University of Southampton

Faculty of Health Sciences

Adult Student Nurses' Experiences of Urinary Incontinence in Their First Year of Study: A Longitudinal Phenomenological Exploration

Claire Margaret Hope Student I.D. 22460632

Doctorate in Clinical Practice

November 2015

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

Faculty of Health Sciences

Doctorate in Clinical Practice

Adult Student Nurses' Experiences of Urinary Incontinence in Their First Year of Study: A Longitudinal Phenomenological Exploration

By Claire Margaret Hope

Urinary incontinence (UI) is a major health care problem which has significant implications for quality of life within an ageing population. Urinary continence can however, be restored by simple rehabilitative strategies and therefore nurses need to be knowledgeable and proficient in providing quality care for patients with UI. However, there is evidence that there is very limited content related to continence promotion within the current pre-registration nursing curricula and there are no specific modules dedicated to this area of clinical practice. Student nurses are also still expected to learn through doing i.e. delivering hands on care for patients with UI and are supported in practice by a qualified mentor. There is evidence however, that suggests that qualified staff have negative attitudes towards UI but what is not known is if these negative attitudes influence student nurses' experiences of dealing with UI in clinical practice in their first year of study.

In order to generate a deeper understanding of the lived experiences of adult branch student nurses a longitudinal phenomenological study was adopted to explore their experiences in their first year of study. Thirteen students volunteered to participate and were recruited from 2 United Kingdom (UK) Universities. The students were interviewed on two occasions; once at the beginning of their first year and again at the end of their first year. Data was analysed using phenomenological and hermeneutical approaches

including iterative reading and interpretation to identify the themes that emerged from the data.

The findings revealed 3 major themes; Being There, Being Understood and the Influence of Others. Being There, showed that student nurses are perplexed and confused about why loss of bladder function, is not viewed as something that requires assessment and investigation and is predominantly the remit of Healthcare Assistants (HCAs). Being Understood, captured the students' problems in 'finding a voice' to express these concerns regarding this approach to UI care delivery in their desire not to 'rock the boat' and to 'fit in' with their nursing colleagues who were predominantly the HCAs in this study. The Influence of Others, encapsulates the role of the HCA in influencing the student nurses' experiences of UI in their first year of study. Student nurses should spend up to 40% of their time in clinical placement supported by a qualified member of staff however, there is considerable evidence in this study that this support is infrequent. Student nurses' experiences of UI therefore do not appear to be negatively influenced by qualified staff as they are infrequently their role models for this aspect of care in their first year of study. They are however, influenced by HCAs who have no formal training in this area of clinical practice or in supporting students in practice. The findings from this study have implications both for the education of student nurses and for HCAs.

LIST OF CONTENTS

CHAPTER 1: INTRODUCTION TO THE STUDY 15

Introduction 15

Background 16

CHAPTER 2: LITERATURE REVIEW 25

Locating the Literature 26

Continence Education in Undergraduate Student Nurse and HCPs Curricula 32

Attitude and Attitude Formation 38

Attitudes of Patients Towards UI and Their Help Seeking Behaviour 41

Attitudes of Healthcare Personnel Towards UI 54

Crossing Boundaries: Delivering Intimate Care 61

Student Socialisation 65

Student Support 69

Summary 76

CHAPTER 3: RESEARCH METHODOLOGY 81

Introduction 81

Research Question 81

Research Aims 82

Methodology and Philosophical Underpinnings 82

Husserlian Phenomenolgy 84

Heideggerian Phenomenology 85

Dasein (Being There) 85

Hermeneutics and the Hermeneutic Circle 87

Summary 90

CHAPTER 4: RESEARCH METHODS 93

Introduction 93

Study Setting 93

Sampling 93

Recruitment 95

Data Collection 97

Interviews 97

The Individual In-Depth Interview 98

Ethical Issues 100

Participant-Researcher Relationship 101

Consent 102

Confidentiality 103

Data Analysis 104

Trustworthiness of the Data 112

Summary 113

Part One Summary 114

Part Two

CHAPTER 5: PRESENTATION OF THE FINDINGS 117

Introduction 117

The Participants 117

Findings 119

Theme 1- Being There 125

Experiencing Care of Patients with UI 126

Idealism of Care versus Realism of

Care for Patients with UI 131

Finding a Voice 134

Theme 2 – Being Understood 137

Fitting In 138

Maintaining the Professional Self 142

Theme 3 – The Influence of Others 145

Feeling Supported in Practice 146

Privacy versus Exposure: Dignity versus Lack of

Respect 153

Summary of Findings 161

Overall Summary of the Key Themes 163

Being There 163

Key Findings from 1st Interviews 163

Key Findings from 2nd Interviews 164

Being Understood **165**

Key Findings from 1st Interviews 165

Key Findings from 2nd Interviews 167

The Influence of Others **168**

Key Findings from 1st Interviews 168

Key Findings from 2nd Interviews 170

CHAPTER 6: DISCUSSION **173**

Introduction 173

Phenomenology as Philosophy and Methodology 173

Revisiting the Aims of the Study 174

Discussion of Main Findings 175

Key Findings 177

Being There 177

Being Understood 177

The Influence of Others 177

Being There – relationship with previous research 177

Being There – relationship to Heideggerian Philosophy 180

Being Understood - relationship with previous research 181

Being Understood - relationship to Heideggerian Philosophy 185

The Influence of Others – relationship with previous research 188

The Influence of Others – relationship to Heideggerian Philosophy 192

Summary 195

CHAPTER 7: SUMMARY AND RECOMMENDATIONS

Contribution to Knowledge 197

Implications for Practice 198

Recommendations 199

Being There 202

Being Understood 203

The Influence of Others 204

Limitations 206

Summary 207

Conclusion: a reflexive account 209

References 211

APPENDICIES 233

Appendix 1: Participant Invitation Letter

Appendix 2: Student Information Sheet

Appendix 3: Individual Reply Slip

Appendix 4: Letter to Volunteers not required for the study

Appendix 5: Consent Form

Appendix 6: Confirmation Letter for Interviews

Appendix 7: Data Consent Form Following Withdrawal

Appendix 8: Ethics Approval Letters

Appendix 9: Sample of transcript and development of themes
2nd Interviews – interview 9 page 3 lines 45 – 81.

Appendix 10: Examples from the 2 HEI curricula regarding the delivery of continence education in yr 1 of pre-registration Adult Nurse Training

Appendix 11: Original Search Terms and results September 2006 : updated September 2015

Appendix 12: Search Terms Combined and results September 2006 : updated September 2015

LIST OF TABLES

Table 1 Original search terms

Table 2: Search terms in combination with original search terms

Table 3: A comparison of studies reviewing continence education in pre-registration curricula spanning 21 years from 1992-2013.

Table 4: Comparison between Jolleys (1988) and Brocklehurst (1993) UK studies exploring attitudes of patients towards UI and their help-seeking behaviour

Table 5 : Summary of the US studies relating to attitudes of patients towards UI and their help-seeking behaviour

Table 6 : Summary of qualitative studies relating to attitudes of patients towards UI and their help-seeking behaviour

Table 7: Summary of 4 key articles re. HCPs attitides towards UI

Table 8: Summary of findings from literature review: Evidence and its relevance to this research study.

Table 9: Participants' experiences of health care prior to commencing the pre-registration Adult Nurse training programme (N.B. all students' names are pseudonyms to maintain confidentiality)

Table 10 : Worked example : analysis from 1st interviews

Table 11: Worked example : analysis from 2nd interviews

Table 12: Summary of findings from literature review: Evidence and its relevance to this research study and the contribution to existing knowledge

LIST OF FIGURES

Figure 1: Structure of the Thesis

Figure 2: Key influences from within the literature that may impact directly on the student experience of dealing with UI

Figure 3: Student Lifeworld to Phenomenological Interpretation: Methodological cohesion

Figure 4: The original themes and sub themes at the first stage of the analysis: First Interviews

Figure 5: The original themes and sub themes at the first stage of the analysis: Second Interviews

Figure 6 : The categorisation of the combined themes and sub themes from the 1st and 2nd Interviews

Figure 7: Final interpretation of the combined themes and sub themes from the 1st and 2nd Interviews

Figure 8: Being There -an example of the themes from the 1st and 2nd interviews and the final combined theme and alignment to Heideggerian Philosophy

Figure 9: Being Understood -an example of the themes from the 1st and 2nd interviews and the final combined theme and alignment to Heideggerian Philosophy

Figure 10: The Influence of Others -an example of the themes from the 1st and 2nd interviews and the final combined theme and alignment to Heideggerian Philosophy

Figure 11: Ideals and realities for UI Practice

Figure 12: The combined themes and sub themes aligned with Heideggerian Philosophical Underpinnings

Figure 13: Recommendations from major themes for practice and further research

Glossary

ACA	**Association for Continence Advice**
AHCPR	**Agency for Health Care Policy and Research**
DH	**Department of Health**
HCA	**Healthcare Assistant**
HCP	**Healthcare Professional**
HEI	**Higher Education Institute**
NICE	**National Institute for Health and Care Excellence**
NMC	**Nursing and Midwifery Council**
QOL	**Quality of Life**
RCN	**Royal College of Nursing**
UI	**Urinary Incontinence**
UK	**United Kingdom**
US	**United States**

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that is all my own work. I also confirm that I fully acknowledge the contribution of others to this thesis.

Ethical approval has been sought and granted by the University of Southampton

Name: Claire Margaret Hope

Signature:

Date: 31/10/2016

Word Count: 51,931

Acknowledgements

The writing of this dissertation has been a transformational journey for me and one of the significant academic challenges I have had to date. There are a number of people that have supported me on this long journey who without I would not have been able to complete this thesis. To you all I owe my deepest gratitude.

- To the students who participated in this study for your honest and open recollections of your experiences which make this thesis come alive, I thank you.
- To my husband Mark, who has been there for me at every stage of this journey always encouraging me and without his love and support this thesis would have never been completed.
- To all my family who have all been behind me in completing this thesis.
- To my very dear friends, you know who you all are. Thanks for the endless chats, cups of coffee and words of advice and encouragement.
- To all my work colleagues past and present, I owe you for all your patience during my periods of highs and lows, I know I have driven you mad!
- Professor Mandy Fader and Dr Julie Wintrup for all their support, wisdom and knowledge.
- Dr John Unsworth and Dr Debbie Porteous and Dr Alison Machin for all their support in allowing me the time to complete this thesis.

I dedicate this thesis to me late mother Mrs Audrey Dyson who always encouraged me to do my best, I am sure she would be very proud of this achievement, Thanks Mum.

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

The purpose of this chapter is to outline the context of this thesis and to give insight into the methodological approach used to explore the phenomena of student nurses' experiences of dealing with urinary incontinence (UI) during their first year of study.

UI is a common and highly treatable condition that can affect anyone at anytime and impacts significantly on the quality of life of the 'sufferer' (Sinclair and Ramsey, 2011). It is the nurse's responsibility to assess, treat and manage this condition and therefore knowledgeable and competent nurses' are essential in order to pro-actively assess this condition and implement care to promote continence (Kelly and Byrne, 2006). This has been clearly identified in the *Good Practice in Continence Services* (DH, 2000) which highlighted the importance of standardised assessment for all patients presenting with UI. For that reason, nurse education in this aspect of healthcare is crucial however, McClurg *et al.* (2013a) found that undergraduate continence education is inadequate and there is further evidence to suggest that pro-active continence promotion is lacking within nursing practice and that healthcare professionals view continence care as a low priority area of healthcare (Goldstein *et al*, 1992; Reymart and Hunskaar, 1994; Mitteness and Barker, 1995; Francis, 2013; Orrell *et al*, 2013). As student nurses spend 50% of their time in clinical practice and 50% of their time in Higher Education Institutions (HEIs), it is essential that both of these areas acknowledge

the importance of education for this fundamental aspect of care from the commencement of their training. To date there have been no studies that have explored first year student nurses' experiences of UI. This research is therefore important in order to understand how the next generation of qualified nurses experience UI care and how this may influence their future practice.

Background

Urinary incontinence is a major health care problem within the United Kingdom (UK) and affects a significant number of people (Shaw, 2001; Hunskaar *et al*, 2005). The Bladder and Bowel Foundation (2015) offer a conservative estimate of the number of people that UI affects and suggest that fourteen million people in the UK have some form of bladder problem. For the majority of people who experience this condition however, it still remains widely under diagnosed and underreported (Wyman *et al*, 1997; Palmer, Athanasopoulos and Lee, 2012; Stenzelius *et al*, 2015). Prevalence of UI however, is difficult to assess due to differing definitions but a review of epidemiological studies on UI, highlighted that the prevalence rates for UI ranged from 25% to 45% in women which almost doubled that reported in men (Buckley and Lapitan, 2010). Norton (1996) states that nurses are often the first health care professionals that patients encounter and therefore, have a responsibility to assess and investigate their incontinence. However, many patients with UI do not come forward for treatment by a health care professional (Jolleys, 1988; O'Brien *et al,* 1991; Brocklehurst, 1993; Harrison and Memel, 1994; Wan, Wang and Xu (2014). The most common reason for not seeking help was because incontinence was not perceived as a

problem for the person and people thought that UI was ‘normal for their age’ and a ‘usual female complaint’ and that, ‘no help was available’ and ‘nothing could be done’ (Jolleys, 1988; Goldstein *et al,* 1992; Reymart and Hunskaar, 1994; Hagglund *et al*, 2003; Teunnissen and Largo-Janssen, 2004; Strickland, 2014). Studies have also frequently suggested that health care professionals sometimes reinforce these misunderstandings (Goldstein *et al*, 1992; Reymart and Hunskaar, 1994; Mitteness and Barker, 1995). More recently, Orrell, *et al.* (2013) found that this was still the case and revealed that negative attitudes towards people with UI were often reinforced by health care professionals due to lack of knowledge and understanding about UI. Nurses therefore, need to be knowledgeable about UI in light of a plethora of literature that demonstrates that continence can be restored by simple rehabilitative strategies (Largo-Janssen *et al,* 1992; McDowell *et al,* 1992; Hahn *et al,* 1993; Milne, 2000; St John, James and McKenzie, 2002; NICE, 2015).

Nurses need to act as advocates and educators for the public and health care professionals alike, to dispel the misperceptions that UI cannot be treated (Milne, 2000). Many healthcare policy documents (DH, 2000; DH, 2001a; DH, 2001b; NICE, 2015) also make reference to the fact that although nurses are often the first point of contact, where UI is regularly identified, it is also the responsibility of all other health care professionals to identify, assess, treat and manage patients with UI. Despite these recommendations, poor standards of continence care persist and reports such as the National Audits of Continence Care (Royal College of Physicians, 2006, 2010, 2012) found that services and treatment for UI was still fragmented and identified gaps in clinical care. Bayliss and Salter (2004)

suggest that this may be because there are many other demands on the time of health care professionals and continence promotion may be a low priority among other more pressing needs. UI therefore, still remains a health care issue that health care professionals fail to engage with (Shaw, 2001; Orrell *et al*, 2013) and is also perceived as an unimportant health need (Francis, 2013; Orrell *et al*, 2013).

Urinary incontinence has been studied widely across the world with the major emphasis being on successful management and treatment strategies. However, despite this evidence many health care professionals still manage UI rather than assess and treat this condition (Largo-Janssen *et al*, 1992; McDowell *et al,* 1992; Hahn *et al,* 1993; Milne, 2000; St John, James and McKenzie, 2002). Studies suggest that the reason that it is often overlooked is due to the health care professionals' passive acceptance of the problem (Cheater, 1991; Palmer, 1995; Vinsnes *et al,* 2001). Palmer (1995) found that health care professionals had a tendency to instigate reactive incontinence management strategies instead of adopting pro-active treatment options. This is also reinforced in a much later study by Wagg *et al.* (2010) who also suggested that UI is often managed rather than assessed and treated. Vinsnes *et al.* (2001) found in their study that the more negative the perception towards UI, the more likely continence promotion strategies would not be implemented. Cheater (1992) suggested that this may be due to the level of knowledge the health care professional has about UI. This was also found by Palmer (1995) and in particular, found that nurses' preparation level, knowledge and attitudes about incontinence, affected staff behaviour and

acted as facilitators or hindrances to the scope, establishment and maintenance of continence programmes.

Studies that have specifically addressed health care professionals' perceptions of caring for patients with UI have all utilised quantitative methods to measure their attitudes towards UI. These studies span 26 years and show similar findings, that there is very little proactive assessment of this condition and it is frequently managed by the use of disposable incontinence products (Yu and Kaltreider, 1987; Yu *et al*, 1989; Cheater, 1991; Palmer, 1995 and Vinsnes *et al,* 2001; Dingwall and McLafferty, 2006; Wagg *et al,* 2010; Orrell *et al,* 2013). These studies also revealed that generally attitudes towards UI were negative and that health care professionals viewed UI as a low priority area of healthcare. Understanding why this is the case however, reveals a gap in the literature. Knowledge and understanding of experiences of UI is patchy and vague and there are no studies to date that explore how health care professionals experience UI as it is lived by the person, including descriptions of the meanings that these experiences have for the individual (lived experience).

Deeper exploration of understanding how these attitudes are influenced therefore requires a methodology that pays attention to the health care professional and the patients' experiences of UI. This would add to understanding and would give more meaning to this aspect of healthcare. As student nurses learn their skills for clinical practice from both education, in HEIs, and by being exposed to health care professionals, this would add understanding to what happens between

education and clinical practice so that both health care professionals and students operate effectively between practice and education.

There is however, a study by Hagglund and Wadensten (2007) who adopted a phenomenological approach in exploring women's care seeking behaviour for long term UI and highlighted that from the patients' perspective, health care professionals fail to actively assess bladder function even in situations where this would be appropriate. This study highlights the frustration people with UI experience and as Hagglund and Wadensten (2007) conclude, nurses make assumptions that UI is a private concern and therefore it is not discussed. Although this study only represented the views of 15 women it does further reinforce the findings discussed earlier, that UI is a low priority area of healthcare.

Although not all of these studies are UK based, pre-registration student nursing curricula have evolved over the last 10 years and all contain the promotion of continence and the importance of assessment which may have impacted on how nurses' now approach UI. The emphasis in both clinical practice and nurse education is now on proactive treatment of this condition as UI is a symptom of an underlying problem and can be successfully treated and nurses are in a position to assess and provide appropriate information to minimise UI (Keegan and Knight, 2009). However, there still appears to be a discrepancy between what is taught and how this is applied in practice. Furthermore, as student nurses' professional roles are determined to a large extent by the availability of role models within the practice setting (Davis, 1993; Filstad, 2004), it would appear that the 'instructors' attitudes towards nursing work will greatly influence

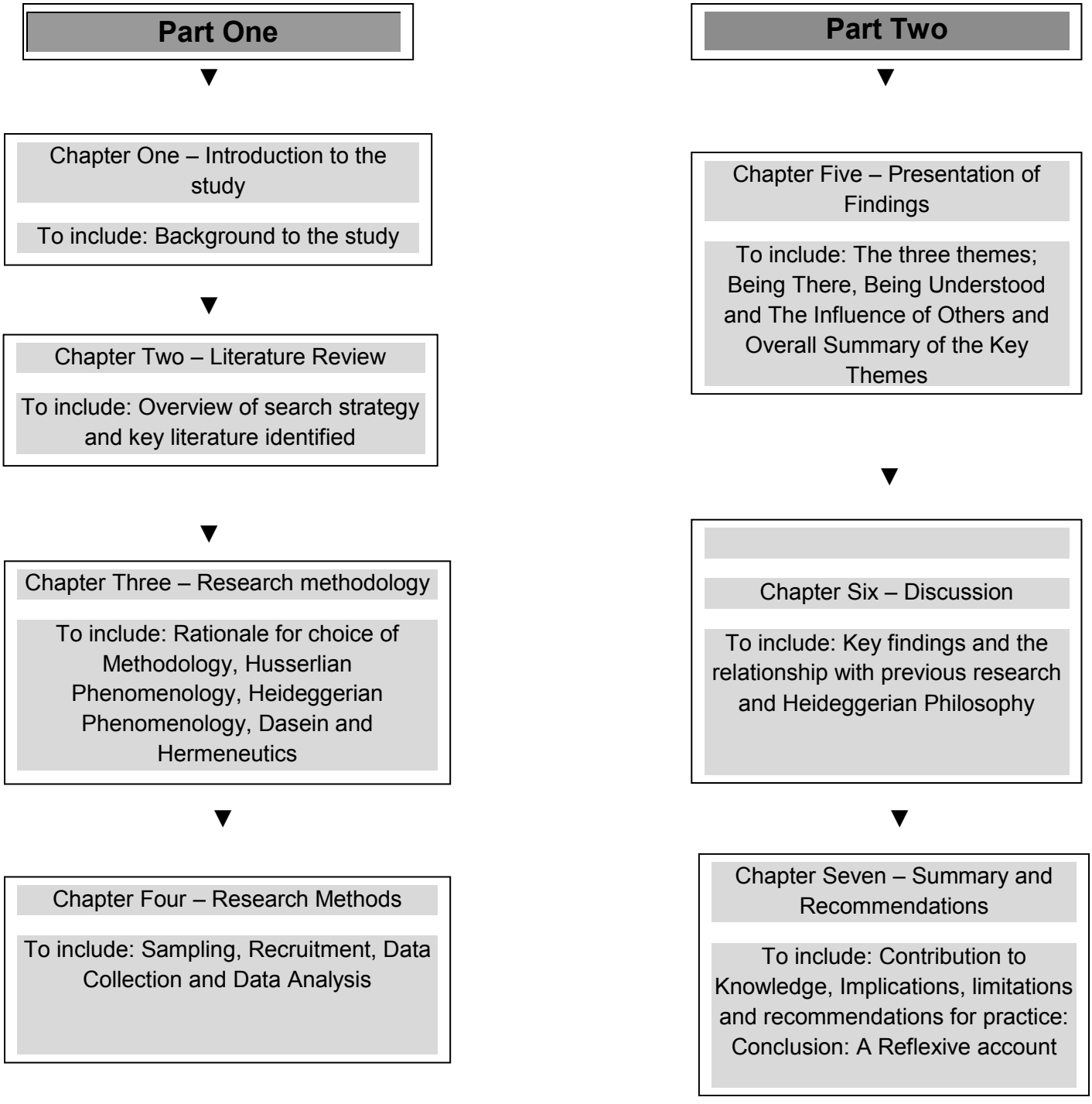
nursing student motives and interests (Campbell *et al,* 1991; Krichbaum, 1994; Donaldson and Carter, 2005). If health care professionals' perceptions of UI are therefore negative, as found by Yu and Kaltreider (1987); Yu *et al.* (1989); Cheater, (1991); Palmer, (1995) and Vinsnes *et al.* (2001), student nurses' own perception of this condition may become influenced by this negativity. This dissonance between what the student is taught in theory about proactive treatment therefore seems to be conflicting with their experiences of clinical practice (Severinsson, 1998). This is further identified by Brown, Stevens and Kermode (2013) who discussed that students have their own values and ideals when they enter the profession of nursing and as Shinyashiki *et al.* (2006) suggest, this may create a dichotomy between their own ideals for nursing practice and the real world of nursing practice.

In order to understand how students experience UI in their first year of study is therefore important if we are to understand why this dissonance exists. Their engagement in practice is a central aspect to their learning and how they develop their skills for practice is a key focus of this thesis. An appropriate methodology that explores these experiences will facilitate an understanding of the complexity of student nurses' experiences of UI in their first year of study. Exploring pre-registration student nurses' experiences and how they make sense of their own perceptions (life world) of how they care for people with UI is therefore the purpose of this thesis as negative perceptions towards UI have a strong correlation to UI being managed and not treated (Vinsnes *et al,* 2001;St John, James and McKenzie, 2002; Wagg *et al*, 2010; Orrell *et al,* 2013). By exploring the experiences of students new into nursing (before clinical exposure) and one

year later (after clinical exposure) will enable a better understanding of their perceptions and illuminate issues grounded in the context of their own personal experiences. This will help inform current pre-registration nursing student education about UI and help to improve the perceptions of those caring for patients with this condition.

The structure of this thesis is within two parts: part one and part two (see Figure 1).

Figure 1: Structure of the Thesis



CHAPTER 2: LITERATURE REVIEW

Introduction

This thesis seeks to understand student nurses' experiences of UI in their first year of a three-year pre-registration nursing programme. The overarching aim of this research was to explore student nurses' experiences of UI during their first year of study however, there are no studies to date that have explored this phenomenon. The literature reviewed was identified through acknowledging key areas that may influence how student nurses experience this area of health care. From personal experience as a Continence Nurse Specialist I had identified that on many occasions both nursing staff and patients seemed to accept that UI was an inevitable consequence of getting older and that nothing could be done to treat this condition. This generated my initial interest in my attempt to understand why this appeared to be an accepted approach to dealing with UI.

Student nurses are exposed to both education and clinical practice areas during their first year of training and these influences on their first year of training has formed the basis of this literature review. There is some debate methodologically as to whether a literature review should be conducted prior to the actual research. The argument against conducting a literature review at the beginning of phenomenological research is that it may influence the researcher and create preconceptions which may not be particularly well informed. My experience of working in the field of Continence Care for several years however, did confirm that I did have prior knowledge and views on the topic and that by acknowledging

this adds to the trustworthiness of a phenomenological study (Lowes and Prowse, 2001). Reviewing the literature subsequently became an ongoing process throughout the study until the final culmination of this completed chapter.

Locating the literature

The current literature search was conducted by identifying key influences that could impact on the student experience of UI during the first year of study and I started my search of the literature by using key terms which included: student nurses, student nurse experiences, student nurse attitudes, student nurse education, student nurse curriculum, pre-registration nursing, urinary incontinence, continence promotion, bladder problems, professional socialisation, student nurse socialisation, attitudes and perceptions, attitudes and attitude change, attitude formation, health care personnel experiences/attitudes, patient experiences/attitudes, help-seeking behaviour, student nurse support in practice, and delivering intimate care (see Table 1 and Table 2). Table 1 shows an example of search terms within one database (CINAHL) showing the number of hits for the original search terms and then the hits from the combined terms in Table 2 to show how many articles were selected for the review.

Table 1 Example of original search terms and hits in CINAHL and Table 2 search terms in combination and hits in CINAHL

TABLE 1: ORIGINAL SEARCH TERMS	CINAHL HITS
Student Nurses	8253
Student Nurse Education	496
Student Nurse Curriculum	80

TABLE 2: SEARCH TERMS IN COMBINATION	TOTAL NUMBER OF HITS WHEN COMBINED CINAHL	TOTAL NUMBER OF ARTICLES DEEMED RELEVANT FOLLOWING ABSTRACT READING IN REVIEW
Student Nurses and Urinary Incontinence	4	2 articles
Student Nurse Education and Urinary Incontinence	11	3 articles
Student Nurse Curriculum and Urinary Incontinence	1 already included in review	No new articles

The only articles chosen to be excluded from the review were articles related to faecal incontinence. Firstly, this was because faecal incontinence is not as prevalent as urinary incontinence and students in their first year of study may not experience this aspect of healthcare. Secondly, this is another under researched area of incontinence that deserves separate investigation which is beyond the scope of this study. Articles that were included all had relevance to the influences that students may be exposed to in both education and clinical practice in relation to how that may impact of their experiences of dealing with patients with UI.

These terms were used to search the major health and social care databases that included:

ASSIA - Applied Social Sciences Index and Abstracts. This database covers the whole area of social sciences. It provides information for social workers, health professionals and other caring professions.

PsycINFO – a database of international literature relevant to psychology and related subjects.

Sociological Abstracts – an index of international literature in sociology and related disciplines in the social and behavioural sciences.

MEDLINE – this database covers a broad range of medical topics relating to research, clinical practice, administration, policy issues, and health care services.

CINAHL - is the Cumulative Index to Nursing and Allied Health Literature. It provides access to nursing journals and articles in biomedical journals.

SOSIG – is the Social Science Information Gateway (SOSIG) and is a freely available Internet service which aims to provide a trusted source of selected, high quality Internet information for students, academics, researchers and practitioners in the social sciences, business and law.

COCHRANE LIBRARY - The Cochrane Library contains high-quality, independent evidence to inform healthcare decision–making. It includes reliable evidence from Cochrane and other systematic reviews, clinical trials, and more. Cochrane reviews bring you the combined results of the world's best medical

research studies, and are recognised as the gold standard in evidence–based healthcare.

I also searched the University library catalogue to identify any books that might be of interest to my study. To complete my search, I used the same terms to search the Internet and relevant websites such as the Association for Continence Advice, RCN Continence Care Forum and the Continence Foundation.

All the literature was reviewed adopting a critical appraisal framework based on LoBiondo-Wood, Haber and Krainovich-Miller (2002) four stage model:

Preliminary understanding – skimming or quickly reading to gain familiarity with the content and layout of the paper

Comprehensive understanding – increasing understanding of concepts and research terms

Analysis understanding – breaking the study into parts and seeking to understand each part

Synthesis understanding – pulling the above steps together to make a (new) whole, making sense of it and explaining relationships

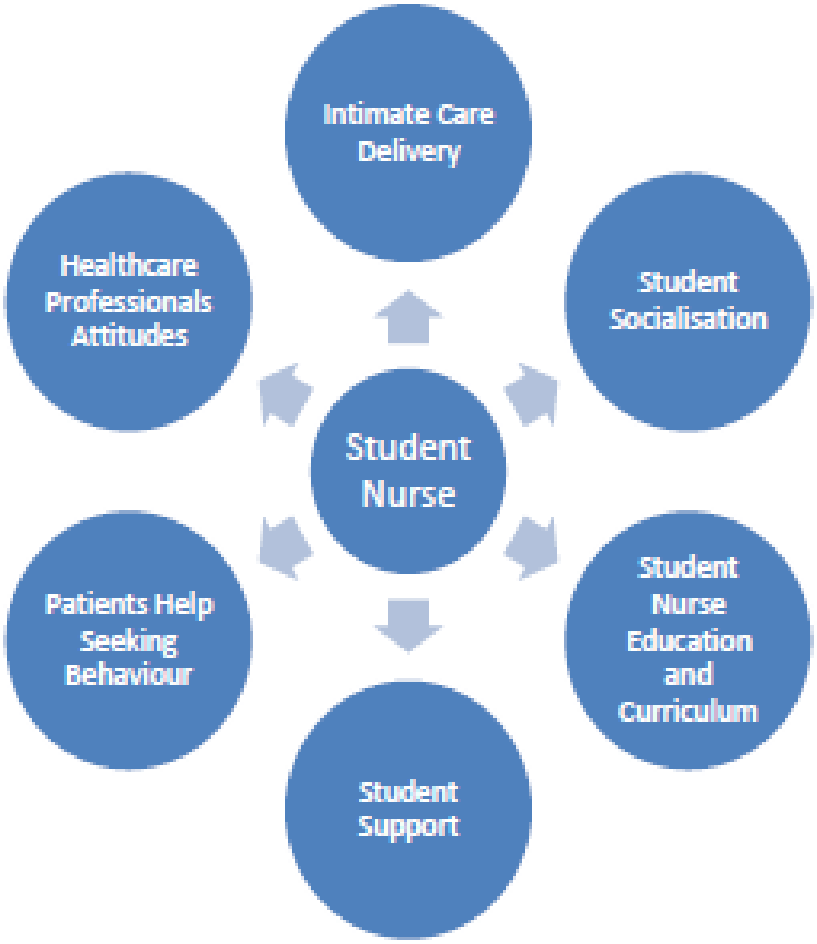
This model was selected in order to critically appraise the literature in a systematic way and to ensure that there is a level of objectivity and not just

personal opinion about which literature was included in the review. It was also selected to combat information overload and it assisted in identifying papers that were clinically relevant.

The Literature Review: Key Themes

From this literature review key themes emerged that related to the student nurse experience regarding UI care and the influences that contributed to that experience. There was no evidence of any research either quantitative or qualitative studies that explored student nurses' experiences of UI per se but what did emerge was that there were a number of areas that could potentially influence the student nurse experience of this phenomenon. The following section presents the key influences which may impact on the student experience of dealing with UI (see Figure 2). These all emerged from the original key word search and the combined key terms as identified from the literature. Appendix 11 and 12 show the full key search terms and combined key terms from all the databases searched.

Figure 2: Key influences from within the literature that may impact directly on the student experience of dealing with UI



These key influences from the literature review formed the basis of this review and developed the following key areas worthy of appraisal and exploration regarding the impact these could have on the student nurse experience of UI in their first year of study. The key areas that emerged for review were; Continence Education in Undergraduate Student Nurse and HCPs Curricula; Attitudes and

Attitude Formation; Attitudes of patients towards UI and their help-seeking behaviour; Attitudes of healthcare personnel towards UI; Crossing Boundaries: delivering intimate care; Student Socialisation and Student Support.

Continence Education in Undergraduate Student Nurse and HCPs Curricula

Clinicians and academic educators have a very influential role to play in the education of the novice nurse. Professional socialisation is the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge, in short, the culture current in the group of which they are, or seek to become a member (Cahill, 1996; Becker Hentz, 2005; Thomas, Jinks and Jack, 2015). Hence student nurses learn not only the skills and knowledge necessary for the role but also its inherent standards and values (Holloway and Penson, 1987). The importance of a non-judgemental approach therefore needs to be fully encouraged and this is a key aspect of nurse education in order to develop a sensitive practitioner (Andrusyszyn, 1989). However, preparing students for a rapidly changing health care system demands and sustains teachers' interest in developing students' thinking abilities at all levels of nursing education. Ironside *et al.* (2003) support this and argue that competent practice requires more than content knowledge applied in clinical situations. It requires an engaged understanding of and persistent thinking about both the context of care and clients' experience of health and illness. Developing an education programme that allows these concepts to advance would therefore appear to be essential.

Furthermore, addressing the current undergraduate adult nursing curriculum, in terms of input regarding UI is worthy of review.

Pre-registration nursing education in the UK is a programme of study that a student will undertake in order to become a qualified nurse and registrant with the Nursing and Midwifery Council (NMC). Currently nurse education is a programme that is split 50/50 between academia (students are taught theory in HEIs) and clinical practice (students work alongside health care professionals (HCPs) in clinical settings) and is completed in three years. The programme is validated by the NMC and is set out in a competency framework which has four domains; professional values, communication and interpersonal skills, nursing practice and decision making and leadership, management and team working (NMC, 2010). There are also standards around what content is to be included within the curriculum that are both generic and specific in order to meet the complex needs of adult patients. Continence promotion and bowel and bladder care are listed as an area of content that requires coverage within the curriculum. However, HEIs make their own interpretations of how much content and how much time is allocated to the delivery of this aspect of practice. Clinical competencies for practice are also generic and specific but there are no core competencies related to continence promotion.

There are four key articles however, that have specifically addressed continence education within healthcare curricula (see Table 3). Cheater (1992) surveyed 543 nurses both qualified and unqualified to establish what input they had experienced regarding continence promotion within their nursing education.

Respondents identified that their education for continence was dominated by the management of UI with no respondents reporting any teaching related to treatment and assessment of UI. A later study by Laycock (1995) surveyed 127 institutions that provided training for healthcare personnel including physiotherapists, medical students, trainee general practitioners and student nurses. There was a good response from all the schools invited to participate and the survey revealed that overall there was an average of 5.6 hours available for continence teaching across all the schools and that this was not set to increase in the future. The content of what that 5.6 hours contained however, was not explored in this study. It had been established three years earlier however, that the content within nursing curricula demonstrated a complete lack of education relating to treatment and assessment. On reviewing both of these studies it is clear that there is not only a minimal number of hours available for continence teaching but what is delivered, related to continence management only, with no evidence of education related to continence assessment and treatment.

Whist these two studies (Cheater, 1992; Laycock, 1995) addressed health care professional education relating to continence promotion, a later study by Cheater (2008) surveyed 1078 patients with UI to establish how UI affected their quality of life (QOL). The findings from this study revealed that UI had a significant impact on the daily lives of patients and affected their QOL on a daily basis. When patients did seek help from HCPs they reported that the focus was on managing the problem by containment for example, the use of incontinence pads. Very few patients in this study reported that HCPs engaged with assessing their problem or discussing treatment options. This appeared to reinforce that there was a lack

of knowledge amongst HCPs regarding continence assessment and treatment for patients with UI. A much later study by McClurg *et al* (2013a) surveyed 86 HEIs regarding the number of hours within health education curricula that was dedicated to continence related education. The findings from this study found that 14% of the HEIs surveyed reported no continence education within their curricula. It is not known which healthcare curricula this specifically applied to but it is a valuable finding as twelve HEIs that deliver healthcare programmes do not contain any continence education at all. For the HEIs that identified that continence education was in their curricula, the average hours dedicated to this subject on average was 4.7 hours but what that education consisted of was not identified.

What is clear from reviewing these four studies is that little has changed in the UK pre-registration curricula relating to the specific content associated with UI and the number of hours allocated to this area of healthcare in the last 21 years (see Table 3). A major consequence of these findings is the fact that there appeared to be a reduction of hours dedicated to continence promotion included in healthcare curricula. This causes a level of discomfort as Newman *et al.* (2008) made very clear recommendations in their study that UI education needed to be specific and that there should be some compulsory inclusion of continence promotion education within all healthcare pre-registration curricula. With growing evidence that the number of patients with UI is on the increase due to our ageing population, it would seem vital that these deficits are addressed for this important aspect of healthcare (McClurg *et al,* 2013a). The National Audits of Continence (Royal College of Physicians, 2006, 2010, 2012) also revealed that there was

inadequate professional education specifically relating to continence promotion and that this was a major factor for poor standards of continence care.

This review of the literature related to undergraduate student nurse education and HCPs curricula confirmed that there is very limited evidence of the educational preparation of undergraduate healthcare professionals in continence care. What evidence is available suggests that continence promotion takes low priority. McClurg (2013b) reinforced these findings and found that HEIs reported very limited continence education and where it did exist showed that it was usually embedded in other modules with no specific standalone module identified for continence promotion. This is especially relevant as it has been recognised that delivering good quality education has a direct link to the development of appropriate attitudes towards patient care (O'Brien, Richards and Walton, 2009). This would appear to be essential in order to promote positive attitudes towards UI in order to meet the needs of a growing older population where UI has a significant prevalence.

Table 3: A comparison of studies reviewing continence education in pre-registration curricula spanning 21 years from 1992-2013.				
Literature-evidence type	Author and Year	Methodology/Methods	Sample	Results
Descriptive study – Nurses educational preparation and knowledge concerning continence promotion	Cheater, F (1992)	Quantitative – questionnaire/survey	543 nurses from 14 acute medical wards, 26 health care of the elderly wards (HCE) from 5 hospitals and 27 learners on their final block in the college of nursing	382 responses – qualified and unqualified Pre-registration education management of incontinence within pre-registration curricula was pre-dominantly concerned with incontinence aids and appliances (72.2%), toileting activities (41.4%) and indwelling catheters (41.0%). Treatment options were infrequently identified. 0 respondents mentioned teaching related to treatment options. The assessment of UI is a largely neglected part of the pre-registration curricula and is pre-dominantly infused with measures aimed at containing the problem.
Survey – questionnaire regarding educational input on continence promotion	Laycock, J (1995)	Quantitative – questionnaire/survey	28 Schools of Physiotherapy 29 Schools of Medicine 28 Regional GP Training Units 42 Schools of Nursing	27 questionnaires returned from Schools of Physiotherapy 21 questionnaires returned from Schools of Medicine 27 questionnaires returned from Regional GP training units 34 questionnaires returned from Schools of Nursing This study highlighted that a relatively small number of hours are spent on continence teaching (5.6hrs overall average across all schools) and future trends indicated that only a small minority of these schools would expect any increase to the teaching hours for this area of healthcare.
Cross sectional cohort study	Cheater *et al* (2008)	Quantitative - questionnaire	1078 patients from 176 community nurses' caseloads in 157 general practices in England	999 patients responded and returned completed questionnaires. UI had a significant impact on many aspects of quality of life. Professional help appeared to be about containment and very few reported having an assessment.
Survey –A Multi-professional UK wide survey of undergraduate continence education	McClurg *et al* (2013a)	Quantitative – on line questionnaire	362 programmes in 86 HEIs	85 HEIs agreed to participate with a response rate of 81% (n=294/362 programmes). 14% reported there was no continence related education within their undergraduate programme. Mean number of hours 4.7hrs overall across healthcare programmes the highest in Adult Nursing (7.3 hrs).

Attitude and attitude formation

Understanding how attitudes form is therefore an important aspect of this literature review in order to understand why some healthcare professionals act in the way that they do towards patients with UI. This is particularly important to consider as student nurses are exposed to both patients and healthcare professionals during their first year of training and this may influence their experiences of dealing with UI. Oppenheim (1992) suggests that everything people do depends on their attitudes. How attitudes form however, and how they can be measured is an area full of intricate complexities. Furthermore, the implications of these measures in relation to understanding attitudes towards UI, needs also to be considered.

Attitudes are central relevant constructs in health education and health promotion and the health field generally (Cross, 2005). The study of attitudes and subjective opinion is important for several reasons, one being that attitudes have an impact on health experience (Eagly and Chalken, 1998), and another being that they affect health positively or negatively (Newble, 1992). In order to affect attitude change towards a given health issue, existing attitudes and the attitudes of lay people, health workers, professionals, policy makers and health researchers may be of interest and the literature is therefore worth exploring.

Current thinking is that attitudes help form cognitive relationships which in turn may predispose behaviours (Cooper, Blackman and Keller, 2015). Several authors offer different definitions (Fishbein and Ajzen 1975; Bennett and Murphy,

1997; Eagley and Chalken, 1998), but common to most is that an attitude is a predisposition to behave in a particular way (Proctor, 2001) and early attitudinal research assumed a strong relationship between attitudes and behaviour (Bennett and Murphy, 1997). Behaviour is an important issue in health since it directly affects the patients' health outcomes and it is supposed that attitudes are concealed and not directly observable in themselves but can cause actions and behaviours that are observable (Cross, 2005).

It is widely agreed that here are three components of attitude: cognitive, affective and behavioural Secord and Backman, 1964; Eagly and Chalken, 1998; Lawton, Conner and McEachan, 2009; Cooper, Blackman and Keller, 2015). The cognitive component consists of knowledge, ideas, beliefs and opinions, although it should be noted that these ideas that comprise the cognitive component need not always be true or correct. The affective component is defined by the person's feelings toward the attitude object, generally favourable or unfavourable. For example, although two people may both hold unfavourable attitudes towards UI their personal feelings may be quite different. One may hate dealing with the consequences of UI whereas the other may feel annoyed and angry towards the patient. This affective or emotional aspect of an attitude is often the deepest rooted component and the most resistant to change (Rokeach, 1968; Ajzen, 2005; Crano and Prislin, 2008). The behavioural component is the tendency to act or react towards the attitude object in particular ways, this may be in terms of what a person says they will do or what they may actually have done. For example, the person who reacts angrily and vociferously to performing

continence assessments demonstrates the behavioural component of their attitude.

