staff. He also taught me the power of smiling and I realised that so many nurses do not smile. The culture on his ward was busy but always lovely and cheerful. The smile can change a culture.	**Nurse leaders VS only one leader** **Self awareness VS lack of self awareness** **Smiling VS not smiling** **Cheerful culture VS frightening culture**
The final placement included me in the team. They bolstered my confidence and let me work autonomously	**inclusion VS exclusion** **Autonomy VS constraint**

I had a mentor who always credited me with things that I had done to other staff, never took the credit for herself. She also ensured I knew if I was doing well or not. So easy when you know where you stand.	**Giving credit to students VS not giving credit**
You cannot teach leadership. It cannot be taught. It is something that you develop over time. Uumm, I think you need a practical application.	**Leadership teaching VS practical teaching**
It did not develop skills, it just gave us more information. And gave us distinct ideas of leadership being distinct, idealistic kind of way, management being tasks, meeting deadlines and things like that, and for me, that is not it. You can have as much theory in the world but…	**Leadership theory VS practical leadership**
I think one thing that would really benefit a lot of people is a real effort on assertiveness. Teaching assertiveness to students because it can be so difficult. Some of us are mature and some of us have got a health service background. And we struggle ! I think it is just hard to speak up. Need some sort of self awareness so that you know what to work on.	**Teaching assertiveness VS struggling in practice** **Self awareness VS none self awareness**

Having difficult conversations, tackling the bullies would really benefit us	**Difficult conversations to tackle bullies VS no input during training**
I think what has helped me is being a mature students has helped. I think if I was younger I would not have had the gumption to be assertive.	**Mature student entrants VS younger student entrants**
The first year should be self awareness. You have to know what you are thinking with difficult situations you need to be aware of yourself and what I am feeling and be very aware of yourself so you can act appropriately. It is about you are not feeling comfortable with this situation. I do not know what you are trying to tell me, can we rephrase it	**Self awareness VS lack of self awareness** **Self management VS lack of independence**

You need diplomacy skills. If you are not comfortable with what the consultant is saying or whoever you need to diplomatically ask, question etc. It is the way you ask for example, the consultant. It is appropriately asking. It is diplomacy.

Diplomacy skills VS poor communication

Appendix 4

Simple list of the first iteration of versus codes

Values and compassion VS bad habits and poor practice

Recognition of what nurses do VS lack of identifying nurses' role

Poor leadership VS effective time management and skill mix

Identifying nursing care VS identifying medical roles

Nurses power to care VS nurses wield power

Attrition VS retention

Nurses as peers VS nurses against nurses

Leading on individual patient care VS lack of compassion and care

Accountability and leadership VS blaming others

Nurses as patient advocate VS too frightened to nurse

Nursing kindness VS bullying and harassment

Caring environment VS uncaring culture

Compassionate VS less compassionate

Nurses moaning VS nurses caring

Inspiring role models VS negative images

Patient disempowerment VS patient empowerment

Managed by HCSW VS led by nurses

Nurse leaders VS HCSW leaders

Gang culture VS caring culture

Subordination VS autonomy

Gang culture VS team work

Professional identity VS conduct unbecoming

Appendix 4

Nurses as advocates VS nurses in it for themselves

Physicians surrogate VS proud to be a nurse

Good delegation VS poor delegation

Doctors VS nurses

Dependency VS independency

Creating caring environment VS people don't matter

Physician's surrogate VS nurses role

Nursing leadership VS no people skills

Nurses image VS society's image

Nurses authority VS nurses disempowerment

Definition of nurses leadership VS no agreed definition

Respect VS lack of respect

Good role model VS poor role model

Consistency VS inconsistency

How I want to be VS how I do not want to be

Graduate nurses VS old school

All nurses as mentors VS bad mentors

Good mentors VS bad mentors

Enthusiastic mentors VS negative mentors

Passionate mentors VS reluctant mentors

Mentors VS students

Threatened by competence VS learning together

Nurses VS students

Bullying nurses VS mentorship

Good learning experience VS bad learning experience

Last positive placement experience VS all other five negative placement experiences

