UNIVERSITY OF SOUTHAMPTON

SURVIVING TODAY: LEARNING FOR TOMORROW

An ethnographic study of how undergraduate nursing students manage their own learning in clinical practice

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Thesis in submission for Doctor of Philosophy
February 2002

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCES
EDUCATION

Doctor of Philosophy

SURVIVING TODAY: LEARNING FOR TOMORROW

An ethnographic study of how undergraduate nursing students manage their own learning in clinical practice

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This ethnography is an account of the journey through clinical placements that undergraduate student nurses take as part of a three year programme. It describes how they attempt to manage their own learning, and analyses the factors that appear to facilitate or impede their ability to be self-directed in learning to nurse. Conclusions are drawn from their experiences, suggesting how curricula could be developed to further enable self-directedness to be achieved. Action learning strategies, introduced to the undergraduate programme as a result of findings from the study, are described.

The research was planned in two stages, an initial stage using focus groups as preparation for entering the culture, and a second stage involving participant observation and reflective interviews. Data was analysed using a modified grounded theory approach.

The nature of support provided for participants in practice was found to be the most significant factor in enabling students to manage their own learning. This led to the conclusion that - students are best able to manage their own learning in clinical practice when they are actively involved and facilitated to learn by 'mentors' who allow them the freedom to take risks, and provide a 'safety net' to protect them in taking such an approach.

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Preface

This study is situated in the changing context of nursing education. In particular reflecting the move of nursing education from being based in hospitals, close to clinical practice, to joining other health care professional education programmes based in higher education and therefore more remote from clinical practice.

The participants are undergraduate student nurses in an English university who study 50% of their programme in clinical practice. In this learning environment they need to take responsibility for their own learning. Although the students have 'supernumerary' status the qualified nurses identified to be their 'mentors' (teachers in clinical practice) tend not to have dedicated 'teaching' time. This results in variations in the quality of teaching and learning. The onus falls on the students to identify and access learning opportunities, a task that some manage better than others.

Experiential learning approaches are used widely within taught components of pre-registration nursing programmes, and occur naturally in the clinical setting. However students do not always perceive the latter and even when they do may not have the knowledge and skills to effectively benefit from them.

The changing role of nurses made it imperative to discover strategies that would develop self-directed learning abilities in order to facilitate students managing their own learning. This study, therefore, was designed to discover what strategies students already used to manage their own learning, how effective these were and how nursing curricula might be developed to increase the effectiveness of student-centred learning.

The language used throughout this ethnography reflects the fact that nursing is predominately a female profession. The participants in this study reflected this fact, only two of them being male. In order to protect their identities all participants have been referred to by female names, and thus the use of the feminine gender has been used throughout the study when referring to nurses. The qualitative nature of the research, with the use of extensive quotations from participants, meant that use of neutral language could have interfered with the 'readability' of data.

Overall when participants have referred to patients or colleagues the correct gender form has been used as this sometimes influences the meaning of the comments. In these cases names have either been changed or omitted. The exception is when participants have made reference to each other; in these instances the feminine gender has been used to avoid identifying the two male students. However when they have referred to other students in clinical placements who have not participated in the study the correct gender form has been used.

Acknowledgements

I would like to express my sincere thanks for the advice, support and encouragement given throughout the course of this research by my supervisors, Robin Usher and Ian Bryant. Their friendly 'critical' comments and enthusiasm helped the study to reach its conclusion.

Special thanks are made to the student nurses who participated in this study, their peers who listened to the early reports and contributed towards development of the research design and colleagues at Bournemouth University and associated NHS Trusts who were willing to include the findings in redesigning the curriculum.

I am grateful to my managers, both at Bournemouth University and the UKCC for supporting me in this research - Howard Nattrass, Iain Graham, Sue Norman and Adrian Reyes-Hughes.

I am particularly indebted to my friends and critical readers who allowed me to use them as 'sounding boards' as the ethnography developed - Immy Holloway (my lifelong mentor), Pam Walter and Keith Cooper.

Finally, and most importantly thanks to my family who kept me sane and coped with me when times were stressful, my husband John and my daughters Pauline and Nikki.

This thesis is dedicated to my mother

Iris Maud McComish

1916-2001

CHAPTER 1

NURSING DEGREE STUDENTS DO IT BY THEMSELVES

Introduction to the study

This ethnography is an account of the journey through clinical placements that undergraduate student nurses take during their programme. It describes how they attempt to manage their own learning, and analyses the factors that appear to facilitate or impede their ability to be self-directed in learning to nurse. Conclusions are drawn from their experiences, suggesting how nurse teachers could develop curricula to further enable self-directedness to be achieved. The final chapter includes examples of curriculum development to illustrate this final point.

Throughout the ethnography personal reflections and words of participants are included to help the reader to understand the perspectives of the researcher and the researched. This is in recognition of the fact that these are not separate entities, but that each influences the actions and perceptions of the other. The first person is used in accordance with the criteria identified by Webb (1992:747) that writing in the first person is acceptable when expressing personal opinions or when the person has had a significant role in shaping the data or ideas presented.