Attitudes also imply evaluation and are concerned with how people feel about an issue (Simmons, 2001). People hold attitudes to, and about, things or objects. In health this encompasses a wide range of issues. Indeed, an attitude 'object' may be anything a person discriminates against or holds in mind - it may be concrete or abstract (Bohner, 2001). It is also believed that attitudes change as people learn to associate the attitude object with pleasant or unpleasant contexts or consequences and that they relate to how people perceive the situations in which they find themselves. Christensson *et al.* (2003) supports this and suggests that it is reasonable to feel positively about performing a behaviour if you believe that its performance will lead to more good than bad outcomes. Eiser (1979) argues however, that behaviour is not only determined by attitudes alone and that external factors e.g. the social situation, also exert a great influence. Ajzen and Fishbein (1980) and Ajzen (2005) further support this idea and suggest that it is reasonable to feel social pressure to not perform a behaviour if you believe that people with whom you are motivated to comply think you should not perform it. Finally, it is also reasonable to weight your personal feelings (attitude) and the perceived social pressure (subjective norm) in arriving at and carrying out your intention (Ajzen and Fishbein, 1980; Ajzen, 2005).

It would appear then that social influence and group norms are more likely to be the main factors reflected in the attitudes. Bandura (1972) supports this and suggests that this is a process whereby individuals develop the qualities essential

to function effectively in the society in which they live and of course, this will lead to the acquisition of 'appropriate attitudes'. Bandura (1972) further adds that the groups to which we belong will have certain social norms which they expect other group members to share and sanctions may be applied to those whose attitudes deviate from these norms. Goffman (1982) and more recently, Schwarzer (2014) supports this and considers that the person is influenced by what specific individuals or groups think regarding whether he should or should not perform the behaviour (subjective norm) and that it is the staff working in an institution who frame the routine, roles and norms, restraining the ongoing activities.

In reviewing how attitudes in general are formed it would appear that the more positive a person's attitude is towards something, the more likely there is to be a successful outcome. This is an essential pre-requisite for health care in order that patients are treated both effectively and efficiently. This review will now turn its focus on reviewing the literature that relates specifically to attitudes of both patients and health care personnel towards urinary incontinence. This is a particularly important aspect of this literature and is justified as exploring patient and healthcare professional attitudes towards UI, may have a direct impact on the students' experiences.

Attitudes of patients towards UI and their help-seeking behaviour

There have been very few studies that have looked at patients' experiences or attitudes towards UI and the majority of studies that have been conducted, have been quantitative in nature. In the United Kingdom (UK) the majority of these

studies were carried out in the early 1990's after the Department of Health published its report *Agenda for Action on Incontinence* (DH, 1991) which gave good guidance on the way that continence services ought to progress and provide a high standard of care for all clients. This document increased awareness about this anomalous condition and a plethora of research articles on all aspects of UI ensued. However, at this point there were still no published papers that looked specifically at patients' experiences or their attitudes towards UI but there were many earlier international articles that discussed the burden of UI and the subsequent impact that this had on the patient (Webb, 1984; Simons, 1985; Norton, 1986; Blannin, 1986).

These studies found that urinary incontinence had considerable personal implications on self-concept and self-esteem and as a result of this, feelings of self-disgust and self-hatred were found to ensue. Later studies also found that changes and restrictions to patterns of social activity were also reported as a result of urinary incontinence, including avoiding exercise and lifting and going out less (Nygaard, DeLancey and Arnsdorf, 1990; Thomas and Morse, 1991; Largo-Janssen *et al*, 1992; Brocklehurst, 1993). This is further reported by Grimby *et al.* (1993) who found incontinence sufferers were socially more isolated. It would also appear that incontinence sufferers make a lot of effort in attempting to assure normality and O'Donnell *et al.* (1992) found that many older people reported that this was due to the fact that many carers' decisions to institutionalise their relatives show incontinence to be a major predictor. Hagglund *et al.* (2003) and Visser *et al.* (2012) also found that women often didn't seek help because they had found a way to cope with UI as it was seen as a

problem that must be self-managed due to the embarrassing nature of the problem.

Studies that have focused on the consequences of UI and the impact this has had on the individual have also found similar findings: embarrassment, odour, avoidance by others, social isolation, personal cost, psychological stress and depression were all found to be major factors (Norton, MacDonald and Stanton, 1987; Grimby *et al*, 1993; Valvanne *et al,* 1996; Dugan, Cohen and Bland, 2000). Furthermore, Hunskaar and Vinsnes (1991), Johnson *et al.* (1998) and Roe and Doll (2000) have all identified that UI is often considered by generalist health care professionals to be secondary to other health problems, a view not necessarily shared by people experiencing UI. Whilst these studies show how incontinence affects the individual, the following two UK pieces of work (Jolleys,1988 and Brocklehurst, 1993 see Table 4) give much more insight into why patients with UI were reluctant to seek any help for their incontinence problem which may lead to an understanding about patient attitudes.

Jolleys (1988) found that many patients with UI did not come forward for treatment by a health care professional: between 12% and 50% of people with UI did not consult a health care professional about their complaint. Three later studies produced similar findings to Jolleys (1988) and also found that the most common reason for not seeking help was because incontinence was not perceived as a problem for the person. However, the next most frequently given reasons related more to the public's lack of understanding of the condition. People thought that UI was 'normal for their age' and 'a usual female complaint'

Table 4: Comparison between Jolleys (1988) and Brocklehurst (1993) UK studies exploring attitudes of patients towards UI and their help-seeking behaviour

Author and Year	Methodology/Methods	Sample	Results
Jolleys, J V (1988)	Quantitative – Survey questionnaire to women over 25 in a GP practice	n=937 833 (89%) completed the questionnaire Prevalence of UI was 41%	Inappropriate leakage of urine appeared to be a common problem and therefore the perception was that was not serious enough to report to a HCP.
Brocklehurst, J.C (1993)	MORI Poll Random sample of men and women interviewed in their own home	1883 men and 2124 women aged 30 and over	52% had contacted their GP at the onset of their incontinence and most thought that they were treated sympathetically by their GP. 54% took a urine sample, 42% referred the patient to a specialist, 36% prescribed medication and only 22% carried out an abdominal, rectal or vaginal examination. Conclusion: although it would appear that many people are contacting their GP about UI the procedures carried out by GP's still seem sub-optimal.

and that 'no help was available' and 'nothing could be done' (Jolleys, 1988; O'Brien *et al,* 1991; Brocklehurst, 1993; Harrison and Memel, 1994).

Brocklehurst (1993) carried out a large a large scale survey to ascertain if patients were incontinent of urine and how they managed the problem. Although many of the findings were similar to the study by Jolleys (1988), some other findings emerged that directly referred to the attitude of health care professionals. The findings clearly showed that almost half of these people with UI had accepted this condition as a normal part of the ageing process therefore had not sought any help. However, perhaps more significantly, of those that had sought advice many reported that they were disappointed at the attitude displayed by the

health care professional and felt embarrassed when talking to health care professionals. A further finding also showed that for the majority that did seek help, management options only were discussed and no patients reported any treatment options being offered (Brocklehurst, 1993).

It is also interesting to note that in the United States (US) at about the same time, urinary incontinence was also developing a higher profile on the healthcare agenda. In 1992 the Agency for Health Care Policy and Research (AHCPR,1992) produced guidelines that reported that urinary incontinence significantly impacted on families and caregivers, as well as patients who were often found to suffer from low self-esteem with isolation and a decreased ability to maintain an independent lifestyle. Several US studies also make a major contribution to understanding how patients deal with the consequences of UI and the impact it has on their lifestyle. (Jeter and Wagner, 1990; Goldstein *et al,* 1992; Fultz and Herzog, 2001 see synopsis in Table 5).

Jeter and Wagner (1990) found that 17% of over 10,000 respondents described their incontinence as a major problem with important social implications. The results from this large national survey of community-dwelling people with incontinence also suggested that each individual perceived their loss of bladder control differently. While a majority of respondents described their loss of bladder control as relatively minor with limited impact on their life style, 17.7% described their UI as a major problem with important social implications. In view of this finding it would appear that UI has a huge impact on the individual's lifestyle and requires help and support. Perhaps more alarmingly, the results of this large

survey also showed that of the 12,097 people that had used an incontinence helpline 56.5% reported that their consultations had been of 'no help at all' with only 9.7% indicating that they had been helpful.

Goldstein *et al.* (1992) found more detailed evidence about the impact that UI had on patients and found that 62% of their participants believed that their incontinence was a natural part of the ageing process. Perhaps more disconcerting however, was that 83% of the participants reported that prior help-seeking relating to their UI had negatively affected any subsequent attempts. Several participants reported that health care professionals had not responded to their questions or comments about their 'bladder trouble' and participants had interpreted this as meaning nothing could be done. Others stated that health care professionals had 'brushed them off' or closed the conversation with 'Oh well that is what happens when you get older'. The findings from this study not only demonstrate how patients themselves view their UI problem but also the sensitive nature of this health care problem necessitates that all health care professionals be alert to even subtle cues. Individuals who receive inadequate or inappropriate responses on their first attempt to discuss the problem may not bring the subject up again resulting in passive acceptance of the problem by both sufferers and health care professionals (Goldstein *et al,* 1992).

In a later survey study, Jeter and Verdell (1993) found that embarrassment was the number one concern, followed by odour. These study findings however, found that the area of least concern was that of isolation from family and friends which does not agree with two of the UK studies conducted around the same time,

which did find that social isolation was a major burden for patients with UI (O'Donnell *et al,* 1992; Grimby *et al,* 1993). Nearly 14% described urine loss as a major problem, 26% said it was an occasional nuisance, and 55% said that although the loss of bladder control was always bothersome, it was manageable. Fultz and Herzog (2001) conducted a telephone survey to ascertain the social and emotional impact of urine loss among individuals age 40 or older. Eighty-one percent (81%) of individuals with incontinence reported no restrictions in their activities and 61% said it did not affect their feelings about themselves. However, people with incontinence who were younger, male, less educated, and in poorer health, as well as those losing greater quantities of urine, were more likely to report psychosocial distress. Although these correlations were not consistently significant, people with incontinence were significantly more likely to feel depressed, lonely, or sad than people who were continent (Fultz and Herzog, 2001).

The findings from these studies demonstrate that the majority of respondents do not seek help for their UI. There are many reasons offered as to why that is the case. Accepting that UI is part of ageing is a common misconception and for those patients that do present to HCPs for help find these consultations overall to be of little help (see Table 5). The majority of the studies above have used quantitative methodologies in order to elicit patients' responses towards UI. Whilst they contribute significantly to understanding the impact UI has on the individual, they lack any detailed in depth information about why people do not seek help.

Table 5 : Summary of US studies relating to attitudes of patients towards UI and their help-seeking behaviour			
Author and Year	Methodology/Methods	Sample	Results
Jeter, K.F and Wagner, D.B. (1990)	Quantitative – postal questionnaire to 36,500 people randomly distributed across the United States	12,097 surveys were returned 10,427 were completed 1,670 responded but did not want to complete the questionnaire Response rate was 33%	17.7% described their UI as a major problem with important social implications 56.5% reported that their consultations had been of 'no help at all' with only 9.7% indicating that they had been helpful. 24.4% felt that the doctor or the nurse was unsympathetic and described them as 'not helpful', and 'too busy' Conclusion: overall HCPs appear to be disinterested in UI and overall not helpful when patients present with UI.
Goldstein, M, Hawthorne, M.E, Engeberg, S, McDowell, J and Burgio, K. (1992)	Quantitative – non-experimental survey 14 item questionnaire	136 subjects 119 women and 17 men between the ages of 55 and 99 (Mean= 76.6 years)	49 of the 136 subjects (36%) had experienced UI (12% men and 39% women) 59% participants had not sought treatment with 62% reporting that this was because they believed that UI was a normal part of ageing. 60% of the Physician responses were to drink more fluids or were given no helpful advice. Conclusion : The prevalence of UI among individuals 55 years and older is high. There is a lack of accurate information for patients with UI and HCPs need to ask direct questions about UI as part of routine history and physical examination.

Fultz, N.H and Herzog, A.R. (2001)	Quantitative Survey – telephone interviews as a supplement to a nationally representative monthly consumer survey	1,116 continent and 206 incontinent respondents aged 40 and older	Eighty-one percent (81%) of individuals with incontinence reported no restrictions in their activities and 61% said it did not affect their feelings about themselves. However, people with incontinence who were younger, male, less educated, and in poorer health, as well as those losing greater quantities of urine, were more likely to report psychosocial distress. Although these correlations were not consistently significant, people with incontinence were significantly more likely to feel depressed, lonely, or sad than people who were continent (Fultz and Herzog, 2001). Although the direct impact of urine loss may be minor in many cases, patients' reports of UI should alert clinicians to the importance of considering the totality of the patients' quality of life.

There are however, a very limited number of studies that have used in depth qualitative methodologies to explore the effect UI has on the individuals. The following studies all used qualitative approaches in all or part of these studies (see Table 6).

Ashworth and Hagan (1993) findings also confirmed that beliefs about UI were surrounded by perceptions that UI was an inevitable consequence of 'being a woman' or that 'nothing could be done'. This study however, also found that sufferers did not see incontinence as a medical condition and therefore was not a legitimate condition, which had prevented the women seeking help. When help had been sought however, the women described difficulties in opening a dialogue with health care professionals and talked about 'teetering around the problem'. This appeared to be due to feelings of embarrassment on their part and a lack of facilitation by health care professionals in engaging with the women when attempting to discuss their problem. This echoes the findings in the study by Goldstein *et al.* (1992), in that a major concern is that, although there may be many client factors for not seeking treatment, many people who seek assistance for UI do not receive meaningful help. Furthermore, later studies have also found that health professionals lack knowledge and/or treat UI as a nuisance or secondary to other conditions and is often not identified by practitioners (McDowell *et al,* 1994) or raised as an issue with clients (McGhee *et al,* 1997).

In a later study by Teunissen and Largo-Janssen (2004) the reasons why people sought help for their urinary incontinence differed between males and females. Men were more likely to seek help when they had less severe incontinence than

women and their help-seeking behaviour was related to distress experienced in daily life. Women's help-seeking behaviour however, was related to the duration of their symptoms and the severity of their incontinence. This study also showed that men and women overall did not seek help as they did not think incontinence was serious enough or they had inappropriate beliefs that 'incontinence is part of getting older' and that nothing could be done for it.

In a hermeneutic phenomenological study by Hagglund and Ahlstrom (2007), women expressed that there were barriers which prevented them from seeking help for their UI. This study explored the meaning of women's experiences of living with UI and confirmed that their major reasons for not seeking help were due to UI being a taboo subject to talk about and their feelings of powerlessness in initiating those discussions. This recent study has reinforced earlier work which looked at the stigma associated with UI and the acceptance by people with UI that 'nothing can be done' (Simons, 1985; Holst and Wilson, 1988; Branch *et al,* 1994). Perhaps of greater significance however, is the fact that thinking 'nothing can be done' leads patients to look for management options not treatment options which as Mitteness and Barker (1995) found in their study, is often reinforced by health professionals. This was also confirmed in a study by Pilcher and MacArthur (2012) who did specifically explore patient experiences of bladder problems post a cerebral vascular accident (CVA). Although this study addressed other issues relating to bladder problems and not specifically UI, the findings did collaborate that patients felt that continence assessment was not a priority for health care professionals and that management options rather than treatment options prevailed.

What is clear from reviewing this literature is that lay beliefs play an important part in their help-seeking behaviour. Many of these beliefs appear to be misguided and subsequently act as barriers to seeking help. Perhaps more importantly for health care practice, these studies frequently suggest that health care professionals sometimes reinforce these misunderstandings. In view of the fact that health care professionals appear to have a pivotal role in the dissemination of information about UI, identifying those attitudes and beliefs that are barriers to providing effective care need to be explored. Moreover, as nurses are the largest single group of health care professionals and the group with the opportunity to care for individuals in diverse settings, they are often the first to become aware that a client is experiencing incontinence (Norton, MacDonald and Stanton, 1987). Nurses therefore, need to be knowledgeable about UI to avoid further perpetuation of the myths that surround this condition and act as advocates and educators for the public and health care professionals alike, to dispel the common misperceptions (Milne, 2000). In view of this, I will now turn my attention to reviewing the literature relating to attitudes of health care personnel towards UI.

Table 6: Summary of qualitative studies relating to attitudes of patients towards UI and their help-seeking behaviour			
Author and Year	Methodology/Methods	Sample	Results
Ashworth, P.D and Hagen, M.T (1993)	Qualitative 28 in depth interviews	28 young or middle aged women who suffered from UI	Incontinence is taboo and a socially unacceptable topic of conversation which inhibits the approach of patients to HCPs. UI is seen as a lack of grip on bodily propriety and fear an association with despised groups. Sufferers of UI fight to subordinate the problem in favour of other priorities. When help was sought the women described their encounter with the HCP as' teetering around the problem' and difficulty in engaging with the HCP regarding their UI.
Teunissen, D and Largo-Janssen, T. (2004)	Quantitative and Qualitative – questionnaire and follow-up in-depth interviews	n=2416 questionnaires to men aged 60 and over and n= 2862 questionnaires to women aged 60 and over with am 88% response rate in both groups n=56 follow-up interviews with men and n= 314 follow-up interviews with women	Qualitative data **Reasons for not seeking help in female patients** n= 119 overall 'not serious enough' n= 69 set ideas related to UI being part of the ageing process n=21 patient-doctor relationship factors negative experiences with doctors no real interest in their problem **Reasons for not seeking help in male patients** n=22 overall 'not serious enough' n=8 set ideas related to UI being part of the ageing process n=4 patient-doctor relationship 'doctor didn't have time for me'
Hagglund, D and Wadensten, B. (2007)	Qualitative Phenomenological hermeneutic method in-depth interviews	N=13 women aged 37-52 years who had not sought help for their UI	Incontinence is a taboo subject which inhibited the women from speaking freely about it. The women also discussed the impact that it had on their intimate relationships and that if they distanced themselves from the problem they dealt with it better. Many women reported that they 'put off' seeking help because there was always something else that took priority in their busy lives. The women in this study also believed that UI was something to be expected after childbirth. In terms of HCPs the women wished that care providers would actively ask them about UI as they stated strongly that they feared humiliation about discussing their UI problem with HCPs.
Pilcher, M and MacArthur, J. (2012)	Qualitative Multi-disciplinary HCPs Focus group discussion	9 participants from took part in the focus group	HCPs recognised that patients were concerned about having a bladder problem but commented that 'nobody's talking about it very much' and there was a need for much more proactive discussion between HCPs in order to improve continence assessments.

Attitudes of healthcare personnel towards UI

There are very few studies to date (Norton, 1986; Cheater, 1992; Roe and May, 1997; DOH, 2000) that have specifically explored health care personnel's experiences/attitudes of dealing with patients with UI. These studies suggest that experiences/attitudes towards people with UI are often expressed in a variety of ways from passive acceptance (Cheater, 1992; Roe and May, 1997; DOH, 2000) that this is what happens as people get older, to overt displays of disgust at the loss of this bodily function, leading to punitive actions (Norton, 1986). As a consequence of these findings these studies are worthy of further exploration as student nurses work closely with clinicians in the delivery of care and may be influenced by their attitudes, which may have an effect on their own experiences of dealing with patients with UI.

Urinary incontinence is a taboo subject in Western society and is surrounded by many myths and misconceptions because it relates to parts of the body which are normally concealed by clothing and are involved with excretory and sexual function (Roe and May, 1999). These myths and misconceptions are common due to lack of awareness of both the general public and health care professionals and the taboo status of UI which restricts open discussion (Roe, Doll and Wilson, 1999). This lack of awareness amongst health care professionals has caused numerous misconceptions about UI which has led to misunderstandings about how to deal with a patient who has UI. In turn, this has led to negative attitude development based on inadequate knowledge of this area of health care (Terzoni *et al*, 2011) and the myths and misconceptions that have alluded to it have only

reinforced negativity amongst health care professionals (Cheater, 1992). As stated previously there have been very limited efforts to explore attitudes of health care professionals towards UI. This may be due to the fact that attitudes towards UI are a complex phenomenon. However, on reviewing the literature there are some seminal pieces of work that have guided this area of research interest (see Table 7).

Yu and Kaltreider (1987) and Yu *et al.* (1989) revealed that nursing staff responses to incontinence included feelings of frustration and helplessness which also related to lack of awareness about the condition and subsequently identified a lack of knowledge and negative attitudes. It has been shown that care delivery towards a patient with UI may be affected by the negative attitude of the health care professional (Yu and Kaltreider, 1987). Perhaps more importantly however, Vinsnes *et al.* (2001) found in their study that negative attitudes towards UI did have a negative impact on the outcome of the intervention patients then received. This reinforces the work of early researchers who found that common societal beliefs about UI affected the behaviour of health care professionals (Gjourp *et al*, 1987; Mitteness, 1987). Both of these studies found that health care professionals contributed towards reinforcing lay beliefs, that UI was part of the ageing process and could not be treated. The outcome of these interventions therefore, led to management strategies being employed rather than pro-active treatment strategies (Woodward, 1995). Vinsnes *et al.* (2001) supports this and argues that attitudes towards UI do influence the care delivered and suggest that this is often due to health care professionals' passive acceptance of UI as

something which cannot be cured despite evidence to the contrary (Hahn *et al.*, 1993: DOH, 2000; Chancellor and Yoshimura, 2003).

Table 7: Summary of 4 key articles re. HCPs attitudes towards UI

Author and Year	Methodology/Methods	Sample	Results
Yu and Kaltreider, (1987)	Quantitative Questionnaire	308 nursing staff invited156 returned the questionnaire (51%) response rate	Staff appear to have both positive and negative feelings towards UI and care delivery towards a pt with UI may be affected by the negative attitude of the HCP.
Yu et al, (1989)	Quantitative Questionnaire	96 females with a mean age of 85.3 years	Patients with UI reported that they felt HCPs avoided them because of their UI and their responses to dealing with UI included frustration and helplessness
Cheater (1992)	Quantitative Questionnaire	543 nurses - 382 returned the questionnaire (70.4% response rate)	UI is largely neglected in pre-registration curricula and is pre-dominantly infused with measures aimed at containing the problem. The majority of nurses in this study failed to identify common causes of UI.
Vinsnes et al (2001)	Quantitative Questionnaire	745 nursing staff invited 535 returned the questionnaire (72% response rate)	The more negative the attitude to UI the more likely the problem will be managed passively with no assessment. Staff may view UI as a major inconvenience

These studies have shown that there are significant differences in attitudes towards UI amongst health care professionals. How and why these differences occur however, is not explained. What is clear from these studies is that the more negative the attitude towards UI, the more likely the health care professional is to manage the problem passively whereas the more positive the attitude appears to correlate with continence promotion (Vinsnes *et al,* 2001).

It is interesting to note however, that these studies do suggest that health care professionals working in different health care settings show differences in attitudes towards UI. For example, studies by Yu (1987), Yu and Kaltreider (1987) and Yu *et al.* (1991) were all conducted in acute care settings but across various specialities of nursing care, including care of the older person and general medical wards. Attitudes amongst staff working in care of older people appeared to have negative responses to the promotion of continence whereas there was a more positive correlation amongst staff working on general medical wards (Yu *et al,* 1991). This would appear to suggest that the context of the environment and the exposure to the levels of UI may affect attitude but what studies cannot show is why this was the case.

In contrast, the findings of Vinsnes *et al.* (2001) study were that people working with older people showed a positive attitude towards UI which suggests that these differences may be due to other influences for example, level of experience of the staff, skill mix, level of knowledge and the cultural context of their work. Cheater (1992) found this in her study about educational preparation of staff relating to UI in that the more knowledgeable the health care professional, the more receptive they were to continence promotion strategies. Palmer (1995) also found this in her study. In particular, she found that nurses' preparation level, knowledge and attitudes about incontinence, affected staff behaviour and acted as facilitators or hindrances to the scope, establishment and maintenance of continence programmes. However, Campbell *et al.* (1991) had previously found that although education was necessary, it was not a sufficient motivator for staff

to change their old behaviours. Henderson and Kashka (2000) study also found this in their study which investigated nurses' knowledge, attitudes, and beliefs about urinary incontinence in adults, as each affects nursing practice with incontinent clients. Multiple regression revealed only attitude had a direct effect on practice. Although knowledge and belief did not exhibit a significant relationship with practice, both were related to attitude.

These findings question the assumption that knowledge directly affects practice; therefore, nursing practice related to UI in adults may be most affected through efforts aimed at attitudinal change. As learning theorists like Bandura (1972) have suggested a great deal of our learning occurs not through direct reinforcement or conditioning, but rather through the observation and imitation of others. This supports McKinlay and Cowan's (2003) findings about student nurses' attitudes towards working with older patients, in that it is not just about their own attitudes but how others wish them to behave towards those patients. Furthermore, Cheater (1992) noted in her study that attitudes towards age being a predictor of UI were high amongst qualified health care professionals reinforcing management strategies rather than assessment and treatment. However, perhaps more distressing are the findings of the study by Bytheway (1995) who reported that humour was often directed at patients with UI, leading to humiliation of the patients. What is very clear from these studies is that negative attitudes towards patients with UI will inevitably impact on the quality of care delivered to patients by nurses (McLafferty and Morrison, 2004).

Tervo, Palmer and Redinius (2004) found in their study of health professional student attitudes towards people with disability, that students with negative biases may behave inappropriately with wide ranging effects. Furthermore, negative attitudes may also adversely influence other students, compounding adverse outcomes (Dunn, Umlauf and Mermis, 1992; Paris, 1993; Antonak and Livneh, 2000). It would therefore appear that the context of where and how the interaction is experienced may be of crucial importance for future attitudes (Fiske, 1998). This evidence suggests that strong attitudes are more likely to affect behaviour, while weak attitudes are more likely to be shaped by behaviour (Holland, Verplanken and Van Knippenberg, 2002). Attitudes therefore, are important because they are viewed as a mediating link between clinical competence and clinical performance (Newble, 1992). More essentially perhaps, it is necessary that the consequences of negative attitudes are recognised and dealt with in health care professional curricula in order to influence more pro-active assessment strategies for these taboo areas of health care, leading to positive outcomes for patients and healthcare professionals (Tervo, Palmer and Redinius, 2004). This confirmed the findings by Sharp (1991) in a much earlier study where observations were made about how the nurses' attitudes influenced the quality of care given to patients, and argued that the profession would be wise to take note of this, as these negative attitudes will impact on the subsequent quality of care delivered. For UI, this would also appear to be the case as there is evidence that patients who encounter nurses who are not supportive, may feel reluctant to access services and subsequently, and perhaps more alarmingly, may lead to them accepting their incontinence (Mitteness, 1987; Jeter and Wagner, 1990; Palmer, 1995; Lekan-Rutledge, Palmer and Belyea,

1998; Hagglund and Ahlstrom, 2007). There is however, some evidence that positive attitudes are related to adequate training and feedback combined with good collaborative working with other members of the healthcare team (Albers-Heitner *et al,* 2011).

On reviewing this literature, it would appear that qualified nurses have a significant role to play in the dissemination of information about UI to both the general public and other health care professionals. It is therefore essential that qualified nurses are knowledgeable about UI to avoid further perpetuation of the myths that surround UI and act as advocates and educators as discussed previously.

In view of the impact that this will subsequently have on the quality of care delivered and essentially on whether there is a positive or negative outcome for the individual concerned, it is essential that we understand how the attitudes of health care professionals towards UI are formed and influenced. In addition, the fact that a student nurse's professional role is determined to a large extent by the availability and the quality of the role models accessible within the practice setting (Davis, 1993; Filstad, 2004; Donaldson and Carter, 2005), it would appear that the 'instructor's' attitudes towards nursing work will greatly influence nursing student motives and interests (Krichbaum, 1994; Morton-Cooper and Palmer, 2000). Displaying negative attitudes towards UI therefore, may directly affect the student nurses' experiences of dealing with this condition. There is however, limited literature that is specifically focused on student nurses' experiences of UI. However, one recent study by Hutchings and Sutherland (2014) found that

student nurses overall are positive towards promoting continence but feel that nurses do not always have positive attitudes when caring for patients with UI. Attitudes and attitude formation in general, suggests that student nurses will enter the profession with a set of values, which may change during the socialisation process to reflect the values the profession holds (Cohen, 1981; Gray and Smith, 2000; Curtis, Horton and Smith, 2012). It is therefore essential that students are exposed to high quality role models, both from education and practice in order to promote and explain the need for positive attitudes in nursing and health care in general (Stewart, 1999; Gray and Smith, 2000; Baldwin *et al,* 2014). Delivering this type of intimate care however, has its challenges.

Crossing boundaries: delivering intimate care

Providing essential nursing care for patients has been at the heart of nursing for decades and traditionally providing this care, which has often been referred to as 'basic', often implies that it lacks importance (Stevens and Crouch, 1995). In light of the recent Mid Staffordshire NHS Foundation Trust Public Inquiry however, it is this fundamental level of care that was found to be sadly lacking in nursing practice leading to poor patient care outcomes and declining professionalism in nursing (Francis, 2013). It would appear that 'technical' nursing is seen as a much higher priority and has much higher status maybe because these aspects of nursing care are predominantly undertaken by qualified nurses leaving the 'basic' care delivered by unqualified staff (Stevens and Crouch, 1995). This level of care is then subsequently managed predominantly by unqualified staff with minimal supervision and there appears to be a tension around the degree to

which students are considered part of the workforce and how 'involved' they are with the delivery of care (O'Driscoll, Allan and Smith, 2010). This study also found that despite students' supernumerary status learning is still expected to occur through doing i.e. through delivering hands on care so are seen as 'workers' which may act as a barrier to learning, findings which are consistent with Elcock, Curtis and Sharples (2007) and Midgley (2006).

Delivering 'hands on' care is a challenge for the novice nurse especially when a large proportion of that care is quite intimate in nature and it can prove to be a challenge for both the carer and the recipient of this type of care (Crossan and Mathew, 2013). The concept of intimate care has been explored within the nursing literature although not widely with respect to student nurses (Inoue, Chapman and Wynaden, 2006; Zang, Chung and Wong, 2008; O'Lynn and Krautscheid, 2011; Crossan and Mathew, 2013).

The seminal work of Elias (1978) clearly states that how we view our bodies and the degree of exposure of our bodies to others is governed by social rules and boundaries as to what is socially acceptable. Foucault (1976) however, argues that when a person is hospitalised these social rules and boundaries are breached as during this time their bodies are subjected to an unwarranted degree of surveillance, which may not take into account the emotional effect this may have on both the patient or their carer. White and Getliffe (2003) suggest that it is generally assumed that nurses are comfortable with this aspect of care and argue that dealing with a person who is not able to control their bodily functions does evoke feelings of disgust and resentment particularly when having to deal with

the smell and the mess. They go on to discuss that as part of dealing with this nurses need to develop ways of managing their reactions as what is also clear is that patients who have lost control of their bodily functions feel socially isolated and lack self-esteem (Shaw, 2001). This care therefore needs to be met while acknowledging the personal feelings of the patient (Crossan and Mathew, 2013). However, this poses as a challenge for the student nurse as they are generally novices in age, social maturity, social responsibility and struggle to take on this professional responsibility of providing intimate care to strangers (Seed, 1995; Crossan and Mathew, 2013). This responsibility is thrust on the students as expected norm by academic, peer, social and professional expectations and students continue to experience high levels of stress in the clinical environment (Sheu, Lin and Hwang, 2002; Inoue, Chapman and Wynaden, 2006). Despite the unnatural and intimate level of interaction with strangers and their bodies when providing intimate care, student nurses get little, if any, support during their educational preparation (Inoue, Chapman and Wynaden, 2006).

Providing intimate care to patients however, is an important aspect of care delivery that the students view as an essential role for the development of a therapeutic relationship with their patients (Boughn, 2001). Developing coping strategies therefore were seen as necessary to deliver this care as often students felt unsupported as previously discussed. Bonis (2009) describes some of these strategies as removing any subjective feelings and experiences in an attempt to desexualise the care that they are delivering in order to interact with the patient effectively. This appears to agree with Seed's (1995) much earlier work where it was found that students really value the intimacy of providing this type of care

and recognise and understand the need to respect a patient's privacy and dignity at all times during the interaction. The ability to provide intimate care was viewed as an essential factor to aid in the recovery and rehabilitation of the patient. This finding concurred with that of Lawler (2006) where student nurses saw that providing intimate care was a part of that role and a role that was highly valued.

Developing a meaningful and therapeutic relationship whilst delivering intimate care is seen as a high priority for student nurses, in fact it would appear that they rate the privacy needs of the patients more than the patients themselves (Back and Wikbald, 1998). There were however, concerns expressed at the speed of which some of this care was delivered and students comment on how everything is 'rushed' and McCabe (2004) reported that that students felt delivering this type of care was like 'a bit of a race'. Mackintosh (2006) also found this and reported that students often felt disillusioned about the realities of practice and that preserving their own personal values, promoting compassion and taking their time when providing intimate care were very important aspects of their practice. Although these are opinions of novice nurses the profession needs to pay attention as it is this very generation that are providing insights into how we care for our patients and we have much to learn from their experiences (Mackintosh, 2006).

Providing intimate care like the care required for people with UI, requires a skilful, knowledgeable, competent and compassionate practitioner. Student nurses therefore need to be exposed to skilful, knowledgeable, competent and compassionate nurses from all disciplines, unqualified staff, qualified staff and all

who have a responsibility for education for nurses (Crossan and Mathew, 2013). Exposure to good role models may therefore be at the centre of this debate to ensure that students are enabled to continue to deliver intimate care with thought and compassion at all times. Traditional ritualistic and task orientated practice may have no place in enabling student nurses to deliver this quality of care leaving them frustrated and disillusioned (Mackintosh, 2006). Some studies have attempted to suggest that 'tasks' are no longer the focal point or the delivery of care (Salvage, 1992; Reed and Ground, 1997) however, Mackintosh (2006) found that routines and tasks still dominate what student nurses are exposed to on a daily basis. This may create a dissonance between what they have learnt in theory and the realities of clinical practice and how students are socialised into the profession of nursing is crucial if the profession is to harness these ideals in order to facilitate and nurture these students as competent and compassionate practitioners of the future.

Student Socialisation

Nursing students have been found to mirror the behaviour of practicing nurses (Sadow, Ryder and Webster, 2002) therefore, individual staff can have a major influence on the effectiveness of the clinical environment for teaching and learning (Gray and Smith, 2000; Hughes 2005). Additionally, the culture of the workplace is paramount to the success of the placement. For example, a ward which is not amenable to making the most of teaching and learning opportunities will not be viewed in such a positive light as one in which students feel valued. The relationships between staff are therefore also important (Gray and Smith,

2000) and furthermore, since their mentor is their linchpin, students often learn their mentors' preferences (Gray and Smith, 1999). It is possible then, that students may learn to conform in order to cope with the reality of becoming a nurse and create a smooth path towards their final goal (Sadow, Ryder and Webster, 2002). This was confirmed in Phillips, Davies and Neary (1999) earlier study, where students discussed 'learning the routine' and 'fitting in' as ways in which conformity was manifested. It is vital to them that they are accepted by colleagues as this facilitates the loss of the 'outsider' role and the associated stigma (Phillips, Davies and Neary, 1999). Later studies continue to confirm this need for student nurses to be accepted by their clinical colleagues in practice and in these later studies it is described as 'belongingness' which is seen as fundamental for their clinical learning (Levett-Jones and Lathlean, 2008; Levett-Jones *et al,* 2009). Furthermore, Melia (1981) in much earlier work had described this process as learning survival skills.

The rewards for conforming have been identified in a study by Gray and Smith (1999) who found that conforming to the prevailing norms increased the likelihood of the student having a good placement, feeling part of the team and like a nurse, pleasing their mentor, receiving a good practical assessment and reducing stigma. However, what can be counterproductive to this relationship is that students learn the art of passive acceptance or compromise, sometimes at the expense of doing what they had been taught was the right thing to do (Woods, 2005).

Maben, Latter and Macleod Clark (2007) suggest that there are three phases that help or hinder nurses in practicing in the way that they want to practice and how they are able to practice. This study found that the sustainability of ideals and values in practice created three categories of experiences. Those that maintained their values and ideals, sustained idealists, those that compromised their ideals, compromised idealists and those who had lost any sense of their own ideals and values, crushed idealists (Maben, Latter and Macleod Clark, 2007). These findings are congruous with the findings of a later study by Murphy *et al.* (2009) who identified that students caring behaviours changed significantly throughout their three years of training. They reported that whilst there is an expectation that nurse education will nurture and develop students' professional behaviour throughout their training, there is some evidence that this process does the exact opposite and actually the students become accustomed to the status quo rather than develop these behaviours. This study appears to relate this to the educational process (Murphy *et al,* 2009) however, as debated already in this chapter this could be due to numerous other influences. It could be argued that economic and sociological factors impact on what is perceived as 'ideal practice' and that this restricts practice however, the findings in Curtis, Horton and Smith (2012) study go beyond that and demonstrate that there are existential issues that come from being human which cannot be explained away by economic and sociological factors and should be recognised and explored.

Student nurses often feel that they are not in a position to challenge the practices of their qualified mentors and often express this as 'feelings of powerlessness' while in the clinical setting (Woods, 2005). In view of the fact that evidence

suggests that health care professionals find UI both time consuming and frustrating (Connor and Kooker,1996), this may therefore present the student nurse with a challenge in applying proactive approaches to treating UI. Yacobi (2012) describes this approach to 'fitting in' as a necessary collaboration which may demand some adaptation and compromise. This dissonance between what the student is taught in theory about proactive treatment therefore, may conflict with reality of clinical practice (Severinsson, 1998). Perhaps what is more alarming about Woods (2005) findings is that they are very similar to findings of a study conducted some eighteen years earlier. This seminal and frequently referenced piece of work is related to the socialisation of student nurses (Melia, 1987).

This study explored what student nurses thought about nursing and were interviewed over a period of eighteen months. A major feature of the students' accounts of their experiences was the emphasis they placed on the trained nurses' attitudes towards them. Students felt that they had a relative lack of power within a traditional ward hierarchy in which the student occupies the bottom place. The students clearly saw themselves in the role of worker, a role both defined and reinforced by their position within the hierarchy in which care is planned by the qualified and delivered by the unqualified (Melia, 1987). This is further supported in Wakefield's (1996) study and argues that as students are now supernumerary and not classed as part of the workforce they have become less visible and as a consequence the nursing interventions that would have been very much in their domain have now become subsumed in the Health Care Assistants' (HCA) role. As a consequence, O'Driscoll, Allan and Smith (2010)

found that HCAs play a significant role in helping students to acquire bedside care skills and therefore as Roberts (2008) argues, when considering professional socialisation of a professional group, it is reasonable to question whether role models are expected to establish not just how to do the job, but also to be competent in the job that they do and that they behave professionally at all times.

Student Support

There is evidence that students are learning the fundamental skills by observing and working with HCAs in practice (O'Connor, 2007) which may affect how they perceive who has responsibility for this type of care (Mackintosh, 2006; O'Driscoll, Allan and Smith, 2010). Furthermore, that puts the fundamental aspects of essential care into the not 'real nursing' category as found by Melia (1981) and puts it firmly in the menial work of nurses. This has major problems for continence promotion as reports by Bittner and Gravlin (2009) and Gravlin and Bittner (2010) have found delegating these aspects of nursing care to unqualified staff has resulted in some aspects of nursing care being omitted including toileting.

This has recently also received much attention form the publication of the Francis Report (Francis, 2013) which highlighted the fact that fundamental essential nursing care was not being delivered and tolerance of poor standards was accepted. Many of the harrowing stories that have come out of this report refer to patients being left lying in their own excrement and patients being denied the

basic human right of being assisted with their personal hygiene needs, including help with toileting (Francis, 2013). If the profession of nursing is willing to delegate these essential aspects of nursing care to unqualified and unregulated staff who are in the main unsupervised, but appear to be supporting student nurses in practice (O'Driscoll, Allan and Smith, 2010), there is a danger that these novices will be influenced by the norms and values demonstrated by this group of care givers. This was raised as a concern in an earlier study by Allan, Smith and Lorentzon (2008) who expressed that 'student nurses may be learning essential care from HCAs and not nurses' pg. 552. Wright (2006) also comments on the fact that despite of this obvious involvement of the HCA in mentoring the student nurse there is no formal recognition for this role and perhaps more alarmingly, the HCA has no training to sustain them in this role. Spilsbury *et al.* (2009) and Wakefield *et al.* (2009) found that there was no mandatory requirement for the HCA to undertake any formal training however, following the Francis Report (2013) the Cavendish Review (2013) was published which made recommendations that all unqualified staff should have a standard level of educational achievement before they could work unsupervised. Rycroft-Malone *et al.* (2014) suggest that this review would appear to be timely to enhance the knowledge and skills of HCAs in order to meet the high profile challenges of providing quality patient care. This has also been welcomed by the Care Quality Commission (CQC, 2015) but as this initiative has only been announced this year there is no evidence to draw on in terms of how this will affect student nurses, who spend a significant amount of time working directly with HCAs in clinical practice. However, this could potentially impact on how direct care is perceived

and could lead to it being viewed as a less important aspect of healthcare (Gordon, 2006; Mackintosh, 2006; O'Driscoll, Allan and Smith 2010).

If student nurses are exposed to HCAs as role models, who are largely unsupervised in their own practice, there may be potential conflict in how student nurses subsequently deliver care. The findings in O'Driscoll, Allan and Smith (2010) study confirm this and they argue students look in vain for leadership for learning and often have little option but to take responsibility for their own learning. Furthermore, if they are then exposed to role models who demonstrate behaviour that conflicts with their sense of professionalism there is potential for student nurses to become desensitised to human need through repeated, mundane exposure to poor nursing practice in clinical environments if they are not supported by proficient staff (Rodgers *et al,* 2013). This was found to be the case in much earlier work where prior unrealistic expectations of nursing care were uncovered as students often faced exposure to poor role models that devalued personal care (Olsson and Gullberg, 1991; Davis, 1993; Greenwood 1993; Stevens and Crouch, 1995). This appeared to also effect patient outcomes and Spilsbury and Meyer (2005) found that as the registered nurse has taken on more technical aspects of care, other aspects of care, particularly associated with personal care has been devolved to the unqualified HCAs. These HCAs are often delivering essential nursing care with poor and ineffective supervision from qualified nurses and as Kalisch, Landstrom and Hinshaw (2009) highlighted, this has led to missed nursing care and poor patient outcomes as discussed previously. There is however, another complication here in terms of how the registered nurse supervises the HCAs work. The majority of continence care

takes place behind closed toilet or bathroom doors and therefore supervising the HCAs practice is concealed (Spilsbury and Meyer, 2005). The registered nurse therefore, may not be aware of the HCAs level of practice abilities and skills and this may have a direct effect on the quality of care that is delivered to these patients and the quality of care that the students are exposed to.