Using evidence for practice VS using no evidence

Relates to one mentor VS many mentor role models

Learn to evidence everything VS not being told by any other mentor

Good mentor VS bad mentorship

Good teaching VS not teaching as part of the role

Trusting VS lack of trust

Evidence VS none

Using evidence for practice VS not encouraging evidence based practice

Using evidence VS not believing in using evidence

Learning together VS always being right

Graduate education VS none graduate education

Constantly learning VS hiding lack of knowledge

Asking too many questions VS just doing it without question

Learning together VS not showing any lack of knowledge

Sharing knowledge withholding knowledge

Power through knowledge VS knowledge is power

Sharing and using nursing knowledge VS lack of using and sharing

Nurses as teachers VS refusing to teach

Ability to recognise limitations VS not recognising

Complacency VS recognition of limits

Lack of recognition of limits VS ability to ask for help and advice

Appendix 4

Reflection VS no reflection

Reflection VS academic twaddle

Policies and processes used intelligently VS stick to beat you with

Patient centred VS rule centred

Nurse leaders VS only one leader

Self awareness VS lack of self awareness

Smiling VS not smiling

Cheerful culture VS frightening culture

Reflection VS none

Inclusion VS exclusion

Autonomy VS constraint

Giving credit to students VS not giving credit

Theory VS not remembering it

Leadership teaching VS practical teaching

Final year leadership theory VS leadership skills consistently all the way through programme

Tailored curriculum VS same for all

Identify potential leadership VS same for all

Teaching assertiveness VS struggling in practice

Self awareness VS none self awareness

Leadership theory VS practical leadership

Difficult conversations to tackle bullies VS no input during training

Gang culture VS part of a learning group

Team VS singled out

You are in VS you are out

Mature student entrants VS younger student entrants

Teach to enthuse VS negative teaching

Positive lecture experience VS negative lecturer experience

Lecturers as mates VS lecturers as leaders

Lecturers as leaders VS weak lecturers

Self awareness VS lack of self awareness

Professional identity VS oppressed

Independency VS dependency

Diplomacy skills VS poor communication

Recognition of best practice VS poor practice

104 codes

Appendix 5

Refined list of the first iteration of 50 versus codes

Values and compassion VS bad habits and poor practice

Nursing identity VS lack of identity

Leadership VS ineffective leadership

Identifying with nursing care VS identifying medical tasks

Attrition VS retention

Accountability VS blaming others

Caring culture VS uncaring culture

Nurses disillusionment VS positive nursing

Inspiring role models VS negative images

Patient disempowerment VS patient empowerment

Oppression VS Autonomy

Gang culture VS team work

In VS out

Physicians surrogates VS Professional nurses authority

Good delegation VS poor delegation

Nurses image VS society's image

Respect VS lack of respect

Consistency VS inconsistency

Good mentors VS weak mentors

Nurses VS students

Good learning experience VS poor learning experience

Using evidence for practice VS lack of an evidence base to practice

Appendix 5

Inspiring role models VS weak role models

Trusting VS lack of trust

Learning together VS always being right

Graduate education VS none graduate education

Asking too many questions VS just doing it without question

Sharing and using nursing knowledge VS lack of using and sharing

Nurses as teachers VS refusing to teach

Recognising limitations VS complacency

Reflection VS academic twaddle

Policies and processes used intelligently VS stick to beat you with

Nurse leaders VS only one leader

Self awareness VS lack of self awareness

Smiling VS not smiling

Inclusion VS exclusion

Giving credit to students VS not giving credit

Leadership theory VS learning in practice

Final year leadership theory VS leadership skills consistently all the way through programme