Origin of The Study

The impetus for the study arose from personal experience with the first cohort of nursing degree students on a programme for which I had been leader of the curriculum planning team. I had commenced work in higher education with the remit of writing and implementing a three-year Bachelor of Science nursing programme. Prior teaching experience had been in a College of Nursing and

Midwifery based in a District General Hospital with students spread through the hospitals and communities of seven NHS Trusts. At the time there was a National move for nurse education programmes to be run in collaboration with, or based within, Higher Education (HE). The local College of Nursing and Midwifery was in negotiation with the Regional NHS Executive and the University to move its staff, students and programmes totally within HE, but this did not happen in reality for a further twenty months. In the meantime there was close collaboration between the University and the College and joint validation of programmes by the University and the English National Board (ENB), the relevant statutory body.

The degree course was to have what was commonly known as a Project 2000 style structure, an eighteen month Common Foundation Programme (CFP) and an eighteen month Branch Programme (UKCC 1986) in which students specialised in a particular field of nursing. In this case it was planned to have branch programmes for both adult and mental health nursing. A similar programme, a Diploma of Higher Education/Registered Nurse (DipHE/RN), was being developed by the College that had branch programmes in adult, mental health and learning disabilities nursing.

Validation of the nursing degree was an eventful experience. Academics from other fields in higher education involved in the approval process appeared suspicious of nursing as an academic subject, tending to perceive it as a practical field. This led to many debates on the art and science of nursing and its honours-worthiness. Parker (1997:4) identified that:

> *It is often said that nursing is more an art than a science, with art being linked, through ignorance and prejudice, to untested practice and strongly held beliefs which are fundamentally inferior to scientific validated knowledge or 'facts'.*

The nursing team found it difficult to articulate the 'scientific' nature of nursing, we could recognise artistry in nursing but were unable to explicate the dialogue

between art and science that results in expert nursing practice. Parker (1997:7) provided an example of this dilemma explaining that experienced nurses may 'know' when things are going well, or when students they are supervising are developing new knowledge and skills, but be unable to account for the source of their knowledge, identifying it as personal rather than academic in nature.

Inexperience in the academic validation process, of those of us defending nursing, led us to compromise and introduce rather more input from accepted academic sciences such as biology, psychology and sociology than we had originally intended. Jowett et al (1994:123) when studying the first Dip.HE nursing courses in 13 demonstration districts quoted a College Principal as saying:

> *... a mistake easily made with new courses (and one made in nursing degree courses too) was to give too much time and emphasis to established academic subjects such as sociology and psychology, and too little to the crux areas of nursing.*

This statement demonstrated that our experience was not unique. Nationally nurse teachers who were moving into, or collaborating with, Higher Education Institutions (HEIs) met with similar attitudes and shared similar experiences.

With regard to teaching and learning strategies the curriculum team were more confident, coming from a background where the Statutory Bodies, in this case the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the English National Board (ENB), required nurse teachers to have formal teaching qualifications. The ENB also required appropriate ratios of qualified teachers to students as part of the course approval process (ENB 1993a). Nurse and midwife teachers were familiar with having to account for the resources to support teaching and learning activities

The theoretical component of the course involved many student-centred approaches such as reflective learning diaries, reflective discussions, student

projects, student led seminars and similar strategies. The relative ease with which such strategies were accepted at validation reflects the view expressed by Wilcox (1996:167) who identified the high value placed by universities on students taking responsibility for their own learning, being self-directed in their approach. He suggested this reflected the 'liberal education value of lifelong learning'.

One of the issues that the curriculum planners had to address was to move from the high face-to-face contact that nurse teachers traditionally had with students to the academic norm of low formal teaching contact and high student-centred activity. D'A Slevin (1993:244) identified that traditional approaches to nurse education resulted in 'programmes of intensive lecturing' that were highly teacher centred. This was in conflict with the HE approach as previously described. Nurse teachers therefore needed to make a philosophical move in their approach to teaching and learning nursing. The course team who delivered the approved programme had to work hard to turn curriculum rhetoric into a student-centred learning experience.

Many of the HE members of the validation panel were essentially only interested in learning that took place in the university, and appeared to take the view that clinical practice was comparable to work placements on other academic courses and thus was not 'teaching', an issue that many nurse teachers and the ENB disputed. This led to further conflict for the team, needing to justify the quality of learning in clinical practice for the Statutory Body and peers (from nursing programmes in other HEIs) on the validating panel, but at the same time being aware that the HE members (non-nursing) had less interest in this component of the course.

The issue of valuing practice is not confined to nursing, but is also evident in other professional courses. Usher and Bryant (1989:71) discussing adult

education, in particular continuing education, identified that a dilemma existed in that the aim of enhancing quality of practice may not be realised due to the emphasis placed on theoretical knowledge. Hyland (1994:327) suggested that professional and vocational courses in HE should be based on expert and reflective practice.

The growth of reflective practice in nursing courses, mainly based on theory by Schon (1983), perhaps suggests that this advice has been taken. Schon's description of a 'technical-rationalist' is typical of a traditionally prepared nurse, a person who values medical knowledge and prescribes care, taking the stance of 'expert'. Current curriculum planners, for nursing, attempt to focus more on developing reflective practitioners who will work in partnership with clients, using their specialised knowledge to facilitate decision making. Palmer et al (1994:1) identified that:

> *The concept of reflective practice is emerging as a means of addressing the alienation brought about by the 'high speed' manner in which nurses are expected to care for their patients.*

This statement reflects the rapidly changing world of knowledge and practice in which nurses perform.