It would appear crucial for students to be exposed to nurses who are knowledgeable, competent and confident in performing essential nursing care in order to provide quality nursing care (Standing and Anthony, 2008). Being supported by HCAs in practice in the delivery of continence care, may result in student nurses observing sub-optimum levels of care for patients with UI. Ironically, following the Francis Report (2013) recommendations were made for pre-registration nursing students to gain up to a year's experience as a healthcare assistant. However, if HCAs remain predominantly unsupervised by registered nurses as discussed above, there is potential that this year of experience may be exposing students to poor quality role models in terms of the delivery of optimum care for UI. Exposure to unqualified mentors may not necessarily be of any advantage in developing compassionate and caring nurses of the future.

However, adequate mentorship in clinical practice is challenged by the other demands such as poor staffing levels (Hurley and Snowden, 2008; Rankin *et al,* 2015) which will have an effect on mentors and, subsequently, students' learning. It has also been suggested that a lack of qualified assessors is the main reason it is increasingly difficult to find clinical placements for students (Audit Commission,

2001). Burns and Glen (2000) and Hurley and Snowden (2008) found similar issues in that, clinical areas are under increasing pressure to find skilled and qualified mentors because of the increasing number of students. This is further exacerbated by the fact that before 2001 there were no national standards for formal mentor preparation (Audit Commission, 2001) leaving many qualified staff feeling inadequate at mentoring students. This has often led to conflict of role for some, in that a nurse co-ordinating a busy ward area may be required to mentor or supervise students and this could lead to unnecessarily high levels of stress for both as, fundamentally, these are two very different roles (Butterworth, 1998; Hurley and Snowden, 2008; Myall, Levett-Jones and Lathlean, 2008).

The *Code of Professional Conduct* (NMC, 2015) however, states that registered professionals have a duty to encourage students to develop confidence. It would appear therefore that the presence of qualified staff as mentors make a major contribution to the quality of the students' experience. Ogier's (1982) early study found that the Ward Sister played a significant role in creating and maintaining the ward learning environment, not just through commitment to teaching but also the organisation of the ward work, leadership style and patterns of interaction which contributed to this environment. This was also discovered by Cahill (1996) and Lambert and Glacken (2004) who both reported that the Ward Sister and their organisation of care delivery had a positive impact on the student nurses' experiences of mentorship. However, over recent decades the role of the nurse has changed extensively and Ward Sisters often have to forfeit clinical teaching in lieu of a myriad of other responsibilities (Lambert and Glacken, 2004) leaving what we commonly call 'bedside nursing' or 'basic nursing care' to HCAs which

may lead to the perception of students that this is not an important element of nursing care (O'Driscoll, Allan and Smith, 2010). Therefore, as Pearcey and Draper (2008) support, it is essential that we listen to the student voice which may produce painful but accurate insights into the clinical 'being' of nursing. This is perhaps even more essential in light of the negative findings from the Francis Report (2013) that nurses lack compassion and that essential nursing is undervalued. These views may be coming from those with little nursing experience but in terms of highlighting the nature of the 'unseen' side of nursing there is much to learn from student nurses personally, clinically and educationally (Pearcey and Draper, 2008).

Students learn by being exposed to practitioners in the clinical environment and by educators within HEI environments. Being exposed therefore to poor nursing practice repeatedly may begin to desensitise the students and their ideals about what good quality care delivery means for them. Rodgers *et al.* (2013) suggest that this may occur if students experience insufficient resources with regard to good close supervision by proficient staff, alongside this is another dilemma. If students lack the confidence to raise their concerns regarding how they are supported in practice, it is likely that they will be subsumed into the traditional task orientation of care, which as Melia, (1987); Walsh and Ford, (1994); Henderson *et al.* (2012) report, may not be conducive to maximise learning in practice. In relation to dealing with UI, this could be crucial. If students are not supported by qualified nurses in this area of health care, there is potential that this type of care will not be viewed as important and not deemed to be the remit of a qualified member of staff.

In order to support students in their transition from a lay person to a nurse, there is a need to ensure that they acquire the values, attitudes, knowledge and skills of a professional group, who not only support the student in valuing the nature of the role but, also enhance their sense of professionalism (Roberts, 2008). Exposure to poor role models has been found to challenge these ideals and can lead to students, in their fear of 'not fitting in', to emulate the behaviour rather than challenge this behaviour.

The new initiative introduced by the UK Government (Willis, 2015) however, may impact on the skill mix within clinical practice and provide a new practitioner to bridge the gap between the Registered Nurse and the Senior Healthcare Assistant. Since the first Willis report (2012) and the subsequent Francis (2013), Berwick (2013), Keogh (2013) and Bubb (2014) reports, there has been much emphasis placed on the need for care that is patient-centred, compassionate and that it is delivered by well informed and educated health care professionals. The new Nurse Associate role is intended to build capacity to care and treat and will sit alongside the care support workers and the qualified registered nurses to deliver hands-on care (Merrifield, 2015). In terms of student support, this may be a way forward to ensure that student nurses are supported in clinical practice by educated and skilled nurses. The new Nurse Associate role may alleviate these areas of concern regarding student nurse support whilst in clinical practice and will be worthy of review when the new role has been established.

Summary

The seven key themes identified in this review suggested that there are many influences which may affect the students' experiences. Table 8 reflects the findings from the seven key themes identified and highlights the evidence that had relevance for this research and subsequent thesis.

This literature review established the following. Pre-registration curricula have limited educational input regarding UI throughout the three years of the pre-registration training programme. In combination with the fact that both patient and HCPs' attitudes are also negative towards UI, student nurses may find themselves exposed to poor quality role models who influence their own thoughts and feelings about UI. This identifies a gap in the knowledge as what is not known is if these attitudes affect student nurses in year one of their training programme. If negative attitudes persist this may impact on student nurses' experiences and UI may continue to be viewed as low priority of healthcare.

Exploring student nurses' experiences could help break this cycle of negativity by understanding what the students' experiences and perceptions are about providing UI care at the beginning of their first year of training and after the completion of their first year. It would appear from this literature review that the attitudes and behaviours of clinicians and educators are of paramount importance if we are to produce student nurses with positive attitudes towards UI. Further exploration of these issues is therefore clearly indicated and this study not only bridges the gap in the knowledge about student nurses' experiences of dealing

with UI in their first year of study but will also provide valuable information for future student nurses, health care professionals who support student nurses in practice and nurse educators.

As I want to appreciate their experiences, the theoretical perspective I will adopt will have emphasis on understanding appreciation of context and acceptance of human beings as active constructers of meaning rather than recipients of externally and objectively defined meanings (Crotty, 1998). The key focus of my research will therefore be to explore their experiences underpinned by the philosophy of phenomenology.

Table 8: Summary of findings from literature review: Evidence and its relevance to this research study.

Key Themes from the Literature Review	Evidence	Relevance for this study
Student Education and the Curricula	Education for UI is in the pre-registration curricula but patchy and what it involves and where it sits within the curricula is not evident. **(Cheater, 1992; Laycock, 1995;Cheater *et al*, 2008; McClurg *et al*, 2013a)**	Lack of pro-active education for UI may influence how UI is subsequently perceived in both education and practice.
Attitudes and attitude Formation	Attitudes are a predisposition to behave in a particular way and there is a strong relationship between attitudes and behaviour. **(Cross, 2005;Ajzen, 2005; Crano and Prislin, 2008; Schwarzer, 2014; Cooper, Blacman and Keller, 2015)**	Student nurses may be influenced by the attitudes of others either positively or negatively.
Attitudes of patients towards UI and their help-seeking behaviour	Poor lay beliefs about UI; 'UI is normal for their age' 'Usual female complaint'. Reinforced by HCPs, no meaningful help offered when mentioned by patients to HCPs. (**Jolleys, 1988; Jeter and Wagner, 1990; Goldstein *et al*, 1992; Brocklehurst, 1993; Ashworth and Hagen, 1993; Fultz and Herzog,2001; Teunissen and Largo-Janssen, 2004; Hagglund and Wadensten, 2007;Pilcher and MacArthur, 2012)**	UI not important. Reinforces negativity about this area of healthcare which could influence how student nurses perceive it. Passive acceptance that UI is not a problem that requires exploration
Attitudes of healthcare personnel towards UI	Passive acceptance of UI by HCPs and display negative attitudes towards UI. Reinforces beliefs of lay people as very little priority given to this area of healthcare**.** **(Yu and Kaltreider, 1987; Yu *et al,*1989; Cheater, 1992; Vinsnes *et al,* 2001)**	Students are exposed to HCPs in clinical practice. Evidence suggests that HCPs have negative attitudes towards UI which may directly affect student nurses own attitudes during their socialisation into the profession.

Crossing Boundaries: delivering intimate care	Ritualistic practice exists that show little respect for UI. Challenges to compassionate practice identified in respect of privacy and dignity, disillusioned students regarding the realities of practice. **(Inoue, Chapman and Wynaden, 2006; Lawler, 2006; Mackintosh, 2006; Crossan and Mathew, 2013)**	Ideal versus realistic practice Students may be disillusioned by realities of practice and be challenged in the provision of pro-active UI care.
Student Socialisation	Students learn from their mentors. This may be positive in relation to UI or a negative experience. Students require good role models 'learning the routine' and 'Fitting in' are important aspects of their socialisation sometimes compromising their ideals for practice. **(Melia, 1987; Wakefield, 1996; Maben, Latter and Macleod Clark, 2007; Levett-Jones and Lathlean, 2008; Murphy *et al*, 2009; Levatt-Jones *et al*, 2009 O'Driscoll, Allan and Smith, 2010)**	Feelings of powerlessness to challenge practice. Dissonance between what is taught and the reality of clinical practice.
Student support	Students spend a lot of time supported by unqualified staff who view UI care as low priority. Qualified staff make a major contribution to student learning. **(Melia, 1981; Wakefield *et al*, 2009; O'Driscoll, Allan and Smith, 2010; Henderson *et al*, 2012; Francis, 2013; Willis, 2013; Bubb, 2014)**	Unqualified staff acting as role models could influence student nurses perceptions about providing quality UI care maintaining a cycle of negativity about this aspect of healthcare.

CHAPTER 3: RESEARCH METHODOLOGY

Introduction

The purpose of this chapter is to describe and justify the approach adopted for this research. It details the chosen research paradigm and methodology and the approach used to gather the data to develop meaning from the data gathered. This study adopted a longitudinal approach, interviewing the students at two different times within their first year, once at the beginning of the first year and again at the end of the first year. This was selected in order to capture the students' experiences and thoughts before commencing their first student nurse clinical placement and on completion of their first year of training.

Framing: the research question and context

The research question provides the hub around which to build the methodology and the research question is worded in this way**:**

What are undergraduate adult nursing students' experiences of urinary incontinence (UI) in their first year of study?

Research Aims

To explore student nurses' experiences of dealing with UI in their first year of study and to illuminate factors that could influence their perceptions of caring for patients with the condition.

The research will specifically explore:

1. Student nurses' experiences of dealing with UI prior to and following clinical exposure, in their first year of study.

2. How student nurses care for patients with UI.

3. What the experience of caring for patients with UI means to them.

4. How student nurses' own perceptions of UI are shaped and influenced in their first year of study.

Methodology and philosophical underpinnings

When searching for understanding of phenomena in the world of caring it is necessary to reflect on ontological and epistemological concerns before choosing a methodological approach. As a researcher I felt that I needed to ask questions not only about the phenomenon under study, but also about the relationship between explanation and understanding and whether the research method is

consistent with the particular view of human nature that the caring science paradigm imposes. Titchen and Ajjawi (2010) make a distinction between epistemological and ontological questions which, they claim, has direct repercussions for the methodology.

Phenomenology is an approach to philosophy and is partly about the epistemological question of 'how we know' and deciding what knowledge is true and legitimate (Gray, 2009). It is also connected to the ontological question 'what is being' and our knowledge about 'how things really are' (Taylor, 1995) and therefore my ontological question involved student nurses' experiences of dealing with patients with UI and what these experiences meant for them in their own lifeworld. Utilising a quantitative approach would not have been congruent with seeking to understand these in depth individual experiences. Quantitative researchers attempt to predict and explain the objects of their research using the research evaluation criteria of objectivity, reliability and validity (Higgs, 2001). As I wanted to explore pre-registration student nurses' experiences and how they make sense of their own perceptions (lifeworld) of how they care for people with UI, these experiences therefore cannot easily be reduced or measured as required in quantitative research.

I would argue that phenomenology was an appropriate methodology for this study as I wanted to understand the student nurses' experiences of dealing with UI and what it meant to them (McManus Holroyd, 2007). Johnson (2000) suggests that the phenomenological researcher aims to describe and/or understand the meaning of the participants' lived experiences and current

phenomenological research in nursing has been most influenced by Husserl and Heidegger (Cohen, Khan and Steeves, 2000).

Husserlian Phenomenology

Husserl's school of phenomenological philosophy argues that there is a phenomenon only when there is a subject who experiences the phenomenon (Sadala and Adorno, 2002). An important component of Husserl's philosophical approach was that in order to grasp the essential lived experience of those being studied; the researcher should strip their own consciousness of all prior expert knowledge as well as personal biases, achieving a state of transcendental subjectivity so as not to influence the object of study (Lopez and Willis, 2004). Husserl described this process as 'bracketing' or '*epoche*' placing the natural attitude towards the world in brackets (Walters, 1995); in an attempt to set these aside in order to capture 'essence' of objective truth and reality (Seymour and Clark, 1998). Heidegger however, argued that Husserl's attempt to explain everything as products of consciousness overlooked dimensions of existence and that it was not possible to bracket one's 'being in the world' in the process of philosophical enquiry (Walters, 1995). Koch (1995) also argues that there is no such thing as uninterrupted observation and that interpretations that emerge from the data are influenced by conceptual learning's and the interpretive background used. Gadamer's (1989) contribution to this debate argues that a value-orientated approach is unavoidable because all people involved in the process have a pre-understanding of the phenomena in question and that these values rather than getting in the way, make the research meaningful.

Heideggerian Phenomenology

Heidegger's phenomenology developed into interpretive philosophy that became the basis for hermeneutical methods of inquiry (Holloway and Wheeler, 2002). Taylor (1995) defines hermeneutics as the analysis and interpretation of language and text and is not considered as a special process, divorced from our everyday lives, it is one of the processes people use in making sense or understanding their everyday world (Walters, 1995). Heidegger's hermeneutic phenomenology goes beyond mere description and into interpretation of meaning (Cohen and Omery, 1994). Draucker (1999) suggests that this interpretive phenomenology explores the meaning of being a person in the world, rather than suspending presuppositions, researchers examine them and make them explicit. In *Being and Time,* Heidegger (1926/1962) shifts the philosophical debate from epistemology to ontology and his analysis of 'Being' is achieved by a study of the ordinary everyday existence of people.

Dasein (Being There)

Heidegger refers to human existence as *Dasein* or being-there, which emphasises the situatedness of human reality and Heidegger's analysis of the human condition is that people are 'in and of the world, rather than subjects in a world of objects' (Reed, 1994). Heidegger notes the task of ontology is to 'explain Being itself and to make the Being of entities stand out in full relief' (Heidegger, 1926/1962, p.49). Thereby Heidegger's methodology pertains only 'to the things themselves!' (p.50) as experienced by us. He does not accept that his

methodology will accidentally stumble on findings. Instead his aim is to uncover existing phenomena, which indicates 'the totality of what lies in the light of day or can be brought to light' (p.51).

Heidegger also describes *Dasein* as ways of being that may not always have been freely chosen by us. Heideggerian thinking talks about this as the 'authentic self' in which one chooses the nature of one's existence and identity (Kierkegaard, 1985). In addition, it also relates to the degree to which one is true to your own personality in spite of external pressures (Langdridge, 2007). According to Dreyfus (2000) if we don't stay true to our own personalities and our own values and beliefs, we are conforming and will lead 'unauthentic lives'. However, there is a paradox here. Being part of society requires us to feel a sense of belonging and a desire to fit in and not be too different although there will be times when we will be our 'inauthentic self' in order to achieve this however, we can go back to our authentic self at any time (Inwood, 1997; Dreyfus, 2000). This notion of 'belongingness' is clearly articulated as an important aspect for student nurses when they commence their training as they need to feel part of the team (Spouse,2001; Levett-Jones and Lathlean, 2009). Remaining true to their 'authentic self' however, is challenging for student nurses as in their attempt to 'fit in' in order to belong, students often revert to their 'inauthentic self', accepting the values and norms of the learning environment, even if this does not reflect their own values (Malouf and West, 2011). This is described as conscience and in the Heideggerian sense this is a voice that is within ourselves which calls us to make sense of what we are doing and makes us responsible for our actions. Responding to our conscience in this way

Heidegger terms as ‘resoluteness’ and is a way of dealing with the consequences of our conscience so we can ‘flee into inauthenticity’ and conform to the norms, values and beliefs of the people around us (Dreyfus, 2000). This idea of fleeing into inauthenticity and doing as everyone else does Heidegger describes as having fallen into the ‘they’, meaning it appears that somewhere along the line we get ‘lost’ and become part of the ‘they’. Heidegger states that this is losing your own identity in the process and describes this as ‘unheimlich’ meaning ‘unhomelike’ or ‘uncanny’ which will go on to cause anxiety (Heidegger, 1926/1962; pg.233). Heidegger acknowledges however, we do not have to follow what everyone else does however, if we do chose this path, then we have to accept the unsettling nature of this as a consequence (Heidegger, 1926/1962) hence raises our anxiety. This is an important aspect for this study in understanding the students’ experiences of dealing with UI throughout the first year of their training programme and what it meant for them.

Another important area within this research approach is the subject of hermeneutics and the hermeneutic circle.

Hermeneutics and the Hermeneutic circle

Acknowledging our pre-understanding of situations is a key aspect of the hermeneutic circle in that it is impossible for human understanding to operate from a detached perspective. This is a contrast to Husserlian phenomenology. The difference is in Heideggerian phenomenology, these pre-understandings are embraced and are valued rather than bracketed out which is associated with

Husserl's philosophy. Heiddeger's thoughts were that we all bring 'baggage' to the research process in terms of our understanding of the world and these pre-understandings of how we interpret things are an important aspect of hermeneutic phenomenology (Heidegger,1926/1962:195). As I was a Nurse Lecturer with a specialist interest in urinary incontinence, it was impossible for me to bracket out my understanding of this area of clinical practice. In fact, by doing this I would have distanced myself away from explicitly evaluating the social reality I wished to portray. I have in my current role identified the phenomena under exploration in this thesis and it could be argued therefore that I was totally immersed in the experience. However, in order that our understanding of a circular *Dasein* does not simply become a self-perpetuating circle in which we can learn nothing new, applying language to interpret lived experience allows a meaningful engagement which leads us beyond everyday understandings. The hermeneutic circle itself is taken to be both a feature of *Dasein* and a device for the interpretation of human experience. In order to understand what this meant for the students', this investigation required them to engage circumspectively with their comportment in their 'ordinary, everyday world' (Valle, 1978).

These multiple perspectives help the researcher to prepare for the data analysis as the researcher melds personal knowledge with emergent understanding which as Rapport (2005) states is about taking part in the 'hermeneutic conversation'. What this meant at the analysis stage of the study was that my own personal 'horizons' would be taken into consideration although during the data collection it was important to actively listen to what was being told and what meaning was being articulated (Rapport, 2003). Listening closely will explain the participants'

experiences and as Heidegger, (1926/1962) states, to live is to listen, interpret and learn from the stories others convey. This 'pre knowledge' and understanding of the world is an important aspect of engaging in the hermeneutic circle as these 'pre-understandings' bring focus so that we can endeavour to understand them more fully (Koch, 1995). As a consequence, my pre-understandings will be made explicit throughout this study. Keeping a reflexive journal was therefore essential for this study on two accounts: one being that it was impossible to eliminate my influence on the interview as I was a Lecturer in Nursing with a specialist interest in continence promotion and therefore this would be known to the students. Acknowledging this through the use of a reflexive journal however, added to the quality of the data collected. Secondly, as this was a longitudinal study, this also enabled me as the researcher, in follow up hermeneutic conversations with the interviewee, to collaborate in interpreting the significance of the preliminary themes (van Manen, 2002). Reflexivity is therefore a defining feature of qualitative research as the researchers' experience also belongs to the data (Finlay, 2003). Figure 3 shows how the students' experiences connect with phenomenological interpretation and how that in turn leads to methodological cohesion. The central component of the figure shows the students' lifeworld and how this is represented by phenomenological description, e.g. lived experience is about being a student and their experiences as they are 'lived'. The left hand side of the figure shows how these experiences are mapped to Heidegger's philosophical underpinnings, e.g. being a student and their lived experiences is connected to *Dasein* – Being there. The right hand side of the figure shows how the formal processes of the research methods are aligned to phenomenological description. Figure 3 overall attempts to show an overall rationale for the choice

of methodology that shows cohesion between the students experiences, phenomenological description and underpinning Heideggerian philosophy.

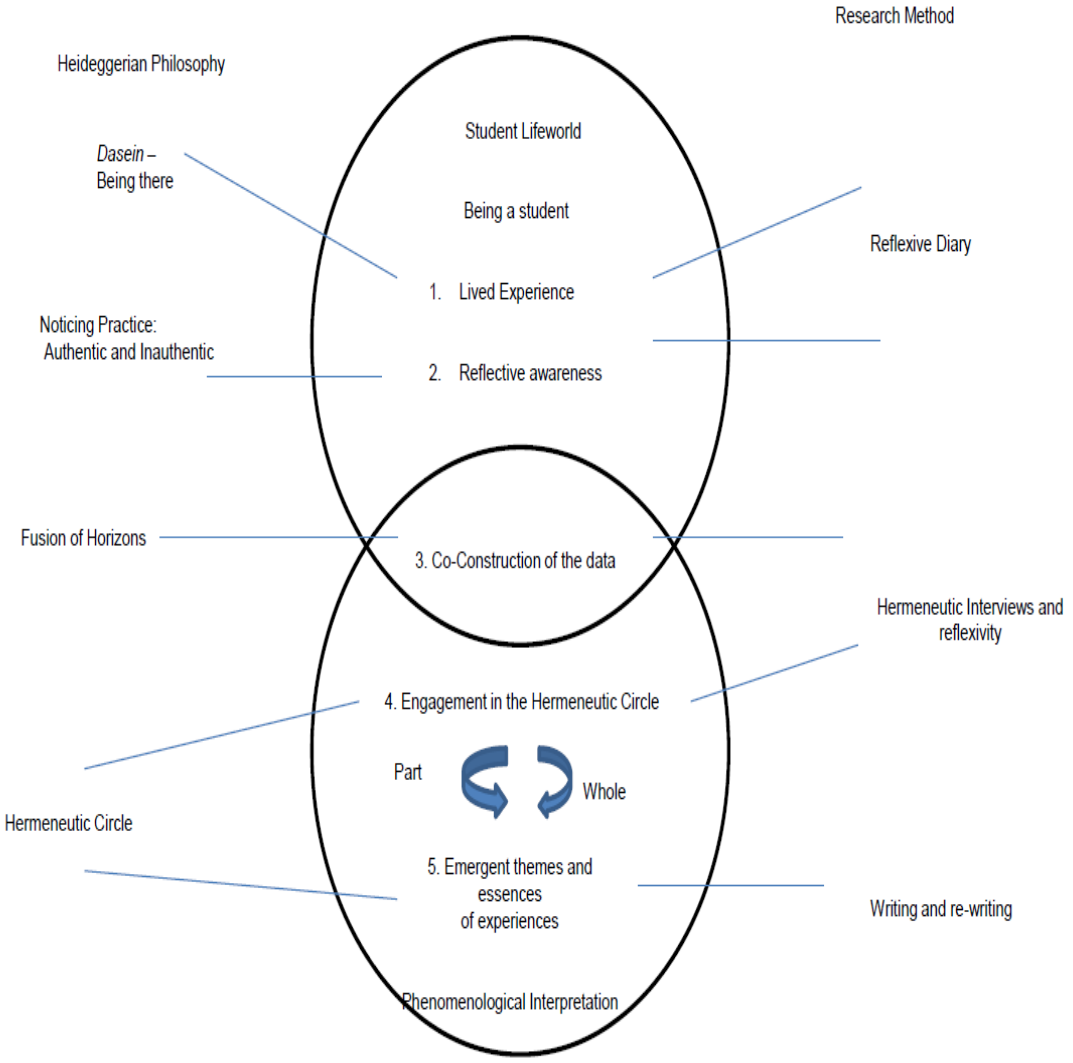
Summary and overall rationale for choice of methodology

This chapter has made a case for the application of hermeneutic phenomenology in order to explore student nurses' experiences of dealing with UI in their first year of study.

Phenomenology is concerned with the lived experience and is a philosophical science which gives meaning and a deeper understanding of human experience. My primary aim for this research was to explore the lived experiences of student nurses dealing with UI in their first year of study in an effort to understand and give meaning to their experiences. Hermeneutic phenomenology allowed me to explore the participants' interpretations and enabled me to add my own. This was facilitated by the use of both communication and language which hermeneutics offers in an attempt to understand and capture human experiences in context (van Manen, 1997).

Figure 3: Student Lifeworld to Phenomenological Interpretation: Methodological cohesion

(adapted from Wilson, 2012)



CHAPTER 4: RESEARCH METHODS

Introduction

The purpose of this chapter is to describe the methods used to gather the data and derive meaning from the data.

Study Setting

Study participants were drawn from two cohorts of student nurses commencing their Bachelor of Nursing and Advanced Diploma in Nursing programmes in September 2010.The students' programme involved 50% theory, which took place in two higher education institutions (HEI). The other 50% of their time, was spent in clinical practice. My relationship to the students was that of a fellow student within the same University completing my Doctorate in Clinical Practice. Permission to approach the cohort was requested from the Head of the School of both institutions and following a successful ethics approval from both institutions (see Appendix 8). All interviews were conducted in a place that was mutually convenient for both the participant and the researcher which was in a meeting room within the University.

Sampling

Pre-registration students from the cohort of September 2010 intake were invited to participate in the study from both HEIs. Participants were purposefully sampled from the 2010 intake of Bachelor of Nursing degree programme students and the Advanced Diploma programme students undertaking a three-year pre-registration

nurse education programme within both HEIs. As I wanted to explore student nurses' own lived experiences of UI I anticipated that up to 15-20 volunteer pre-registration student nurses would allow for rich data collection. There were no specific inclusion and exclusion criteria for this study.

Purposeful sampling is used most commonly in phenomenological inquiry as the logic and power of purposeful sampling lies in selecting information rich cases for study (Reed, Procter and Murray, 1996). Sandelowski (1995) however, views all qualitative research as purposeful but suggests that are three different kinds of purposeful sampling; maximum variation, phenomenal variation and theoretical variation. Maximum variation allows for the sample to be selected from a wide variety of people with a broad range of perspectives. Phenomenal variation is also referred to as selective or criterion sampling where the sample is selected to meet certain criteria for example, all nurses selected are the same age. Theoretical variation is where the researcher controls the sample in order to maximise or minimise a category and both phenomenal and theoretical sampling are more synonymous with grounded theory studies (Sandelowski, 1995). As I adopted a phenomenological approach to this study maximum variation was chosen for my sample as one cohort of student nurses offered many differences which in turn, added to the richness of the data collected (Higginbottom, 2004).

Although one of the tenets of hermeneutical phenomenological research is to see informants not in terms of individual characteristics that can be seen as variables (Streubert Speziale and Carpenter, 2003), there are times when identifying variables is applicable, but care should be taken so as not to over simplify the

complex human world (Steeves, 2000). The characteristics I considered for my study were demographic in nature for example; age, gender, ethnicity, education and previous care experience were all considered as this ensured maximum variation within my sample. In view of this, the size of the sample was not determined by a desire to provide data that was generalisable (Murphy *et al*, 1998), but data that provided in depth information into the phenomena. This is supported by Steeves (2000) who suggests that the important criteria for determining sample size for the hermeneutic phenomenological researcher is the intensity of the contact needed in order to gather enough data regarding the phenomenon or experience. As I wanted to explore student nurses' experiences of UI during their first year of clinical practice, I would be interviewing my sample on more than one occasion therefore increasing the intensity of the contact throughout the study.

Recruitment

Contact was made directly to both HEIs once permission was given to approach the cohorts. four hundred and twenty students from the September 2010 Bachelor of Nursing cohort and Advanced Diploma cohort in one HEI were approached and they were all invited to take part. Twenty students from the other HEI were also invited to take part. A recruitment pack consisting of a covering letter (Appenidx 1) with an information sheet about the proposed study (Appendix 2) and a reply slip (Appendix 3) was sent out to all members of the September 2010 Bachelor of Nursing cohort and Advanced Diploma cohort via their academic tutor. Volunteers were asked to return the reply slips to the researcher

via a self addressed, stamped envelope which was provided. A deadline of two weeks from the date on the letter to reply was given and I supplied my contact details if any of the information needed clarification. No less than 15 students would be selected from the sample identified to maximise variation. If there were more volunteers than required, a letter thanking them for their interest in the project would be sent to them requesting that their name be kept in the event of another particiapant withdrawing and advising them that if they wish to see a summary of the findings that this could also be shared with them (Appendix 4). As a way of thanking the students that participated and acknowledging that they had given up time and shared their experiences in this study block, book tokens of £10 would be issued to each participant at the end of each interview cycle.

In total, I had access to 420 students in one HEI and 20 students in the second HEI. All were registered on a pre-registration programme in Adult Nursing and commenced their training in September 2010. The response rate from the first HEI was n=5 and from the second HEI n=8. A total of 13 students were therefore recruited to the study from both HEIs. Each participant completed a consent form (see Appendix 5) and a summary of my participants can be seen in Table 9.

Table 9: Participants' experiences of health care prior to commencing the pre-registration Adult Nurse training programme (N.B. all students' names are pseudonyms to maintain confidentiality)

Number	Student Nurse	Care Experience prior to commencement of training
1	James	Previous heath care experience
2	Danielle	Limited experience with family members
3	Lianne	Previous health care experience
4	Joanne	Limited experience with family members
5	Chris	Previous health care experience
6	Gemma	Previous health care experience
7	Rachel	Previous health care experience
8	Anne	Limited previous health care experience (work experience)
9	Martin	Previous health care experience
10	Lauren	Previous health care experience
11	Nicola	Previous health care experience
12	Elise	Previous health care experience
13	Susan	Limited previous health care experience (work experience)

Data collection

Method – Interviews

The aim of the interview is to develop a conversational relationship with the participants to explore what their experiences are and how and what events or influences shape them allowing the participants to share their stories in their own words (Ajjawi and Higgs, 2007). This was achieved by collecting data by face to face interviews which allowed me to probe and investigate hidden and suppressed views and experiences. This took the form of a reflective dialogue

that recognises the value of both participant and researcher in the generation of research data considered to be consistent with hermeneutic techniques (van Manen, 1984).

The individual in depth interview

All of the interviews were held at the participants' place of work/study, as the students were familiar with their surroundings which decreased the participants' sense of unfamiliarity and awkwardness.

Semi- structured face to face interviews were carried out with the participants as a means of exploring and gathering their stories. There were no specific interview questions generated as the aim was to allow the participant to be as open as possible. Koch (1996) described 'openness' as critical so that the interview process stays as close to the lived experience as possible. Each interview was unique and, what was most important, had '...openness to what 'is' – to the play of conversation' (Smythe *et al,* 2008, p. 1392). All the interviews started with one question;

'Can you please tell me about your experience(s) of UI and what does it mean to you to have had this experience?'

The interview then developed from the participants' responses and involved asking student nurses to talk through their specific experiences relating to UI (see Appendix 9). In depth interviews allowed the participants to recall, reveal and

construct aspects of their subjective experiences and interpretations in a meaningful and coherent manner. The data was produced through a collaborative partnership between the participants and me as the researcher.

Data was collected through audio taped individual interviews and took the form of a reflective dialogue that recognised the value of both participant and researcher in the generation of the research data considered to be consistent with hermeneutic techniques (van Manen, 1984). The length of the interviews varied from 38 minutes – 64 minutes in total.

As this was a longitudinal study the interviews took place on two occasions, once at the beginning of participants' programme, before clinical exposure and again at the end of their first year. All of the first interviews were conducted within the first 8-10 weeks of their theory block within both HEIs and the second interviews were all completed within the last 4 weeks of the first year of their training. It was anticipated that the lived experiences of the students would arise from the students' recollections of incidents and events relating to the care of patients with UI. This is indeed what happened and the students spoke freely throughout the interviews.

In phenomenology, the purpose of the interview is not to explain, predict or generate theory, but to understand shared meanings by drawing from the respondent a vivid picture of their lived experience, complete with the richness of detail and context that shaped the experience (Sorrell and Redmond, 1995). Habermas (1990) similarly argued that hermeneutic principles do not support the

systematic collection of data which is also supported by Gadamer (1989) who asserts that data collected during the hermeneutic interview illuminates the ordinary process of understanding.

As previously discussed earlier in this chapter engaging in the hermeneutic circle enabled me as the researcher to gain an understanding of the meanings that both the participant and me as the researcher gave to the situation in such a way that did not strip human actions of their context (Pascoe, 1996). In the process of interviewing, stories were told by self-interpreting participants and the researcher's situation and background influenced the interpretation of the participants' stories (Koch and Harrington, 1998). Thus, within the hermeneutic circle the interview had a collaborative conversational structure that lended itself particularly well to the task of reflecting on phenomenological meanings (van Manen, 2002). This notion of reflexivity is the critical gaze turned towards the self and the making of the research product and therefore, a reflexive journal was kept throughout the research process (Koch and Harrington, 1998). Reflexivity describes the process in which researchers are reflective about their own relevant prior experience (Langdridge, 2007) and this reflexive journal was also used in the data analysis as a way of understanding the data and helping demonstrate that the interpretations of the data were reasonable (Savage, 1995).

Ethical issues

Engaging in any health care research requires compliance with scientific and ethical standards in order to treat participants with sensitivity, consideration and care (Oliver, 2010). In order to safeguard participants in research Beauchamp

and Childress (2009) outline four principles to guide researchers. These are ideally to do good, not do harm, respect the individuals' autonomy and adhere to the agreed principles of justice. The necessary permission to conduct any research was therefore required for my research study. Access to students for this study was provided by the Local University Ethics Committee in both Universities as the participants were student nurses. The appropriate forms were submitted to these Committees prior to commencement of this study in order to obtain approval which was granted by both Universities (See Appendix 8). There were no concerns raised from either Local Ethics Committees.

Participant – researcher relationship

I was however, mindful of the potential power relationship between me as a Lecturer in Nursing interviewing a Student Nurse, which could have prevented the participants from divulging their 'lived experiences'. The potential for ethical problems therefore, may include coercion and lack of confidentiality however, students are rarely identified as a vulnerable group in nursing texts (Dalziel, 1996) and yet it is apparent that they may experience overt or subtle pressure from Lecturers to take part in their studies (Diamond and Reidpath, 1994). As a researcher however, I was obliged to respect the human rights of the subjects based on the ethical principles of beneficence, respect for human dignity and justice in order to avoid causing them harm (DH, 2001c; Polit and Hungler, 1999).

As this study was longitudinal in design and the participants were involved in the co-construction of the data, a level of trust was developed within the relationship,

which reassured the students further. However, in keeping with the NMC Code of Practice (2015) I explained that if in the unlikely event that vulnerable adults or the students were at risk of significant harm, this would have to be shared with an appropriate third party and this was included in the information sheet. Students were also reassured that there would be no penalty or discrimination against any student if they wished to withdraw, nor in any way, would it affect the relationship between me as a Lecturer in Nursing and the Student Nurse. Student nurses are autonomous adults and as Brody, Cluck and Aragon (1997) suggest, that means that they are able to make decisions based on appropriate information

Consent

The open nature of qualitative research makes informed consent impossible because neither the researcher nor participants can predict exactly how data will present themselves during the interview (Holloway and Wheeler, 1995; Robley, 1995). The emergent design of qualitative research therefore demands a different approach to informed consent. Process informed consent appeared to be more appropriate for the conduct of a longitudinal qualitative investigation as it allowed me as the researcher at varying points in the research process to re-evaluate participants consent (Munhall and Boyd, 1993). As I conducted a longitudinal study this appeared to be a sensible strategy to adopt as consent given at the beginning of year 1, cannot be assumed to be valid for the length of the study (Gray and Smith, 1999). Furthermore, as Munhall and Boyd (1993) suggest process consent offered the opportunity to change the original consent as the study emerged. Written consent was therefore obtained from each participant at

every interview and written information about the study was given out each time. Participants were also reminded that they had the right to withdraw from the study at any time.

Confidentiality

This is difficult to maintain when research is conducted in small numbers however, students were reassured that their names would not be used either during the taped interviews or in the writing up of the data. Pseudonyms were adopted that were not known to the students. It is recognised however, that maintaining anonymity and confidentiality would be difficult for my study as some of the demographic information collected to give maximum variation to my sample such as age and gender, could lead to recognition of individuals (Clark and McCann, 2005). This was further challenged in my study as the longitudinal design of the study meant that I had prolonged contact with the students however, every effort was employed to use this demographic data selectively in order to maximise anonymity and confidentiality. Students were also informed that as I was the sole researcher in this study and I was the only person who had access to the data. All the recorded interviews and interview transcripts were stored in a locked filing cabinet when they were not in use. Furthermore, following transcription of the interviews the tapes were destroyed. Circulation of the research was also restricted to protect participants' identity at the publication stage of the study. Publication of the results could have resulted in a breach of confidentiality and permission to use direct quotes was acquired (Clark and

McCann, 2005). Participants therefore were informed how the results would be used.

Data analysis

There is no one way to analyse qualitative data which is why it can feel so complicated and as there is no 'off the shelf' solution for each project the analytic strategy is 'custom built' (Creswell, 2012 pg. 182). This section considered the process of analysis used by describing a general framework within which a researcher may organise their particular methodological requirements. This was guided by the underpinning philosophy of hermeneutic phenomenology and the interpretive development of the practical aspects of analysis were used to demonstrate the process undertaken in this study. Despite there being no one way to 'do' qualitative analysis there does appear to be some key features. Morse (1994) asserts that there are four common 'cognitive processes' involved in all qualitative methods, comprehending, synthesising, theorising and re-contextualisation.

When I was considering how to approach my data analysis in the very early stages of this thesis I became very confused about a number of frameworks that existed to assist in this process. Below was my interpretation of these frameworks which were reflected in my reflexive journal during the process and I think are worthy of including in this thesis.

There are a number of frameworks that can be used for the analysis of qualitative data for example Colaizzi (1978) and Giorgi (1989), who both developed their frameworks for analysing phenomenological data. These two frameworks are very similar in their intention although they vary in the number of different stages within the analytical process (Webb, 1999). There is however, a distinct difference in these two frameworks as Colaizzi's final step is to go back to the participants within the study to validate the researcher's findings. This is rejected by Giorgi who firmly believes that the aim of understanding the phenomena in question is done with the intention of removing what is perceived and leaving only what is required (Giorgi, 1989). Therefore, no effort is made to understand the meaning of what are often unique and subjective phenomena which Colaizzi discards, as his belief is that different perspectives of the phenomenon are possible. In summary, it would appear that in Giorgi's framework idiographic details are discarded which rather lends itself to being more in line with a descriptive and Husserl inspired method rather than an idiographic and inductive method (Finlay, 2012).

Whilst Colaizzi's framework lends itself more to the idiographic inductive method there is still some debate as to the development of these frameworks as they are seen to compromise the researchers' interpretative skills and furthermore are often seen as a rigid approach to data analysis which is akin to quantitative research (Finlay, 2009). This application of a step wise set of procedures when interpreting the data from conversations between researcher and research participant is not advocated by van Manen (1997) who did not advocate such a set of procedures in his approach to phenomenological analysis and argues that

phenomenological descriptions have an interpretive element which avoids any pre-determined set of fixed procedures and techniques. It is interesting to note that Colaizzi (1978) describes his framework as being derived from Heideggerian existential phenomenology however, Koch (1995) argues that such structured approaches are anathema to Heidegger's interpretive approach.

Furthermore, Colaizzi (1978) discusses the use of self-reflection during the interviews which can then be used in the analysis process however, the purpose of these self-reflections are to become aware of one's own biases and assumptions in order to bracket them out or set them aside. Using self-reflection in this way is much more affiliated to Husserlian philosophy where this awareness is to protect from imposing these biases or assumptions of the researcher on the study. Cohen and Omery (1994) confirm this and state that this approach to data analysis is from the Duquesne (Husserlian) School and is well suited to Husserlian phenomenology as Husserlian descriptive principles underpin this method of analysis (Koch, 1995).

In contrast, a hermeneutical approach specifically acknowledges that these biases and assumptions are not bracketed out or set aside but are rather embedded and essential to the interpretive process (Laverty, 2003). On discovery of what underpins Colaizzi's framework for analysis I decided that this did not match the philosophy that underpinned hermeneutic phenomenology and therefore I also rejected Colaizzi's framework for my analysis. Finding a suitable method for the analysis of my data was therefore a challenge however, going through this process was a very good and productive learning curve for me and

after a significant amount of reading around all the approaches to data analysis for interpretative hermeneutic phenomenology, it became very clear about the importance of the philosophical underpinnings that supported these approaches.