Tailored curriculum VS same for all

Identify potential leadership VS same for all

Effective teaching for leadership VS struggling in practice

Self awareness VS lack of self awareness

Theory in practice VS practice without theory

Tendency for School playground VS part of a learning group

Teach to enthuse VS negative teaching

Lecturers as leaders VS weak lecturers

Self awareness VS lack of self awareness

Independency VS dependency

All nurses are leaders VS all nurses should not be leaders

Appendix 6

Second iteration of versus coding: Initial 15 categories of the 50 versus codes

Category 1: Defining nurse leadership

Related codes

Values and compassion VS bad habits and poor practice

Leadership VS ineffective leadership

Good delegation VS poor delegation

Consistency VS inconsistency

Trusting VS lack of trust

Policies and processes used intelligently VS stick to beat you with

Nurse leadership defined VS no clear definition

Category 2: Status of nursing

Related codes

Nursing identity VS lack of identity

Identifying with nursing care VS identifying medical tasks

Led by others VS Nurses authority

Physicians surrogates VS Professional nurses autonomy

Nurses image VS society's image

Patient disempowerment VS patient empowerment

Oppression VS autonomy

Values and compassion VS bad habits and poor practice

Appendix 6

Graduate education VS none graduate education

Category 3: Role models

Related codes

Inspiring role models VS poor role models

Giving credit to students VS not giving credit

Category 4: Culture of disillusionment and disappointment

Related codes

Attrition VS retention

Nurses disillusionment VS positive nursing

Smiling VS not smiling

Category 5: Mentors

Related codes

Good mentors VS weak mentors

Good learning experience VS poor learning experience

Category 6: Only one

Related codes

Nurse leaders VS only one leader remembered

Category 7: Personal responsibility

Related codes

Self awareness VS lack of self awareness

Independency VS dependency

Category 8: Organisational behaviour

Related codes

Accountability VS blaming others

Caring culture VS uncaring culture

Respect VS lack of respect

Nurses VS students

Inclusion VS exclusion

Category 9: Conundrum of the HCSWs

Related codes

Gang culture VS team work

Category 10: Evidence base for practice

Related codes

Using evidence for practice VS lack of an evidence base to practice

Category 11: Whose knowledge

Related codes

Learning together VS always being right

Asking too many questions VS just doing it without question

Sharing and using nursing knowledge VS lack of using and sharing

Nurses as teachers VS refusing to teach

Category 12: Recognition of limitations

Related codes

Recognising limitations VS complacency

Category 13: Reflection

Related codes

Reflection VS academic twaddle

Appendix 6

Category 14: Theory of leadership

Related codes

Theory in practice VS practice without theory

Final year leadership theory VS leadership skills consistently all the way through programme

Tailored curriculum VS same for all

Identify potential leadership VS same for all

Effective teaching for leadership VS struggling in practice

Leadership theory VS learning in practice

Teach to enthuse VS negative teaching

Lecturers as leaders VS weak lecturers

Category 15: Behaviour unbecoming

Related codes

In VS out

Tendency for School Playground Behaviour VS part of a learning group

Appendix 7

Second iteration of versus coding following Initial categorisation to 8 categories

Category 1: Identifying Nurse Leadership

Related codes

Leadership VS ineffective leadership

Good delegation VS poor delegation

Consistency VS inconsistency

Trusting VS lack of trust

Policies and processes used intelligently VS stick to beat you with

Nurse leadership defined VS no clear definition

Accountability VS blaming others

Graduate education VS none graduate education

Led by others VS Nurses authority

Physicians' surrogates VS Professional nurses' autonomy

Category 2: Identifying Nursing

Related codes

Values and compassion VS bad habits and poor practice

Nursing identity VS lack of identity

Identifying with nursing care VS identifying medical tasks

Nurses image VS society's image

Patient disempowerment VS patient empowerment

Oppression VS autonomy

Values and compassion VS bad habits and poor practice

Appendix 7

Category 3: Role models

Related codes

Inspiring role models VS poor role models

Giving credit to students VS not giving credit

Good mentors VS weak mentors

Good learning experience VS poor learning experience

Nurse leaders VS only one leader remembered

Category 4: Personal accountability

Related codes

Self awareness VS lack of self awareness

Independency VS dependency

Tendency for School Playground Behaviour VS part of a learning group

Category 5: Creating an effective culture

Related codes

Caring culture VS uncaring culture

Respect VS lack of respect

Nurses VS students

Inclusion VS exclusion

Nurses disillusionment VS positive nursing

Nurses image VS society's image

Patient disempowerment VS patient empowerment

Oppression VS autonomy

Values and compassion VS bad habits and poor practice

Smiling VS not smiling

Category 6 Organisational behaviour

Related codes

Nursing identity VS lack of identity

Identifying with nursing care VS identifying medical tasks

Led by others VS Nurses authority

Physicians surrogates VS Professional nurses autonomy

Nurses image VS society's image

Patient disempowerment VS patient empowerment

Oppression VS autonomy

In VS out

Gang culture VS team work

Attrition VS retention

Nurses VS students

Category 7: Always done it that way

Related codes

Using evidence for practice VS lack of an evidence base to practice

Recognising limitations VS complacency

Learning together VS always being right

Asking too many questions VS just doing it without question

Sharing and using nursing knowledge VS lack of using and sharing

Nurses as teachers VS refusing to teach

Reflection VS academic twaddle

Theory in practice VS practice without theory

Appendix 7

Category 8 : Theory of leadership

Related codes

Final year leadership theory VS leadership skills consistently all the way through programme

Tailored curriculum VS same for all

Identify potential leadership VS same for all

Effective teaching for leadership VS struggling in practice

Teach to enthuse VS negative teaching

Lecturers as leaders VS weak lecturers

Final year leadership theory VS leadership skills consistently all the way through programme

Leadership theory VS learning in practice

Appendix 8

Third iteration of versus coding following Initial categorisation to 8 categories

Category 1: Professional identity - Conflicting images of nursing

Subcategories:

Identifying Nurse Leadership

Identifying Nursing

Role models

Personal accountability

Category 2: Creating a culture in which care giving is possible - Organisational conflicts

Subcategories:

Creating a culture

Organisational behaviour

Category 3: Knowledge for nursing - Conflicting sources of knowledge

Subcategories:

Always done it that way

Curriculum conflicts/Theory of leadership

Appendix 9

Module Profile

Module Title: Leadership & Management

Module code NPCG3007

Faculty	Health Sciences
ECTS Credit Points	
Level	HE6
Any pre-requisite and/or co-requisite modules	Successful completion of year 1
Programmes in which the module is core	Diploma with Advanced Studies in Nursing BN (Hons) Nursing
Total study time	200 hours
Date approved by School Board	

Aims

To provide knowledge, understanding and preparation for transition to a qualified practitioner within a dynamic interprofessional health and social care environment.