The need for practitioners to develop theory from practice as well as use theory in practice is paramount. Usher and Bryant (1989:75) identified that as a result of continually changing contexts the practitioner's situational knowledge needs to be flexible and dynamic. This issue is explored further in chapter 7 in relation to the preparation of mentors - qualified practitioners who support students in practice.

Pre-registration preparation programmes cannot produce knowledge for life, as the context in which nursing is practiced, and the knowledge base from which it is practised, are dynamic. Thus the emphasis, supported by the ENB (1994a), is on developing 'lifelong learners' who can develop their own knowledge and

skills in practice settings, supported by academic study when appropriate. This issue is discussed further in chapter 2.

The balance of the nursing degree was 50% theory and 50% practice. The teaching team had addressed the use of student-centred learning strategies for theory, and attempted to integrate theory and practice in assessment, however there was little control over learning in clinical practice. The main strategy was the provision of mentors, qualified staff to whom the students were linked for the length of a clinical placement.

The student handbook defined mentors as 'wise and reliable advisors', they were expected to act as role models for their students, guide learning and facilitate them to access learning opportunities within clinical practice. More controversially they were expected to act as assessors, identifying student progress through the use of a Profile (Appendices 1 & 2). Jowett et al (1994:129), when considering student supervision, argued that it was unrealistic to expect student supervision and assessment to be added on to the workload of practitioners who were already overstretched.

The course team found that the support required by mentors was high, particularly as they had no previous experience of degree students at pre-registration level. Student and mentor evaluations during the course supported this finding. All mentors had been prepared, at least to a minimum standard, to support pre-registration students from the College of Nursing and Midwifery. Additional preparation was provided by the degree course team near the beginning of each semester to enable mentors who were going to supervise students in placements to gain a deeper understanding of the course in order to be able to meet the needs of the students.

As the first cohort progressed through their course their evaluations indicated that learning in clinical practice was of variable quality and approach, frequently traditionally teacher [mentor] centred since this mirrored the learning experiences of the mentors who had been prepared to nurse through more traditional methods. This initiated my interest in discovering how students did or could control their own learning in clinical practice.

My interest was further developed by an experience as the first cohort reached their final day in the university before graduating. Twenty-six, of the thirty-three students who had commenced the course and two who had joined with advanced standing at the beginning of the branch programme, graduated; the remainder having either been discontinued or had transferred courses. Two attained a first class honours, one a third class degree and the remainder were fairly equally distributed between upper and lower second classifications. The outcome was pleasing, particularly since many of the group had been recruited through 'clearing' due to the course not being approved until the late Spring of 1990 making it too late to use the normal academic application process.

I had been the course leader for the past three years and was now able to see the students complete their course and enter employment. When they finally left I went to check the classroom. The message left on the board as a farewell by the group stated:

Nursing Degree Students do it by Themselves.

As our relationship was, and still is, a friendly one I perceived this as a tongue in cheek reflection of my attempts to make learning on the course as student-centred as possible. Sometimes it had worked well and at others the students felt overloaded with seminars and projects to prepare, whilst at the same time being expected to take part in experiential learning strategies in both classroom and

clinical practice. The whole process of delivering the course had been a learning experience, for teachers as well as students.

Changing Approaches to Learning to Nurse

My interest in, and concern with, student-centred learning had arisen from personal experience and previous research into the influence of individual learning styles as a factor affecting nursing curricula (Gosby 1987), from which I concluded that nursing students learnt more effectively when actively engaged in the learning process. This finding was supported by the other studies on nursing students available at that time (Ostmoe et al 1984; Laschinger & Boss 1984; Laschinger 1986). The message left by the undergraduates prompted me to develop my knowledge further, finally resulting in this current study.

The stimulus was not just a personal or a local one; the past decade had seen rapid changes occurring within nurse education. Jowett et al (1994:1) identified that the case for reform arose from concern about educational standards, service delivery, recruitment and retention of students, and additionally organisational changes in the National Health Service (NHS) and changes in the health needs of the population. Significantly the move of nursing courses, from the health sector in to higher education, to achieve academic validation had focused the attention of nurse teachers on justifying what it was that nursing students learnt, and what strategies ensured such learning was of higher education standard.

The personal experience of validating a nursing degree was similar to that of colleagues in other parts of the country. Jowett et al (1994:123) quoted a College Principal as saying:

> *... there was a real danger of 'fragmentation' - of ending up with the high level* ***separate*** *courses in sociology, psychology and other subjects, which* ***added*** *up to a nursing course, rather than a course which was relevant and integrated from the start.*

Having now seen the first cohort of nursing degree students complete I was in a position to review the strengths and weaknesses of the course and to begin, with colleagues, the process of review ready for re-validation of the course. The curriculum team were now more experienced in academic validation and more confident to argue the case for practice based learning. An account of curricula changes developed for this revalidation, which were influenced by this research, is given in chapter 7.

The introduction of new preparation courses for nursing (UKCC 1986) had altered the status of nursing students from apprentices to supernumerary students, recognising that they were no longer 'pairs of hands' to meet the needs of the health care system, but instead were academic students learning the professional skills and knowledge required by a nurse to work in the next millennium, the change being known colloquially as Project 2000. The UKCC set up an Education Commission in 1998 to review this approach to nursing education and the report from the Commission, *Fitness for Practice* (UKCC 1999), made recommendations to further develop nursing education. These are discussed further in chapter 2.