The typical features of phenomenological analysis involve a researcher adopting a phenomenological attitude, reading the 'whole' data for meaning and working closely with the detail, in order to transform the everyday into disciplinary language and seek the essential structure of an experience (Cohen, Khan and Steeves, 2000). The interpretive strategy at the basis of hermeneutics is to engage with both the parts and the whole. As Smith (2007: 5) states, 'to understand the part, you look to the whole; to understand the whole, you look to the part'. In this way, each supports the understanding of the other as Hermeneutic phenomenology uses interpretation and personal or theoretical sensitising to highlight important themes. It seeks to enhance understanding in readers by presenting plots or stories in a narratively coherent way (Wiklund, Lindholm and Lindstrom, 2002). Gadamer (2004) appeared to offer me a guide to hermeneutic analysis that was guided by four principles which is useful for me as a novice researcher and acted as guide for my analysis. The four principles used are as follows:

Principle one: Transcribed interviews are treated as text for hermeneutic analysis. I read and re-read all written texts for each participant to become familiar with the transcribed material and to get a general picture of what the participants were recounting (develop a sense of the whole of the text) (Draper, 1997,Gadamer, 2004). Developing thoughts were then documented. This can

also be described as immersion and understanding (Ajjawi and Higgs, 2007). Although interpretation began during the interviews with active attempts to make sense of participants' responses, I immersed myself in the data within each interview which involved listening to the audio recordings, transcribing, reading the transcripts and maintaining my reflexive diary. I considered each interview as a whole in the initial stages of the analysis and reading and re-reading allowed me to get a feel for the dominant content within each interview. Having established a sense of the whole, detailed reading of each transcript line by line subsequently enabled me to annotate, paraphrase and summarise each point relating to the student nurses' experience of dealing with patients with urinary incontinence. I inductively grouped the resulting lists of short phrases, or 'first order constructs' (Ajjawi and Higgs, 2007: 624) distilled in this way, into thematic categories. I collated these initial thematic clusters along with the holistic readings and presented them to participants at the second interview. I asked them about their initial responses to seeing such interpretations of their accounts, and invited a detailed commentary on their thoughts about each set of themes. They clarified a few minor points that required a little more explanation (this is discussed in more detail in Part Two :Chapter 5 of this thesis) but on the whole they all felt that the themes reflected their experiences as a student nurse experiencing dealing with patients with urinary incontinence. This allowed for the co-construction of meaning between me and the participants (Nicolson, 2003) and enabled me to develop a better understanding of their experiences which continued to develop throughout the analysis and interpretation.

I did consider initially the use of the NVivo Qualitative Data Analysis Programme to help me to undertake the initial coding as one of the advantages of using NVivo is that this software can list selected quotations according to the given codes. However, accessing this software was problematic and in addition personally, I like reading things on paper, not on the computer screen, and, also, feared that the computer might crash at any time which had happened on many occasions. Fearing this possibility and the thought that I could lose the analysed data, I decided in the end that adopting the paper route via the use of repositionable post it notes and flip chart paper was a much better option for me. I was also reassured by Greatrex-White (2008) who concluded that it was better to analyse the data without the aid of a computer in order to stay close to the original data.

.

Principle two: Understanding first and second order constructs. First order constructs refer to the participants' ideas expressed in their own words, which capture the precise detail of what the person is saying (Titchen and McIntyre, 1993). Second order constructs refer to my (researcher's) ideas expressed in my reflexive journal for each interview. This process of abstraction, synthesis and theme development promoted and deepened my understanding of the student nurses' experiences. The analysis proceeded on a case by case basis and cross-cut themes began to emerge which I subsequently coded and the collective findings were further analysed and synthesised by writing and re-writing. This allowed for further insights and more in depth understanding and as supported by van Manen (1997) and Smythe *et al.* (2008), assisted the analytical process. By this further analysis and writing process it allowed for the transformation of the

'first order constructs' into more synthesised 'second order constructs' (Ajjawi and Higgs, 2007: 624) based on the accumulation of insights from the various data including the interviews and my reflective journal. The process here was a circular (or spiralling) process of incremental understanding by describing the whole phenomenon, attending to the detail, coming to a new understanding of the 'whole', followed by a 'testing out' for verification of the new interpretation (Dahlberg, Drew and Nystrom, 2001). It required maintaining an orientation towards the research question, constantly asking 'What does this say about student nurses' experiences of urinary incontinence?' The outcome was a synthesis, in the form of notes and paragraphs, of the emergent understandings. The hermeneutic part of the analytical process also demanded engagement with pre-existing knowledge in the literature and my own knowledge as I developed themes, it was important to explore their relationship with existing theoretical interpretations and to help position the findings within a wider context. I therefore extracted significant statements and formulated meanings from each extracted significant statement and texts were coded to identify these constructs.

Principle three: Synthesis and theme development. In this stage themes and sub-themes were elaborated and their relationship clarified by reading and re-reading all the data. This stage involved moving backwards and forwards between the entire text (hermeneutic circle) and then identifying themes reflecting upon the interpretations of my own experience and the phenomena being studied (Draper, 1997; Gadamer, 2004). Writing and rewriting became the main technique (van Manen, 1997) which allowed me to dwell even more with the data and interpretations, contemplating how they could represent the experience and

meaning of being a student nurse dealing with urinary incontinence. Using themes and sub-themes allowed me to look for links to support further theoretical development and analysing the interrelationships between the themes and sub-themes helped me to look at each participants' experiences to highlight the key findings from the data.

Principle four: Interpretation and integration. One of the strengths of the hermeneutic approach is that it permits the researcher to respect and maintain the perspective of the participant while concurrently approaching the text from different perspectives (horizon of meaning). These multiple stages of interpretation allowed patterns to become apparent as critical in hermeneutic phenomenology (Koch, 1995). I involved the participants in the co-construction of the data allowing them to read an exhaustive description of the investigated phenomenon rather than the final essential structure as Holloway and Wheeler (2002) suggest, this appears to be more recognisable for the participant to make comment and also helps to ensure rigour. Some Heideggerian researchers, such as Smythe *et al.* (2008) have been keen to emphasise the open-endedness of their analysis and conclusions, and the primacy of extending understanding: What matters is not accuracy in the sense of reliability, or how the researcher came to make certain statements; what matters is what has held the thinking of the researcher and in turn holds the thinking of the reader; what calls, what provokes them to wonder. Any insight gleaned is not about the ‘generalised’ or ‘normalised’ person who is, in fact, no one, but what shows ‘me’ how better to understand human experiences (Smythe *et al,* 2008: 1393). These words challenge some common assumptions about what makes research credible, but

highlight that a phenomenological researcher has a responsibility to present new insights and understandings in a way that resonates with the reader.

Following these principles allowed me to progress in the co-construction of the data with the participants as they engaged in the hermeneutic circle of understanding. In view of the fact that this was a longitudinal study, the analysis took place after data transcription on two separate occasions. This allowed both me and the student nurse to bring life to the experience being explored and collaboratively interpret the significance of the themes (van Manen, 2002).

Trustworthiness of the data

Many studies apply Lincoln and Guba (1985) criteria for evaluating the rigour of their research. However, by using hermeneutic phenomenology, applying Lincoln and Guba criteria might produce philosophical inconsistencies (de Witt & Ploeg, 2006). For example, an underlying assumption of credibility is that the goal of research is truthfulness. Credibility is a qualitative parallel for internal validity in the quantitative criterion of rigour. The goal of quantitative research, informed by the positivist world view, is finding the epistemological single truth that lies in an objective real world. In contrast, in the interpretive paradigm, the researchers are not searching for particular truth, and reality is assumed to be multiple and constructed rather than singular and tangible (Sandelowski, 1993). In order to stay true to the data Taylor (1995) suggests that Heideggerian phenomenology accept that the researcher is an integral part of that process and that the researchers experience is accepted as an essential component of the

understanding and interpretation, as they are so immersed in the data. The use of my reflexive journal throughout allowed these interpretations to be explicit in the data and they sat alongside the voices of the participants allowing an understanding of how the interpretations of the data occurred. Remaining true to Heideggerian thinking throughout the process and making explicit reference to the work of Heidegger ensured trustworthiness of the data.

Summary

This chapter has described and justified the research design in the context of hermeneutic phenomenology and Heidegger's philosophy. It has shown how the use of a reflective journal and in-depth interviews were used to enrich and enhance understanding of the lived experience of the student nurses when dealing with patients with urinary incontinence. As the data was analysed by hermeneutic interpretation, rich data was achieved that illuminated and captured phenomenological descriptions of student nurses' experiences of urinary incontinence. The next chapter draws on these phenomenological descriptions and vocative texts in order to explore the student nurses' experiences.

PART ONE: SUMMARY

Part one of this thesis has been involved in setting the scene for this study both theoretically and methodologically. Before I commence with the analytical presentation of the findings of this study it is worth summarising the previous chapters.

This research aimed to explore the lived experiences of student nurses dealing with UI in their first year of study. The purpose was to develop a deeper and more meaningful understanding of their experiences as they actually experienced them and what meaning these experiences had for them in their first year of study. The research is important as it was increasingly evident within the literature that health care professionals and patients who have UI seem to passively accept this condition as a normal part of the ageing process and that nothing can be done to cure it. This creates an overall negative approach to dealing with UI which could influence the students' own experiences of dealing with this anomalous condition.

Exploring what student nurses' experiences and perceptions are when they first enter the profession and at the end of their first year of training will illuminate what these experiences are and how they make sense of these experiences in their lifeworld. Utilising hermeneutic phenomenology will allow for these experiences to be explored from within the interpretive paradigm which seeks to interpret the social world, which for this research, refers to the experiences and perceptions of first year student nurses. Key considerations for this thesis was to ensure that the student voice was presented through description of human

actions, behaviours and experiences as they happen in their lifeworld. The collection of data taken at two points in their first year enabled a rich insight into the student world and illuminated their experiences as they were lived during that first year of study.

Developing an insight from the students' perspective will enable health care professionals in practice and educators in Higher Education establishments, a more informed perspective of what it is like to be a student nurse dealing with UI. How they cope with these experiences and how this may influence their own perceptions about dealing with UI will also be explored.

PART TWO - CHAPTER 5: PRESENTATION OF FINDINGS

Introduction

This chapter will discuss the themes identified from this hermeneutic phenomenological study. The purpose of this study was to explore pre-registration nursing students' experiences of UI in their first year of study. Semi-structured interviews were facilitated on two occasions, once at the beginning of their first year (before being exposed to clinical practice) and again at the end of year one (after clinical exposure) in order to capture their experiences to develop a deeper and meaningful understanding of their lived experiences.

The participants: First Year Student Nurses

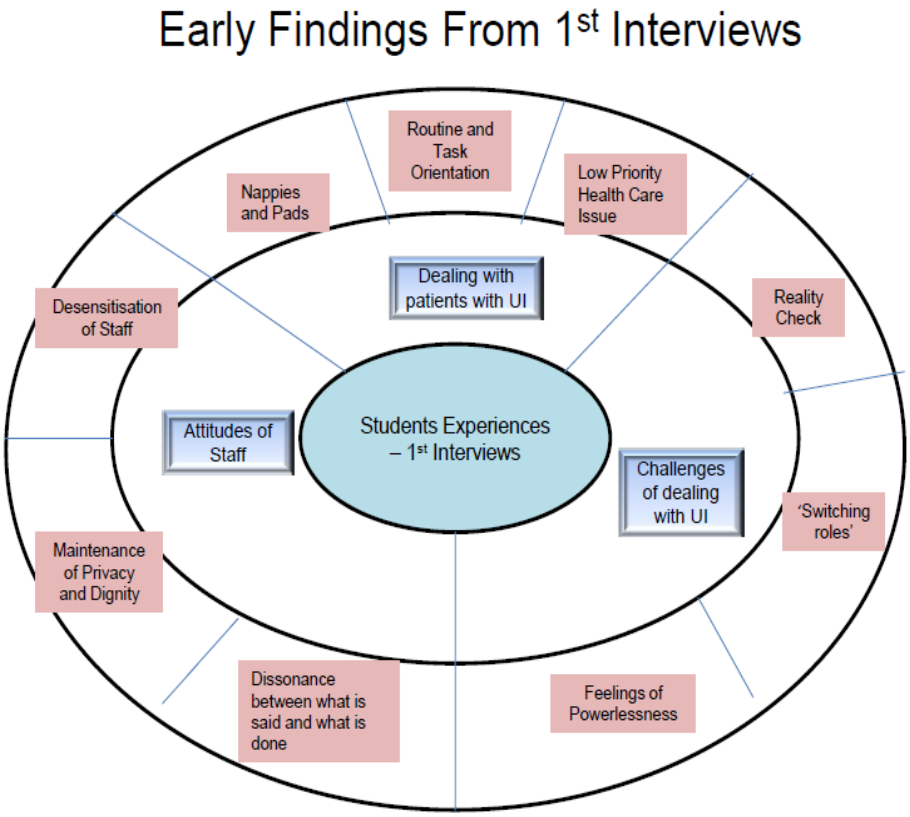
Thirteen student nurses volunteered to participate in this study. Ten of these students were female and three were male with an age range spanning from 18 - 40 years of age. They were also at varied stages in their career and life ambitions but all cited becoming a nurse as their lifelong goal for their future careers. All of the participants had some experiences of clinical practice and caring for patients in either a personal or professional setting which added the potential for richness in the data as their multiple perspectives and experiences further illuminated this phenomenon. In keeping with the phenomenological aspect of the methodology adopted for this study, this chapter explores these experiences which were analysed, interpreted and synthesised and collated into themes that were then layered with my own interpretations which were then presented as three

overarching themes that were aligned to Heideggerian philosophy. These findings illuminated that there were many similarities and differences in what themes and sub-themes emerged from the data in both sets of interviews (see Figure 4 and Figure 5). These themes are presented to show what was identified in order to provide a rich, meaningful and holistic understanding of the research phenomena as experienced by the students. The findings are presented as thick rich descriptions of the students' experiences as they completed their first year of nurse training and are represented by excerpts that predominantly reflect the student experiences from their interviews during their first year of study in order to highlight the students' voices and are presented in italics within this chapter. Table 10 and Table 11 show sections from the original first and second interview transcripts and show how the emergent themes were categorised into sub-themes and main themes. An example of a section of the analysis of these interviews can be found in Appendix 9.

Table 10 : Worked example : analysis from 1st interviews

Original Transcript	Emergent themes from transcript	Identification of sub-themes	Main themes
Student - 'I knew it would be a personal hurdle for me because I didn't know if I could cope with the smell and I didn't know how I would cope cleaning people up following an incontinent episode. I really didn't know if I would be able to do it so this was a big hurdle for me and one of the first things I thought of when I came into nursing, so I'm glad I had some experience of it before I started my training'.	Personal issue dealing with UI Dealing with the smell Living in the 'real world' Personal hurdle	Reality Check	Challenges of dealing with UI

Figure 4: The original themes and sub themes at the first stage of the analysis: First Interviews



Findings

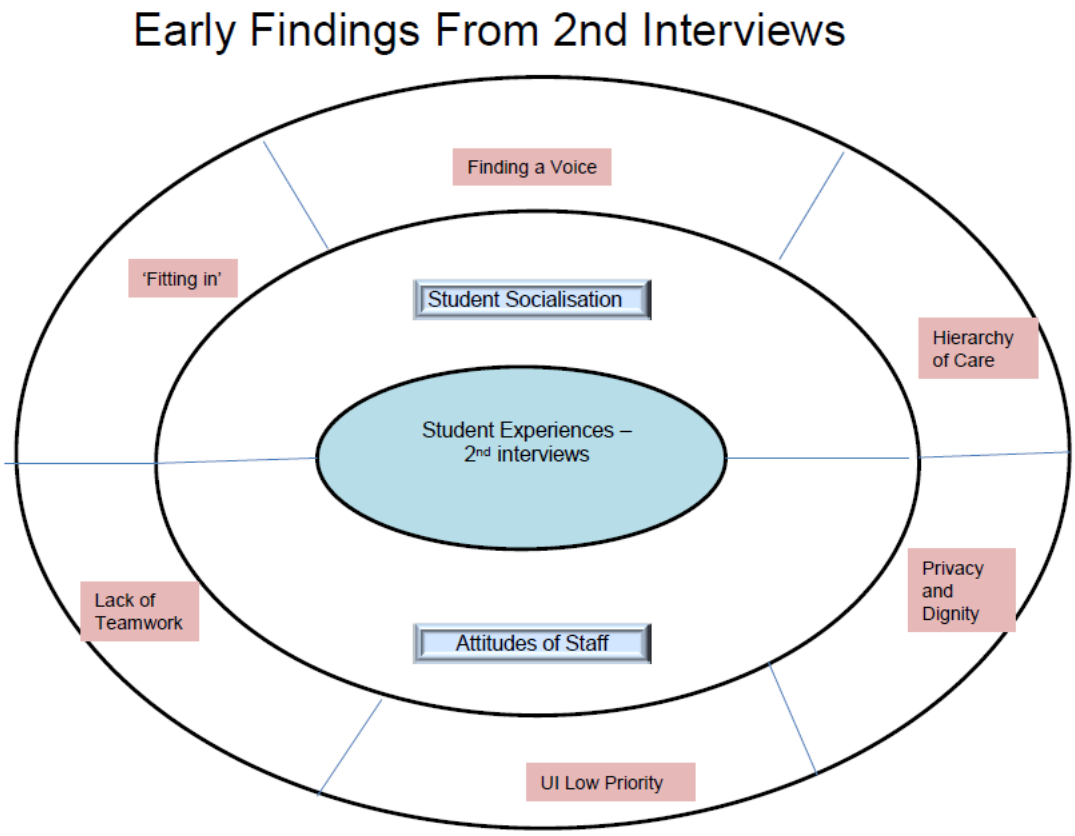
After dwelling with the data, living the constant circular process of reading, thinking, writing and reflecting, the findings are presented in a way that demonstrates how my thinking evolved with the aim of 'uncovering understanding towards building an argument' Smythe, (2011, p. 47). On completion of the analysis of the second interviews and comparing the findings with the first set of interviews, I found myself going backwards and forwards between the data and other understandings began to emerge. The first set of interviews showed quite concrete and abstract sub-themes which was no real surprise as the students had limited experience to draw on as a student nurse and they were factual in

their experiences. For 11 of the students however, although they had no clinical experience as a student nurse, they all had previous experiences of specific job roles within health care and therefore were able to draw on these experiences in the discussion. From these experiences the students talked about being initially shocked about the realities of dealing with patients with UI which was far removed from their ideals and expectations. In the second interviews these concrete and abstract themes had lessened to some extent because the students were able to rationalise why there were marked differences between their ideals for UI practice and the realities of UI practice. As the second interviews were at the end of their first year they also had more knowledge and understanding and more clinical experiences to draw upon and therefore their original feelings of shock and surprise at how UI was managed had been subsumed into their overall experiences.

Table 11: Worked example : analysis from 2nd interviews

Original transcript	Emergent themes from transcript	Identification of sub-themes	Main themes
Student - 'I think because UI is so common especially in the elderly it's just seen as normal. The carers just seem to be fixated with doing the job of cleaning it up without thinking outside the box as to why, it's …. well it's just routine with no flexibility, they just deal with the consequences and whilst I know there is so much more we could do it's not going to happen and who am I to suggest otherwise (laughs) … so I manage it the best way I can, but I'm not happy about it'	UI low priority Routine and task orientation UI treatable but just managed Student confused as UI not 'normal' Reality of practice Being listened too Challenges to expressing their own ideas	UI low priority Finding a voice Fitting in	Attitudes of staff Student socialisation

Figure 5: The original themes and sub themes at the first stage of the analysis: Second Interviews



Reflecting on both sets of findings I decided to re visit Heidegger's notion of 'Being-in-the-world' and reviewed Heidegger's understanding of what 'Being-in-the-world' meant in his own words;

'*But while Being-in-the-world cannot be broken up into contents which may be pieced together, this does not prevent it having several constitutive items in its structure'* (Heidegger, 1926/1962, pg. 78).

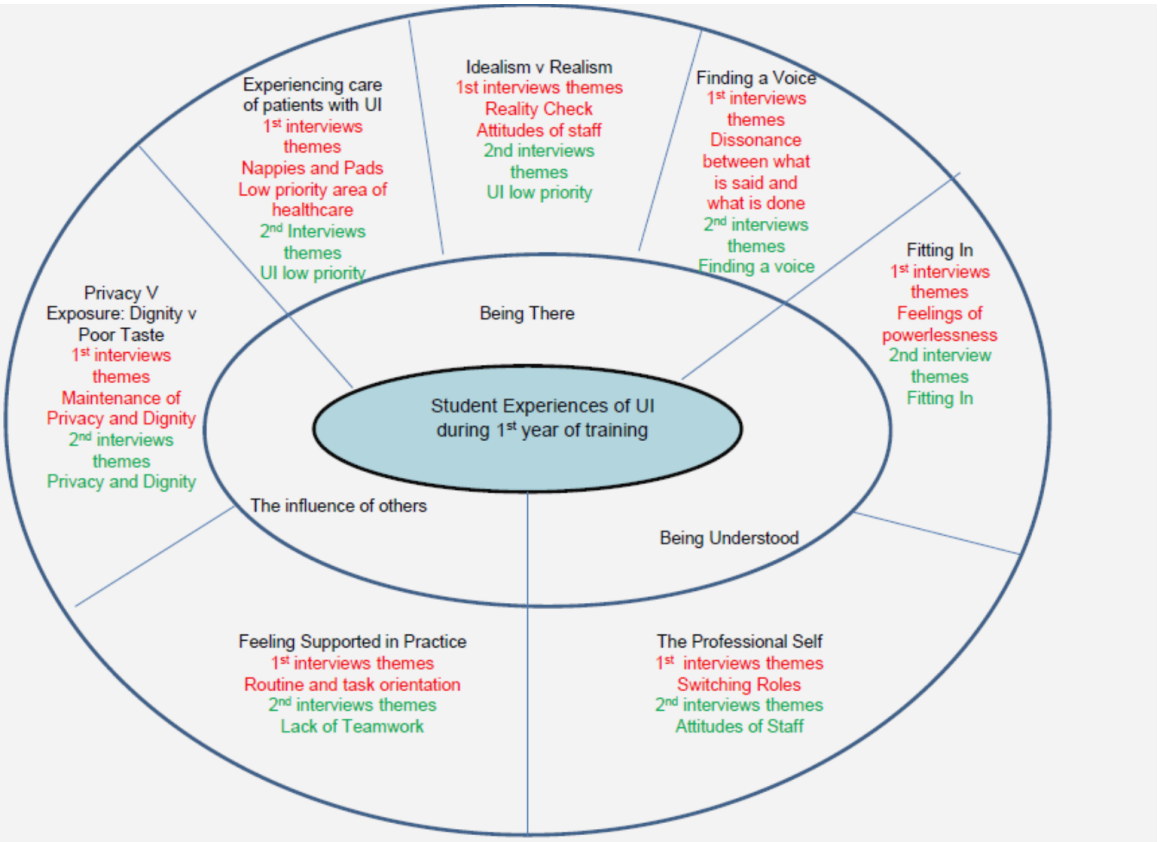
Re-reading Heidegger's thoughts allowed me to develop a sense of what that meaning meant for the students and I re visited my original themes and sub themes with a clearer sense of understanding in order to interpret what 'Being-in-the-world' meant to the students. Constantly reflecting, reading and thinking as mentioned earlier, allowed me to go beyond the explicit meanings in order to interpret more implicit interpretations. This is described by Schmicking (2010) as detecting and grasping and by exploring the data in this way, challenging the data and making meaning of it is all part of the process. This appeared to be in harmony with the hermeneutic circle, moving from parts to the whole and then back again which made sense to me as a researcher as I could make sense and meaning out of the data at an interpretive level.

Involving the students in the co-construction of the data as they engaged in the hermeneutic circle also allowed the students to comment on my interpretation of the themes and sub-themes. Overall the students agreed with the themes and sub-themes although there was a discussion regarding one of the sub-themes identified in the second interviews. Originally, in the theme Student Socialisation, the sub-theme Lack of Empowerment was identified along with Fitting-in and Hierarchy of Care. In discussion with the students however, they felt strongly that the sub-theme Lack of Empowerment reflected that they didn't feel that they had permission to raise issues in practice and their concern was that this did not reflect their experiences. The students felt that it was not about permission, but more about not being able to express their ideas and issues and that finding a voice that was actively listened to was a challenge. As a result of this discussion the sub-theme was changed to Finding a Voice.

This resonated with what Heidegger points out ‘Being-in-the-world’ is context bound’ and therefore previous experiences will influence further understandings about what it is to be a student in the world as they progress through it. These experiences do not stand alone at any moment, rather they are the beginning on which to build from, in at attempt to explore meaning. Combining the themes from both sets of interviews allowed me to establish what the lived experiences of the students were in dealing with UI and Figure 6 shows how the combined themes from both sets of interviews were categorised and Figure 7 shows my final inerpretations of the combined themes and sub themes from both sets of interviews.

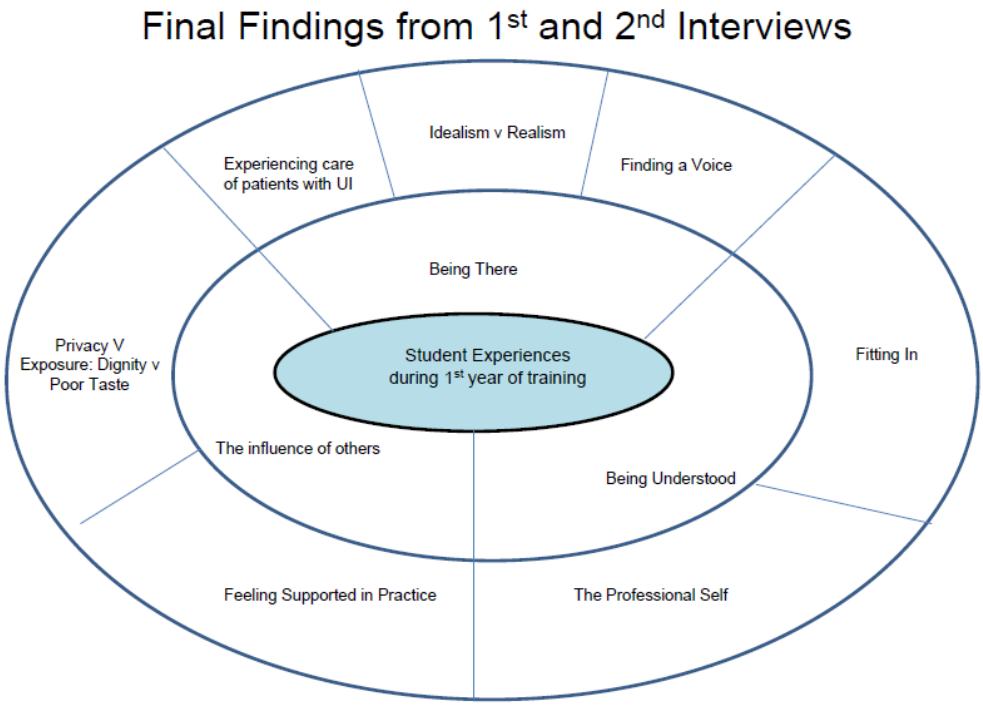
This was my interpretation at that time but, I am aware that my interpretations of what I have uncovered from the data could be different from another persons’ interpretation. However, I still felt close to the participants and was conscious that the more I analysed the data there was a danger that I moved away from the participants’ meanings and reflected more of my own understanding. Smith, Flowers and Larkin (2009) support this observation when analysing phenomenological data but argue that this is part of the process as ‘the you’ is closely involved with the lived experiences of the participant’ (Smith, Flowers and Larkin, 2009:91). Heideggerian thinking embraces this and suggests that it is this interaction between the researcher and the participant that generates the understanding of meaning and that we are not looking for ‘real meaning’. Indeed, this would seem to be more in line with Husserlian thinking in that the truth is out there waiting to be uncovered (Kvale, 1996).

Figure 6 : The categorisation of the combined themes and sub themes from the 1st and 2nd Interviews



Reflecting on my own experiences and incorporating Heideggerian thoughts into my interpretations whilst analysing the students' experiences has helped me be more certain that I am staying true to it, which I suggest gives the work more credibility. As suggested earlier there is not one fixed approach when it comes to phenomenology, therefore highlighting the ongoing process is important. By referring back to process issues I was able to provide real world examples of the theories and concepts in action. Working in this way explicitly links the process decisions to the actual reality of the research, side by side, on the page. What now follows are the findings which are presented as three themes, Being There, Being Understood and The Influence of Others.

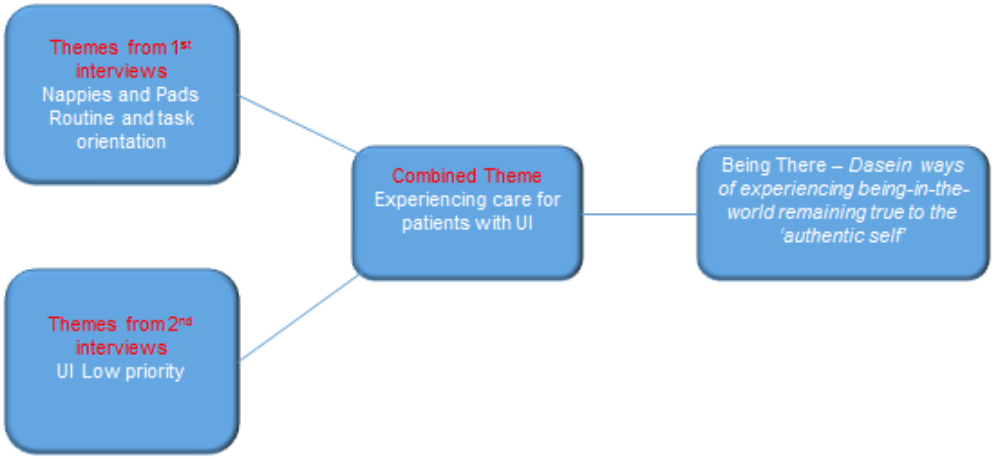
Figure 7: Final interpretation of the combined themes and sub themes from the 1st and 2nd Interviews



Theme 1 – Being There

Physically being exposed to clinical practice is something that all student nurses are exposed to as part of their training. In fact, of the 4600 hours they have to achieve for registration (NMC, 2010), 2300 of these are in academia with the remaining 2300 in clinical practice. Being in clinical practice and experiencing care at first hand therefore means that the students are immersed in practice for a significant amount of time during their first year. Figure 8 shows a worked example displaying how the combined themes and sub-themes from 1st and 2nd Interviews were aligned to Heideggerian Philosophy.

Figure 8: Being There -an example of the themes from the 1st and 2nd interviews and the final combined theme and alignment to Heideggerian Philosophy



Being-in-the-world and experiencing care for patients with UI was therefore a strong theme that emerged from the data. Within this theme were three clear sub themes that explored what experiences they had of being in practice as a first year student nurse. Understanding how care was delivered by being there, created the sub themes of Experiencing care of patients with UI, Idealism versus Realism and Finding a Voice.

Sub theme 1 – Experiencing Care of Patients with UI

As discussed earlier all of the students in this study had some care experience prior to commencement of their training albeit some had more than others. The students therefore had variations in how they thought they would experience care for patients with UI and this was something that was much more evident in the

first set of interviews before they went out on clinical placement for the first time. For some this was not a new experience and clearly for those with limited experience of health care, it was apparent that there were some concerns about having to deal with UI. This appeared to more from their perspective as carers and how they personally felt they would handle it;

> *'Erm …. I think I will feel a bit uncomfortable…maybe a bit awkward as it is a little bit intimate erm….. but I mean I will be fine dealing with it, there must be worse things to deal with being a nurse, I mean dealing with a patient with a diagnosis of cancer would be worse for me to deal with than a patient with UI'*
> ***Anne, Interview 8 (1st Interview)***

Recognising that UI would be difficult to deal with due to the intimate nature of the care required is highlighted here. It would seem that this student feels that dealing with a symptom such as UI requires a level of sensitivity but she was also rationalising how she would deal with UI by comparing it to dealing with a life threatening diagnosis. Reacting to dealing with UI was a common concern for some of the students and this manifested itself in many ways from the personal internalisation of making the distinction between a symptom and a life threatening diagnosis as mentioned above, to the more physical elements related to UI. A common experience around this was regarding the actual physical smell of urine and how they felt that they would cope with it;

> *'I knew it would be a personal hurdle for me because I didn't know if I could cope with the smell and I didn't know how I would cope cleaning people up following an incontinent episode. I really didn't know if I would be able to do it so this was a big hurdle for me and one of the first things I thought of when I came into nursing, so I'm glad I had some experience of it before I started my training'*
> ***Elise, Interview 12 (1st Interview)***

'My first experience was before I started my training and I thought I would react worse to how it really was. I mean … there is the smell to deal with and not knowing what you are going to find. I thought I would not be able to deal with it but actually it's not as bad as I thought. It's just people needing help with the toilet, it's no big deal for me, what's important is that I deliver the best care I can for the patient …. It must be awful for them so why should I worry!! '
Susan, Interview 13 (1st Interview)

From these first early reflections it is clear that the students' experiences of either dealing with UI or anticipating this type of care were varied. Some students had given it a lot of thought, particularly in relation to coping with their own thoughts and feelings. Prior personal experiences before commencing their training appeared to have prepared them for this aspect of care but an area that caused a lot of confusion was their experiences of how this care was managed;

'I think I must have been very green behind the ears because my personal experience was that people went to the loo when they needed to so I found it really odd in practice because there was this routine going on that everyone was expected to go to the loo at the same time! That didn't feel right somehow'
Martin, Interview 9 (1st interviews)

For this student, being continent and having control over your own bladder was a very different experience to managing people who had no bladder control. He clearly reflected on the fact that everyone had different needs and that taking everyone to the toilet at the same time as routine appeared to create this confusion. This theme of routine and ward routine was mentioned in every one of the first student interviews. The students fully appreciated that to some extent routine was inevitable due to the nature of caring and the ratio of staff to patients. However, they also expressed some of the challenges and anomalies that this

meant for individualised patient care. Even at this very early stage of their training their care experiences clearly reflected these issues;

> *'I understand the need for routine so that no one is missed and I think it's there to act as a guide for everyone so the carers know what they are doing and the patients know what to expect but there has to be some flexibility I mean …. Well you know …. We all go to the toilet at different times of the day so how can you make that a routine?'*
> ***Anne, Interview 8 (1st Interviews)***

> *'I don't understand sometimes how it makes logical sense to toilet everyone all at the same time… I mean …….. you take them at 3pm and change them and they were dry and then when you take them again later they have been incontinent so why don't they take them somewhere in between the two times and the patient may well stay continent'*
> ***Lauren, Interview 10 (1st Interviews)***

In the second interviews the students' experiences suggest similar things but by the end of year 1 the students are beginning to raise questions about how UI is treated;

> *'I don't really understand how they think managing UI with these routines works and I can't understand why no one is making any connections that this UI may be a result of other health conditions. It really is just seen as something to clean up and be dealt with'*
> ***Danielle, Interview 3 (2nd Interviews)***

> *'UI can lead to other problems and pressure sores can develop and then everyone suddenly becomes interested but no one seems to make the connection that they may have developed as a result of UI. No one thinks of any solutions to UI it's all just about managing it so it's very reactive and there is no real pro-active effort to wonder why this may be happening'*
> ***Rachel, Interview 11 (2nd Interviews)***

The students in both sets of interviews were now clearly feeling challenged about their own values and beliefs for providing quality patient centred care for patients

with UI. The lack of pro-active management was beginning to be highlighted and this was further explored by the following students who reflected on the use of incontinence products for containing the problem;

> '*I don't think much assessment took place everything to do with UI was focussed on the pads and how we used them and I think carers got lazy and just used any old pad… it wasn't just about using pads it was also that they just used anything that was around so no assessment took place for the type of pad used either*'
> ***Rachel, Interview 7 (1st Interviews)***

> '*At the beginning of my training I remember thinking how good the pads were for people that were incontinent because we were keeping them comfortable but now I don't feel that they are always used appropriately (pause)……in fact if I really think about it they were really used for the convenience of the staff. That makes me feel bad because I've just gone along with it but I knew it wasn't always right*'
> ***Joanne, Interview 6 (2nd Interviews)***

In summary, it is clear that there are a number of aspects of UI that have shaped and influenced these students' experiences. These insights included their own personal reactions to dealing with UI, the way UI was managed in practice and the use of containment products to manage the consequences of UI. This was beginning to highlight a dissonance between what the students expected from practice related to their own ideals of dealing with UI and the realities of being in practice, experiencing how this care was actually delivered. The students however, appeared to be positive about managing patients with UI although intrigued as to some of the practices they had experienced. This leads into the next sub theme in Being There, Idealism of care versus Reality of care for patients with UI.

Sub Theme 2 - Idealism of care versus Reality of care for patients with UI.

From a very early stage in their training the students in this study were discovering that what they had been taught in theory (see Appendix 10) and what they were experiencing in clinical practice did not always match their own ideal for care of patients with UI. They did identify however, that UI was a common problem in clinical practice but that overall it was not viewed as a priority problem. In the previous theme the students identified how routine and task orientation was utilised in order to deal with the consequences of UI but many of the students commented on the reasons as to why they thought this approach to care had been adopted. They were also beginning to understand the effect that this had on proactive UI care and which was beginning to challenge their own ideals for practice;

> '*I appreciate to some extent why task orientation and routines are implemented as it is a very common problem but I think that this approach to managing UI is because it's not a priority in the scheme of things and yet I think so much could be done to promote continence'*
> ***James, Interview 1 (1st Interviews)***

> *'I just think the carers just get so entrenched in the routine of toileting that they don't stop to think about what they are doing and it's not that important. Finding out why someone is incontinent is not something I have ever come across to date but that may be because my experience is with working with older people where UI is common and accepted as a normal part of getting older….. I mean…… my grandparents are not incontinent so if they did become incontinent there must be a reason for it but that never seems to be discussed'*
> ***Martin, Interview 9 (1st Interviews)***

> *'I think as far as people are concerned incontinence is just an on-going issue usually secondary to other health problems and its therefore not a*

priority and let's face it it's not life threatening is it so it just becomes a problem rather than a symptom that requires assessment'
Gemma, Interview 6 (1st Interviews)

These students appeared to be attempting to understand why this may be the case however, it is clear from their experiences that there is a level of uneasiness about how UI is dealt with, which is less than ideal. One student attempted to rationalise why this may be the case;

'I think that because it's so common they (carers) become quite complacent about it and that it's 'no big deal'. I mean if it was a wound for example, then it would be taken more seriously, whereas UI is just seen as 'Ok she has UI well that's fine' and they just manage it by either toileting or pads. Maybe it's because a wound is something of a more immediate concern which is why UI is not seen as important so they get left …….. well…. not left but they are not as urgent because it's not life threatening on the whole and it's viewed as not being important so its managed rather than being treated'
Anne, Interview 8 (1st Interviews)

This was beginning to cause some apprehension amongst the students and therefore was beginning to create a dissonance between what they thought should happen in practice and the reality of practice;

'I think for the patient it's probably what bothers them the most because all their other ailments are being taken care of and in my experience for most of the people I have cared for that was certainly the case. Following it up would not have taken long but that never happened The carers just didn't seem to see it that way it was just something that had to be dealt with but I remember how bad it made the patients feel but we just glossed over it as if it wasn't important. That made me feel uncomfortable because it was so clear sometimes that this was the one thing that bothered them the most and we were ignoring it… worse still I was going along with it, that made me feel bad'
Gemma, Interview 6 (1st Interviews)

This continued to be a clear theme in the second interviews but there was a subtle difference. In the first interviews the students' ideals for practice appeared to be fresh and enthusiastic and they appeared surprised that the reality of practice did not match their ideals. In the second interviews there is a difference. There appeared to have been a shift in their thinking and whilst they remained positive about care delivery their level of optimism for delivering care close to their ideals had diminished. What is interesting in the second interviews is that the students are beginning to sense that the nurse they would like to be is being challenged by external influences. The students appeared to be succumbing to the realities of practice;

> '*UI appears not to be important and it is certainly treated differently to what we have been taught in theory and what actually happens in practice. I thought it was an important aspect of care and could really see why as it's a large part of care in some wards. It's seen as a chore though rather than an opportunity to find out why. I guess that's the reality, that's how it is and we just get on with it'*
> ***Chris, Interview 2 (2nd Interviews)***

> *'I think because UI is so common especially in the elderly it's just seen as normal. The carers just seem to be fixated with doing the job of cleaning it up without thinking outside the box as to why, it's …. well it's just routine with no flexibility, they just deal with the consequences and whilst I know there is so much more we could do it's not going to happen and who am I to suggest otherwise (laughs) … so I manage it the best way I can, but I'm not happy about it'*
> ***Martin, Interview 9 (2nd Interviews)***

In summary, it would appear from these findings that there is some disharmony between what the students perceived as their ideals for practice and their lived experiences of dealing with UI. Whilst they remained optimistic overall, it was emerging that trying to stay true to their ideals was becoming compromised by the reality of practice. Although it would seem that the students had not fully

adopted this approach to the care of UI, it was evident that adaptations were being made about how they managed their own ideals for this area of healthcare. Having the confidence as a student to articulate their own opinions however, was clearly a challenge which leads into the next sub theme, 'Finding a voice'.