Learning outcomes

On successful completion of this module you will be able to:

1. Demonstrate a comprehensive understanding of the wider health and social care context influencing leadership and management, and driving contemporary service development
2. Critically appraise the relevant underpinning theories of leadership and management that may influence or direct their role
3. Critically evaluate a range of qualities and skills required to effectively lead and manage people within a health and social care setting
4. Reflect on interprofessional working in the chosen service development initiative and apply this learning to future professional roles
5. Critically explore the contribution of effective team working and problem solving to the functioning of an interprofessional team
6. Demonstrate a critical understanding of professional and organisational cultures, and their potential impact on professional practice, service delivery and improvement in contemporary health and

Summary of syllabus content

The wider health and social care context for leadership and management:

- the NHS
- funding of the NHS and private, voluntary and independent sector
- primary and secondary care
- policy
- Institutions for quality
- Entrepreneurship and social enterprise

The role of leader and manager:

- Leadership
- Professionalism and accountability
- management
- power
- user involvement

Leading and managing people:

- working in and with teams
- managing conflict
- motivation
- overcoming resistance
- organisational structure and culture, and professional culture
- preceptorship
- mentorship
- coaching skills
- Recognising and managing poor performance

Leading and managing service delivery:

- Change
- Translating research evidence into practice – overcoming barriers to changing practice
- clinical governance
- risk management
- maintaining and improving on quality and costs
- developing and delivering patient/client-centred services
- planning and decision making
- handling and managing complaints
- Service Innovation

Summary of teaching and learning methods

The students will have an opportunity to experience

- Lectures
- Guided reading
- Technology enhanced learning

Appendix 9

Summary of assessment methods

A 4000 word summative essay –PASS/REFER 40% Pass mark

Task
In P5, identify a service development initiative, and with reference to this

- Explore 2/3 leadership qualities and management skills that will be needed in its delivery
- Explore the contribution of interprofessional working to its effective delivery

Summative assessment of practice AOP6 –PASS/REFER

Authentic World Test –

Students are required to access and successfully complete the AW Drug package prior to the completion of AOP6. They will have a dedicated time to complete each attempt at the test

Resources

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Websites

http://www.institute.nhs.uk/ Institute of Innovation and Improvement, supporting managers and clinicians in improving services

http://www.cqc.org.uk/ The care quality commission,

Appendix 10

Profile of participants

Focus group 1

Gender	Age range	Previous employment	Personal Code
Female	25 – 30	Healthcare	1G:1F
Male	40 – 50	IT	1G:2M
Female	30 – 40	Healthcare	1G:3F
Male	30 – 40	Armed Forces	1G:4M
Female	20 - 25	FE	1G:5F
Female	20 - 25	School	1G:6F
Female	30 – 40	Housewife and FE	1G:7F

Focus Group 2

Female	30 – 40	Business	2G:8F
Male	25 – 30	Armed Forces	2G:9M
Female	20 - 25	School	2G:10F
Female	20 -25	FE	2G:11F
Female	30 - 40	Healthcare	2G:12F
Female	30 – 40	Healthcare	2G:13F

Focus group 3

Female	30 -40	Housewife and FE	3G:14F
Female	25 – 30	Sales	3G:15F
Male	25 - 30	Healthcare	3G:16M
Female	30 – 40	Business	3G:17F

Focus group 4

Male	30 – 40	Healthcare	4G:18M
Female	20 – 25	FE	4G:19F
Female	20 – 25	FE	4G:20F
Female	25 - 30	Sales	4G:21F
Female	40 – 50	Healthcare	4G:22F

Focus group 5

Female	25 – 30	Housewife and FE	5G:23F
Female	30 – 40	Healthcare	5G:24F
Female	20 – 25	FE	5G:25F
Female	30 – 40	Business	5G:26F
Male	20 – 25	School	5G:27M

Focus group 6

Female	20 – 25	FE	6G:28F
Female	20 – 25	FE	6G:29F
Female	20 – 25	School	6G:30F
Female	30 – 40	Healthcare	6G:31F
Male	25 - 30	Airline	6G:32M
Female	25 - 30	Business	6G:33F
Female	40 - 50	Healthcare	6G:34F
Female	20 – 25	School	6G:35F

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