Practitioners, who took on the role of mentor to such students, were also coping with major change in other areas of their working lives such as the philosophy of Primary Nursing, the market approach of purchasers and providers for the delivery of health care, rapidly changing skill mix, and medical advances in the treatment of diseases, which demanded new and increasing skills to be mastered. The need therefore was not just to change the learning experiences of students in clinical practice but also to prepare and support practitioners in order that they could fulfil new and demanding roles. Further changes in the context of nursing education and practice are discussed in chapter 7.

The Theory Practice Dilemma

Taking all of the changes into account the case for developing student's abilities to manage their own learning in clinical practice appeared to be a strong one, although not without danger. Hislop et al (1996:177) assert the importance of practice in developing the meaning of theory, and the need to plan programmes that facilitate the articulation of theory and practice. Their argument is further highlighted by Usher and Bryant (1989:76) who state that:

> *The learning of theory cannot tell anyone how to practice; in a very real sense practice is learnt in practice. Practice is located in practical knowledge which is situational and action-oriented.*

My personal concern was to value practice equally with theory, to enable students to understand how these two components complemented rather than competed with each other. It was necessary to view theory and practice as a whole, each able to enhance the meaning of the other, in order to achieve an integrated programme and avoid the danger of fragmentation. Pryjmachuk (1996:680) argues that theory has to be extracted from practice if it is to have any relevance, and that 'foreign theories cannot dictate practice'.

Nursing theory needed to be derived from nursing practice rather than 'borrowed' from associated sciences such as medicine, biological and psychosocial sciences. However, as the qualified teachers were university based, and the practice teachers [mentors] were recognised as being over-stretched, the need for students to be facilitated so that they could learn through practice, in order to develop an integrated knowledge base, was identified as being vital. Pryjmachuk (1996:683) suggested that:

> *Novice nurses literally have no idea of how to practise. Whilst the novice nurse may well have informal theories (that is ideas) of how to act in a particular situation, the nurse cannot feasibly test those theories (and indeed reflect on them) because of the risks to patients if the nurse blunders.*

This notion of 'informal theory' is an important one. Many academics when discussing this concept identify a relationship with Polanyi's theory of tacit

knowledge (Benner 1984; Carper 1978; Greenwood 1993; Johns 1995; Powell 1989; Rolfe 1993; Usher and Bryant 1989).

It appeared to be recognised that practitioners developed knowledge without necessarily being aware of what they knew, and that this knowledge influenced their decision making in practice. Maeve (1994:11) suggested that:

> *While formalized knowledge presented through a curriculum is basic to 'knowing that', clinical knowledge is 'knowing how' and is personal, dependent on contextualized experience.*

In order to facilitate students learning to both 'know that' and 'know how' it was necessary to consider how they could become self-directed learners in clinical practice. My assumption was that this was a skill that able students developed with little help from a teacher, being naturally self-directed, perhaps a characteristic of their individual learning style? However I felt that less able students would need more help to develop this ability. I believed that all students, if they were facilitated to integrate theory and practice through reflective strategies, would be more able to identify and meet their own learning needs, developing 'know that' and 'know how'.

Usher and Bryant (1989:75) describe the phenomenon of:

> *... knowing something 'in theory' and yet being unable to do it and its obverse, being able to do something but being unable to specify what one does in terms of 'theory.'*

This was something I had witnessed in previous teaching and assessing experience, particularly as a Clinical Teacher. The previous RGN training courses utilised a system of four practical assessments - aseptic technique, drug administration, total patient care and ward management. As a teacher I was involved in acting as an assessor for these. I concluded that student nurses, especially in their first and second years, appeared to have difficulty integrating theory and practice. This led to what is often called the 'theory practice gap'. The more clinical experience students had the better they were able to integrate

theory and practice, therefore third year students appeared more able to practice with confidence and justify their actions from knowledge.

Rolfe (1993:176) argues that nursing theory does not adequately account for 'what happens in real life situations'. He proposed a model of 'nursing praxis' (Rolfe 1996:36) that used experiential strategies to achieve integration of theory and practice. Through the use of hypothetico-abductivism, commencing with reflection-on-action, he suggested that personal knowledge was constructed and could be stored as 'paradigm cases' or used immediately to construct informal theory. This in turn, he suggested, led to the formation of hypotheses that could be tested in practice.

It may be argued that formal theory can influence the construction of informal theory, in that we make sense of new experiences in the light of what we already know. The 'novice nurse' has a minimal empirical knowledge base from which to 'make sense' of new experiences. Whilst many students do have some practice experience, having worked as Health Care Assistants (HCAs), few have had formal theoretical input. However, they do all bring life experience to the new learning situation. This provides them with personal knowledge that they can use to interpret new knowledge.

Whilst Rolfe's model of nursing praxis may explain how qualified practitioners could be self-directed in developing further nursing knowledge, it appears that a greater level of facilitation is necessary for student nurses. Undergraduate student nurses need to acquire a foundation of theoretical knowledge, and learn how to reflect in a critical manner, in order to gain the most value from their practice experiences. Parker (1997:22) suggested that knowledge developed through reflection-in-action was more likely to lead to a holistic approach to caring.

However, as nursing practice was limited in the early stages of the programme, students initially learnt through reflection-on-action. At this stage they needed facilitation from an experienced practitioner or teacher to help them to make sense of their reflections. In this way a dialogue between theory and practice could be achieved that enabled them to adopt a holistic approach to care delivery.