Sub Theme 3 – Finding a voice

The previous two themes identified the students' experiences of dealing with UI and show that adaptations as to how they had dealt with practice issues had taken place. The students clearly identified that often the practice of dealing with UI was steeped in routine with very little attention given to patient centred care. This created feelings of discomfort for the students but finding a way to express their own thoughts and feelings about dealing with UI appeared to be fraught with difficulties. This was a particularly powerful finding in the second set of interviews and appeared to be creating a challenge for how the students addressed this in practice. Being able to find a way to discuss and sometimes challenge why things were done in certain ways appeared to cause anxieties for the students;

> *'I know from previous experience that changing people's habits and routines is difficult and trying to stop this task orientated approach to toileting I think I will find frustrating. I mean…. It's clear to me that it doesn't work but for the HCAs it's what they have always done so challenging that as a first year student nurse is going to be hard but I will have to find a way because I'm sure there are other like-minded people out there. I hope there is because otherwise I'm going to feel defeated and powerless'*
> ***Martin, Interview 9 (1st Interviews)***

> *'It's quite frustrating at times but who am I to say and try and change the way they have done this for years if the qualified staff haven't addressed it. You feel you are a nobody to tell anybody anything. As a student you*

are the lowest rank, have no voice or certainly not one that is listened to – right now it's about not stepping on anyone's toes'
Danielle, Interview 3 (2nd Interviews)

'I think I chose to step back a bit because you are not sure how staff would react if you suggested anything. I kind of got the feeling that we were to be seen and not heard isn't that what they say about children?! That's what it felt like at times and actually I think we have a lot to offer if only they weren't so defensive …. I mean I don't think I would have been critical just well……. Well it's frustrating really because I think we see things with fresh eyes that may help change some of this ritualistic routine which would benefit both the staff and the patients'
Lianne, Interview 8 (2nd Interviews)

It was evident however, that whilst tackling their concerns around what they perceived as poor practice had its difficulties, some students had developed strategies to address this;

'You do find your own way to address issues but it really does feel negotiating with the firing squad! I just used to slip in the odd thing into conversations with the staff about what we had learnt in school and what is now viewed as best practice to do xyz and some staff would be receptive to that. It is difficult though as you don't want to get into their bad books by challenging their practice all the time'
Joanne, Interview 6 (2nd Interviews)

'I did question on occasions why they used a set routine to toilet the patients and some staff did say having students around really did make them think about what they were doing. I was able to chat about looking at doing things differently and they did take it in board. I think they accepted it because I worked with them in trying to do things differently'
Susan, Interview 10 (2nd Interviews)

Some students did feel that their views were encouraged to be discussed by their mentors but again it varied in how this was articulated and this subsequently had an impact on how they felt about expressing their views;

'My mentor was really supportive and encouraged me to say it as it was. I found as a student you are learning but you sometimes can't see the logic behind some of the toileting routines because you have fresh eyes

but exploring that with staff is a challenge and made worse by the fact that as a student you don't know how to speak up'
Lianne, Interview 8 (2nd Interviews)

Being listened to was important for these students but they did not all experience being encouraged to raise any issues that they had in practice. In fact, some students experienced quite the opposite;

'I think I must be naïve because I presumed as students the trained staff would welcome us with open arms and want to get to know the latest thoughts about how we do things in practice and I certainly went out there full of enthusiasm. It was soon trashed though by the experienced staff, in fact I was often told 'oh your enthusiasm will soon wear off' I mean…. how sad is that! I tried not to let it affect me but it gave me a clear message and I had to find ways of not destroying my confidence and that I kept motivated regardless which I'm pleased to say I did but no thanks to some of the experienced staff!!'
Anne, Interview 1 (2nd Interviews)

'I know I am always asking 'why?' but that's because I'm interested but they just saw me as a pain in the backside and it makes you feel like not bothering because they are not listening to you'
Nicola, Interview 13 (2nd Interviews)

This student felt that she did have a 'voice', but was sceptical about how her information may be utilised and was also concerned about the covert nature of how it could be gathered;

'Never felt I was in the right place to say anything but my mentor asked me to tell her if I saw anything that I thought was not good practice to let her know but that made me feel like an undercover reporter! If she spent the time with the carers she herself could have identified that, so I felt a bit used as a student, on the one hand giving me support to voice my views but on the other hand in rather an underhanded way which made me feel a bit uncomfortable. It is difficult to challenge as a student but I have found ways that this can be done without upsetting the 'apple cart'!'
Lauren, Interview 7 (2nd Interviews)

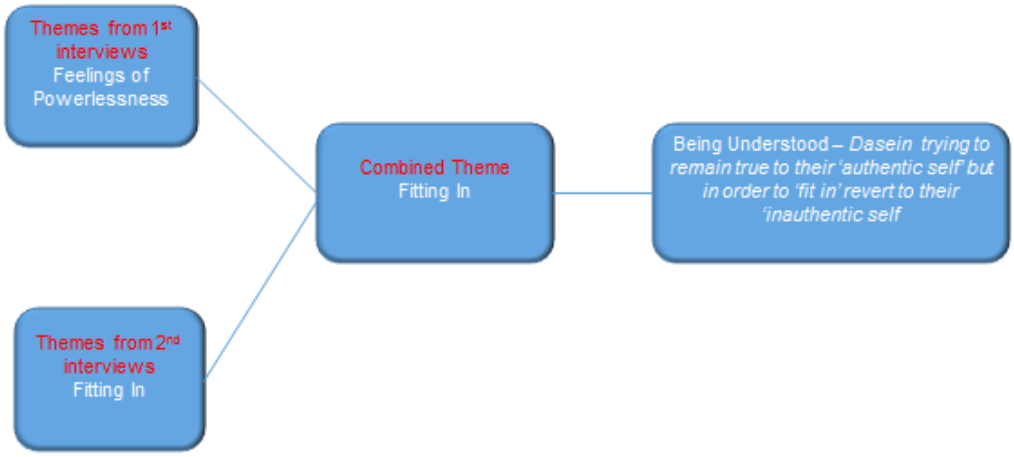
In summary, there are mixed reactions amongst these students' experiences regarding finding a voice and being listened to in order to express their concerns or observations about UI in practice. It would appear that there are some excellent supportive mentors who actively encouraged students to raise their concerns, right the way through to mentors who appeared to want to dampen down the student's enthusiasm for practice. Weaving their way through the overt and covert aspects of the realities of dealing with UI featured largely on the student's agenda and was a very important aspect of how they were socialised into the practice setting. Being there and experiencing practice in this first year of study has clearly been a challenge for these students. Being understood in how they made sense of their experiences appeared to be the next major theme to emerge from the data.

Theme 2: Being Understood: Coping with being there

As can be seen from the previous theme Being There, the experiences of dealing with UI in everyday practice generated a variety of issues that the student had to cope with. These everyday experiences created challenges for the student in dealing with UI and from the analysis of the interviews their lived experiences were clearly communicated. Figure 9 shows a worked example displaying how the combined themes and sub-themes from 1st and 2nd Interviews were aligned to Heideggerian Philosophy. Two sub themes emerged from this theme which included, 'Fitting in' and Maintaining the professional self: 'Switching Roles' Both these sub themes were articulated clearly and illuminated the students'

experiences of what is was like for them in their attempt to find meaning and understanding about how they coped with dealing with UI in their own life world.

Figure 9: Being Understood -an example of the themes from the 1st and 2nd interviews and the final combined theme and alignment to Heideggerian Philosophy



Sub Theme One: 'Fitting in'

Fitting in to their practice environment was very much at the heart of these students' experiences. They demonstrated a need to be part of the team that they were working with but at the same time felt challenged about maintaining their own values and beliefs. There was however, an overwhelming desire to be part of the team that they were working in and the students had a clear understanding about why this was important to them and this was evident right from the first interviews;

'It's difficult really as you don't want to 'rock the boat' but at the same time you know when practice is at its worst and when it's at its best. Doing something about it however, is a challenge and you don't want to upset the apple cart! At the end of the day the people you are working with, which was on the whole the carers, are going to have their say in your report so 'fitting in' was a necessity!'
Lauren, Interview 10 (1st Interviews)

'I didn't want to be known as a 'know all' because that went against you when working day to day with the staff and I wanted to 'fit in' but at the same time we are learning the most up to date practice and it's exciting but at the same time daunting. I mean …. Well you want to share it with them but you have to find a way so that it won't get their backs up, after all you want to get on in the placement!'
Lianne, Interview 3 (1st Interviews)

The ultimate desire for these students in practice was to successfully pass each placement and the students identified very early on in their training that this was a rite of passage they needed to complete. They were however, extremely conscious that this desire to successfully complete their placements and fit in with the team, had some disadvantages;

'It's hard being a student because you are new, you want to make a good impression and you want to demonstrate that you know what you are doing. That's hard to do though because sometimes you have to let some of that enthusiasm go otherwise you just wind everybody up. I wanted to challenge everything at first but soon realised you could make yourself unpopular'
Anne, Interview 8 (1st interviews)

This student also identified with this but by the second interviews they had clearly started to think about how they struck a balance between being understood as an enthusiastic student wanting to learn everything and fitting in to the ward team. This student had quite a unique coping strategy;

'I found that after my first placement I could see where the goal posts where and it felt like a game! Trying to please everyone and not 'rocking

the boat' was proving to be a game of two halves… I really did play it as a game in order to get through, pleasing my mentor was one thing, but fitting in with the health care assistants was vital to survive… sounds dramatic doesn't it but it's a lions den out there! It made me feel uncomfortable though because I was being untrue to what I really thought but I just knew when to play my cards and when to keep them close to my chest!! (Laughing)… that's the only way I could cope'
Gemma, Interview 5 (2nd Interviews)

Two students however, found a way of 'fitting in' which did not challenge their own values and beliefs, however, it did have consequences which the students found challenging;

'I really wanted to fit in which ever placement area I went to but on occasions I've stuck my neck out and risked it! I've had the experience of going against the routine and I accompanied a man to the toilet because I really really couldn't see him struggle any longer. You could see he was in pain, and this man hadn't passed stools for days on end and I thought oh maybe now he will, so without asking permission and I got up and I took him and he managed to have his bowels open and was very relieved but I got told off for taking him to the loo without permission. But you know, after it I felt good (laughs)'
Anne, Interview 1 (2nd Interviews)

'I decided I've been around too long to worry about whether staff like me or not and I have enough experience hopefully for staff to recognise that and respect my experience. Mmmm ……. Wasn't actually like that when I got out on placement! It was like starting at the bottom of the pile again and I had to be careful how I handled people because I had experience but I'm now in a student nurse uniform and I was surprised how their attitudes changed towards me'
James, Interview 4 (2nd Interviews)

These last excerpts show a significant shift from the first interviews in how the students negotiated their way through practice. The first interviews showed a different level of anxiety to fitting in with practice which was much more around feeling powerless;

> *'I'm not sure how I will handle it if I hit placement and see that everyone is toileted at the same time regardless of need and how I can possibly influence that. I know we have covered stuff in school so far about what is good practice but how can I challenge practice as a student with little experience? Not sure how I will be able to do this and this will make me feel… well… that I'm not doing my job properly… powerless almost'*
> ***Anne, interview 8 (1st Interview)***

This feeling of powerlessness appeared to be reflected in a number of the first student's interviews and it was apparent they had given this some thought into how they would address this in practice. It was also clear that the students felt they would need to be exposed to good role models to help maintain their enthusiasm for this area of care. In the second interviews, they appeared to have developed strategies to cope as can be seen earlier and there was a noticeable difference in their level of confidence to challenge practice.

In summary, it's clear from these students' life world views, that 'fitting in' to the placement team was an essential part of their overall placement experience and it was very important to them. It would seem that one of the issues around this 'fitting in' was about finding out how they 'fit' within the clinical team without compromising their own professional ideals. Whilst this was a very important aspect of their socialisation into the profession the physical aspect of coping with caring for patients with UI was also identified. Remaining professional at all times was important to these students but remaining professional to themselves seemed a dominant thread throughout the interviews in their attempt to cope with these challenges and forms the next sub theme, Maintaining the professional self.

Sub Theme 2- Maintaining the Professional Self: 'Switching Roles'

Maintaining their professional integrity as a student nurse, whilst coping with the aspect of dealing with UI in practice, was a very powerful theme throughout both sets of interviews. It would appear that students adapted in many ways in coming to terms with this intimate aspect of nursing care and this sub-theme of 'Switching Roles' emerged as a lived experience that enabled the students to cope with the challenges of dealing with UI as a first year student nurse. Understanding their role in caring for patients with UI materialised as an important aspect in relation to addressing gender issues when caring for patients of both sexes. One of the male students found this a particularly distressing area of care in his past experience as an HCA in a Neurological Disability Unit;

> *'Dealing with people of a similar age to me was really difficult I mean they were young men like me and then having their accidents they were now in a wheelchair with a pad on or a catheter in and that was pretty hard to take. It was the age thing that really got to me I think in the first instance and then actually having to change their catheters, conveens and pads became another issue, I mean ……...I had to change them! (laughs) that was really difficult you know ..well… you know …. having to touch another man's penis to put on a conveen well….. it was difficult and I remember saying to myself 'no, no I can't do this' but I did and I think it was because I put out of my mind that I was a bloke touching another bloke and that I was a nurse first and that this patient needed my care but it really freaked me out to begin with but the uniform helped … I was a nurse first and I had to put the gender thing on the back burner'*
> ***Chris, Interview 5 (1st Interviews)***

This notion of 'switching roles' became apparent in this interview and even this early on in their training the students seemed to understand the importance of professionalism in their role as a nurse. This seemed to be helped by the wearing of their uniform which allowed them to make the distinction between them as a

'normal person' and them as a professional nurse. This was further explored by another student who made the distinction between her role as a nurse and her role as a female when caring for male and female patients;

> *'It will take some time to get used to the idea that I am not there as a female I am there as a nurse and I will have to put the stereotyping of the female behind me in order to accomplish my job especially when nursing male patients. I mean…… I guess I have to switch roles, when I am at work, I am a nurse first and will have to deal with it. Being properly dressed though in uniform and gloves and apron will help me overcome this'*
> ***Danielle, Interview 2 (1st Interviews)***

This student also makes reference to the fact that the wearing of her uniform and the use of her apron and gloves to protect her also appear to psychologically help her 'switch roles' from that of a female to that of a nurse. This was also reflected in several other of the interviews and it seems to help them deal with UI in a positive manner, again demonstrating their professionalism;

> *'I find that part of the routine of wearing a uniform transforms me into being a nurse first and a female, daughter, sister and girlfriend second and that helps me be what I should be, a professional caring nurse, I know that may sound ridiculous but it really does help to put things into perspective and I think it will help me overcome dealing with UI'*
> ***Joanne, Interview 4 (1st Interviews)***

> *'I found my uniform and the other protective clothing helped me because once you had your gloves and apron on it was like using props in a theatre you …. well…. you almost became someone else which made it easier to deal with their bodily fluids and I managed to remain professional – well I think I did anyway!*
> ***Rachel, Interview 7(1st Interviews)***

The use of uniform is an interesting thread in these interviews and the students have identified what that represents for them and their patients when dealing with UI. Maintaining their professional self was important to these students and helped

to develop their own understanding about how they coped with dealing with UI. This was also clear in the second interviews and there is a real sense of achievement in how they have maintained their professional status;

> *'Wearing a uniform has helped me because when I am in it I represent the profession of nursing and therefore I am able to switch off from all my other roles and keep the focus on my role as a nurse. I think for the patients too they are familiar with our uniform and it helps them begin to trust us and it develops an understanding which may help them come to terms with some of the intimate care we have to deliver … not that they won't be bothered but just well…. that they feel they can trust us and I think this alleviates some of their anxieties and some of my own'*
> ***Martin, Interview 9 (2nd Interviews)***

Interestingly one student offered another view relating to how patients dealt with the delivery of intimate care. Whilst he felt that it helped him understand the importance of delivering this type of care he appeared to be acutely aware that this may not be the same for the patients in his care;

> *'I know over time I can overcome the intimate nature of some of the care that I deliver and that yes … the uniform helps to some extent and allows me to become a nurse first and a 'normal bloke' second when I am on duty and vice versa when I am not on duty so that's me sorted but I often wonder what it's like for the patient they can't switch roles that easily I mean. well they are a patient and we do things to them like change their pads and conveens and what I noticed was that they looked away… it was almost like detachment from what I was doing… I guess that was their way of dealing with it'*
> ***Chris, Interview 2 (2nd Interviews)***

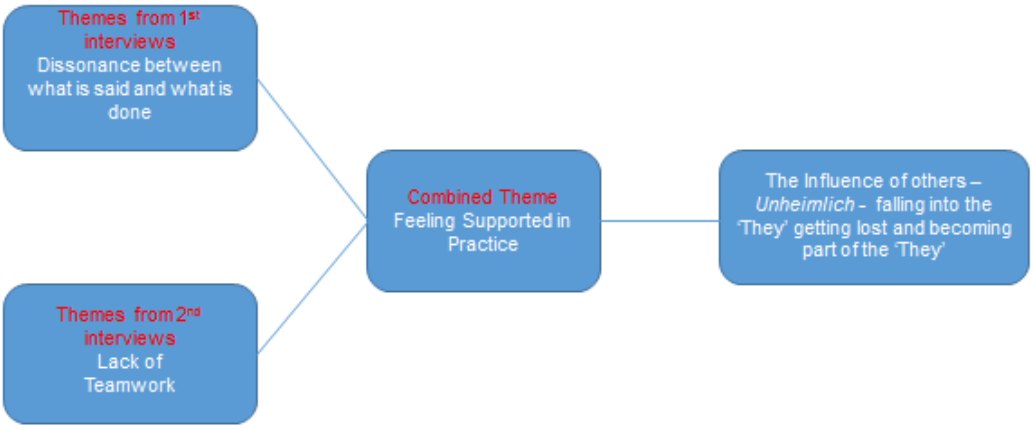
In summary, this notion of 'switching roles' between being a professional nurse and being a 'normal' member of the general public seemed to assist the students in delivering the intimate care necessary for dealing with patients with UI. Furthermore, it was quite clear that the wearing of their uniform appeared to contribute towards their experiences of being able to cope with the delivery of this

care. Being professional was clearly articulated through these experiences and the students even at this stage of their training had the ability to recognise the importance of this when dealing with intimate care of this nature. Maintaining their professional self appeared to be a very important part of their understanding of their role although the students did realise that maintaining this was influenced by other factors. This leads into the next theme that emerged from the data; The Influence of Others.

Theme 3: The Influence of Others

It was obvious throughout all of the interviews that the students' lived experiences of dealing with UI were infused by outside influences as part of their socialisation into professional practice. This was evident in both sets of interviews and was of particular relevance about how this affected the students' experiences. This was articulated in a variety of ways but was broken down into two clear areas of practice. Figure 10 shows a worked example displaying how the combined themes and sub-themes from 1st and 2nd Interviews were aligned to Heideggerian Philosophy.

Figure 10: The Influence of Others -an example of the themes from the 1st and 2nd interviews and the final combined theme and alignment to Heideggerian Philosophy



Feeling supported in practice by other staff members emerged as the first sub theme and secondly, how the influence of others affected care delivery and the maintenance of privacy and dignity when caring for patients with UI emerged as the second sub theme, Privacy versus Exposure: Dignity versus Lack of Respect.

Sub Theme 1 – Feeling supported in practice

The findings that emerged from this data clearly reflected that it was essential for the students to know who their support was in their clinical placements and what was expected of them. Feeling supported in clinical practice was a robust finding throughout these interviews and appeared to be paramount to having a successful placement. The students in the first interviews were keen and excited about going out to practice but doubts about how well they would be supported in practice were evident;

'We had a lot of input in school about being a healthcare professional and that in practice we would be supported by a qualified member of staff who would be our mentor I feel really excited that we will be supported by a qualified Registered Nurse and I'm really looking forward to my placement but some of the third years who are in school at the moment said not to hope for too much as they rarely got to spend time with their mentors. I'm a bit disappointed by but I've decided to take that with a pinch of salt and I'll see what it's really like for myself – I'm excited!! '
Lauren, Interview 10 (1st interviews)

This student was clearly looking forward to her clinical placement and prepared to make her own mind up about the event when she had experienced it. This was not always easy for these students as they do mingle with students from all stages in their nurse training and they can send shock waves and horror stories out to the

more novice nurses. One student identified this in her hopes and aspirations for clinical practice:

'My friend is just at the end of her second year and to listen to her you would think she never got to work with a member of qualified staff! I think that's a little farfetched as I'm sure that you get to work with your mentor a lot. We were told in school that we should spend a minimum of 40% of our time with our mentors so I'm looking forward to that especially when dealing with UI because I want learn how to improve things for patients'
Elise, Interview 12 (1st interviews)

It was very clear from the first interviews that the students were excited about going to their first placements and putting some of their new found knowledge into practice;

'I'm really looking forward to going on my first placement and putting some of my knowledge into practice and I am sure that I will learn loads. It will be interesting to see how what we have learnt in school relates to practice … some of the third years were telling us that what we do in school is not necessarily what happens in practice so not sure what they meant but will be interesting to see'
Anne, Interview 8 (1st Interviews)

The students appeared to be comfortable about what to expect in terms of the level of the support they would receive in clinical practice. However, the second interviews revealed some anxieties about how they were supported in clinical practice;

> *'I've thoroughly enjoyed my first year of nursing and am chuffed at my progress but it's not been easy. Practice is hard work and whilst I don't mind that there were times when I lost sight of who I was supposed to learning from. I would say I spent 80% of my time in clinical practice working with HCAs. I don't have a problem with that at this stage of my training but I do worry that I'm not acquiring the right skills. I mean they don't do anything bad but they just deal with UI as in clear it up they don't ever think to ask why and I know from reading and completing my academic stuff during this year that UI is a symptom and therefore has a cause but not if you're a HCA!!'*
> ***Gemma, Interview 5 (2nd Interviews)***

It was apparent from the second interviews that how care for UI was prioritised in practice had some clear divisions of labour and as the students spent a lot of time working with HCAs, concerns were beginning to register with these students;

> *'It was very clear who did what in most of my placements and anything to do with toileting or UI was the responsibility of the HCAs or carers. I saw very little involvement from qualified staff which really surprised me considering this is something treatable, I couldn't make sense of it really but there was definitely a hierarchy attached to some areas of practice'*
> ***Gemma, Interview 5 (2nd Interviews)***

Several students also identified with this concept of a hierarchy in relation to how some areas of nursing practice were divided up and split between staff. In particular, how managing UI was organised and how this type of nursing care was perceived was noted;

> *'There was a very clear line of 'who did what' in my placement areas and in relation to who dealt with UI this was very clear. Basically, the carers did all the changing and toileting of patients and the staff nurses did the medications and the paperwork'*
> ***Lauren, Interview 7(2nd Interviews)***

This was elaborated upon by the following two students in relation to how this type of work was viewed;

> *'Dealing with UI was left with the carers mainly and the staff nurses were not really involved, I think they saw it as 'dirty work' and not in their remit'*
> ***Martin, Interview 9 (2nd Interviews)***

This student related to this experience as a missed opportunity to see what Staff Nurses did as they spent most of their time in practice working with HCAs;

> *'From my experiences it was quite clear how the nursing care was delegated. Anything to do with UI was regarded as 'dirty work' so that was the carers job and the staff nurses did the clean work, the medications and the paperwork but we were often left to work with the carers so I'm now worried that I'm not up to speed with medications or the paperwork that a staff nurse does'*
> ***Danielle, Interview 3 (2nd Interviews)***

Although it would appear from the students' experiences that patients with UI were cared for mainly by carers, which influenced their own experiences, some of the students did realise that when qualified staff were involved with the care, their experiences of dealing with UI was a different encounter

> *'I noticed a marked difference in how patients with UI were cared for when a staff nurse was directly involved in their care. For me, my learning experience was so much better…. I'm not saying that the carers were bad or anything but to them it was just a job to get on with. With the staff nurse, I noticed they paid attention to other things like skin integrity and I learnt from that as it was not always addressed by the carers, I suppose because they don't necessarily have the experience or knowledge to pick up on the importance of these other things that may be happening as a consequence of their UI'*
> ***Anne, Interview 1 (2nd Interviews)***

> *'When I worked with the staff nurses I noticed a definite difference and it was a very different experience. I mean ….well for a start more time was spent assessing why the patient had been incontinent which never happened when I worked with carers, they don't really teach you anything it's all about getting the job done as fast as possible and I was just another pair of hands in that process!'*
> ***Susan, Interview 10 (2nd Interviews)***

'Although there seemed to be some sort of hierarchy as in, the carers did the 'dirty work' like deal with UI and the qualified staff did the medications and the paperwork, when qualified staff did get involved with dealing with UI it made a difference. The carers worked differently and they were much more respectful of the other jobs that the staff nurses had to do that took them away from direct care'
Lianne, Interview 8 (2nd Interviews)

This students' last comment raised the issue about how this lack of involvement and this hierarchy of care seemed to influence the carers themselves and this was also commented on in several other of the student interviews;

'To be honest I found that when the ward sister got involved with dealing with UI and helped the carers, those carers were much more knowledgeable about the consequences that UI could have on like the skin for example. When I worked with carers I never had that opportunity and it was definitely different and they certainly were not as aware of how UI can affect other aspects of care. I think learning by example is a good philosophy and I know I certainly have more respect for qualified staff that get involved in the direct care than I do for those that don't so I guess that's how the carers must feel. I know that the carers feel resentment when the qualified staff are in the office and they feel that they are left to do the donkey work'
James, Interview 4 (2nd Interviews)

This was echoed by the following students although they added a very interesting observation regarding the delegation of care;

'Carers certainly have more respect for the qualified staff when they get more 'hands on' with the care. For me, I found this a bit odd, on the one hand staff nurses are seen as too high up to take part in basic care which the carers resent and on the other hand it seems to be so important that qualified staff are involved because they can help educate the carers so that they know the reasons behind why things should be done properly! Seems weird to me and it confuses me in terms of the role of the carer and the staff nurse…. I mean… they should work as a team shouldn't they?'
Danielle, Interview 3 (2nd Interviews)

'Carers don't seem to see what they do as important because the qualified staff are not involved and I think this sends out the wrong message to the carers. They think that this basic care is not as important as doing the medications and the paperwork because they are left to do it so when we arrive as students we get used as another pair of hands most of the time. I actually think some of the carers don't like students because we float in all enthusiastic and full of ideals and they seem to want to drag us down to how they feel about everything and some of them have even actively avoided me! I think it's because 'I'm always asking questions!'
Rachel, Interview 11 (2nd Interviews)

The students clearly felt that there was a strong influence on how they perceived care in the clinical environment which was largely as a result of how this care was delivered and by whom. The students also could see how this care had evolved and made some interesting observations;

'Staff just seem to do things automatically and don't think about it. They almost go into autopilot when they come on duty you know like right…. We have this to do and this to do and then its coffee break and it all seems to revolve around their breaks and not what is necessarily best for the patient. Staff nurses work differently though they talk and listen to the patients and they don't get so regimented about care and time and takes to do things, I always notice that when I work with qualified staff'
Susan, Interview 13 (1st interviews)

'It seems to become second nature and just something they do every day, it's almost mechanical and no one thinks about it. I also notice that on occasions taking someone to the toilet seems to involve a lot of 'huffing and puffing' from the staff. There seems to be a lot of fuss when a patient asks to go to the toilet and many staff say to them they can wait, but some of them can't wait and wait for what exactly, that's what always gets me! There are some carers that you can ask to help you and it's usually the younger ones as they don't seem to have the routine drilled into them! (laughing) so yeah… I always ask the younger ones'
Martin, Interview 9 (2nd Interviews)

Working with qualified staff had a significant influence on remaining positive about delivering care for patients with UI and the issue of working as a team brought this to light;

'I think they (Staff nurses) could spend 5-10 minutes after handover seeing how things are on the ward and look at ways in which they could improve what they are doing. I think this would benefit the carers and the patients, just to reinforce that it's OK to be a bit more flexible with the routine around toileting and I think the carers would become more confident about trying to a bit more individualised with their care'
Martin, Interview 9 (2nd Interviews)

One student however, felt that it was qualified staff that were driving the routine and not allowing the carers to be more flexible;

'Sometimes we can be really busy and you have to stop what you are doing to take someone to the loo which I don't have a problem with because I'm not going to say 'no you will have to wait' I mean how can you say that? So you break off what you are doing and take them, it's common sense to me but we had a complaint that we were working slow that morning and the staff nurse said we should have the patients up dressed and toileted by now, don't understand, what's the rush?'
Elise, Interview 12 (2nd Interviews)

In summary, feeling supported in practice was a vital component in care delivery for patients with UI. The students have clearly identified that they spend a large proportion of their time in clinical practice working with HCAs and initially the students didn't seem too concerned about that. They did comment however, that they were keen to put their new found knowledge into practice whilst being supported by their mentor. There was very little evidence in these findings that they had many opportunities to do this but what is apparent, is that they spend a significant amount of time working alongside HCAs.

In the second interviews the students still discuss this but there is much more understanding about the implications of this for their own learning. They found that when they worked with a qualified member of staff there was a major difference in their own learning and things seemed to be much more about

assessment and treatment. This was the opposite when they worked with HCAs and the students openly reflected on this as something that concerned them. This is an important sub-theme as there is the potential for students to become disillusioned with clinical nursing practice which is identified in one of the student's experiences above. Furthermore, if this does happen then there is also the potential for students to devalue the academic ideal and without careful guidance this dissonance could cause the students discomfort about what they feel when an action differs from what they believe (Meyer and Xu, 2005).

The influence of others in their support network in practice is therefore a significant finding as this has a direct effect on their experiences of caring for UI. Subsequently, this could have implications for their understanding about how care should be delivered for these patients which may have some negative connotations. Feeling supported in practice by the appropriately qualified member of staff is important to these students and also has an effect on certain aspects of care delivery. Maintaining a patient's privacy and dignity when caring for patients with UI was an area of care that was highlighted expressively in relation to how this was affected by who they worked with and forms the next sub theme, Privacy versus Exposure.

Sub Theme 2 - Privacy versus Exposure: Dignity versus Lack of Respect

Without exception every student made reference to the importance of maintaining privacy and dignity in both sets of interviews. The students recognised very early

on in their training, that patients with UI requiring care were very much at risk of being exposed during the care interactions required to deal with the consequences of UI. The students also realised that this type of care was very intimate in nature and therefore required a lot of sensitivity, regardless of the gender of the patient;

> *'I know it will be a big part of what I do and ensuring that I maintain the patients' privacy and dignity at all times is really important to me and for the patient of course! Not sure how that will work though as a female caring for a male, I guess in that situation it's even more important to respect their privacy and dignity and let them do as much for themselves'*
> ***Susan, Interview 13 (1st Interviews)***

This was also raised in the second interviews by a male nurse;

> *'I think that all patients had good care overall and as a male nurse I probably thought about privacy and dignity issues a bit more as I mainly looked after female patients so was rather conscious about it but overall I think I've found that the way to look at it is that they are all patients needing my help regardless of their gender and for that matter regardless of my gender too. Privacy and dignity should always be respected and therefore gender should never be an issue…. Well… that's my thoughts anyway!'*
> ***Chris, Interview 2 (2nd Interviews)***

Respecting a patient's privacy and dignity regardless of gender was clearly an area that the students had given consideration to in both sets of interviews. The influence of other staff they were working with however, appeared to affect their own position on what they regarded as sensitive privacy and dignity care;

> *'We had a lot of input in school about being a healthcare professional and what that meant which really helped me put things into perspective about professionalism but my experience in practice to date doesn't always reflect that … it's like everyone knows how they should be really but then you hear HCAs saying that they provide excellent care for their patients and then tell them it's ok to pee in their pad when they ask to go to the toilet, I don't get that… how can that be good care… I mean it's not very dignified is it?'*
> ***Lauren, Interview 10 (1st Interviews)***

'One minute they were telling me about the importance of maintaining privacy and dignity for patients who were incontinent of urine and the next minute shouting across the patients' lounge for help because the patient was wet!! (laughs) I mean …. well, that's hardly promoting privacy and dignity is it!!'
Elise, Interview 12 (1st Interviews)

It is evident from these excerpts that the physical aspect of caring for patients with UI and the maintenance of privacy and dignity whilst doing so were essential components in delivering this type of care. The students were also recognising that privacy and dignity went beyond the exposure of body parts when delivering continence care and included other elements for example, being sensitive when seeking help and support for patients with UI. They were also beginning to identify some of the subtler factors associated with privacy and dignity;

'Sometimes I think as carers we take over and do everything for our patients particularly the elderly and frail, but sometimes I wonder if that is done more for our benefit rather than for the patient, I mean……. It's much easier and quicker to do it for them but then we are taking away some of their independence and I think that really is also not respecting their privacy and dignity'
Nicola, Interview 11 (1st Interviews)

Some students had also made that connection but also discussed how often carers failed to discuss with patients what they were doing when it came to assisting patients with their toileting needs;

'A lot of the carers are really nice and have a nice way with the patients and they talk to them and explain what is happening. Others just announce 'I am going to change you' I mean that's not asking for consent first of all and it's not letting them have a say in their care, so I think how the nurse approaches the patient depends how the patient then reacts. I mean the first thing I got told was that patients with dementia who have little awareness of what is happening still need an explanation as to what you are doing I mean …… if someone just gets hold of your arm and starts pulling your pants down well…. it's a bit of an invasion of privacy

and I certainly wouldn't like it, so I think talking to them and explaining what you are doing is vital as at the end of the day we need to protect their privacy and dignity at all times even a patient with dementia is still aware so they need extra care for reassurance'
James, Interview 1 (1st Interviews)

How care was about to be delivered was also highlighted by this student in terms of maintaining privacy and dignity;

'I have limited experience of dealing with UI but one of the things I did observe on my work experience was how carers were quite blasé about announcing that someone had been incontinent. I can remember one instance in particular where two carers just approached the patient and announced to the whole lounge that she had been incontinent and they would have to change her, I mean …. I was shocked I mean I know I was naïve but I don't think that was necessary to announce it to everyone, how embarrassing and certainly not maintaining the patients' privacy and dignity'
Susan, Interview 13 (1st Interviews)

Maintenance of privacy and dignity by carers was a well discussed issue by the students, particularly in relation to the environment and their immediate surroundings. Two of the students recognised the need for privacy and dignity when the patient was taken to the toilet;

'Sometimes carers leave the toilet doors open which I don't understand why they do that. I mean I'm sure that they don't sit on the toilet with the door open. I think they forget as oppose to doing it on purpose but I really noticed it and thought this is something so private why don't the carers respect that?'
Martin, Interview 9 (1st Interviews)

'I think what I noticed as a HCA was the number of carers that stood over the patient when they were sitting on the loo which may have been for their safety but most of the time they were also holding a conversation with each other about what they did at the weekend, I mean… that must have made the patient feel really uncomfortable just waiting for them to do their business in front of them!'
Nicola, Interview 11 (1st Interviews)

Both of these students however, also discussed how they dealt with it in the practice setting. They were becoming conscious that patients were being exposed unnecessarily and these two students were starting to find their own way at addressing this;

> *'I have actually said 'shall we just close the door?' and the look on their faces……and of course they say 'yes of course' but you can tell by their faces that it's almost like a jump start again and it raises their awareness because we learn from them and they learn from us and we refresh their memories and I found that really good'*
> ***Martin, Interview 9 (1st Interviews)***

> *'I at least close the bathroom door before starting to remove their clothing that is simple enough to do, or maybe even wait outside the door if they can be left so that they know that you are there should they need you. I don't think it's necessary to stay in the toilet with them unless they cannot be left but I have seen this happen frequently. I don't think it takes much to make sure we maintain privacy and dignity and to be fair I think most of the time it does happen but why some nurses don't do it I really don't understand'*
> ***Nicola, Interview 11 (1st Interviews)***

Maintaining privacy and dignity and reducing over exposure of the patient remained a very clear sub theme in the second set of interviews. There were however, some very different observations of how nurses addressed how these essential elements of nursing practice were met. It appeared for some students that it depended on what type of ward you were on;

> *'I found that throughout this first year maintaining a patients' privacy and dignity whilst dealing with UI differed depending on what type of ward you were on. My first experience was on a Stroke Rehabilitation Unit and they were excellent about maintaining privacy and dignity at all times, not just around continence care. I couldn't fault them and they were also interested in assessing the patients' incontinence and certainly pads were not a priority so I think I got a really good grounding into the principles of continence promotion'*
> ***Gemma, Interview 5 (2nd Interviews)***

'I worked on a dementia care ward and privacy and dignity was well respected on there and all staff made an effort to ensure that it was maintained at all times and especially when assisting patients to the toilet. I was really impressed, just because they had dementia did not mean that were not aware and the staff were great with them at all times and that's how it should be, but then I worked on an acute surgical area and that was a different story! Privacy and dignity were not breached as such, it was more that UI was just not of any concern to them, it was a secondary problem so it was just, well…..'mopped up' really, with no real thought about what it must feel like for the patient so in my view, not dealt with in a dignified way, just a lack of respect really'
Lianne, Interview 8 (2nd Interviews)

The type of ward appeared to show that there were differences in how privacy and dignity issues were viewed which the students above highlighted. The physical act of actually dealing with UI was also addressed by several of the students and they directly linked this to issues of lack of respect for the patients' privacy and dignity;

'Some staff would complain about the patient when other patients could hear them. They would complain about the smell and how much urine had been passed. They seemed to do this with the quiet patients but not the vocal patients for some reason. I've also heard staff say to patients 'it's not time for the toilet yet, you have a pad on use it'! It's hardly maintaining privacy and dignity is it! It must make them feel worthless and that they are just not important…. awful really'
Elise, Interview 12 (2nd Interviews)

'Some carers' attitudes towards maintaining patients' privacy and dignity are awful …. I've heard them telling the patients to hurry up when they are sat on the toilet and it's like it's all a big inconvenience to them and it's all so rushed. Dignity and respect should be their major priority in this area of health care as it is such a private function. However, that's not always the case which is sad because it doesn't take much to preserve someone's privacy and dignity and it makes such a difference to the patient. I'm not saying that they do it with bad intent (sighs) …. I just think they get so entrenched in the day in and day out they just forget'
Susan, Interview 10 (2nd Interviews)

This issue about maintaining patients' privacy and dignity was also highlighted in the following students' experiences with a direct relation to how the staff dealt with patients with UI;

'Attitudes of some of the staff towards maintaining privacy and dignity surprised me… I mean……. they talked over the patients about their social lives and sometimes they didn't even acknowledge the patient! Now that's bad taste and very impersonal and certainly is not being respectful of the patients' privacy and dignity'
Lauren, Interview 7 (2nd Interviews)

'Some carers talked over the patient whilst they were cleaning them after an incontinent episode and that really annoyed me. I found it hard to cope with in terms of their privacy and dignity because when the person you are working with starts talking to you about what they are doing at the weekend whilst you are cleaning the patient you feel awful as the focus should be on the patient I mean …. well they must feel bad enough as it is and then for their carers to completely ignore them, well they must feel like they are being processed like some factory product!'
Rachel, Interview 11 (2nd Interviews)

'I've seen staff changing older patients with absolutely no conversation at all with them, totally ignored them. It's not good is it..you know… I think everyone has a right to have their privacy and dignity respected and it should be a priority amongst all staff but sadly that is not always the case'
Susan, Interview 10 (2nd Interviews)

One particular student held quite a unique view regarding the maintenance of privacy and dignity and had observed this in a more covert way than the students above had discussed;

'Regarding the use of pads I had mixed experiences in relation to the maintenance of privacy and dignity. The patients would have their pad changed and they would be offered the use of the toilet before a new pad was applied. For me that is respectful and dignified practice. However, there were also occasions where the patient would not be offered the toilet and a new pad would be applied and for me that is not maintaining the patients' dignity. I guess some people may not see it in that way because it's not obvious, but it's these subtle aspects of practice that I think say so much more. It's like when they are toileting they do try but they all queuing up to be taken to the toilet and those waiting can't help but be exposed to what is going on when the carers open the toilet doors, I mean I think that could be done so much better and without a great deal of effort'
Martin, Interview 9 (2nd Interviews)

There were however, some positive elements to the students' experiences with regards to the maintenance of privacy and dignity, which was summed up very articulately by one of the students;

> *'I think on the whole the carers really try hard to ensure the patients are well cared for and that their privacy and dignity is respected at all times. I can see how they gradually fall into what I call 'sloppy practice' though at the same time. They are left to do most of the toileting with very little input from qualified staff and trying to maintain that standard of care with no support from the staff nurses must be hard for them. They all have different levels of experience and there doesn't appear to be any standard re their own training so poor or below standard practice just melts into the better standards of practice and then we get this mish mash of standard or sub-standard quality of care. I feel sorry for the carers at times because I think on the whole they try really hard but with very little support'*
> ***Gemma, Interview 5 (2nd Interviews)***

It is quite clear from these student interviews that the maintenance of the patients' privacy and dignity is a very important aspect of nursing care. They have been exposed to a variety of different practises, some of which have caused the students mixed emotions ranging from frustration and annoyance, to being pleasantly surprised at how staff attempt to provide dignified care. What is clear is that these students think this care should be delivered with respect for the patient at all times regardless of their UI and that all patients have a right to privacy and dignity, particularly when dealing with UI. These interviews however, illuminate the fact that there are deficits in the provision of dignified care and there are attempts within the interviews to try and understand why this is the case. The students in this study obviously felt that the promotion of privacy and dignity was a very important constituent of care delivery for patients with UI and they have made some very interesting observations about privacy versus exposure and the maintenance of dignity that sometimes lacks respect.

Summary of Findings

Student nurses' lived experiences of UI have identified a number of issues for practice. The experiences they have shared and the themes and sub themes that have emerged from the data show how these experiences have been shaped and how the students made sense of their everyday experiences and how this helped them understand how UI is dealt with in practice.

There was a difference between the two sets of interviews especially related to the students' own way of dealing with UI. This was much more obvious in the second set of interviews and a major theme was identified that illustrated this. The students were very comprehensive about their experiences of dealing with UI which was not really surprising as they have got more experiences to draw on and dealing with UI was no longer a novel experience. The major concerns that the students appeared to have in the second set of interviews were more associated with their own socialisation into their chosen profession and coping with other staff members' attitudes towards UI. The focus in the second set of interviews was mainly around the realities of clinical practice and their individual approaches to rationalising how this compared to their own ideals. The students remained enthusiastic about UI but there did appear to be a difference between the two sets of interviews regarding their own ideals and the realities of practice. However, the second set of interviews also showed a level of maturity towards dealing with this that was not so apparent in the first interviews.

The findings from the second set of interviews also show many similarities to the findings in the first interviews. However, the students appear to have the ability to use reflection more to articulate the meaning these experiences had for them on a personal level. All of the students remained enthusiastic about their practice experiences although it is quite clear from these interviews that their experiences of the realities of being a student in clinical practice had many challenges. There are many examples of how their experiences have influenced how they managed dealing with UI but the complexities surrounding how these experiences have been cultivated are multifaceted. The students remained positive about their own ideals for practice but it is clear from the findings that they are influenced by a number of issues that has lead them to adapt in the clinical environment, to balance out all of these influences and issues. This is reflected in Figure 11 which shows where the students think they are in their own life world in terms of holding their own ideals for practice and the realities of practice that they have experienced to date.

Whilst in the first interviews they were all enthusiastic and proactive in how they thought patients with UI should be cared for, there was level of realism as they had all had previous experiences to draw on which challenged some of these ideals regarding the realities of practice. This level of realism still existed following the second interviews although it is clear from the findings that many adjustments have taken place and the students appear to have adapted some of their original ideas and expectations from their first interviews which will be discussed in the next chapter.

Overall Summary of the Three Key Themes

Three key themes emerged from the analysis of the extensive data analysed which encapsulated the students' experiences of dealing with UI in the first year of their training programme. There were a variety of experiences captured that reflected both positive and negative aspects of care delivery for patients with UI during the course of their first year of training.

To conclude the findings were as follows;

Theme 1 – Being There

Being in clinical practice and experiencing care at first hand meant that the students were immersed in practice for a significant amount of time during their first year. Being-in-the-world and experiencing care for patients with UI was therefore a clear theme that emerged from the data.

Key findings from First Interviews

In the first interviews the students were shocked at how UI was managed and there was almost a sense of disbelief at the organisation of care for these patients. It was clear that the students were discovering that what they had been taught in theory and what they were experiencing in clinical practice did not always match their own ideal for care of patients with UI. This dissonance was evident but it is clear that they did not feel in a position to voice their concerns in

practice. In spite of this, they appeared to be positive about managing patients with UI and remained enthusiastic although intrigued as to some of the practices they had experienced.

Key findings from the Second Interviews

In the second interviews, whilst there were many similarities to the findings in the first interviews, the emphasis had moved from the physical aspect of caring for patients with UI. They appeared to be more at ease with the physical side of caring for patients with UI in the second interviews and the focus was now more on their own abilities to find ways to challenge these practices without 'rocking the boat'.

Their own socialisation into the profession of nursing was very evident and the students were beginning to question what they were experiencing which was less evident in the first interviews. Whilst they remained positive about care delivery, their level of optimism for delivering care close to their ideals had diminished. The students were beginning to sense that the nurse they would like to be is being challenged by external influences. Although this was causing concern, there appeared to be inevitability in their acceptance of juggling their ideals with the realities of practice but tensions were becoming apparent. This created a disharmony as it emerged that trying to stay true to their ideals was becoming compromised by the reality of practice.

There was much more evidence of frustration about how care was delivered for patients with UI and tackling their concerns around what they perceived as poor practice had its difficulties. However, the students had developed strategies to address this. It was also clear from the second interviews that having a supportive mentor who encouraged them to voice their concerns made all the difference to the student's experience.

In summary, weaving their way through the overt and covert aspects of the realities of dealing with UI featured largely on the students' agenda and was a very important aspect of how they were socialised into the practice setting. Being there and experiencing practice in this first year of study had clearly been a challenge for these students.

Theme 2: Being Understood: Coping with being there

Being understood was a very strong theme throughout both sets of interviews and was clearly articulated in both the first and second interviews.

Key findings from the First Interviews

In the first set of interviews, finding strategies to cope with the transition from lay person to student nurse were clearly challenges for them at the beginning of their training. Articulating these thoughts and feelings was very prevalent in the first interviews and the students expressed concerns about how they would be viewed by their peers in the practice setting. They were conscious that being over

enthusiastic and challenging everything they saw may be problematic and could affect how they were perceived in practice.

Being understood in practice therefore was a vital component of their desire to want to fit in to their practice areas without ‘rocking the boat’. This was articulated as feelings of powerlessness in the first interviews which is hardly surprising due to their limited experiences. There was however, an overwhelming desire to be part of the team that they were working in and the students had a clear understanding about why this was important to them and this was evident right from the first interviews.

Being professional was also important to these students and in the first interviews this was all about remaining professional even when dealing with the consequences of UI. The students worried about how they would react to dealing with UI and remain professional in their approach. Being in uniform appeared to assist them in making that transition from lay person to student nurse and the students talked about this as ‘Switching Roles’. This notion of ‘Switching Roles’ involved the wearing of their uniform which allowed them to make the distinction between them as a ‘normal person’ and them as a professional nurse. For the students in the first interviews this was an important aspect of how they coped when dealing with UI and it came from a personal perspective.

Key findings from the Second Interviews

In the second interviews, whilst this remained a priority there was less evidence about dealing with UI personally. By now they had experience and therefore this was no longer their anxiety, the students appeared to more at ease with physically dealing with UI by the end of year one. Their major anxiety at this stage of their training emerged as a strong desire to challenge practice but at the same time 'fit in' with the ward staff and culture of the organisation they were working in. It was far more evident in the second interviews that they had struck a balance between being understood as an enthusiastic student wanting to learn everything and fitting in to the ward team which was less evident in the first interviews.

Being professional was also important in the second interviews and the students were aware of the importance of their behaviours when in uniform. The difference in these second set of interviews was that it was no longer just about being professional from a personal perspective but also how they were perceived by the patients and how this allowed them to form therapeutic relationships with their patients.

In summary, 'fitting in' was a strong finding in this study and during the first year the students have found ways of doing this which has on occasions compromised their own ideals for practice. Being professional was also clearly articulated through these experiences and the students even at this stage of their training had the ability to recognise the importance of this when dealing with intimate care

of this nature. Maintaining their professional self appeared to be a very important part of their understanding of their role although the students did realise that maintaining this was influenced by other factors.

Theme 3: The Influence of Others

It was obvious throughout all of the interviews that the students lived experiences of dealing with UI was infused by outside influences as part of their socialisation into professional practice. This was evident in both sets of interviews and was of particular relevance about how this influenced the students' experiences. This was articulated in a variety of ways but was broken down into to two clear areas of practice which referred to the influence of the staff the students were working with. This developed the sub theme, feeling supported in practice and privacy versus exposure emerged as the second sub theme.

Key findings from the First Interviews

Feeling supported in clinical practice was a robust finding throughout these interviews and appeared to be paramount to having a successful placement. The students in the first interviews were keen and excited about going out to practice but there were seeds of doubt about how they would be supported in practice. This was largely as a result of being exposed to other cohorts of students when they were in University. The students were clearly looking forward to their clinical placements and whilst apprehensive they appeared to be prepared to make their

own mind up about the placement once they had experienced it. This was not always easy for these students as they do mingle with students from all stages in their nurse training and they can send shock waves and horror stories out to the more novice nurses about the lack of support they have when in placement. This did not however, affect the students' enthusiasm and they were excited about going to their first placements and putting some of their new found knowledge into practice. They did not seem to be concerned at this stage about who supported them in practice it was more about having the experience that mattered. The maintenance of privacy and dignity in those experiences however, was a very important aspect of care delivery for patients with UI.

There was an awareness that recognising that privacy and dignity went beyond the exposure of body parts when delivering continence care and included other elements for example, being sensitive when seeking help and support for patients with UI. They were also beginning to identify some of the subtler factors associated with privacy and dignity for example, promoting patient independence rather than taking over from the patient without any consent. Maintenance of privacy and dignity by carers was a well discussed issue by the students, particularly in relation to the environment and their immediate surroundings and they questioned carers' attitudes towards maintaining the patient's privacy and dignity on occasions. Although they had limited experiences to draw on it was clear they were becoming conscious that patients were being exposed unnecessarily.

Key findings from the Second Interviews

In the second interviews, feeling supported in clinical practice remained a key concern for the students but there was much more understanding about the implications of this for their own learning. They found that when they worked with a qualified member of staff there was a major difference in their own learning and things seemed to be much more about assessment and treatment. This was the opposite when they worked with HCAs and the students openly reflected on this as something that concerned them. The students also closely linked this to the maintenance of privacy and dignity and reducing over exposure of the patient.

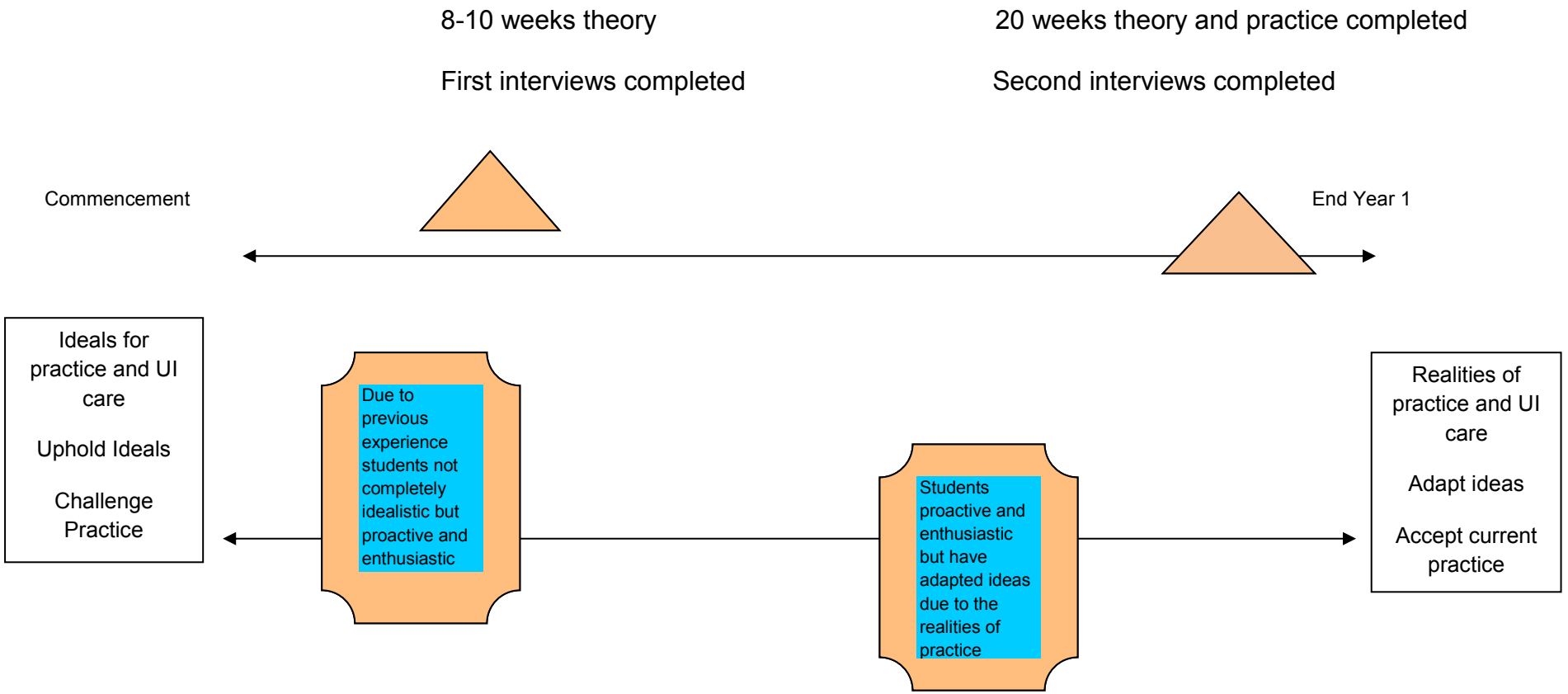
There were however, some very different observations of how practice addressed how these essential elements of nursing practice were met. It appeared for some students that it depended on what type of ward they were working on and there were clearly differences noted across the areas that the students were working in. They have been exposed to a variety of different practices some of which have caused the students mixed emotions ranging from frustration and annoyance to being pleasantly surprised at how staff attempt to provide dignified care.

The second interviews in particular however, illuminate the fact that there are deficits in the provision of dignified care and there are attempts within the interviews to try and understand why this is the case. The students in this study obviously felt that the promotion of privacy and dignity was a very important constituent of care delivery for patients with UI and they have made some very

interesting observations about privacy versus exposure and the maintenance of dignity and the lack of respect that they sometimes observed when caring for patients with UI.

In summary, feeling supported in practice was a vital component in care delivery for patients with UI. The students clearly identified that they spend a large proportion of their time in clinical practice working with HCAs and initially the students didn't seem too concerned about that. They did comment however, that they were keen to put their new found knowledge into practice whilst being supported by their mentor. There was very little evidence in these findings that they had many opportunities to do this but what is apparent, is that they spend a significant amount of time working alongside HCAs.

Figure 11: Ideals and realities for UI Practice (Adapted from Curtis, Horton and Smith, 2012)



CHAPTER 6: DISCUSSION

Introduction

The previous chapter presented the findings from the student nurses' experiences of dealing with UI. This chapter moves towards acquiring an integrative consciousness of understanding this phenomenon of being a student nurse dealing with UI. The aim of this study was to understand the phenomenon of how student nurses' experience dealing with UI in their first year of training. To date there have been no studies that have specifically explored student nurses' lived experiences of dealing with UI. Understanding the students' own life world in how they experience UI and what shapes these experiences therefore is unique to this study and will form the basis of this discussion chapter. The implications for further research and for practice will also be discussed and a critical reflection of the limitations of the work and what conclusions can be drawn from the work will also be discussed.

Phenomenology as philosophy and methodology

There have no studies to date using quantitative or qualitative methodology to explore student nurses' experiences of UI in their first year of study. As I wanted to understand how student nurses' experienced this phenomenon I chose to adopt the phenomenological methodology underpinned by the philosophy of Martin Heidegger. This approach has allowed me to develop a deeper understanding about what is like to be a student nurse in their first year of study and their experiences of UI. Utilising this methodology has yielded rich thick

descriptions of each individual student's experiences which give an invaluable insight into their world and what it is like being there. Heidegger's interpretive hermeneutic phenomenology has enabled me to explore the student nurses' experiences whilst recognising my own experiences. Husserlian descriptive phenomenology would not have allowed me to do this as I would have had to bracket my experiences from the research which would not have given the depth of understanding reached in this study. This knowledge was an essential part of this study and it helped to develop the relationship between myself and the participants which maintained rigour and trustworthiness throughout the study.

Revisiting the aims of the study

The study proposed 4 major aims;

1. Student nurses' experiences of dealing with UI prior to and following clinical exposure, in their first year of study.

2. How student nurses care for patients with UI.

3. What the experience of caring for patients with UI means to them.

4. How student nurses' perceptions of UI are shaped and influenced in their first year of study.

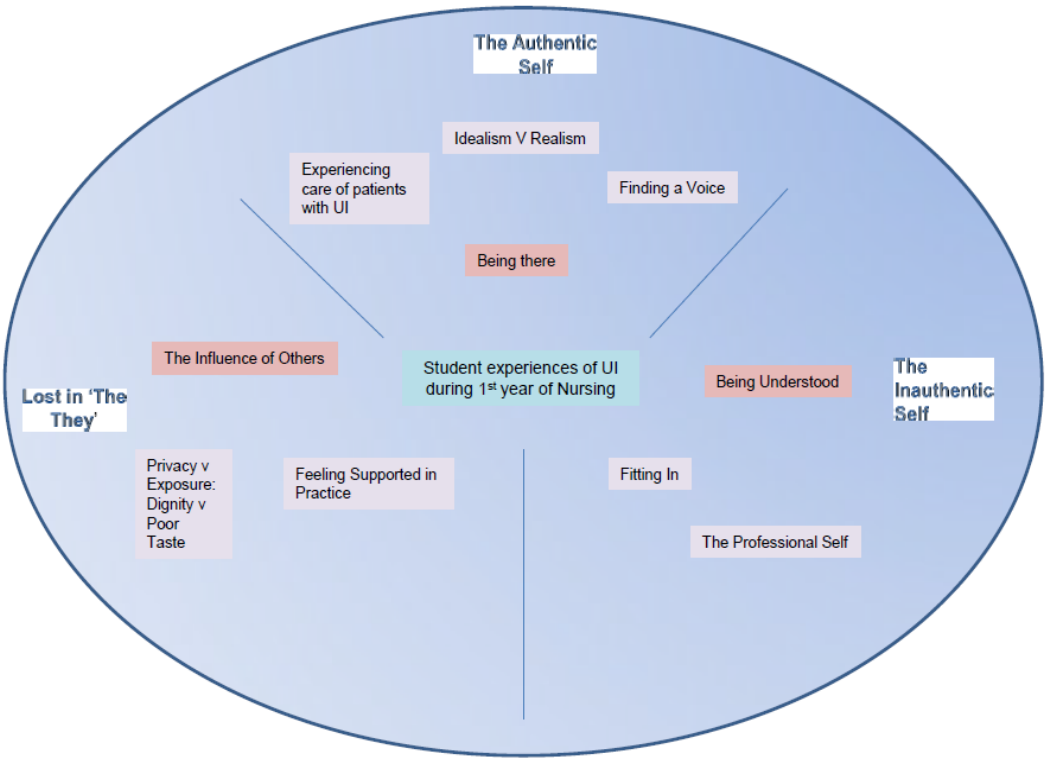
The first aim was exploring the student nurses' experiences of dealing with UI prior to and following clinical exposure, in their first year of study. This was

achieved by in depth interviews on a one to one basis at the beginning of their training before they went into clinical practice and again at the end of their first year of study. The remaining three aims were all explored within the interviews and as there are no other studies to compare my findings to, they form a unique view of the students' lived experiences of dealing with UI, caring for patients with UI and what it meant for them and how these experiences were shaped and influenced in their first year of study.

Discussion of main findings

Each of the 13 students in this study had their own unique view of their own life world in how they dealt with UI in the first year of their training programme. These experiences gave an exclusive insight into their ideals and expectations before they went out into clinical practice at the beginning of year one and how these ideals and expectations were influenced during their exposure to clinical practice throughout the first year of their training. The emergent themes and sub themes that have materialised from these experiences reflect the complexities of these encounters and gave me as the researcher a privileged insight into the students' experiences and what meaning it had for them. It would seem that when developing themes, it is important to explore their relationship with existing theoretical interpretations to help position the findings within a wider context. This will form the basis of this chapter in order to give the findings a meaningful whole. There was also some methodological cohesion at this point in how the students' experiences merged into the philosophical underpinnings of Heideggerian phenomenology and this will also be discussed in this chapter (see Figure 12).

Figure 12: The combined themes and sub themes aligned with Heideggerian philosophical underpinnings



Key Findings

1. **Being There:** Student nurses in their first year of training are motivated and enthusiastic about continence care. According to Heideggerian philosophy they are being their 'authentic self'. This will be discussed in this chapter.

2. **Being Understood:** Exposure to poor continence care is apparent during their first year of training. Heideggerian philosophy aligns these experiences to the challenges the students face in practice and their discovery of 'the inauthentic self' which will go on to be discussed in this chapter.

3. **The Influence of Others:** Exposure to staff with negative attitudes had the potential to challenge the students' own attitudes, values and beliefs during their first year of training. This fits in line with what Heidegger terms 'lost in the they' and 'tranquilised familiarity' which will be discussed further in this chapter.

Being There – the relationship with previous research

It is clear from the outset that these students entered into the profession of nursing with a positive outlook about the fact that human beings are in control of their bladder function and they are motivated and enthusiastic about delivering

this type of care which reflects the findings in Hutchings and Sutherland (2014) study. Whilst this is still apparent at the end of year one, it is clear that there has been a level of acceptance about how UI is treated in clinical practice. Passive acceptance of the problem of UI was therefore clear from these students' experiences and this seemed to create a tension between theory and practice. The students were all positive and enthusiastic about UI during their first year but their ideals for UI care did not match the reality in practice. Their experiences reflected how UI was managed and that there was an acceptance of this condition as something that happened as people age and that there was a level of complacency about dealing with it by healthcare professionals.

These findings are broadly in line with previous research regarding how health care professionals respond to dealing with UI in clinical practice. Passive acceptance of UI exists despite evidence that UI can be easily treated (Largo-Janssen *et al,* 1992; McDowell *et al,* 1992; Hahn *et al,* 1993; Milne, 2000; St John, James and McKenzie, 2002; NICE, 2015). The students saw little evidence of UI being pro-actively addressed and furthermore reported that healthcare professionals were ritualistically managing UI with task orientated routines. This reflects the findings of Mackintosh (2010) who found that as students enter into nursing as a novice they find themselves in a world full of interactive processes that they need to fit into in order to gain acceptance. This however, causes some concerns as there is the potential danger that students could get sucked into the continuance of ritualised practice and this may cause some disturbance particularly regarding their loss of idealism (Stevens and Crouch, 1995; Manninen, 2001). This is exactly what the students articulated throughout this

particular theme but they were beginning to find ways of challenging practice without feeling compromised towards the end of year one.

Staff attitudes overall were still negative towards dealing with UI and therefore it remained a health care issue that health care professionals failed to engage with which confirmed earlier findings by Shaw (2001). It was also perceived as an unimportant health need which resonated with a more recent study by Orrell, *et al.* (2013). This created a lot of confusion and tension for the students in this study as they became acutely aware that what they had been taught in theory did not match the reality of clinical practice and finding ways to address this proved to be challenging. Student education and knowledge however, remained consistent throughout the study and throughout the first year of their training these students remained pro-active in their perceptions about how UI should be treated and not just managed. Previous research however, has suggested that little has changed overall in the number of hours allocated to continence care in health care professionals curricula (McClurg *et al*, 2013b) which may have a direct link to the development of appropriate attitudes towards patient care (O'Brien, Richards and Walton, 2009). The findings in this study however, do not reflect these concerns.

Students in this study clearly demonstrate understanding that UI is a symptom that requires assessment and treatment throughout their first year of training. My own observation of the two pre-registration curricula that these students were following showed that continence promotion was covered in their first year. Within the two universities in this study UI did have a presence in both curricula during

year 1 with an emphasis on the fact that UI was a symptom that required investigation in order to establish its cause, but the delivery of this content varied between the universities. One university included a total of 2 hours of teaching in year 1 around the renal system with urinalysis and continence / incontinence included as a workbook for students to complete as directed study which also included urinary catheterisation. The second university dedicated 2 hours in total in year 1 which covered the renal system, types and causes of UI and urinary catheterisation (see Appendix 10). In this study, the major problem for these students did not therefore appear to be their own lack of knowledge, it was more related to the fact that this was not reflected by the majority of staff that they were exposed to during their first year of study, which may be attributable to lack of knowledge on their part.

Being There – the relationship to Heideggerian Philosophy

The students in this study commenced their first year of training as enthusiastic and motivated individuals and there was an expectation that UI would be seen as something that required assessment and treatment. Being incontinent therefore, meant that there was a reason why this was happening which required investigation. This was clearly the students understanding at the beginning of their training but by the end of their first year, students were finding it more difficult to remain true to their own ideals for this area of clinical practice.

Heideggerian thinking acknowledges this as being the 'authentic self' where we stay true to our own values and beliefs as we exist in the world. However,

maintaining this ideal is fraught with the complexities of being-in-the-world and Dreyfus (2000) suggests that staying true to our 'authentic self' is challenged when we are socialised into the shared practices of the world. For the students in this study this was evident as their ideals and expectations for their experiences of UI did not appear to match the realities of being-in-the-world. Their relationship to the world therefore is challenged by the shared meanings and practices that already exist in the areas of clinical practice that they are exposed to. In addition, it also relates to the degree to which one is true to your own personality in spite of external pressures (Langdridge, 2007). The students in this study found this to be of significance from their own personal experiences of dealing with UI.

Being Understood - the relationship with previous research

Being understood for the students in this study consisted of remaining true to their professional self, or as Heidegger terms it, their 'authentic self', whilst fitting in to the environment they were working in. Students seemed to find ways of coping with this in their attempt to 'fit in' to their new professional role. This was not an unusual finding for novice nurses who rely on their relationship with their mentor as key to their learning opportunities in clinical practice furthermore, since their mentor is their linchpin, students often learn their mentors' preferences (Gray and Smith, 1999; Gray and Smith, 2000; Hughes 2005). It is possible then, that students may learn to conform in order to cope with the reality of becoming a nurse and create a smooth path towards their final goal (Sadow, Ryder and Webster, 2002). This was confirmed in Phillips, Davies and Neary (1996) earlier study, where students discussed 'learning the routine' and 'fitting in' as ways in

which conformity was manifested. It is vital to them that they are accepted by colleagues as this facilitates the loss of the 'outsider' role and the associated stigma (Phillips, Davies and Neary, 1996). This notion of 'belongingness' is clearly articulated by the students in this study and 'fitting in' was important which reflects the findings of Spouse (2001) and Levett-Jones and Lathlean (2009) who found that student nurses needed to feel part of the team. Remaining true to their 'authentic self' however, is challenging for student nurses as in their attempt to 'fit in' in order to belong, students often revert to their 'inauthentic self', accepting the values and norms of the learning environment, even if this does not reflect their own values (Malouf and West, 2011). Furthermore, Melia (1981) in much earlier work had described this process as learning survival skills. Whilst the students in this study identified with the findings of these earlier studies there is a significant difference in how these students coped at the beginning of their training and how they coped at the end of year one.

At the beginning at year one, they lacked the confidence to challenge practice that they deemed to be different from their theoretical teaching. For the majority, this was accepted and the need to be *'part of the team'* and '*not to rock the boat'* were common expressions throughout the interviews. Whist this remained a theme throughout the second interviews the students appeared to have struck a balance and had found ways of challenging practice without compromising their own position. This was associated with having a supportive mentor in practice who actively encouraged the students to discuss their experiences. These findings support other findings in the literature. Lambert and Glacken (2004) reported that a good mentor was important for the organisation of care delivery

which had a positive effect on the student nurses' experiences of mentorship. However, over recent decades the role of the nurse has changed extensively and mentors often have to forfeit clinical teaching in lieu of a myriad of other responsibilities (Lambert and Glacken, 2004) leaving what we commonly call 'bedside nursing' or 'basic nursing care' to HCAs which may lead to the perception of students that this is not an important element of nursing care (O'Driscoll, Allan and Smith, 2010). The students in this study did identify with this in terms of working alongside HCAs and the challenges that this gave them in remaining positive about UI but their experiences reflect that they still perceived UI to be an important area of practice. They were however, well aware that there was potential for this to influence their experiences in the future.

The student's main priority appeared to lie with being socialised into their new professional role but not at the cost of losing their ideal for practice. A hierarchy of care however, exists and the students often found themselves floundering at the bottom of this hierarchy and yet had much to offer the development of practice. This is an important finding that both practice and education need to take notice off. More than twenty-five years ago Andrusyszyn (1989) identified that a key aspect of nurse education was to promote the acquisition of a non-judgemental approach in order to develop a sensitive and autonomous practitioner. Fourteen years on from this, Ironside *et al.* (2003) argued that competent practice required more than content knowledge applied in clinical situations. Practitioners of the future needed to be engaged in the understanding of and the persistent thinking about both the context of care and clients'

experience of health and illness. Developing an education programme that allows these concepts to advance would therefore appear to be essential.

Clinicians in practice and education need to expedite this in an attempt to harness the enthusiasm and level of optimism that the students genuinely feel in this study about dealing with patients with UI. The findings in this study have identified that students in their first year of training did have a level of enthusiasm and motivation to provide proactive continence care. It would appear that there is much to learn from how these students had managed this aspect of their transition from lay person to nurse as this could be key to understanding behaviours that conflict with the students' ideals, giving them some insight into how to deal with it. Being professional was also important to these students and there were some unique findings in this study that are worthy of discussion.

Remaining professional whilst dealing with the consequences of UI was a challenge for the students in this study. This was much more evident at the beginning of their training in an attempt to not be misunderstood by their patients or the staff that they were supported by in practice. The students were conscious that their own reactions to dealing with UI could have a major effect on the relationship that they subsequently developed with their patients and the staff they were working with.

Lawler (2006) found that student nurses saw that providing intimate care to their patients was very much part of their role and to be valued. The students in this study certainly related to that but as novices they had found ways in which to

cope with dealing with the intimate nature of UI in order to remain true to their professional self. The findings in this study showed the students had a unique way of coping with UI in their attempt to remain professional. The students talked about the use of their uniform as a 'theatrical prop' that characterised their professional role and enabled them to carry out their nursing care for patients with UI in a caring and professional manner. In addition, the students in this study talked about 'switching roles' so that when they were in uniform, they were a nurse first and this helped them in dealing with both male and female clients with UI. These findings are unique and are not reflected in any other studies related to UI.

Being Understood – the relationship to Heideggerian Philosophy

Being understood in an attempt to 'fit in' to professional practice and remain true to their professional self was a challenge for the students in this study. Heidegger acknowledges this and points out that we do not have to follow what everyone else does however, if we do chose this path, then we have to accept the unsettling nature of this as a consequence (Heidegger, 1926/1962). None of what these students' experienced were uncommon. Woods (2005) found that student nurses often feel that they are not in a position to challenge the practices of their qualified mentors and often express this as 'feelings of powerlessness' while in the clinical setting. In Heideggerian terms, what was actually happening was that by being idealistic was actually being 'authentic' but this caused anxiety at times in an attempt to 'ft in' with the world around them (Heidegger, 1926/1962). Heidegger (1926/1962:234) terms this as 'tranquilised familiarity', somewhere we

can ‘dwell’ when we become ‘lost’ in the ‘they’. The students in this study however, were able to identify ways in which they could approach dealing with this but this became much more obvious in the interviews at the end of year one.

At the end of year one the students showed that they had found a way of being able to use their own initiative to enhance patient care whilst at the same time knowing that they were going against the norms of the practice setting;

> *‘I really wanted to fit in which ever placement area I went to but on occasions I’ve stuck my neck out and risked it and felt good about it!’*
> ***Anne, Interview 1 (2nd Interview)***

This student was demonstrating the difficulties in trying to remain true to her ‘authentic self’ but recognised the implications in doing so. The challenge of taking the risk to do something differently was clearly highlighted here but conforming to the norms of the practices around us means we are being ‘inauthentic’ (Dreyfus, 2000). According to Inwood (1997:27) in order to fit in with society and be accepted by society, there are times in our lives when we all live in inauthentic ways but we can go back to being our ‘authentic self’ whenever we chose to. Heidegger talks about this in terms of ‘resoluteness’ or in simpler terms ‘call of conscience’ and how we make sense of our life as a whole (Inwood, 1997:83). Having the ability to address our own level of conscience or resoluteness allows us to detach ourselves from the world so that we become a ‘free floating I’ (Heidegger, 1926/1962:344). This is what these students were experiencing and had become a ‘free floating I’ as they had gone against the routine of their practice areas. This did however, come with a consequence which for one of the students, was being reprimanded by the staff for taking a patient to

the toilet without permission. This student identified with that but acknowledged how it made her feel and that by remaining her 'authentic self' she had remained true to herself and demonstrated her resoluteness to provide quality continence care.

Heidegger (1926/1962) suggests that most people on a day to day basis, being-in-the-world, are not themselves when they become absorbed in the work world of our everyday lives and in the social world of our interpersonal relationships. This would appear to be how the students see themselves in their world, balancing out how they want to care for patients with UI, maintaining the 'authentic self', whilst attempting to fit in with the practices of those around them. Heidegger explores this and terms this as 'selfhood' and suggests that when we live in the eyes of others we are as they see us and therefore understanding who we are is gained from what people say about us and how they react to us. This is clearly how the students viewed their position in clinical practice and by refraining from doing what was unaccepted and open to criticism by the 'they', the students were conforming to their patterns of behaviour, becoming like them, in their attempt to fit into their area of clinical practice.

Conforming in this way was not an unusual finding as the students progressed through their first year of training. As they experienced clinical practice they were beginning to identify with the behaviour of others in order to fit in. Paradoxically, in their attempt to fit in, they were increasing the level of authority of the 'they' and the students' ability to take control over their everyday *Dasein*, (being there) was being eroded by the constraints and control of the 'they'.

The Influence of Others- the relationship with previous research

The findings in this study showed that students in both sets of interviews unanimously discussed that their major support when dealing with patients with UI in practice were the HCAs. Wakefield (1996) identified that when students went to supernumerary status they became less visible and often did not come to the attention of the qualified staff as much as when they had been part of the workforce. This was reflected in a later study by O'Connor (2007) who reported that students are learning fundamental essential care skills from unqualified healthcare professionals. This could potentially influence how direct care is perceived and could lead to it being viewed as a less important aspect of healthcare (Mackintosh, 2006; O'Driscoll, Allan and Smith, 2010). This raised concerns for the students in this study who clearly related to this and expressed that their future reaction to dealing with this aspect of health care could be compromised. This finding echoes the findings of Lloyd-Jones, Walters and Akehurst (2001) in an earlier study where this was also identified and it was argued that if student nurses are exposed to HCAs, it is likely their skills for delivering this type of care will be influenced by them and may affect both the students' learning experience and their subsequent approach to the delivery of this type of care.

The concern for dealing with UI in nursing practice is therefore evident and the findings from this study still reported that students are often left working with HCAs in practice. This has major problems for continence promotion as recent reports by Bittner and Gravlin (2009) and Gravlin and Bittner (2010) have found

delegating these aspects of nursing care to unqualified staff has resulted in some aspects of nursing care being omitted including toileting. There is a potential risk that this is what influences students when they are out in practice. In an attempt to address this The Cavendish Review (2013) has made recommendations to standardise a level of educational achievement for HCAs before they are allowed to work unsupervised in practice. Whilst this covers 15 specific areas of clinical practice there is no specific category for the promotion of continence which is an opportunity missed based on the findings from the Francis Report (2013) which clearly identified many omissions in relation to poor continence care.

The findings in this study however, indicate that at the point of entry into practice students are well informed about pro-active approaches to patient care and do not appear to have negative attitudes towards dealing with UI. However, if students are not supported by proficient staff and are exposed to role models who demonstrate behaviour that conflicts with their sense of professionalism there is potential for student nurses to become desensitised to human need (Rodgers *et al,* 2013). Although the students in this study were recognising this, they did not appear to be becoming desensitised to wanting to deliver high quality for patients with UI at this stage of their training.

There is however, debate that the standards taught in education about these areas of nursing practice could be brought into question as nursing and nurse education have been poor at articulating that this type of care has value (Gordon, 2006). The students in this study however, did not demonstrate that this was the case, on the contrary, the findings in this study showed a sense of determination

not to devalue this type of care and there was some insight into how students coped with this which was encouraging.

Delivering compassionate care for patients with UI is crucial as UI is already a taboo subject (Roe and May, 1999). The students recognised this and developed their own strategies for dealing with this, but their experiences are not to be ignored. They offer invaluable insights into why this may not be the case in practice and some of the dilemmas that this poses for nursing practice. The students identified that the majority of care delivered to patients with UI was carried out by unqualified members of the nursing team. Whilst this was not perceived as an issue, these student nurses' experiences identified that if this care remains unsupervised by qualified staff, unqualified staff may fail to see its importance. This was clearly acknowledged in the Mid Staffordshire NHS Foundation Trust Inquiry (Francis, 2013) which raised concerns about the basic lack of fundamental care that patients received. In particular, and more alarmingly for continence care, it highlighted that nurses failed to respond to requests for assistance to use the toilet resulting in episodes of incontinence and that staff themselves had been identified as uncaring and lacking in compassion. Whilst overall in this study this was not a finding, it did uncover the potential for this to become a reality.

Although it is apparent from these students' life experiences that the care they expected to be delivered was not always carried out to the standards that they anticipated, not one of the students identified any obvious signs of a deliberate lack of compassion towards the patients. What they did notice however, was a

lack of appreciation by some staff members of the more covert aspects of delivering compassionate care. The Department of Health (DH, 2010) view that that the delivery of compassionate care is complex and requires value based care that is sensitive and competent. The students recognised this in these findings and suggested that the delivery of this type of intimate care required a skilled and competent practitioner. At the macro level there is a strong commitment to what skills are required to deliver this type of care (DH, 2010) but at the micro level, UI care is still viewed as a task that is predominantly delivered by unqualified staff who have only recently had any formal standard of education and are not registered with any regulatory body (Francis, 2013). This creates a dissonance between what is the 'gold standard' for the delivery of this type of care and the reality of organising and delivering this type of care in clinical practice.

The students' experiences in this study clearly reflect this potential risk and have difficulty in rationalising this in their own lifeworld. This appeared to be because the benefits are twofold, firstly all staff would appreciate the complexity of this type of healthcare and the influence that this has on the individual and secondly, the students would be able to identify sound robust role models from whom they would learn their essential skills for practice. The students' experiences clearly identified the difference when qualified members of staff got involved in the care delivery, not only for themselves and the patients, but also for the unqualified members of staff. This involvement seemed to be crucial in order to raise the profile for this area of health care to ensure that patients got the best possible

care that they deserved and that the staff involved were competent, sensitive and skilled in the delivery of such care.

Searching for leadership in this area of healthcare was a concern for the students' experiences as they were often lead by unqualified staff that lacked leadership in this area of healthcare. What is clear from these findings is that when students did encounter involvement from qualified staff, they had a different experience relating to dealing with UI than when they were supervised by unqualified staff. However, negotiating their way around the levels of staff that students came into contact with and their desire to be part of 'the team' all created a multifaceted and intricate series of hurdles that students must navigate in their attempt to feel a sense of their own identity within the profession. This reflects a number of entries in my own reflective journal regarding how staff perceived UI and my own struggles with understanding who in fact takes the leadership for the care delivery of patients with UI. I fully appreciated the students' dilemmas and their need for some genuine leadership in this aspect of health care.

The Influence of others – the relationship to Heideggerian Philosophy

Turning to Heideggerian philosophy, these experiences reflect an understanding of what Heidegger calls the 'they' and that what these students experience in practice is the influence the 'they' have on their own behaviours and their 'authentic self'. Heidegger explains this as *Das Man* or the 'they self' which we distinguish from the 'authentic self' or in a more applied way, there are times

when our ‘authentic self’ is challenged by ‘falling into the they’ and there is the potential that we lose some of our own identity in the process (Heidegger, 1926/1962: 322). This can be seen as part of the socialisation process that the students experienced in their attempt to be part of the team but it also created anxiety as they began to lose some of their ‘authentic self’. This is a good example from this study which illustrated exactly what Heidegger talks about regarding the anxieties faced when the ‘authentic self’ is challenged in order to become part of the ‘they’;

> ‘*I hate to admit this but I know I have just gone along with whatever the carers have done because I found it hard to challenge anything they did. I did once ask why they did something in a particular way but they just laughed and said ‘oh no not another one who thinks they know it all!’ and I think from then on I realised that ‘fitting in’ with team was essential if was going to learn anything in that placement. It seemed as though once you had been accepted by the carers that was it, placement passed! I remember thinking this is crazy but never really felt sure how to deal with it’*
> ***Danielle, Interview 3***

Whilst this appears to be the students’ experiences, they had found their own solutions in how to find an acceptable route in balancing a way of challenging what they perceived as less than idealistic practice, without compromising their own values and norms. This was really important for the students but negotiating their way through these complexities of ‘being in the world’ is fraught with obstacles that the students needed to overcome to become part of the profession.

These findings correlated with Maben, Latter and Macleod Clark (2007) who suggested that there were three phases that helped or hindered nurses in practicing in the way that they wanted to practice and how they were able to

practice. Those that maintained their values and ideals, were known as sustained idealists, those that compromised their ideals were known as, compromised idealists and those who had lost any sense of their own ideals and values were crushed idealists (Maben, Latter and Macleod Clark, 2007). Although these findings related to newly qualified nurses' experiences, applying this to the findings of my study clearly showed that at this stage of their training the students are sustained idealists in their articulation of their experiences of UI although there are under currents developing at the end of year 1 that suggests that these ideals are becoming compromised, therefore a shift to the compromised idealist. These findings are congruous with the findings of a later study by Murphy *et al.* (2009) who identified that students' caring behaviours changed significantly throughout their three years of training. They reported that whilst there is an expectation that nurse education will nurture and develop students' professional behaviour throughout their training, there is some evidence that this process does the exact opposite and actually the students become accustomed to the status quo rather than develop these behaviours. This study appears to relate this to the educational process (Murphy *et al,* 2009) however, as debated already in this chapter this could be due to numerous other influences.

Juggling all these ideals and values whilst remaining true to themselves is summed up by Heidegger who has a term for how the students manage to stay true to them but at the same time find a strategy to manage the '*they'.* Heidegger talks about this as an almost in between stage from remaining true to the 'authentic self' but not getting 'lost' to the '*they'* and that there is a danger in desiring to fit in as we therefore adopt what is accepted by others and as

discussed earlier, he terms this as ‘tranquillised familiarity’ (Heidegger, 1926/1962 pg. 234). He refers to this as being directed by the values and norms of the culture that we are enveloped within. However, Heidegger does make the distinction between conformity and a general shallowness on the part of the participant and that rather than conforming, they are being directed by the expectations of the group, or in this case, the carers.

Summary

These student’s experiences noticeably acknowledged this quandary surrounding their own socialisation into their chosen profession. They experienced this in terms of acknowledging their own ideals for clinical practice versus the clinical realities of practice that they have been exposed to. They had developed their own way of ‘finding a voice’ very early on in their student nurse training. Regardless of these dilemmas for their practice, being part of a team appeared to give the students confidence in questioning aspects of practice that they were unsure about. More importantly the students appeared to value the support they received from their clinical mentor.

Yacobi (2012) describes this approach as a necessary collaboration which may demand some adaptation and some inauthentic compromise. I think this describes exactly what the students are doing in order to maintain the status quo within their practice but still maintaining some of their authentic self. The students are faced with uncertainty in delivering the appropriate care for patients with UI and this may be a paradox for them as in order to remain true to their authentic

self they need to be immersed in uncertainty however, as Yacobi (2012) states, uncertainty hinders the discovery of the true self. Making sense of their experiences is therefore a complex dilemma. This appears to be very true in terms of the conflicts that these students face between what they perceived to be the right course of action in treating patients with UI and their overwhelming sense of wanting to belong to their chosen profession and to 'fit in'.

CHAPTER 7: SUMMARY AND RECOMMENDATIONS

The purpose of this study was to explore student nurses' experiences of dealing with UI in their first year of study in order to develop a meaningful insight into their lifeworld. Within the previous chapter there was a wide discussion on the findings that this study has explored and their relationship with the previous literature and the philosophical underpinnings of Heideggerian phenomenology. This chapter will now focus on the overall contribution that this study has added to the knowledge base about this phenomenon and the implications, limitations and recommendations for clinical practice. To conclude, I have included a reflexive account of my journey whilst conducting this research.

Contribution to Knowledge

Exploring student nurses' experiences of UI within their first year of study offered a unique insight into the lifeworld of these neophyte nurses. There have been no studies to date that have explored this phenomenon and therefore the findings of this study are exclusive and worthy of further analysis regarding the implications and recommendations for future nursing practice. The findings from this study will add to the existing body of knowledge (see Table 12) both for the development of clinical practice and pre-registration adult student nurse education and to the body of research utilising Heideggerian Hermeneutic Phenomenology. In broad terms this study enhances the growing body of evidence regarding student nurses' experiences of entering the profession (socialisation), dissonance

between theory and practice and the overall body of literature associated with health care professionals' attitudes towards UI.

Implications for Practice

Every student's account of their experiences was unique and sometimes these experiences were often associated with previous experiences of dealing with UI. These experiences were exclusive to these students within their own lifeworld and illuminated that their previous experiences have an effect on their ways of dealing with these experiences in the present. Heidegger talks about this as a concept of 'historicality' which is basically that we are shaped by our past experiences and that it is these past experiences that shape our boundaries for our future experiences. It would seem that this is occurring with the students in this study during their first year of their training programme. The findings clearly showed not only the effect that this had on their own practice but also has gained a fundamental insight into their perspective about the organisation and delivery of this type of nursing care. These findings showed that at the end of year one the students remained enthusiastic about being proactive regarding managing and treating UI however, there had been compromises to their ideals within that first year of study. This is mainly attributable to the fact that they are infrequently supported by qualified staff in practice and that they are 'picking up' their skills from HCAs who have little training in either providing pro-active treatment for UI or supporting students learning in practice. The students in this study show that as a result, their ideals for pro-active treatment for UI are compromised in order to 'fit in' with the HCAs management of UI. The students are also aware at the

end of year one that their learning opportunities to establish any changes to this approach to UI care are limited as they infrequently have the opportunity to work with their mentors to express these concerns.

Recommendations

Three major themes emerged from this data which encapsulated the students' experience of UI in their first year of training; Being There; Being Understood and The Influence of Others. The overarching commonality across and within each theme was that regardless of their experiences the students remained enthusiastic and positive about providing quality continence care to their patients. This demonstrates a level of versatility and resilience. Throughout their first year of training however, they encountered areas of practice that shocked them, areas of practice that they could not make sense of and challenges and difficulties in expressing their thoughts to healthcare professionals who treated UI as a low priority area of healthcare. Recommendations for practice will now be discussed for each of the major themes identified.