Nolan and Nolan (1997a) argued that self-directedness had to be learnt and that nurse teachers should not assume that because nursing students were adults they would possess the characteristics of adult learners, as identified by Knowles (1975). Their study suggested that although nursing students become more self-directed as they progressed through their course, initially they required a higher level of structure and support, typical of the pedagogical approach. Whilst it may be argued that this approach leads to self-directedness it may also be argued that it fosters dependence of the student on the teacher. It is perhaps a high level of support, through facilitated learning, that is necessary rather than structure. The reality of nursing practice is that it is unpredictable and does not have a coherent structure. Boud et al (1993:11) suggested that different learners construct and reconstruct the same experiences differently. This makes it important to recognise the individual learning experiences of each student.

Whilst it is not possible, nor advisable, to adopt an individual approach to learning for all students they can be facilitated to identify their own learning needs through reflective strategies. This may enable them to identify strategies to meet their needs that are appropriate to their individual learning styles. In this way self-directedness can be facilitated, enabling the student to manage their own learning at the time, and to develop transferable lifelong learning skills for future learning.

Past experience as a Clinical Teacher and Tutor with practice responsibilities had led me to conclude that student nurses needed to be able to 'stand on their own two feet' in clinical practice, as the actual support available there did not always meet the level that nurse teachers, and indeed the students, would require. Through developing self-directed learning skills I believed that students would be able to gain independence from their teachers.

Literature Review

A qualitative approach was chosen to answer the research questions that were being formulated from a consideration of the issues identified. Consequently the initial literature review was deliberately restricted in order to enable me to enter the study with as Fetterman (1989) suggested an 'open' rather than an 'empty' mind. To this end reading was directed more towards methodological issues, particularly ethnography. Holloway and Wheeler (1996:24) stated that:

> *Although it is inappropriate to start with a fully developed theoretical model and an in-depth literature review, there is a danger in starting without any prior idea of what has already been done in the field.*

In common with all professionals who update their knowledge relevant to the role they perform I was already aware of research that had been carried out related to learning in clinical practice. My task, therefore, was to reconsider this knowledge and determine how to avoid pre-judging the experiences of the participants in the study. This issue is considered in more depth in chapter 3.

Many studies in nursing have considered the clinical learning environment (Fretwell 1982; Gott 1984; Ogier 1982; Orton 1981 and Pembrey 1980) these concentrated mainly on the influence of the ward sister on the learning environment. Studies which had examined the socialisation of students into nursing (Benner 1984; Campbell et al 1994; Melia 1987 and Smith 1992) were more useful in analysing how students learnt to nurse but did not necessarily address how the student could control this process. A significant finding by Melia (1987) was the importance of 'fitting in' - behaviour she described as

necessary for students to negotiate their way through training. Participants in this study demonstrated similar behaviour, which may indicate the strength of occupational socialisation despite the changes that have occurred in strategies for learning to nurse. Students in Melia's study had been following a more traditional 'apprenticeship' type programme, whereas participants in this study were following a Project 2000 style programme, taking the status of supernumerary students.

The UKCC (1986) introduced supernumerary status with the intention of changing status from that of employee to that of a student. This was to allow learning experiences to be educationally led rather than service driven. To facilitate this change Health Care Assistants (HCAs) were introduced, initially called support workers, to replace the loss to the workforce of employed students. Supernumerary status meant that students should not be counted in workforce numbers when in clinical practice. The early project 2000 style programmes included a period of 'rostered' service in the final year of the programme where student were counted in service numbers. This was intended to give them the opportunity to be a full member of the team, although the experience continued to be defined as 'educationally led' (UKCC 1986).

Studies had been commissioned by Professional and Statutory Bodies (PSBs) to evaluate Project 2000 style courses (Jowett et al 1994; Phillips et al 1994; Miller et al 1994; Eraut et al 1995), their focus was more on evaluating course structure and implementation processes than on the student's contribution to effective learning. Other academics were writing proliferatively about 'Project 2000' and its students (Elkan and Robinson 1993; Casey 1996; Hislop et al 1996; Parker and Carlisle 1996; Le Var 1997a, Le Var 1997b; Macleod-Clark et al 1997; Neary 1997). Once again the focus was different to that of the proposed research. Issues arising from these studies and academic papers are considered in chapter 2.

Self-Directed Learning

The concept of self-directed learning underpins this research. Wilcox (1996:165) defines self-directed learning as:

> *... a process of learning in which learners function autonomously, taking responsibility for planning, initiating and evaluating their own learning efforts.*

Student nurses are adult learners and as such adopt approaches to learning similar to those described in Knowles (1984) in his andragogical theory. Experience gained from teaching nurses suggests that they value the past experience that they bring to nursing, using this to make sense of new situations and transferring skills learnt previously to their new role. Once they perceive that they are ready to learn they can set and achieve their own learning goals, but to do this they tend to require immediacy of application.

The potential to be self-directed was therefore evident. However exposure to new, and sometimes frightening, learning experiences may inhibit students from achieving this potential. The fear of 'doing wrong' is very strong when dealing with patients. Students in this study often identified that they would 'stand back' and let others deal with situations rather than risk making a mistake themselves. This echoes advice from Florence Nightingale (1859) that nurses should first do the patient no harm.