Table12: Summary of findings from literature review: Evidence and its relevance to this research study and the contribution to existing knowledge.			
Key Themes from the Literature Review	**Evidence**	**Relevance for this study**	**Contribution to existing knowledge**
Student Education and the Curricula	Education for UI is in the pre-registration curricula but patchy and what it involves and where it sits within the curricula is not evident. **(Cheater, 1992; Laycock, 1995;Cheater *et al*, 2008; McClurg *et al*, 2013a)**	Lack of pro-active education for UI may influence how UI is subsequently perceived in both education and practice.	Students in year 1 are pro-active and enthusiastic about UI care.
Attitudes and attitude Formation	Attitudes are a predisposition to behave in a particular way and there is a strong relationship between attitudes and behaviour. **(Cross, 2005;Ajzen, 2005; Crano and Prislin, 2008; Schwarzer, 2014; Cooper, Blacman and Keller, 2015)**	Student nurses may be influenced by the attitudes of others either positively or negatively.	Students in year 1 are influenced by behaviours of the people they are exposed to in clinical practice.
Attitudes of patients towards UI and their help-seeking behaviour	Poor lay beliefs about UI; 'UI is normal for their age' 'Usual female complaint'. Reinforced by HCPs, no meaningful help offered when mentioned by patients to HCPs. (**Jolleys, 1988; Jeter and Wagner, 1990; Goldstein *et al*, 1992; Brocklehurst, 1993; Ashworth and Hagen, 1993; Fultz and Herzog,2001; Teunissen and Largo-Janssen, 2004; Hagglund and Wadensten, 2007;Pilcher and MacArthur, 2012)**	UI not important. Reinforces negativity about this area of healthcare which could influence how student nurses perceive it. Passive acceptance that UI is not a problem that requires exploration	Students in year 1 are shocked that UI is accepted and can see that it does affect the patients.
Attitudes of healthcare personnel towards UI	Passive acceptance of UI by HCPs and display negative attitudes towards UI. Reinforces beliefs of lay people as very little priority given to this area of healthcare**.** **(Yu and Kaltreider, 1987; Yu *et al,*1989; Cheater, 1992; Vinsnes *et al,* 2001)**	Students are exposed to HCPs in clinical practice. Evidence suggests that HCPs have negative attitudes towards UI which may directly affect student nurses own attitudes during their socialisation into the profession.	Students in year 1 express a level of negativity that is displayed by other health care professionals towards UI but they struggle to understand why this is the case.
Crossing Boundaries: delivering intimate care	Ritualistic practice exists that show little respect for UI. Challenges to compassionate practice identified in respect of privacy and dignity, disillusioned students regarding the realities of practice. **(Inoue, Chapman and Wynaden, 2006; Lawler, 2006; Mackintosh, 2006; Crossan and Mathew, 2013)**	Ideal versus realistic practice Students may be disillusioned by realities of practice and be challenged in the provision of pro-active UI care	Students in year 1are challenged in providing pro-active UI care. They however, remain compassionate, although the reality of what they see in practice does lead to compromise of their own ideals.

Student Socialisation	Students learn from their mentors. This may be positive in relation to UI or a negative experience. Students require good role models 'learning the routine' and 'Fitting in' are important aspects of their socialisation sometimes compromising their ideals for practice. **(Melia, 1987; Wakefield, 1996; Maben, Latter and Macleod Clark, 2007; Levett-Jones and Lathlean, 2008; Murphy *et al*, 2009; Levatt-Jones *et al*, 2009 O'Driscoll, Allan and Smith, 2010)**	Feelings of powerlessness to challenge practice. Dissonance between what is taught and the reality of clinical practice.	Students in year 1 do experience feelings of powerlessness to challenge what they see in practice however, they adapt and utilise strategies to help them make sense of their experiences showing versatility and resilience.
Student support	Students spend a lot of time supported by unqualified staff who view UI care as low priority. Qualified staff make a major contribution to student learning. **(Melia, 1981; Wakefield *et al*, 2009; O'Driscoll, Allan and Smith, 2010; Henderson *et al*, 2012; Francis, 2013; Willis, 2013; Bubb, 2014)**	Unqualified staff acting as role models could influence student nurses perceptions about providing quality UI care maintaining a cycle of negativity about this aspect of healthcare.	Students in year 1 do spend a lot of time being supported by unqualified staff in practice. They are not however, negative about this aspect of healthcare although they do adapt their ideals for UI practice and become aware that their learning could be compromised.

Being There

In the first major theme from the findings 'Being There', there is a clear message that we need to value education (see Figure 13). The role of the HEIs and the professions regulatory body, Nursing and Midwifery Council (NMC), therefore have a major contribution to make to facilitate the students' experiences and ensure that we value their input into planning for pre-registration adult nursing curricula of the future.

- Students clearly articulated in this study that 'finding a voice' to express issues raised in practice was a challenge for them. A learner centred curriculum where these aspects of the realities of practice could be explored in their first year of training could offer a valuable opportunity to focus on the students' experiences to support their learning in practice.

- Using reflective practice in a more structured way could allow the students to explore their experiences to date and their coping mechanisms which could continue to encourage and support their 'authentic self' and help maintain their enthusiasm and optimism for UI in year 2 and year 3 of their training programme.

- The development of specific competencies related to the assessment for continence need to be considered within the students' practice assessment document across their three-year training programme as this could raise awareness of its importance for nursing practice.

- An exploration of the current pre-registration curricula for the coverage of theoretical content regarding UI is required to establish not only content but at which point in the curricula UI care is delivered.

In summary, the findings from this study clearly reflected that the students in year one remained positive and proactive about delivering quality care for patients with UI. Whether this level of enthusiasm continues into year two and three is therefore worthy of further exploration.

Being Understood

This theme highlighted valuing learning and the sub themes 'fitting in' and the professional self-identified areas for some joint understanding (see Figure 13). Exploring the students' own lifeworld during year 1 has clearly recognised that the students want to share their learning with their clinical colleagues but finding a way to do that has proved to be a challenge.

- Consideration needs to be given to the preparation of mentors' education programmes. These valuable insights from this study could be shared as part of that training package with particular reference to how it affects the students during year 1.

- Students develop strategies in order to manage their transition from lay person to nurse and this affects their experiences of dealing with the intimate nature of care for patients with UI. A more in depth exploration of

the strategies they adopt to manage this would influence current pre-registration curricula.

The Influence of Others

The third major theme indicated that valuing practice had equal importance to the students' experiences of UI during the first year of their study (see Figure 13). The healthcare professionals they were exposed to during their first year of study had a major influence on how these students viewed UI. Exposure to UI care that did not meet their expectations during their first year of training highlighted a dissonance between their own ideals and that of the nursing profession. This could shape how these experiences influence their practice in year 2 and year 3.

- Consideration needs to be given for further phenomenological studies into the student experience of UI in year 2 and year 3 in order to have an in depth overview of the student journey and how this influences their experience of UI.

- Enhancement of current mentorship programmes infused with the students' experiences of support in clinical practice would develop insight into the student experience.

- A qualitative approach to understanding unqualified and qualified healthcare professionals' experiences of UI is worthy of consideration.

Due to the ever changing environment of care delivery within the NHS, resources have become more fragile. As a consequence, skill re distribution in the nursing workforce means that HCAs have taken on more responsibilities for direct nursing care with little tra ining or support whilst qualified nurses extend their roles. However, this should not affect how students are supported in practice. The findings in this study do reflect that in their first year of training, student nurses spend a lot of time working with HCAs which they acknowledge, does influence their experiences of dealing with UI. HCAs therefore need support in increasing their level of knowledge in order to ensure that they are competent and skilled in carrying out continence assessments and continence promotion strategies for this group of patients. The Francis Report (2013) clearly highlighted the many deficits associated with poor continence care and the subsequent Cavendish Review (2013), has missed the opportunity at ensuring the new Care Certificate for HCAs includes the promotion of continence as a specific topic in its own right. However, there are two standards which could help improve continence care, standard five: work in a Person Centred Way and standard seven: Privacy and Dignity, could influence how UI is perceived and further research into student experiences of UI following this new initiative would therefore appear timely in order to contribute to this body of knowledge.

Figure 13: Recommendations from major themes for practice and further research

Limitations of the study

This research involved thirteen first year adult nursing students and was a small Heideggerian hermeneutic phenomenological study which has produced rich, thick data about their experiences of UI. This study has offered a unique insight into their lifeworld but it is acknowledged that these experiences of UI could not be generalised across the board as all first year students' experiences. There

could have been more focus on the wider cultural and environmental factors that affected their experiences however, I was conscious that this would take me away from the students' own unique experience. This could be identified as strength as it allowed for greater in depth focus on the student nurses themselves.

This study concentrated on adult nursing students only which could be seen as both a limitation and a strength. A limitation could be that if students from other branches of nursing e.g. mental health, child and learning disability, had been included, a different set of findings could have emerged. Limiting it to just adult nursing students however, could also be viewed as strength as the study has remained concentrated on one particular branch of nursing students. Having a variety of participants could have diluted the findings due to specific differences in their training programmes and practice experiences.

I acknowledge that these are limitations within this study but they could inform ideas for future research.

Summary

The findings from this study support the fact that there is a need for education to be more creative in exploring how students cope with the realities of clinical practice, especially around dealing with patients with UI and the complexities that surround this. This study has also identified the role that the HCA has in supporting student nurses in the development of their care for patients with UI.

There is therefore a need for educators to engage with the education of HCAs in order to improve the student experience and continence care for their patients. This is particularly important as it can be acknowledged from this study, that UI is still an area of low priority and is predominantly the role of the HCAs to provide this area of care. Exploring the students' experiences therefore could be beneficial in post placement tutorials where issues in practice can be discussed and students can express themselves in a safe and supportive environment. The majority of students in this study did say following completion of the interviews that being able to talk through some of the challenges that they faced in practice whilst dealing with UI had really helped them to understand the complexities of care delivery and their own individual role in that process.

Engaging in sharing these stories could help the students to feel empowered in believing in their authentic self and not feel compromised in remaining true to their own thoughts and feelings. Educators and clinicians therefore need to be seen as professionals who are experienced in some of what they are describing and have the ability to listen, acknowledge and above all, to offer support to the students.

Heideggerian philosophy has enabled me to make a lot of sense out of my data. His thinking on authenticity, conscience and resoluteness has taught me a lot about how student nurses negotiate their way through their clinical placements and make sense of the care that they see being delivered. It has personally helped me to understand why sometimes students do have difficulty in challenging areas of practice that do not match their own expectations. The

student nurses in this study for example, do reflect on incidents from a personal perspective and this has been utilised to make sense of their experiences in their clinical practice. This has influenced their own approach to caring for patients with UI and sharing this in a meaningful way, could help empower students to keep true to their authentic self and understand how sometimes this could lead to compromise. The development of a more learner centred curriculum could be more meaningful for the future pre-registration nursing education programmes against the back drop of the professional regulators and the ever changing political dynamic of the NHS.

Conclusion: a reflexive account

Completing this thesis has been a very long transformational journey both for me as the researcher and the participants in this study. Undertaking this research study has been an invaluable learning experience. From a personal perspective I have gained some understanding about the nature of research and the cyclical and sometimes messy nature of the research process. I have learned for example, that things do not fit into neat little categories or themes and that research is complex and at times frustrating. I have also learned a lot about myself. I have been surprised about my level of tenacity throughout this process and delighted at my own self-determination to complete this thesis which has been an immensely rewarding experience. Having the experience of sharing the students' lifeword related to their own unique experiences of UI throughout their first year of study has been a privilege. I have learnt a lot from Heidegger's philosophy about how we experience being-in-the-world and what meaning that

has for our experiences. Hermeneutic phenomenology has given these students a voice to express their personal and unique experiences of dealing with UI, which to date have been an unspoken aspect of nursing practice. My empathy as a researcher, grounded in my own personal experience, has enhanced my ability to dwell in the lived experiences of the student nurse and bring meaning to their thoughts, values and beliefs about caring for patients with UI. Interpretive work is fluid and flexible and the hermeneutic circle is not yet complete and is open to much more interpretation and further discussion. I am hopeful that the completion of this thesis will enable these discussions to take place and that it generates more opportunities for student nurses to be heard and that their unique experiences remain valued and inform pre-registration curricula of the future.

REFERENCES

AHCPR (Agency for Health Care Policy and Research) Urinary Incontinence Guideline Panel (1992) *Urinary incontinence in Adults: Clinical Practice Guideline.* Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services.

Ajjawi, R. and Higgs, J. (2007) Using Hermeneutic Phenomenology to Investigate How Experienced Practitioners Learn to Communicate Clinical Reasoning. *The Qualitative Report,*12(4): 612-638.

Ajzen, I. and Fishbein, M. (1980) *Understanding Attitudes and Predicting Social Behaviour.* Prentice-Hall, New Jersey.

Ajzen, I. (2005) *Attitudes, Personality and Behavior*. 2nd Edn. Open University Press, Maidenhead, England.

Albers-Heitner, P.C, Largo-Janssen, T.A, Joore, M.M, Berghmans, B.L, Nieman, F.F, Venema, P.P, Severens, J.J and Winkens, R.R. (2011) Effectiveness of involving a nurse specialist for patients with urinary incontinence in primary care: results of a pragmatic multicentre randomised controlled trial. *International Journal of Clinical Practice*, 65(6): 705-12.

Allen, H.T, Smith, P.A and Lorentzon, M. (2008) Leadership for learning: a literature study of leadership for learning in clinical practice. *Journal of Nursing Management,* 16 (5): 545-555.

Andrusyszyn, M. A. (1989) Clinical evaluation of the affective domain. *Nurse Education Today*, 9(1): 75-81.

Antonak, R.F. and Livneh, H. (2000) Measurement of attitudes towards persons with disabilities. *Disability and Rehabilitation,* 22(5): 211-24.

Ashworth, P. D. and Hagen, M. T. (1993) The meaning of incontinence: a qualitative study of non-geriatric urinary incontinence sufferers. *Journal of Advanced Nursing*, 18(9): 1415-23.

Audit Commission (2001) *Hidden Talents: Education, Training and Development for Healthcare Staff in NHS Trusts.* London.

Back, E. and Wikbald, K.W. (1998) Privacy in Hospital. *Journal of Advanced Nursing,* 27: 940-945.

Baldwin, A, Mills, J, Birks, M and Budden, L. (2014) Role modelling in undergraduate nursing education: An integrative literature review. *Nurse Education Today,* 34(6): e18-e26.

Bandura, A. (1972) *Encyclopaedia of Psychology*. Search Press.

Bayliss, V. and Salter, L. (2004) Pathways for evidence-based continence care. *Nursing Standard.* Nov 10-16; 19(9): 45-52.

Beauchamp, T.L. and Childress, J.F. (2009) *Principles of Biomedical Ethics* (6th edition). Oxford: Oxford University Press.

Becker Hentz, P. (2005) Education and socialisation to the professional nursing role. In K. Masters (Ed.) *Role development in professional nursing practice* (pp. 99-127). Sudbury: Jones and Bartlett Publishers.

Bennett, P. and Murphy, S. (1997) *Psychology and Health Promotion*. Open University Press, Buckingham.

Bittner, N.P. and Gravlin, G. (2009) Critical thinking, delegation and missed care in nursing practice. *Journal of Nursing Administration*, 39(3): 142-146.

Bladder and Bowel Foundation (2015) Bladder Care. http://tinyurl.com/mvk9o7t (accessed 30 July 2015)

Blannin, J. (1986) Continence Promotion. *Nursing-Oxford,* 3 (10 suppl.): 1-3.

Bohner, G. (2001) Attitudes. In Hewstone, M and Stroebe, W (Eds.) *Introduction to Social Psychology,* 3rd edn. Blackwell, Oxford, pp. 239-282.

Bonis, S.A. (2009) Knowing in Nursing: A concept analysis. *Journal of Advanced Nursing*, 65(6): 1328-1341.

Boughn, S. (2001) Why women and men choose nursing. *Nursing and Health Care Perspectives,* 22 (1): 14-19.

Branch, L .G, Walker, L. A, Wetle, T .T, DuBeau, C. E. and Resnick, N. M. (1994) Urinary incontinence knowledge among community dwelling people 65 years of age and older. *Journal of Americam Geriatric Society*, 42 (12): 1257-1262.

Brocklehurst, J. P. (1993) Urinary incontinence in the community – analysis of a MORI poll. *British Medical Journal,* 306: 832-34.

Brody, J. L, Cluck, J. P and Aragon, A. S. (1997) Participants' Understanding of the Process of Psychological Research: Informed Consent. *Ethics & Behaviour*, 7(4): 285-298.

Brown J, Stevens, J and Kermode, S. (2013) Measuring student nurse professional socialisation: The development and implementation of a new instrument. *Nurse Education Today*, 33 (2013): 565-573.

Buckley, B.S and Lapitan, M.C. (2010) Prevalence of urinary incontinence in men, women and children- current evidence: findings of the Fourth International Consultation on Incontinence. *Urology,* 76(2): 265-70.

Burns, I. and Glen, S. (2000) *Problem Based Learning in Nursing*. Palgrave, Basingstoke.

Butterworth, T. (1998) Clinical supervision as an emerging idea in nursing. In Butterworth,T, Faugier, J and Burnard, P. (Eds) *Clinical Supervision and Mentorship in Nursing,* 2nd Edn, Stanley Thornes Cheltenham.

Bytheway, B. (1995) *Ageism.* Open University Press, Buckingham**.**

Cahill, H. A. (1996) A qualitative analysis of student nurses' experiences of mentorship. *Journal of Advanced Nursing*, 24(4): 791-799.

Campbell, E. B, Knight, M, Benson, M and Colling, J. (1991) Effect of an incontinence training programme on nursing home staff's knowledge, attitudes and behaviour. *Gerontologist*, 31(6): 788-794.

Care Quality Commission (CQC) (2015) *CQC welcomes launch of the Care Certificate.* www.cqc.org.uk accessed online April 2015.

Cavendish, C. (2013) *The Cavendish Review*. *An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings.* Department of Health, England.

Chancellor, M. B and Yoshimura, N. (2003) Conservative Management of Stress Urinary Incontinence in women. *Advanced Studies in Medicine*, 3(10): 1052-9.

Cheater, F.M. (1991) Attitudes towards urinary incontinence. *Nursing Standard*, 20(5): 23-27.

Cheater, F.M. (1992) The aietology of urinary incontinence. In Roe, B.H (Ed.). *Clinical Nursing Practice. The Promotion of and Management of Continence.* London: Prentice Hall, pp. 20-48.

Cheater, F.M, Baker, R, Gillies, C, Wailoo, A, Spiers, N, Reddish, S, Robertson, N and Cawood, C. (2008) The nature and impact of urinary incontinence experienced by patients receiving community nursing services: a cross-sectional cohort study. *International Journal of Nursing Studies*, 45(3): 339-51.

Christensson, L, Unosson, M, Bachrach-Lindstrom, M and Ek, A. C. (2003) Attitudes of nursing staff towards nutritional nursing care. *Scandinavian Journal of Caring Sciences*, 17(3): 223-231.

Clark, E. and McCann, T. V. (2005) Researching students: an ethical dilemma. *Nurse Researcher,* 12(3): 42-51.

Cohen, H. (1981) *The Nurse's Quest for Professional Identity*. Addison-Wesley, CA.

Cohen, M. Z and Omery, A. (1994) Schools of Phenomenology: Implications for Research. In Morse, J M (ed.) *Critical issues in Qualitative Research*, Thousand Oaks, Sage, pgs. 135-156.

Cohen, M. Z, Kahn, D. L and Steeves, R. H. (2000) *Hermeneutic Phenomenological Research: A Practical Guide for Nurse Researchers*. Sage Publications, London.

Colaizzi, P.F. (1978) Psychological research as the phenomenologist views it. In Valle, R. and King, M. (Eds.) *Existential Phenomenological Alternatives for Psychology,* pp. 48-71. Oxford: Oxford University Press.

Connor, P. A and Kooker, B. M. (1996) Nurses' knowledge, attitudes and practices in managing urinary incontinence in the acute care setting. *Medical Surgical Nursing*, 5(2): 87-92.

Cooper, J, Blackman, S and Keller, K. (2015) *The Science of Attitudes*. Routledge, New York and London.

Crano, W and Prislin, R. (Eds.) (2008) *Attitudes and Attitude Change (Frontiers of Social Psychology).* Psychology Press, New York, London.

Cresswell, J.W. (2012) *Qualitative Inquiry and Research Design: Choosing Among Five Approaches.* 3rd edition, Sage Publications, London.

Cross, R.M. (2005) Exploring attitudes: the case for Q methodology. *Health Education Research,* 20(2): 206-213.

Crossan, M. and Mathew, T.K. (2013) Exploring sensitive boundaries in nursing education: Attitudes of undergraduate student nurses providing intimate care to patients. *Nurse Education in Practice*, 13(4): 317-322.

Crotty, M. (1998) *The Foundations of Social Research.* Sage, London.

Curtis, K, Horton, K and Smith, P. (2012) Student nurse socialisation in compassionate practice: a grounded theory study. *Nurse Education Today* , 32 (7): 790-795.

Dahlberg, K, Drew, N and Nystrom, M. (Eds.) (2001) *Reflective lifeworld research*. Lund, Sweden: Studentlitteratur.

Dalziel, J. R. (1996) Students as research subjects: ethical and educational issues. *Australian Psychologist*, 31(2): 119-123.

Davis, E. (1993) Clinical Role Modelling: uncovering hidden knowledge. *Journal of Advanced Nursing,*18 (4): 627-636.

de Witt, L. and Ploeg, J. (2006) Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing*, 55(2): 215 – 29.

Department of Health (1991) *Agenda for Action on Incontinence*. London, DH.

Department of Health (1999) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. The Stationery Office, London.

Department of Health (2000) *Good Practice in Continence Services*. London, DOH.

Department of Health (2001a) *Essence of Care. Patient-focused Benchmarking for Healthcare Practitioners.* London, The Stationery Office.

Department of Health (2001b) *National Service Framework for Older People.* London, The Stationery Office.

Department of Health (2001c) *Research Governance Framework for Health and Social Care*. London, DOH.

Department of Health (2010) *NHS Constitution: The NHS belongs to us all – interactive version.* Department of Health, London.

Diamond, M.R and Reidpath, D. D. (1994) Are students really human? Observations on institutional ethics committees. *Australian Psychologist*, 29(2): 145-146.

Dingwall, L and McLafferty, E. (2006) Do nurses promote urinary incontinence in hospitalised older people: An exploratory study. *Journal of Clinical Nursing*, 15(10); 1276-86.

Donaldson, J.H and Carter, D. (2005) The value of role modelling: perceptions of undergraduate and diploma nursing adult students. *Nurse Education in Practice*, 5(6): 353-9.

Draper, P. (1997) *Nursing Perspectives on Quality of Life*. Routledge, London.

Draucker, C. B. (1999) The critique of Heideggerian hermeneutical nursing research. *Journal of Advanced Nursing*, 30(2): 360-73.

Dreyfus, H.L. (2000) Husserl, Heidegger and Modern Existentialism. In Magee, M. (Ed.) *The Great Philosophers*. Oxford: OU Press.

Dugan, E, Cohen, S. J and Bland, D.R. (2000) The association of depressive symptoms and urinary incontinence among older adults. *Journal of American Geriatric Society*, 48 (4): 413-416.

Dunn, M.E, Umlauf, R.I and Mermis, B.J. (1992) The rehabilitation situations inventory: staff perception of difficult behavioural situations in rehabilitation. *Archives of Physical Medicine and Rehabilitation*, 73: 316-19.

Eagly, A.H. and Chaiken, S. (1998) Attitude structure and function. In Gilbert, D.T, Fiske, S.T and Lindzey, G. (Eds.) *The Handbook of Social Psychology* (4th edn.) McGraw-Hill, New York, pp. 56-67.

Edward, N. (2003) First impressions last. *Active Learning in Higher Education,* 4(3): 226-242.

Eiser, J. R. (1979) Attitudes. In Connolly, K (Ed.) *Psychology Survey No 2*, Allen and Unwin, London.

Elcock, K. S, Curtis, P and Sharples, K (2007) Supernumary status- An unrealised ideal. *Nurse Education in Practice*, 7(1): 4-10.

Elias, N. (1978) *The Civilizing Process: The history of manners*. Urizen Books, New York.

Filstad, C. (2004) How newcomers use role models in organisational socialisation. *Journal of Workplace Learning*, 16(7): 396-409.

Finlay, L. (2003) The reflexive journey: mapping multiple routes. In Finlay, L. and Gough, B. (Eds.) *Reflexivity: A Practical Guide for Researchers in Health and Social Services*, Oxford, Blackwell, pgs. 3-20.

Finlay, L. (2009) Debating Phenomenological Research Methods. *Phenomenology and Practice*, 3(1): 6-25.

Finlay, L. (2012) Unfolding the Phenomenological Research Process: Iterative Stages of 'Seeing Afresh'. *Journal of Humanistic Psychology*, 53(2): 172-201.

Fishbein, M. and Ajzen, I. (1975) *Belief, Attitude, Intention and Behaviour: An Introduction to Theory and Research.* Addison-Wesley, London.

Fiske, S. (1998) Stereotyping, prejudice and discrimination. In Gilbert, D.T, Fiske, S.T and Lindzey, G. (Eds.) *The Handbook of Social Psychology* (4th edn.) McGraw-Hill, New York, pp. 357-411.

Foucault, M. (1976) *The History of Sexuality Volume 1: An Introduction*. London: Allen Lane.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London. The Stationary Office.

Fultz N.H and Herzog, A.R. (2001) Self-reported social and emotional impact of urinary incontinence. *Journal of The American Geriatric Society*.49 (7):892-899.

Gadamer, H. G. (1989) *Truth and Method*. Sheed and Ward, London.

Gadamer, H. G. (2004) *Truth and Method*. (3rd edition). London: Continuum International Publishing Group.

Getliffe, K. and Dolman, M. (2003) *Promoting Continence: A clinical and research resource* (2nd edition). Balliere Tindall, London.

Giorgi, A. (1989) One type of analysis of descriptive data: procedures involved in following a scientific phenomenological method. In *Methods: A Journal for Human Science*, Annual Edition.

Gjorup, T, Hendriksen, C, Lund, E and Stromgard, E. (1987) Is growing old a disease? A study of the attitudes of elderly people to physical symptoms. *Journal of Chronic Disability*, 40(12):1095.

Goffman, E. (1982) *The Presentation of Self in Everyday Life.*10th edn. Penguin, Middlesex.

Goldstein, M, Hawthorne, M.E, Engberg, S, McDowell, B.J and Burgio, K.L. (1992) Urinary incontinence: why people do not seek help. *Journal of Gerontological Nursing*. 18(4): 15-20.

Gordon, S. (2006) The New Cartesianism: Dividing Mind and Body and Thus Disembodying Care. In Nelson, S. and Gorson, S. (Eds.) *The Complexities of Care: nursing reconsidered*. USA: Cornell University Press, pp. 104-122.

Gravlin, G. and Bittner, N.P. (2010) Nurses' and nursing assistants' reports of missed care and delegation. *Journal of Nursing Administration*, 40(7-8): 329-335.

Gray, D.E. (2009) *Doing Research in the Real World* (2nd edition). London: Sage.

Gray, M.A and Smith, L.N. (1999) The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29(3): 639-647.

Gray, M.A and Smith, L.N. (2000) The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study. *Journal of Advanced Nursing*, 32(6): 1542-1549.

Greatrex-White, S. (2008) Thinking about the nature of research findings: a hermeneutic phenomenological perspective. *International Journal of Nursing Studies,* 45: 1842-1849.

Greenwood, J. (1993) The apparent desensitisation of student nurses during their professional socialisation: a cognitive perspective. *Journal of Advanced Nursing,* 18: 1471-1479.

Grimby, A, Milsom, I, Molander, U, Wiklund, I and Ekelund, P. (1993) The influence of urinary incontinence on the quality of life of elderly women. *Age and Ageing,* 22 (2): 82-89.

Habermas, J. (1990) *Moral Consciousness and Communicative Action*. Cambridge, Polity Press.

Hagglund, D, Walker-Engstrom, M.L, Larsson, G and Leppert, J. (2003) Reasons why women with long-term urinary incontinence do not seek professional help: a cross-sectional population-based cohort study. *International Urogynecology Journal,* 14(5): 296-304.

Hagglund, D and Ahlstrom, G. (2007) The meaning of women's experience of living with long-term urinary incontinence is powerlessness. *Journal of Clinical Nursing*, 16(10):1946-1954.

Hagglund, D and Wadensten, B. (2007) Fear of humiliation inhibits women's care-seeking behaviour for long term urinary incontinence. *Scandinavian Journal of Caring Sciences*, 21(3): 305-12.

Hahn, I, Milsom, I, Molander, U and Ekeland, P. (1993) Long term results of pelvic floor training in female stress urinary incontinence. *British Journal of Urology*, 72 (4): 421-7.

Harrison, G.L and Memel, D.S. (1994) Urinary incontinence in women: its prevalence and its management in a health promotion clinic. *British Journal of General Practice,* 44(381): 149-52.

Heidegger, M. (1926/1962) *Being and Time* (J. Macquarrie and E. Robinson translation). New York: Harper and Row.

Henderson, J.S and Kashka, M.S. (2000) Effect of knowledge, attitude, and belief on nurses' practice regarding urinary incontinence in adults. *Urologic Nursing*, 20(5): 291-8.

Henderson, A, Cooke, M, Creedy, D.K. and Walker, R. (2012) Nursing student's perceptions of learning in practice environments: A review. *Nurse Education Today*, 32: 299-302.\

Higginbottom, G.M.A (2004) Sampling issues in qualitative research. *Nurse Researcher,* 12(1): 7-19.

Higgs, J. (2001) *Qualitative Research: Discourse on Methodologies*. Sydney, NSW: Hampden Press.

Holland, R.W, Verplanken, B and Van Knippenberg, A. (2002) On the nature of attitude-behaviour relations: the strong guide, the weak follow. *European Journal of Social Psychology,* 32: 869-876.

Holloway, I and Wheeler, S. (1995) Ethical issues in qualitative nursing research. *Nursing Ethics*, 2(3): 223-232.

Holloway, I. and Wheeler, S. (2002) *Qualitative Research in Nursing* (2nd edition). Oxford: Blackwell.

Holloway, I.M and Penson, J. (1987) Nurse education as social control. *Nurse Education Today*, 7 (5): 235-241.

Holst, K. and Wilson, P. (1988) The prevalence of female urinary incontinence and reasons for not seeking treatment. *New Zealand Medical Journal*, 101 (857): 756-8.

Hughes, S. (2005) Student attendance during college based lectures: a pilot study. *Nursing Standard,* 19(47): 41-49.

Hunskaar, S, Burgio, K, Clark, A, Lapitan, M, Nelson, R and Sillen, U. (2005) *Epidemiology of urinary and faecal incontinence and pelvic organ prolapse*. In Abrams, P, Khoury, S, Cardozo, L and Wein, A. (Eds.) WHO-ICS International Consultation on Incontinence. 3rd Ed. Paris: Health Publications Ltd; 255-31.

Hunskaar, S and Vinsnes, A. (1991) The quality of life in women with urinary incontinence as measured by the sickness impact profile. *Journal of the American Geriatric Society,* 39 (4): 378-82.

Hurley, C and Snowden, S. (2008) Mentoring in times of change. *Nursing in Critical Care*, 13(5): 269-275.

Hutchings, J and Sutherland, L. (2014) Student Nurse Understanding Of the Psychosocial Impact Of Urinary Incontinence. *Urologic Nursing*, 34(6): 318-325.

Inoue, M, Chapman, R and Wynaden, D. (2006) Male nurses' experiences of providing intimate care for women clients. *Journal of Advanced Nursing*, 55(5): 559-567.

Inwood, M. (1997) *Heidegger: A Very Short Introduction*. Oxford: Oxford University Press.

Ironside, P.M, Scheckel, M, Wessels, C, Bailey, M, Powers S and Seeley, D. (2003) Experiencing chronic illness: Co-creating new understandings. *Journal of Qualitative Health Research*, 13 (2): 167-179.

Jeter K. F and Verdell L. L. (1993) *Consumer focus 93. A survey of community-dwelling incontinent people*. Union, SC: Help for Incontinent People.

Jeter, K.F and Wagner, D.B. (1990) Incontinence in the American home: a survey of 36,500 people. *Journal of the American Geriatric Society,* 38(3): 379-83.

Johnson, M.E. (2000) Heidegger and meaning: Implications for phenomenological research. *Nursing Philosophy*, 1: 134-146.

Johnson, T.M, Kincade, J.E, Shulamit, L.B, Busby-Whitehead, J, Hertz-Picciotto, DeFriese, G.H. (1998) The association of urinary incontinence with poor self-related health. *Journal of the American Geriatric Society,* 46 (6):693-9.

Jolleys, J.V. (1988) Reported prevalence of urinary incontinence in women in a general practice. *British Medical Journal,* 296:1300-2.

Kalisch, B.J, Landstrom, G.L. and Hinshaw, A.S. (2009) Missed nursing care: a concept analysis. *Journal of Advanced Nursing*, 65(7): 1509-1517.

Keegan, W and Knight, J. (2009) Addressing the problem of urinary incontinence. *Practice Nurse*, 38(8): 43-8.

Kelleher, C, Cardozo, L.D, Khullar, V and Salvatore, S. (1997) A new questionnaire to assess the quality of life of urinary incontinent women. *British Journal of Obstetrics and Gynaecology.* 104 (12):1374-1379.

Kelly, A.M and Byrne, G. (2006) Role of the continence nurse in health promotion. *British Journal of Nursing*, 15(4): 198-204.

Kierkegaard, S. (1985) *Fear and Trembling*. Harmondsworth: Penguin.

Koch, T. (1995) Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21: 827-36.

Koch, T. (1996) Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing,* 24(1): 174-184.

Koch, T. and Harrington, A. (1998) Reconceptualizing rigour: the case for reflexivity. . *Journal of Advanced Nursing*, 28(4): 882-890.

Krichbaum, K.E. (1994) Clinical teaching effectiveness described in relation to learning outcomes of baccalaureate nursing students. *Journal of Nursing Education*, 33 (7): 395-404.

Kvale, S. (1996) *Interviews: An introduction to qualitative research interviewing*. London: Sage Publications.

Laing, C, Robinson, A and Johnston, V. (2005) Managing the transition into higher education: an on-line Spiral Induction Programme. *Active Learning in Higher Education,* 6(2): 243-255.

Lambert, V and Glacken, M. (2004) Clinical education facilitators: a literature review. *Journal of Clinical Nursing*, 14(6): 664-673.

Langdridge, D. (2007) *Phenomenological Psychology Theory, Research and Method.* Pearson Education Ltd.

Largo-Janssen, A.L.M, Debruyne, F.M.J, Smits, A.J.A and van Weel, C. (1992) The effects of treatment of urinary incontinence in general practice. *Family Practice*. 9(3): 284-289.

Laverty, S.M. (2003) Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3): Article 3.

Lawler, J. (2006) *Behind the Screens: Nursing, Somology and the Problem of the Body*. Sydney University Press.

Lawton, R, Conner, M and McEachan, R. (2009) Desire or reason: predicting health behaviours from affective and cognitive attitudes. *Health Psychology*, 28(1): 56-65.

Laycock, J. (1995) Must do better. *Nursing Times*, 91(7): 64.

Lekan-Rutledge, D, Palmer, M.H. and Belyea, M. (1998) In their own words: Nursing assistant's perceptions of barriers to implementation of prompted voiding in long-term care. *Gerontologist,* 38(3): 370-378.

Levett-Jones, T, Lathlean, J, Higgins, I and McMillan, M. (2009) Staff – student relationship and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing* , 65(2): 316-324.

Levett-Jones, T and Lathlean, J. (2008) Belongingness: a prerequisite for nursing students' clinical learning. *Nurse Education in Practice*, 36: 103-111.

Levett-Jones, T and Lathlean, J. (2009) 'Don't rock the boat': nursing students' experiences of conformity and compliance. *Nurse Education Today*, 29(3): 342-9.

Lincoln, Y.S and Guba, E.G (1985) *Naturalistic Inquiry*. Sage Publications.

Lloyd-Jones, M, Walters, S and Akehurst, R. (2001) The implications of contact with the mentor for preparation of nursing and midwifery students. *Journal of Advanced Nursing*, 35(2): 151-160.

LoBiondo-Wood, G, Haber, J and Krainovich-Miller, B. (2002) Critical reading strategies: overview of the research process. In LoBiondo-Wood, G. and Haber, J. (Eds.), *Nursing Research: methods, critical appraisal and utilisation*, 5th edition. St Louis, Mosby.

Lopez, K. and Willis, D. (2004) Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research*, 14(5): 726-735.

Lowes, L and Prowse, M.A (2001) Standing outside the interview process? The illusion of objectivity in phenomenological data generation. *International Journal of Nursing Studies,* 38: 471-480.

Maben, J, Latter, S and Macleod Clark, J. (2007) The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. *Nursing Inquiry*, 14(2): 99-113.

Mackintosh, C. (2006) Caring: the socialisation of pre-registration student nurses; a longitudinal qualitative descriptive study. *International Journal of Nursing Studies*, 43(8): 953-962.

Mackintosh, C. (2010) *The socialisation of registered nurses responses to post-operative pain: a descriptive qualitative study*. Presented at Royal College of Nursing International Nursing Research Conference. Gateshead. EScholarID: 264071.

Malouf, N and West, S. (2011) Fitting in: a pervasive new graduate nurse need. *Nurse Education Today*, 31(5): 488-493.

Manninen, E. (2001) Changes in nursing students' perceptions of nursing as they progress through their education. *Journal of Advanced Nursing*, 27(2): 390-398.

McCabe, C. (2004) Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing*, 13(1): 41-9.

McClurg, D, Cheater, F.M, Eustice, S, Burke, J, Jamieson, K and Hagen, S (2013a) A Multi-Professional UK Wide Survey of Undergraduate Continence Education*. Neurology and Urodynamics,* 32(3):224-229.

McClurg, D, Jamieson, K, Hagen, S, Cheater, F, Eustice, S and Burke, J. (2013b) Improving continence education for nurses. *Nursing Times*, 109(4): 16-18.

McDowell, B.J, Burgio, K.L, Dombrowski, M, Locher, J.L and Rodriguez, E. (1992) An interdisciplinary approach to the assessment and behavioural treatment of urinary incontinence in geriatric outpatients. *Journal of the American Geriatric Society*, 40(4): 370-4.

McDowell, B.J, Silverman, M, Martin, D, Musa, D and Keane, C. (1994) Identification and intervention for urinary incontinence by community physicians and geriatric assessment teams. *Journal of the American Geriatric Society*, 42 (5): 501-5.

McGhee, M, O'Neill, K, Major, K and Twaddle, S. (1997) Evaluation of nurse-led continence services in the south-west of Glasgow, Scotland. *Journal of Advanced Nursing*, 26(4): 723-8.

McKinley, A. and Cowan, S. (2003) Student nurses' attitudes towards working with older patients. *Journal of Advanced Nursing,* 43(3): 298-309.

McLafferty, I. and Morrison, F. (2004) Attitudes towards hospitalised older adults. *Journal of Advanced Nursing,* 47(4): 446-453.

McManus Holroyd, A.E. (2007) Interpretive Hermeneutic Phenomenology: Clarifying Understanding. *Indo-Pacific Journal of Phenomenology*, 7(2):1-12.

Melia, K. (1981) *Student nurses' accounts of their work and training*. Unpublished PhD thesis, Nursing Studies Research Unit, University of Edinburgh.

Melia, K. (1987) *Learning and Working: The Occupational Socialisation of Nurses*. Tavistock Publications, London.

Merrifield, N. (2015) New Band 4 ‘associate role’ set to be created. *Nursing Times*. *nursing times.net 30 November, 2015.*

Meyer, T and Xu, Y. (2005) Academic and clinical dissonance in nursing education: Are we guilty of failure to rescue? *Nurse Educator*, 30(2): 76-79.

Midgley, K. (2006) Pre-registration student nurses perception of the hospital learning environment during clinical placements. *Nurse Education Today*, 26(4): 338-345.

Milne, J. (2000) The Impact of Information on Health Behaviours of Older Adults with Urinary Incontinence. *Clinical Nursing Research*, 9(2): 161-176.

Mitteness, L.S. and Barker, J.C. (1995) Stigmatizing a ‘normal’ condition: urinary incontinence in late life. *Medical Anthropology Quarterly*, 9(2): 188-210.

Mitteness, L.S. (1987) ‘So what do you expect when you’re 85?’ Urinary incontinence in later life. In Roth, J.A. and Conrad, P. (Eds.) *Research in the Sociology of Health Care*, vol. 6. Connecticut, Jai Press.

Morse, J. M. (1994) Designing funded qualitative research. In Denzin, N.K. and Lincoln, Y.S. (Eds.) *Handbook of Qualitative Research*, pp. 220-35. Thousand Oaks: Sage.

Morton-Cooper, A. and Palmer, A. (2000) *Mentoring, Perceptorship and Clinical Supervision: A Guide to Professional Roles in Clinical Practice*. 2nd edition. Blackwell Science, Oxford.

Munhall, P.L. and Boyd, C.O. (1993) *Nursing Research a Qualitative Perspective*. National League for Nursing Press, New York.

Murphy, E, Dingwall, R, Greatbatch, D, Parker, S and Watson, P. (1998) Qualitative Research Methods in Health Technology Assessment: a review of the literature*. Health Technology Assessment*, Vol. 2, No. 16.

Murphy, F, Jones, S, Edwards, M, James, J and Mayer, A. (2009) The impact of nurse education on the caring behaviours of nursing students. *Nurse Education Today*, 29(2): 254-264.

Myall, M, Levett-Jones, T and Lathlean, J. (2008) Mentorship in contemporary practice: the experiences of nursing students and practice mentors. *Journal of Clinical Nursing*, 17(14): 1834-1842.

National Institute for Health and Care Excellence (NICE) (2015) *Urinary incontinence: The management of urinary incontinence in women*. NICE Clinical Guideline 171.

Newble, D.I. (1992) Assessing clinical competence at the undergraduate level. *Medical Education*, 26 (6): 504-11.

Newman, D.K, EE, C.H, Gordon,D, Srini, V.S and Williams, K. (2008) *Committee 21: Continence Promotion, Education and Primary Prevention*. International Continence Society, www.ics.org/Publications/ICI_4/files-book/comite-21.pdf

Nicolson, P. (2003) Reflexivity, 'bias' and the in-depth interview :developing shared meanings. In Finlay, L. and Gough, B. (Eds.) *Reflexivity: A practical guide for researchers in health and social care sciences*. Oxford: Blackwell Science.

Norton, C. (1986) *Nursing for Continence.* Beaconsfield Publishers.

Norton, C. (1996) *Nursing for Continence.* Second edition. Beaconsfield, Beaconsfield Publishers.

Norton, P, MacDonald, L and Stanton, S.L. (1987) Distress associated with female urinary complaints and delay in seeking treatment. *Neurological Urodynamics*, 6,170-172.

Nursing and Midwifery Council (NMC) (2010) *Standards for pre-registration nursing education*, NMC, London.

Nursing and Midwifery Council (NMC) (2015) *The Code: Professional Standards of practice and behaviour for nurses and midwives.* NMC, London.

Nygaard, I, DeLancey, J.O. and Arnsdorf, L. (1990) Exercise and Incontinence. *Obstetrics and Gynaecology,* 75(5): 848-51.

O'Brien, J. (1996) Evaluating Primary Care interventions for incontinence. *Nursing Standard,* 10(23): 40-43.

O'Brien, J, Austin, M, Sethi, P and O'Boyle, P. (1991) Urinary incontinence prevalence, need for treatment and effectiveness of intervention by nurses. *British Medical Journal*, 303: 1308-12.

O'Brien, D, Richards, J and Walton, K.E. (2009) Survey of teaching/learning of healthcare-associated infections in UK and Irish medical schools. *Journal of Hospital Infections,* 73:171-5.

O'Connor, S.J. (2007) Developing professional habitués: a Bernsteinian analysis of the modern nurse apprenticeship. *Nurse Education Today*, 27(7): 748-754.

O'Donnell, B.F, Drachman, D.A, Barnes, H.G, Peterson, K.E, Swearer, J.M and Lew, R. A. (1992) Incontinence and troublesome behaviours predict institutionalisation in dementia. *Journal of Geriatric Psychiatry and Neurology,* 5 (1): 45-52.

O'Driscoll, M.F, Allan, H.T. and Smith, P.A. (2010) Still looking for leadership-who is responsible for student nurses' learning in practice? *Nurse Education Today*, 30(3): 212-7.

O'Lynn, C and Krautscheid, L. (2011) 'How should I touch you?': A Qualitative Study of Attitudes on Intimate Touch in Nursing Care. *American Journal of Nursing*, 111(3): 24-31.

Ogier, M.E. (1982) *An ideal sister?: a study of the leadership style and verbal interactions of ward sisters with nurse learners in general hospitals*. London: Royal College of Nursing. (RCN Research Series).

Oliver, P. (2010) *The Student's Guide to Research Ethics* (2nd edition). McGraw – Hill: Open University Press.

Olsson, H.M. and Gullberg, M.T. (1991) Nursing education and definition of the professional nursing role. Expectations and knowledge of the nurses role. *Nurse Education Today*, 11: 30-36.

Oppenheim, A.N (1992) *Questionnaire Design, Interviewing and Attitude Measurement.* Pinter, London.

Orrell, A, McKee, K, Dahlberg, L, Gilhooly, M and Parker, S. (2013) Improving continence services for older people from the service-providers' perspective: a qualitative interview study. *British Medical Journal* Open,3:e002926.bmjopen-2013-002926.

Palmer, M.H. (1995) Nurses' knowledge and beliefs about continence interventions in long-term care. *Journal of Advanced Nursing*, 21(6): 1065-1072.

Palmer, M.H, Athanasopoulos, A and Lee, K.S. (2012) Sociocultural and environmental influences on bladder health. *International Journal of Clinical Practice*, 66(12): 1132-8.

Paris, M.J. (1993) Attitudes of medical students and health professionals towards people with disabilities. *Archives of Physical Medicine and Rehabilitation*, 74 (8): 818-25.

Pascoe, E. (1996) The value to nursing research of Gadamer's hermeneutic philosophy. *Journal of Advanced Nursing*, 24(6): 1309-1314.

Pearcey, P. and Draper, P. (2008) Exploring Clinical Nursing Experiences: Listening to Student Nurses. *Nurse Education Today*, 28(5): 595-601.

Phillips, R.M, Davies, W.B and Neary, M. (1999) The practitioner-teacher: a study in the introduction of mentors in the pre-registration nurse education programme in Wales. *Journal of Advanced Nursing*, 23(5): 1037-1044.

Pilcher, M and MacArthur, J. (2012) Patient experiences of bladder problems following stroke. *Nursing Standard*, 26 (36): 39-46.

Polit, D.F. and Hungler, B.P. (1999) *Nursing Research Principles and Methods*. Sixth edition. Lippincott, Philadelphia.

Proctor, M. (2001) Measuring attitudes. In Gilbert, N (Ed.) *Researching Social Life*. 2nd edn. Sage, London, pp. 105-122.

Rankin, J, McGuire, C, Matthews, L, Russell, M and Ray, D. (2015) Facilitators and barriers to the increased supervisory role of senior charge nurses: a qualitative study. *Journal of Nursing Management*, Online 14 September 2015 DOI: 10.1111/jonm.12330.

Rapport, F. (2003) Exploring the beliefs and experiences of potential egg share donors. *Journal of Advanced Nursing*, 43(1): 28-42.

Rapport, F. (2005) Hermeneutic Phenomenology; the science of interpretation of text. In, Holloway, I. (Ed.) *Qualitative Research in Health Care*. Milton Keynes: Open University Press, 125-131.

Reed, J. (1994) Phenomenology without phenomena: a discussion of the use of phenomenology to examine expertise in long-term care of elderly patients. *Journal of Advanced Nursing*, 19: 336-341.

Reed, J. and Ground, J. (1997) *Philosophy for Nursing*. Arnold, London.

Reed, J, Procter, S and Murray, S. (1996) A sampling strategy for qualitative research. *Nurse Researcher*, 3(4): 52-68.

Reymart, J and Hunskaar, S. (1994) Why do only a minority of perimenopausal women with urinary incontinence consult a doctor? *Scandinavian Journal of Primary Health Care*, 12: 180-3.

Roberts, D. (2008) Learning in clinical practice: the importance of peers. *Nursing Standard,* 23(12): 35-41.

Robley, L.R. (1995) The ethics of qualitative nursing research. *Journal of Professional Nursing*, 11(1): 45-8.

Rodgers, S, Stenhouse, R, McCreaddie, M and Small, P. (2013) Recruitment, selection and retention of nursing and midwifery students in Scottish Universities. *Nurse Education Today,* 33(11): 1301-1310.

Roe, B. (Ed) (1991) *Clinical Nursing Practice. Promotion and Management of Continence.* London, Prentice Hall.

Roe, B. and Doll, H. (2000) Prevalence of urinary incontinence and its relationship with health status. *Journal of Clinical Nursing*, 9 (2):178-88.

Roe, B. and May, C. (1997) Effective and ineffective management of incontinence: a qualitative study with implications for health professionals and health services. *Clinical Effectiveness in Nursing*, 1(1): 16-24.

Roe, B. and May, C. (1999) Incontinence and sexuality: a qualitative perspective. *Journal of Advanced Nursing,* 30(3): 573-579.

Roe, B, Doll, H and Wilson, K. (1999) Help-seeking behaviour and health and social services utilisation by people suffering from urinary incontinence. *International Journal of Nursing Studies*, 36(3): 245-53.

Rokeach, M. (1968) *Beliefs, Attitudes and Values.* Jossey-Bass, San Francisco.

Royal College of Physicians (2006) *National Audit of Continence Care for Older People*. London: RCP. tinyurl.com/rcp-continence-older http://www.rcplondon.ac.uk/resources/national-auditcontinece-care.

Royal College of Physicians (2010) *National Audit of Continence Care.* London: RCP. tinyurl.com/rcp-continence http://www.rcplondon.ac.uk/resources/national-auditcontinece-care.

Royal College of Physicians (2012) *National Audit of Continence Care: Pilot audit evaluation report*. London

Rycroft-Malone, J, Burton, C, Hall, B, McCormack, B, Nutley, S, Seddon, D and Williams, L. (2014) Improving skills and care standards in the support workforce for older people: a realist review. *British Medical Journal Open* 2014;4: e005356 doi:10. 1136/bmjopen-2014-005356.

Sadala, M.L and Adorno, Rde C. (2002) Phenomenology as a method to investigate the experience lived: a perspective from Husserl and Merleau-Ponty's thought. *Journal of Advanced Nursing*, 37(3): 282-293.

Sadow, D, Ryder, M and Webster, D. (2002) Is education of health professionals encouraging stigma towards the mentally ill? *Journal of Mental Health*, 11(6): 657-665.

Salvage, J. (1992) The New Nursing: empowering patients or empowering nurses? In Robinson,J, Gray, A and Elkan, R. (Eds.) *Policy Issues in Nursing*. Open University Press, Milton Keynes.

Sandelowski, M. (1993) Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2): 1-8.

Sandelowski, M. (1995) Focus on Qualitative Methods: sample size in qualitative research. *Research in Nursing and Health*, 18: 179-183.

Sandelowski, M (1998) Writing a good read: Strategies for representing qualitative data. *Research in Nursing & Health***,** 21(4**):** 375 – 382.

Savage, J. (1995) *Nursing Intimacy. An Ethnographic Approach to Nurse Patient Interaction*, London, Scutari.

Schmicking, D. (2010) A toolbox of pheomenolgical methods. In Gallagher, S. and Schmicking, D. (Eds.) *Handbook of Phenomenology and Cognitive Science*. New York: Springer, pp. 35-55.

Schwarzer, R. (2014*) Self-efficacy: Thought control of action.* Routledge. London and New York.

Seed, A. (1995) Crossing the boundaries – experiences of neophyte nurses. *Journal of Advanced Nursing*, 21(6): 1136-1143.

Severinsson, E.I. (1998) Bridging the gap between theory and practice: a supervision programme for nursing students. *Journal of Advanced Nursing*, 27 (6): 1269-1277.

Seymour, J. and Clark, D. (1998) Phenomenological approaches to palliative care research. *Palliative Medicine,* 12:127-131.

Sharp, T. (1991) Whose Problem? *Nursing Times*, 87(3): 36-38.

Shaw, C. (2001) A review of the psychosocial predictors of help-seeking behaviour and impact on quality of life in people with urinary incontinence. *Journal of Clinical Nursing,* 10 (1):15-24.

Sheu, S, Lin, H.S and Hwang, S.L. (2002) Perceived stress and physio-psycho-social status of nursing students during their initial period of clinical practice: the effect of coping behaviours. *International Journal of Nursing Studies*, 39(2): 165-175.

Shinyashiki, G.T, Mendes, I.A.C, Trevizan, M.A and Day, R.A. (2006) Professional socialisation : students becoming nurses. *Revista Latino-Americana de Enfermagem,* 14(4): 601-607.

Simmons, R. (2001) Questionnaires. In Gilbert, N (Ed.) *Researching Social Life*. 2nd edn. Sage, London, pp. 85-104.

Simons, J. (1985) Does incontinence affect your clients self-concept? *Journal of Gerontological Nursing,* 11(6): 37-42.

Sinclair, A.J. and Ramsey, I.N. (2011) The psychosocial impact of urinary incontinence in women. *The Obstetrician and Gynaecologist.* 13(3): 143-148.

Smith, J.A. (2007) Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, 2: 3-11.

Smith, J. A, Flowers, P and Larkin, M. (2009) *Interpretive phenomenological analysis: Theory, method and research*. London, Sage.

Smythe, E. A. (2011) From beginning to end: how to do hermeneutic interpretive phenomenology. In Thompson, G, Dykes, F and Downe, S. (Eds.) *Qualitative Research in Midwifery and Childbirth Phenomenological Approaches*. Routledge.

Smythe, E. A, Ironside, P. M, Sims, S. L, Swenson, M. M and Spence, D. G. (2008) Doing Heideggerian hermeneutic research: A discussion paper. *International Journal of Nursing Studies*, 45: 1389- 1397.

Sorrell, J.M. and Redmond, G.M. (1995) Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing*, 21: 1117-1122.

Spilsbury, K. and Meyer, J. (2005) Making claims on nursing work: exploring the work of healthcare assistants and the implications for the Registered Nurses' role. *Journal of Research in Nursing,* 10(1): 65-93.

Spilsbury, K, Studdard, L, Adamson, J, Atkin, K, Broglin, G, McCaughan, D, McKenna, H , Wakefield, A and Carr-Hill, R. (2009) Mapping the introduction of assistant practitioner roles in acute NHS (Hospital) Trusts in England. *Journal of Nursing Management*, 17, 615-626.

Spouse, J. (2001) Work-based learning in health care environments. *Nurse Education in Practice*, 1(1): 12-8.

St John, W, James, H and McKenzie, S. (2002) 'Oh, That's a Bit of a Nuisance': Community-dwelling Clients' Perspectives of Urinary Continence Health Service Provision. *Journal of Wound Ostomy and Continence Nursing*, 29(6): 312-319.

Standing, T.S. and Anthony, M.K. (2008) Delegation: what it means to acute care nurses. *Applied Nursing Research*, 21(8): 8-14.

Steeves, R.H. (2000) Sampling. In Cohen, M Z, Kahn, D L and Steeves, R H (Eds.) *Hermeneutic Phenomenological Research: A Practical Guide for Nurse Researchers*. Sage Publications, London pgs. 45-55.

Stenzelius, K, Molander, U, Odeberg, J, Hammarstrom, K.F, Franzen, P, Samuelssom, E and Andersson, G. (2015) The effect of conservative treatment of urinary incontinence among older and frail older people: a systematic review. *Age and Ageing,* 44(5): 736-744.

Stevens, J. and Crouch, M. (1995) Who cares about care in nursing education? *International Journal of Nursing Studies,* 32(3): 233-242.

Stewart, D. (1999) The attitudes and attributions of student nurses: do they alter according to a person's diagnosis or sexuality and what is the effect of nurse training. *Journal of Advanced Nursing*, 30(3): 740-748.

Streubert Speziale, H.J. and Carpenter, D.R. (2003) *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. Third Edition. Lippincott, Philadelphia.

Strickland, R. (2014) Reasons for not seeking care for urinary incontinence in older community-dwelling women: A Contemporary Review. *Urologic Nursing*, 34(2): 63-68.

Taylor, B. (1995) Interpreting phenomenology for nursing research. *Nurse Researcher*, 3(2): 66-79.

Tervo, R.C, Palmer, G. and Redinius, P. (2004) Health professional student attitudes towards people with disability. *Clinical Rehabilitation*, 18 (8): 908-915.

Terzoni, S, Montanari, E, Mora, C and Destrebecq, A. (2011) Urinary incontinence in adults: nurses' beliefs, education and role in continence promotion. A narrative review. *Arch. Ital. Urol. Androl*, 83(4): 213-6.

Teunissen, D and Largo-Janssen, T. (2004) Urinary incontinence in community dwelling elderly: are there sex differences in help-seeking behaviour? *Scandinavian Journal of Primary Health Care.* 22(4): 209-16.

Thomas, J, Jinks, A and Jack, B. (2015) Finessing incivility: The professional socialisation experiences of student nurses' first clinical placement, a grounded theory. *Nurse Education Today*. 35(12): e4-e9.

Thomas, T.M. and Morse, J.M. (1991) Managing urinary incontinence with self care practices. *Journal of Gerontological Nursing,* 17(6): 9-14.

Titchen, A and Ajjawi, R. (2010) Writing contemporary ontological and epistemological questions about practice. In Higgs, J, Cherry, N, Macklin, R and Ajjawi, R (Eds.) *Researching Practice: a Discourse on Qualitative Methodologies.* Rotterdam: Sense Publishers. Pp. 45-55.

Titchen, A. and McIntyre, D. (1993) A phenomenological approach to qualitative data analysis in nursing research. In Titchen, A. (Ed.) *Changing nursing practice through action research* (Report no. 6 pp. 29-48). Oxford: National Institute for Nursing, Centre for Practice Development and Research.

Valle, R. (Ed.) (1978) *Phenomenological Inquiry in Psychology: Existential and Transpersonal Dimensions.* New York: Springer Science.

Valvanne, J, Juva, K, Erkinjuntti, T and Tilvas, R. (1996) Major depression in the elderly: a population study in Helsinki. *International Psychogeriatrics,* 8(3): 437-443.

van Manen, M. (1984) *'Doing' Phenomenological Research and Writing: An Introduction*. Alberta, Canada: Department of Secondary Education.

van Manen, M. (1997) *Researching lived experience: Human science for an action sensitive pedagogy* (2nd edition), London, Canada: The Althouse Press.

van Manen, M. (2002) *Hermeneutic Interview Reflection*. Phenomenology Online, www.phenomenologyonline.com. Accessed 20/04/06.

Vinsnes, A.G, Harkless, G.E, Haltbakk, J, Bohm, J and Hunskaar, S. (2001) Healthcare personnel's attitudes towards patients with urinary incontinence. *Journal of Clinical Nursing*, 10(4): 455-61.

Visser, E.H, Kollen, B.J, Meijerink, M, Berger, M.Y and Dekker, J.H. (2012) Systematic screening for urinary incontinence in older women: Who could benefit from it?. *Scandinavian Journal of Primary Health Care*, 30(1): 21-28.

Wagg, A, Harari, D, Husk, J, Lowe, D and Lourtie, J. (2010) *National Audit of Continence Care for Older People.* Available at www.rcplondon.ac.uk/projects/national-continence-audt-reports (accessed 5 June, 2015).

Wakefield, A. (1996) The practicalities of organising surgical nursing work. PhD thesis unpublished, Manchester University, Manchester, UK.

Wakefield, A, Spilsbury, K, Atkin, K, McKenna, H, Borglin, G and Stuttard, L. (2009) Assistant or substitute: Exploring the fit between national policy vision and local practice realities of assistant practitioner job descriptions. *Health Policy*, 90(2): 286-295.

Walsh, M. and Ford, P. (1994) *New rituals for old: Nursing through the looking glass*. Butterworth-Heinemann.

Walters, A. (1995) The phenomenological movement: implications for nursing research. *Journal of Advanced Nursing*, 22(4): 791-799.

Wan, X, Wang,C and Xu, D. (2014) Disease stigma and its mediating effect on the relationship between symptom severity and quality of life among community dwelling women with stress urinary incontinence: a study from a Chinese city. *Journal of Clinical Nursing*, 23(15): 2170-80.

Webb, C. (1984) Promoting continence. How would you feel? *Community Outlook, 8* Feb: 45-46.

Webb, C. (1999) Analysing qualitative data: computerised and other approaches. *Journal of Advanced Nursing,* 29(2): 323-330.

White, H. and Getliffe, K. (2003) Incontinence in Perspective. In Getliffe,K. and Dolman, M.(Eds.) *Promoting Continence: A Clinical Research Resource*. Edinburgh: Balliere Tindall.

Wiklund, L, Lindholm, L and Lindstrom, A. (2002) Hermeneutics and narration: a way to deal with qualitative data. *Nursing Inquiry*, 9(2): 114-125.

Wilson, A. (2012) *Supporting Student Nurses By the Educational Use of Self: A Hermeneutic Phenomenological Exploration of the Mentor Experience*. PhD Thesis The Open University.

Woods, M. (2005) Nursing Ethics Education: Are we really delivering the goods? *Nursing Ethics*, 12(1): 5-18.

Woodward, S. (1995) Assessment of urinary incontinence in neuroscience patients. *British Journal of Nursing*, 4(5): 254-8.

Wright, K. (2006) The role of healthcare assistants in supporting student nurses. *Nursing and Residential Care*, 8(10): 35-36.

Wyman, J.F, McClish, J.A, Harkins, D.K, Taylor, J.R and Ory, M.G. (1997) Effect of bladder training on quality of life of older women with UI. *International Urogynecology Journal and Pelvic Floor Dysfunction*. 8:223-229.

Yacobi, B.G. (2012) The Limits of Authenticity. *Philosophy Now,* April/May 2015.

Yu, L.C, Kaltreider, D.L, Hu, T, Igou, J.F. and Craigland, W. E. (1989) The ISQ-P tool: measuring stress with incontinence. *Journal of Gerontological Nursing*, 15(2): 9-15.

Yu, L.C. (1987) Incontinence Stress Index: Measuring Psychological Impact. *Journal of Gerontological Nursing*, 13(7): 18-25.

Yu, L.C. and Kaltreider, D.L. (1987) Stressed nurses dealing with incontinent patients. *Journal of Gerontological Nursing*, 13(1): 27-30.

Yu, L.C, Johnson, K, Kaltreider, D.L, Hu, T.W, Brannon, D and Ori, M. (1991) Urinary Incontinence: nursing home staff reaction towards residents. *Journal of Gerontological Nursing,* 17(11): 34-41.

Zang, Y, Chung, L.Y.F and Wong, T.K.S. (2008) A review of the psychosocial issues for nurses in male genitalia-related care. *Journal of Clinical Nursing,* 17(8): 983-998.

APPENDICIES

Appendix 1: Student Invitation

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Name of researcher: Claire Hope
Supervisors: Dr Mandy Fader and Dr Magi Sque

Dear Student,

My name is Claire Hope and like you I am also a student currently studying towards a Doctorate in Clinical Practice.

I would like to invite you to take part in a research study that explores your lived experiences of urinary incontinence (UI) in your first year of study.

I enclose:

- An information sheet describing the study
- A reply slip which you can return to me, the researcher if you would like to take part in the study
- An addressed envelope so that you can return the reply slip to me

If you are interested in participating in this study please could you return the reply slip in the envelope provided by the xxxxxxx.

Thank you for taking time to read the enclosed information

Kind regards,

Claire Hope
Doctorate in Clinical Practice Student
[redacted]

Appendix 2: Pre-registration student Information sheet

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Name of researcher: Claire Hope
Supervisors: Dr Mandy Fader and Dr Magi Sque

I would like to invite you to take part in a research study that explores what your experiences are in dealing with urinary incontinence (UI) during the first year of your training programme.

Your cohort has been chosen as you have just commenced your training programme in September 2010. Before you decide whether or not you want to take part in this study, it is important for you to understand why the research is being done and what it would involve for you. Please consider the following information carefully and take time to decide whether or not you would like to take part. This information sheet will describe the study.

Thank you for taking time to read this and for your consideration

What is the purpose of the study?

The purpose of this study is to explore student nurses experiences of dealing with urinary incontinence at the beginning of training and after the first year of training. This information will be used to:

- Explore pre-registration nursing students personal experience of dealing with UI
- Identify how pre-registration nursing students experiences are shaped and influenced in the first year of their training programme
- To enhance the learning and teaching of UI in nursing
- Contribute to a Doctorate in Clinical Practice for which I am studying

In addition information and data from the study may be used for:
a) Teaching research students
b) Further analysis and subsequent research projects following the study

How will the study be undertaken?

One to one interviews: these will take place on two occasions. Once at the beginning of your training before you go out to clinical practice and once again at the end of your first year after you have been in clinical practice. The interviews will be held in a place of your own choice. What I hope to talk about are your experiences of dealing with UI and what your thoughts are about dealing with UI. This will help me to learn about your views, feelings, experiences, beliefs and actions about how you deal with UI and how it connects to nursing practice.

Who has been invited to take part?

2010 intake of Advanced Diploma in Nursing Studies pre-registration nursing students based at [redacted] campus.

Who is undertaking the study?

The study is being undertaken by me; Claire Hope, a Principal Lecturer in Nursing. I am undertaking this study as part of my Doctorate in Clinical Practice and not as part of my role as Principal Lecturer.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form to say that you agree to take part in the study. If you decide you don't want to take part in the study that is OK, you won't have to give a reason and your decision will not affect any part of your pre-registration nurse training.

Will my academic tutor know I am taking part?

Your academic tutors are aware that your cohort has been approached to take part. However, any information that you share as part of the study will be confidential and will not be shared with your Academic Tutor.

How will the study be undertaken?

One to one interviews: these will take place on two occasions. Once at the beginning of your training before you go out to clinical practice and once again at the end of your first year after you have been in clinical practice. The interviews will be held in a place of your own choice. What I hope to talk about are your experiences of dealing with UI and what your thoughts are about dealing with UI. This will help me to learn about your views, feelings, experiences, beliefs and actions about how you deal with UI and how it connects to nursing practice.

What is the purpose of the one to one interview?

The purpose of the interview is for me to be able to collect detailed stories and descriptions about your experiences, beliefs and awareness about UI and then explore these with you in conversation.

From my interviews with you and others I hope to be able to add to body of knowledge about how pre-registration nursing students experiences are shaped and influenced throughout their first year of training towards dealing with UI. This may help teachers of nursing to provide the necessary experiences to help student nurses such as yourself learn about UI and for this reason you will be asked to consent that information and data from the study may be used for:

a) Teaching research students
b) Further analysis and subsequent research projects following the study

What will happen when I take part?

The interviews will involve you talking with me one to one on two occasions during the first year of your training programme. Once at the beginning of your first year and once again at the end of your first year of training. Each interview should last for about 45 minutes.

I will contact you and confirm and explain arrangements for conducting the interviews. The first interview will take place in October or November 2010 either in the morning or afternoon but no later than 4pm and not during lecture time. The second interview will take place in October or November 2011 either in the morning or afternoon but no later than 4pm and not during lecture time

After each interview we will spend a few minutes talking about how you felt during the interview process.

What if I don't know what to say?

Sometimes it might be difficult to tell your story, or you might forget it by the time we meet for an interview. Before each interview therefore it may be useful to write down your feelings and why you think you are feeling them so we can build on this in our conversation and I can begin to learn about your views, feelings, experiences, beliefs and actions from your lifeworld and how it connects to nursing practice.

Will the interview be recorded?

Yes, each interview will be digitally recorded with your permission so that an accurate written account of the discussion can be made.

Will what I say be confidential?

Yes. The procedures for handling, processing, storage and destruction of the data comply with the 1998 Data Protection Act. This means that all information about your contact details will be kept in a secure place. All information you share with me will be confidential and will only be seen by myself and my two supervisors. At all times your identity as participant in the study will be protected by me.

In keeping with the NMC Code of Conduct (2008), in the very unlikely event of evidence that vulnerable adults, children or yourself are at risk of significant harm, I would have to share relevant information with an appropriate third party. There will be no individual identifiable material in the written account from the one to one interviews.

Both the digital recordings and the written accounts will be stored anonymously using a unique code that would not identify you to anyone else except myself. All documentation will be stored in a computer file that is password protected.

After the study has finished any information relating to the study will be stored securely for15 years and then destroyed as confidential waste in line with [redacted] information storage policy.

What are the possible benefits of taking part?

There are no clear individual benefits for you from taking part in this study. However, your contribution to the overall study may be beneficial for your clinical practice in the future and how you deal with UI. Simply participating in a research project may assist your own understanding of what it is like to be involved in such a project and may lead to developing your own understanding of the research process, which may be beneficial for your future career in nursing. However,as a way of thanking the students that participate and acknowledging that they have given up time and shared their experience in this study block, book tokens of £10 will be issued to each participant at the end of each interview cycle.

What will happen to the results of the research study?

When all the data are analysed the study will be written up for my thesis and possibly for publication in a number of nursing and research journals. It will not be possible to identify you from these written reports. If you are interested in receiving a summary of the results please let me know and I will arrange for you to be sent a copy. Your data will be stored in a secure place at all times and I will be the only person that will have access to it. At the end of my research I would like to invite participants back together so that I can share my findings with them.

Who has reviewed the study?

The study has been reviewed by the [redacted] Ethics Committee.

What if I change my mind about being interviewed?

If you consent to take part you will still be able to change your mind at anytime by contacting me either by e-mail or telephone. You won't have to give me any reason and this will not affect your pre-registration training. However, should you choose to withdraw you will be sent a form to return in a stamped addressed envelope asking you to clarify if you are still happy for data collected from you to that point to be used in the study or withdrawn.

What if I have a concern or complaint?

If you have a concern or a complaint about this study you should contact [redacted]). If you remain unhappy and wish to complain formally Susan Rogers can provide you with details of the [redacted]

What do I do if I am interested in taking part in this study?

If you would like to take part in this study please:

- Complete the reply slip indicating that you would like to participate
- Place it in the addressed envelope provided
- Place the envelope xxxxxxxxxxxxxxx
- Please can you do this within 14 days of receiving this invitation

Thank you for reading this information sheet and I look forward to meeting you should you decide to participate in this study. If you require any further information about this study please do not hesitate to contact me by e mail [redacted]

Many thanks
Claire Hope
Doctorate in Clinical Practice Student

Appendix 3 : Individual reply slip

Study Number:
Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Name of researcher: Claire Hope
Supervisors: Dr Mandy Fader and Dr Magi Sque

Please tick box

I have read the information sheet and I am interested in taking part in the study ☐

Your name (please print) .....

Signature .....

Telephone contact no: .....

E –mail address: .....

Best time to contact you .....

Preferred method of contact .....

Appendix 4: Letter to Volunteers not required for the study

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Dear
Thank you for volunteering to take part in the above study. However, I have now recruited the required number of volunteers to participate in the study and will not be requiring you at this time.

However, if you would like me to keep your details on record and contact you again should another participant withdraw or if you wish me to contact you with a summary of the findings following completion of the study please contact me: Claire Hope: Doctorate in Clinical Practice Student., [redacted]

Thank you very much for considering taking part in this study

Kind regards

Claire Hope

Appendix 5: Consent Form for Interviews

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Name of researcher: Claire Hope
Supervisors: Dr Mandy Fader and Dr Magi Sque

	Please initial box
1. I confirm that I have read and understood the information sheet version 4: 18.01/2010 for the above study and have had the opportunity to consider the information and ask questions.	
2. I understand that my participation is voluntary and that I am free to leave the study at any time, without giving a reasonand that my pre-registration training will not be affected.	
3. I agree to direct quotes being used in any presentation of the research (verbal presentation or paper publication).	
4. I agree to my voice being audio (sound) recorded.	
5. I agree that the audio recordings and transcription of my interviews can be used for the purposes of analysis by the researcher.	
6. I agree that the researcher can analyse the interview to describe my feelings and experiences and that this will be shared with me for my comment.	
7. I agree that the audio recordings and transcription of my interview can be used for the purposes of teaching research students.	
8. I agree that the audio recordings and transcription of my interview can be used by researchers for future secondary analysis.	
9. I agree to take part in the above study.	

Particpant name: ……. Researchers name:……

Participant Signature :…….. Researcher Signature : …….

Date: …….. Date: ……

1 copy to participant ☐

1 copy to researcher ☐

Appendix 6: Confirmation Letter for Interviews

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Name of researcher: Claire Hope
Supervisors: Dr Mandy Fader and Dr Magi Sque

Dear.....

Further to my [e-mail./telephone call] on [date], I would like to confirm that the interview will take place at [insert address venue] on [insert date] at [insert time].

If your plans change or this is now not a good time for you please contact me on: [telephone number], or e –mail me at the address below and we can arrange a better time to meet.

Kind regards

Claire Hope
Doctorate in Clinical Practice Student
Tel : [redacted]

E-mail[redacted]

Appendix 7 : Data consent form following withdrawal

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

Name of researcher: Claire Hope
Supervisors: Dr Mandy Fader and Dr Magi Sque

Dear

I understand that you are withdrawing from the above study.

I would like to thank you for your participation and ask that you indicate on the tear off slip below whether or not you are still happy for data collected from you to this point to be used in the study or withdrawn. Please return the slip in the stamped addressed envelope provided.

Kind regards

Claire Hope
Doctorate in Clinical Practice Student
Tel : [redacted]
E-mail: [redacted]

Study Number:

Study Name: What are student nurses' lived experiences of urinary incontinence (UI) in their first year of study?

I am withdrawing from the above study and **I AM*/ I AM NOT** (**delete as appropriate*) happy for any data collected from me to this point to be analysed and contribute to the study findings.

Participant Name ..... Participant Signature .....

Date

Appendix 8: Ethics Approval Letters
Detail removed for confidentiality

[redacted]

Claire Hope
[redacted]

09 June 2010

Dear Claire

Ethics Submission No: SoHS-ETHtCS-2010-019
Title: Nursing students' practice experiences of urinary incontinence (UI)

J am pleased to confirm full approval for your study has now been given. The approval has been granted by the School of Health Sciences Ethics Committee,

You are required to complete a University Insurance and Research Governance Application Form (IRGA) in order to receive insurance clearance before you begin data collection. The blank form can be found at http://www.soton.ac.uk/corporateservices/rgo(reqprojs(whatdocs.html

You need to submit the following documentation in a plastic wallet to [redacted]

- Completed IRGA Research Governance form
- Copy of your research protocol/School Ethics Form (final and approved version)
- Copy of participant information sheet
- Copy of SoHS Risk Assessment form, signed
- Copy of your information sheet and consent form

- Copy of this SoHS Ethical approval letter

Your project will be registered at the RGO, and then automatically transferred to the Finance Department for insurance cover. You can not begin recruiting until you have received a letter stating that you have received insurance clearance.

Please note that you have ethics approval only for the project described in your submission. If you want to change any aspect of your project (e.g. recruitment or data collection) you must request permission from the Ethics Committee and RGO (students should discuss changes with their supervisor before submitting the request to the Ethics Committee).

Yours sincerely

[redacted]

[redacted]

Dear [redacted]

I am writing to ask for your permission to approach our first year student nurses and invite them to take part in my doctorate research. I am a registered student with the [redacted] y final two years of my taught doctorate which involves a research dissertation. I have full ethics approval from the [redacted] n but my recruitment is not as strong as I would like it to be to make my thesis viable.

I have discussed this with my Supervisor, [redacted] n and she has agreed that with your permission I could also approach our cohort of students in order to boost my participants. The design of my study requires me to interview the students on two occasions, once at the beginning of their training and once again at the end of their first year.

This will of course be on a voluntary basis and students will be reassured that their consent to be involved or not to be involved will have no bearing on their nurse training programme. There will be no coercion from me to be involved as this will be purely on a voluntary basis.

I have included all my Ethics Submission documentation from th [redacted] and my research proposal which has also been through a peer review process at the [redacted]

As I need to commence the first part of my study imminently I would really appreciate your decision as soon as possible.

Many thanks

[redacted]

Claire Hope

Hope, Claire

From: [redacted]
Sent: 02 November 2010 16:09
To: Hope, Claire
Cc: [redacted]
Subject: RE: Amendments to the consent form and the information sheet [Scanned]

Approved,
Please proceed.
David

From: Hope, Claire
Sent: 02 November 2010 09:29
To: [redacted]
Subject: Amendments to the consent form and the information sheet [Scanned]

Hi [redacted]
Many thanks for your support and advice re this. Attached is the research proposal with the amendments
Amendments are on pages 14,15,16 on the info sheet and page 22 the consent form
Thanks Claire

Claire Hope
[redacted]

02/11/2010

Appendix 9: Sample of transcript and development of themes
2nd Interviews – interview 9 page 3 lines 45 – 81. Text highlighted in yellow are in the findings chapter.

	Emergent themes from transcript	Identification of sub-themes	Main themes
Student – For me urinary incontinence is something that should be addressed, maybe if the carer is educated in what things to look out for, but they are just there to take care of and deal with toileting and they don't know what else to do. If they had some more training maybe they might ask why is this happening and then they can inform the Staff Nurse but as it is the job just gets done as if it's not happening, people just don't notice it and it's just another job there's no teamwork between the carer and the qualified staff. **Researcher** – How did you feel about that? Student - 'I think because UI is so common especially in the elderly it's just seen as normal. The carers just seem to be fixated with doing the job of cleaning it up without thinking outside the box as to why, it's …. well it's just routine with no flexibility, they just deal with the consequences and whilst I know there is so much more we could do it's not going to happen and who am I to suggest otherwise (laughs) … so I manage it the best way I can, but I'm not happy about it '	UI not seen as important/low priority More education needed Needs assessment UI low priority 'just a job' Poor integration between carers and qualified staff UI low priority Routine and task orientation UI treatable but just managed Student confused as UI not 'normal' Reality of practice Being listened too Challenges to expressing their own ideas	UI low priority Lack of teamwork UI low priority Finding a voice Fitting in	Attitudes of Staff Student Socialisation

Researcher – Why are you not happy about it? **Student** – 'I understand that sometimes you are pressed for time and maybe they then just get on with the job but I don't understand why they can't prioritise like, you know, some things can wait, like if you have to do a dressing, that dressing can wait, the person needing to go to the toilet can't wait, so maybe prioritising their time would be better. They have to put themselves in their shoes, if you have to go you have to go so if the patient has to go, they have to go so you take them when the patient says but they (the carers) are so fixated about the ward routine that this does not always happen'. **Researcher** – Why do you think that? **Student** – 'Again I don't think they understand and to be fair they have no support from the qualified staff who have the knowledge so they just do what they can. It's hard being a student though because I could see that there were better ways of dealing with it but found it difficult to have that conversation and besides I didn't feel I could I was only the student what did I know!! (laughs) you feel helpless sometimes but you suss out the staff eventually and there are some that you can discuss this with and there are some that 'know it all' and don't want some first year student asking why they do things that way and they would soon show you who was the boss here!! (laughing) so I kept my head down most of the time which I wasn't comfortable with but I just wanted to fit in and get on with my placement'.	Routine and task orientation Prioritising care – UI not as important as other aspects of care delivery Ward routine Lack of knowledge Lack of support from qualified staff Finding a voice Hierarchy system within the delivery of care Feelings of helplessness Disempowerment Hierarchy of staff Turned a blind eye Wanting to fit in Desire to pass placement	UI low priority UI low priority Lack of teamwork Finding a voice Hierarchy of care Finding a voice Hierarchy of care Fitting in	Attitudes of Staff Attitudes of Staff Student socialisation

Appendix 10: Examples from the 2 HEI curricula regarding the delivery of continence education in yr 1 of pre-registration Adult Nurse Training

1st HEI	**NS0400 (Sem 1)**	**NS0401 (Sem 2)** **NS0402 (Sem 2)**
Content	1 hr session covering urinalysis and continence/incontinence identified as symptom requiring assessment	Anatomy and physiology 1 Anatomy and physiology 2 1 hr overall including Renal System and brief overview of continence assessment – directed work – continence workbook to complete including assessment and urinary catheterisation (1hr)
2nd HEI	**ZJ1002 (Sem 1)**	**ZJ1004 (Sem 2)**
Content	1 hr session covering anatomy and physiology of Renal System – continence and incontinence included.	1 hr session covering Elimination Analysis – urinalysis, types of incontinence, assessment and urinary catheterisation covered

Appendix 11: Original Search Terms and results September 2006 : updated September 2015

SEARCH TERMS	CINAHL	ASSIA	MEDLINE	COCHRANE	WEB OF SCIENCE
Student Nurses	8253	5375	2,834	4 (none relevant)	5,211
Student Nurse Education	496	3924	109	2 (none relevant)	18,788
Student Nurse Curriculum	80	757	10	1 (not relevant)	5,155
Pre- Registration Nursing	532	0	500	83	776
Student Nurse Experiences	702	1829	59	1 (not relevant)	9,563
Urinary Incontinence	7174	647	35,134	88	35,656
Continence Promotion	85	38	80	1	67
Attitudes	168,774	34,244	153,555	79	328,244
Attitudes and Perceptions	213,452	4,602	13,985	0	54,539
Attitudes and Attitude Change	4670	22,928	702	43	53,270
Student Nurse Support	163	1,016	34	1 (not relevant)	5,953
Student Nurse Socialisation	55	78	8	5	299
Intimate care	2917	489	4326	4 (none relevant)	3,010

Appendix 12: Search Terms Combined and results September 2006 : updated September 2015

SEARCH TERMS IN COMBINATION	CINAHL	ASSIA	MEDLINE	COCHRANE	WEB OF SCIENCE	Total number of articles included in review
Student Nurses and Urinary Incontinence	8253 (4) 2 relevant	5375 (5) 2 relevant	2,834 (2) 1 relevant already included in review	4 (none relevant)	5,211 (15) 5 relevant 4 already included in review 1 new article	5 articles
Student Nurse Education and Urinary Incontinence	496 (11) 3 relevant	3924 (3) articles already included in review. 0 result	109 (15) 8 relevant 3 already included in review 5 new articles	2 (none relevant) (0)	18,788 (8) 4 relevant already included in review	8 articles
Student Nurse Curriculum and Urinary Incontinence	80 (1) already included in review	757 (1) already included in review. 0 result	10 (7) 3 relevant already included in review	1 (not relevant) (0)	5,155 (0)	No new articles
Pre- Registration Nursing and urinary incontinence	532 (1) already included in review	0	500 (5) 0 relevant	83 (30) none relevant add Title, abstract and keywords (0)	776 (0)	No new articles
Student Nurse Experiences and Urinary Incontinence	702 (8) 3 relevant articles	1829 (2) already included in review. 0 result	59 (7) 3 relevant already included in review	1 (not relevant)(1) not relevant	9,563 (4) 2 relevant already included in review	3 articles
Continence Promotion and Assessment	85 (14) 7 relevant articles	38 (10) 5 relevant articles	80 (12) 5 relevant 3 already in review (2 new)	1(not relevant) (0)	67 (20) 6 relevant already included in review	14 articles
Attitudes and Urinary Incontinence	168,774 (171) refined further (see below)	34,244 (22) 7 relevant articles	153,555 (191) refined further see below	79 (0)	328,244 (59) refined further see below	7 articles
Attitudes, urinary incontinence and healthcare professionals	(5) 1 relevant	N/A	(4) 2 relevant already included in review	0	59 (8) 4 relevant already included in review	1 article
Attitudes, urinary incontinence and student nurses	(1)Already included in review	N/A	N/A	0	8 (3 relevant already included in review)	No new articles

Attitudes and Perceptions and Urinary Incontinence	213,452 Refined further (see below)	4,602 (1) relevant article	3,985 (18) 8 relevant 5 already included in review (3 new)	0	54,539 (56) Refined further see below	4 articles
Attitudes and Perceptions Urinary Incontinence and patients	31 (8 relevant)	N/A	5 (1 relevant)	0	32 (6 relevant 4 already included in review 2 new)	11 articles
Attitudes and Attitude Change and urinary Incontinence	4670 (4) already included in review	22,928 (15) – no new articles identified	69 refined further see below	43 (13) 2 relevant articles	53,270 (52)refined further see below	2 articles
Attitudes and attitude change urinary incontinence and nurses			26 (12 relevant 8 already included in review (4 new)	3 (2 relevant already included in review)	19 (8 relevant 6 already included in review 2 new articles)	6 articles
Student Nurse Support and mentorship	163 (25) refined further see below	1,016 (33) 10 relevant	34 (2) both relevant both already in review	1 (not relevant) 0	5,953 (107) Refined further see below	10 articles
Student Nurse Support and mentorship and clinical practice	7 (5 relevant)		N/A	N/A	49 (11 relevant already included in review 1 new article	6 articles
Student Nurse Socialisation and Student Nurse Experience	55 (7) 5 relevant	78 (21) 5 articles relevant	8 (0)	5 (2 relevant articles)	299 (150) refined further see below	12 articles
Student Nurse Socialisation and Student Nurse Experience and Adult Nurse Student					150 (36) 10 articles relevant 5 articles already included in review 5 new articles	5 articles
Intimate care/personal care and urinary incontinence	2917 (9) 4 relevant	489 (7)3 relevant articles	4326 (12)4 articles relevant already included in review	4 (none relevant) 0	3,010 (6) 2 relevant articles already included in the review	7 articles