The intention of this study was to discover how self-directedness could be facilitated in clinical practice, an environment over which I felt that university teachers had little control. The important concept of self-directedness in relation to the social context of learning to nurse is discussed in greater depth in chapter 2. Hislop et al (1996:173) discussed the assumption that students who were being exposed to new ideas and approaches would be able to effect change on existing practitioners identifying that for this to occur students would have to 'resist the inevitable pressures of occupational socialisation'.

Personal experience with the first cohort of students had led me to perceive that the need to 'fit in' was stronger than the need to apply theory learnt in the university to clinical practice. This perception needed to be explored to determine its significance and to consider how to enable students to be assertive with regard to their learning needs. D'A Slevin and Lavery (1991:376) suggested that teachers needed to be willing to take risks and allow students more responsibility for their own learning. The desire to facilitate self-directed learning in clinical practice might be considered unrealistic, as the risks are great. Thus an important aspect of the research was to determine how to manage the risks of self-directed learning in practice and propose appropriate strategies to curriculum developers.

Taking into account the argument by Nolan and Nolan (1997b:103), who found in their study that although students wanted to be involved and consulted they also wanted ground rules established, it was necessary to consider the issue of teacher support. Ryan (1993:56) identified that in providing such support the teacher was recognising that students who may have been independent learners in one situation were not necessarily able to be independent in another new and unfamiliar situation.

Experience as an HE teacher had taught me that many new undergraduates needed time to settle down and become familiar with student-centred educational approaches before becoming productive. I believed that they would probably take even longer to gain confidence in managing their own learning in clinical practice because of the fear of 'doing something wrong'. It was likely that they would perceive greater risks in learning in clinical practice and be more ready to unquestioningly 'do as they were told'. Rose (1997:40) identified that:

> *Ritual nursing actions, though not therapeutic in themselves, create an environment, and relationships, in which rational nursing activities can take place.*

Thus another aspect to consider in this research was how to use the ritualistic practice to which students would be exposed productively, to enable them to learn from it but at the same time question its knowledge base.

The traditions of nursing practice may be said to create a psychologically safe environment for practitioners, knowing that you are doing something the way others do it may help you to feel that you 'fit in'. New approaches to care delivery are not necessarily better, but need to be critically appraised. Parker (1997:5) identified the importance of critically appraising the strengths and limitations of new and traditional approaches to nursing knowledge, theory and practice, so that care delivered could incorporate the 'richness of a wide range of perspectives'.

Whilst it may be reasonable to expect that student nurses would carry out this critical appraisal, they needed to be supported in this activity. Without an appropriate knowledge [theory and practice] base they could only interpret new experiences from a personal point of view. Those who were new to nursing and had no previous experience would not know whether the practice they were learning was traditional or new, and thus had limited criteria on which to base their judgements.

To this extent the argument that students needed structure was supported. However my personal belief, that learning in clinical practice could quickly become student-centred and self-directed providing that appropriate support was given, remained.

The Research Questions

This study was designed to determine how undergraduate student nurses took control of their own learning in clinical practice. At its commencement it was anticipated that, in finding out how independent students were in managing

their own learning, it would be possible to develop the curriculum to maximise strategies that would assist them in gaining appropriate control. Pedley and Arber (1997:405) argued that research strategies in nurse education should enable the development of student-focused educational methods, which in turn needed to be evaluated to determine their effectiveness in preparing nurses. As preparation programmes for nursing are required to be fifty percent practice based this argument needed to be extended to learning strategies in the clinical environment.

The research questions were thus specifically defined as:

- **What strategies do students currently utilise in clinical practice to manage their learning?**
- **How effective are these strategies?**

and as a result

- **How could the curriculum be developed to enhance self-directed learning in the clinical environment?**

These questions reflected interest that had been aroused through previous research, personal experience of teaching in clinical practice in a variety of roles, and the response of the first cohort of nursing degree students. A qualitative approach was chosen, using focus groups, participant observation and reflective interviews to collect data, in order to answer the questions posed. The methodological approach is considered in greater depth in chapter 3, and findings of the study discussed in chapters 4, 5 and 6.

Conclusion

Strategies for self-directed learning in university settings may be considered to be relatively well established whereas this is not true of clinical practice. Colleagues and practitioners were unlikely to be persuaded by my high motivation alone, I was aware that they would need to be convinced of the value and validity of such an approach. The need to discover how students actually

managed their own learning in practice was paramount. The research was necessary to explore the personal beliefs that I had identified and answer the questions that had been formulated.

Whilst I could not carry out the study with an 'empty' mind I could ensure that I entered it with an 'open' mind (see Chapter 3: 57, 68-72, 84 and Chapter 4). The study that began as a personal interest and flourished through experience of delivering a nursing degree course developed into a major research project. The subsequent chapters tell the story of how the research 'came to life'. They describe how I entered the world of student nurses in clinical practice, analysed the behaviour observed and drew conclusions that would influence future nursing education programmes.

The final chapter explains how knowledge gained from this experience was used to facilitate a new cohort of students to achieve a degree of control over learning in clinical practice and how the preparation of their mentors was changed to improve the quality of support for students. At the time of writing this study this approach has been recently reviewed and a new programme, in line with the UKCC competencies (UKCC 2000a) and the ENB curriculum guidelines (ENB 2000) have been approved.

CHAPTER 2

LEARNING OPPORTUNITIES
The social context of the study

The past two decades have seen considerable change in nurse education, particularly with the move of pre-registration programmes into Higher Education (HE). This chapter explores how nursing education has developed, the changing context in which nursing is carried out, the specific context for the participants of this research and the approaches to teaching and learning used in their course. Finally consideration is given as to how these issues influenced development of the research study.

Traditional Nurse Education - a lived experience

My personal experience of nurse education started with nurse training in a district general hospital in the mid 1960's. This was a traditional apprenticeship style course, commencing with a 12 week Preliminary Training School, followed by long clinical placements interspersed with blocks of study. The latter related to acquiring medical knowledge such as anatomy and physiology, medicine, surgery, gynaecology, trauma and orthopaedics. The curriculum was typically disease led, learning the name of a condition, the underlying pathology, signs, symptoms and investigations, the medical treatment and, almost as an afterthought, the nursing care.

The course included invalid cookery, bandaging techniques, damp dusting and practical skills for nursing such as wound dressing, giving an enema and drug administration. The focus was entirely physical and dominated by medical theory. The course aimed at socialising nursing students into obedience to a medical hierarchy. We were taught to call doctors sir, to open doors for them and never to question their authority.

Skills for clinical practice were learnt through copying the behaviour of the qualified nurses and more senior students on wards, commonly known as 'sitting by Nellie'. Community input was limited to a day with a District Nurse and health education visits to a dairy and a sewage farm. There was a defined hierarchy to learning nursing skills, for example first year students were 'allowed' to make beds, wash patients, give pressure area care and under supervision administer injections and enemas. Second year skills included wound dressings, preparing patients for theatre and carrying out post-operative observations. Finally third year students were involved in the drug round. Technical skills were thus accorded a 'high status'.

Lawler (1991:31) identifies this traditional approach as progression from low status tasks to those of high status. The former is often described as 'basic nursing care', a term which most nurses will say they understand but appear to have difficulty defining. Melia (1987:136) identified, in her study of the occupational socialization of nurses, that students categorised 'real nursing' as that which had a medical or technical overlay. This is also identified in Schon's (1983) technical rationality model as described in chapter 1.

The strong medical influence over the nursing curriculum in the 1960's and 70's influenced the perspectives of traditionally trained nurses. This is a legacy which today's nurse educators are still contending with, as traditionally prepared practitioners are often the role models who 'socialize' current students. Bradshaw (1989:1) identified the inappropriateness of apprenticeship approaches to learning to nurse. He identified that student nurses, in traditional preparation courses, were not attached to particular named nurses but learn the craft of nursing from a variety of practitioners, including fellow students who may have had little more experience than themselves.

Development of Nurse Education

There have been many changes in the way that nurses are educated. Today the main focus is on a health based curriculum with a holistic approach to care recognising the patients physical, psychological, social and spiritual needs (UKCC 1986; UKCC 2000a). The philosophy of care in the 1990's identified the patient as a member of a wider community, with nursing care extending to family, friends and associates where relevant. The nurse's role was one of facilitator of health, carer in ill health and supporter when needs were changing and for developing coping abilities as a result of disease, disability and death.

In order to meet the changing demands of nursing care the approaches to educating nurses have changed frequently. The 1970's introduced a modular curriculum in order to match theory more closely to practice (Briggs 1972). In the 1980's an objectives approach was adopted to try to determine the specific knowledge and skills of a nurse (DoH 1979), and the 1990's saw integration with HE in order to change the status of the nurse from apprentice to student (UKCC 1986) recognising the professional status of nursing. Proposals for generic education for health care professionals have been made (Schofield 1996) and also suggestions that there are common caring skills that doctors and nurses share, and thus could be educated in together (Greenhalgh 1994). The end of the millennium saw a further development to competency-based outcomes (UKCC 2000a).

Many of the changes to nurse education that were implemented in Project 2000 style programmes (UKCC 1986) can be traced back to the preceding reviews of nursing and nurse education (Horder 1943; Wood 1945; Platt 1964 and Briggs 1972). Whilst the changes that were introduced following the UKCC's consultative paper (UKCC 1986) are generally attributed to the two major informing reports carried out for this consultation exercise (ENB 1985 and RCN 1985) their origins were clearly within the previous reports.

In particular the Briggs report (1972) proposed a Certificate course, of eighteen months in length, followed by an eighteen month Registration course. The former was to consist of generic knowledge and skills and the latter would develop specialist knowledge and skills. This proposal relates closely to the Common Foundation and Branch programme structure of Project 2000 style courses. Key issues arising from other reports that were finally introduced in Project 2000 were the separation of students from working obligations (Horder 1943), supernumerary status for students (Wood 1945, Platt 1964), financial independence of education from employment (Platt 1964) and third year contribution to service (Platt 1964). The latter was ultimately translated into rostered service for Project 2000, a specified period of time (20%) in the third year of the course when students 'counted' in ward staffing numbers, acting as full members of the nursing team. This was required to be educationally led although service driven (UKCC 1987).

The preceding reports all informed the work of the UKCC Educational Policy Advisory Committee (EPAC), which had delegated responsibility:

> *To determine the education and training required in preparation for the professional practice of nursing, midwifery and health visiting in relation to projected health care needs in the 1990's and beyond and to make recommendations (UKCC 1986:3).*

The EPAC set up a project group, covering the various professional specialisms and including general educationalists, which was representative of the four UK countries. This group carried out a wide-ranging review and consultation process, issuing six project papers. The key issues considered by the project group included:

- The learner status of students
- How many levels of nurse should there be?
- The future of Enrolled Nurses
- The boundaries of nursing education
- Future health care needs

The project group had determined that there was a need to separate students from workforce requirements, identifying that the apprenticeship model led to students being used to deliver care that potentially inhibited their access to learning opportunities. The final proposals stated that:

> *It is recognised that the preparation has a high practical content and that de facto the students will make a contribution to service. The UKCC believes that it is feasible for educationalists and service managers at a local level to so plan education and training programmes that recognition is given to this service contribution, provided that the programme is educationally determined (UKCC 1997:7).*

The change to student status was supported by the recommendation to develop a 'helper grade', subsequently developed as the Health Care Assistant (HCA). Concern was expressed at the inappropriate use of Enrolled nurses who received a shorter and more practically orientated preparation. The project team recommended that this level of preparation should be discontinued. Similarly it was considered that there was duplication of learning by having a general preparation followed by separate post-registration programmes for different professional specialisms. A common preparation was recommended to be followed by specific programmes for different specialties. The then current preparation programmes were considered to be too illness focused and the need to increase health promotion and disease prevention recognised.

Responses to the consultation report and an assessment of the financial implications were published as further project papers, with subsequent publication of the final proposals (UKCC 1987).

The significant changes agreed were therefore the situation of nursing and midwifery education within or associated with higher education; discontinuation of Enrolled nurse (level 2) preparation programmes; creation of a common foundation programme leading to four branches of nursing each with a period of rostered service in the final year and a change to a health focused curriculum. These changes responded to important demographic changes,

provided sustained emphasis on cost-effectiveness and value for money and reflected policy shifts towards community provision of health care and the increased importance being given to prevention of ill health.

New parts of the Register were opened for the Project 2000 style nurses, reflecting the four branch programmes and preparation programmes for second level part of the Register were discontinued. Programmes to facilitate conversion from level 2 to level 1 nursing were commenced for those Enrolled Nurses who had the desire and ability to convert. Funding was diverted through Regional NHS Executives to education providers, with a proportion of money being paid to service providers to support the development of HCAs and mentor preparation. Subsequently Purchasing Consortia were established following government policy changes (DoH 1989a and DoH 1989b) that became responsible for purchasing both pre-registration and continuing development programmes with their associated costs.

The UKCC's Education Commission reviewed the 'new' project 2000 style programmes in 1998 and their conclusions published in 1999. This review has endorsed many of the Project 2000 characteristics but refined others leading to further changes in nursing education (see chapter 7:207).

Changes in Nursing

Changes in the delivery of care have been as dynamic, if not more so, as those in nurse education. The National Health Service has experienced many reforms as successive governments try to deal with the issue of 'providing more for less'. Ranade (1994:28/29) identified four major areas of change in demography that have influenced health, illness and the delivery of care (Table 2:1). These trends suggest that there is a smaller number of the population available to be recruited into nursing, and a rising number of the population who will require health care. Whilst the demographic time bomb had been apparent for some while the

predicted drop in recruits to nursing did not immediately materialise. This was thought to be due to the effects of the 1990's recession (Ranade 1994:32).

Declining Fertility	35% reduction in the number of 18 year old in the period 1984-94
Ageing Work force	1985 statistics show 32 million in the 16-65 age group of whom only 26 million were economically active
More Women Working	By the end of the 20th century it was expected that 45% of the labour force would be women
Growing Elderly Population	A growth from 1.8 to 2.6 million of 80+ year olds is expected between the end of the 20th century and 2011

Table 2:1 : Demographic Trends Affecting Health Care (after Ranade 1994)

Evaluation of Project 2000 style courses (Le Var 1997a; Le Var 1997b) indicated that a significant number of mature entrants, 24-28% were commencing nursing courses in the period 1992-96. This provided a short-term solution to recruitment but potentially created a longer-term problem. It may be argued that mature entrants have less working years ahead of them; thus increasing the problem of an ageing workforce with low replacement numbers to take their place at retirement.

At the time of writing NHS Trusts and the independent sector are experiencing staffing shortages. This is being dealt with by actively recruiting overseas nurses. Such a solution can only be short term. There is a limit to how many nurses can be taken from other countries without depleting that country's workforce, and it is reasonable to expect that overseas nurses may wish to return home or travel

further after a few years in the UK. The current Labour government has initiated a second recruitment campaign to attract new nurses and also returning nurses. However the supply may not meet the demand.

One of the arguments for Project 2000 style courses was that they would reduce wastage. A Project carried out by the Glasgow Royal Infirmary in 1956 (Scott-Wright 1961) provided evidence for this assumption. In the Glasgow project students were supernumerary, nurse education was financially separated from the hospital, the curriculum closely related theory and practice and tutors supervised students in clinical practice. The course was two years in length, demonstrating that nurses could be prepared in a shorter time period. The project demonstrated lower attrition rates than traditional nurse preparation courses. Le Var (1997b:269) identified that wastage from Project 2000 courses had averaged at 13%, well below the target set of 19%.

The period since the introduction of Project 2000 has also seen changes in the skill mix of qualified to unqualified nurses. As previously identified one of the recommendations of Project 2000 (UKCC 1986) was the introduction of Health Care Assistants (HCAs). These were intended to address the issue of the loss of students from the work force numbers and a growth in the number of HCA's resulted in skill mix changes.

Changes in the management of health care delivery, particularly following the Conservative government papers *Caring for People* (DoH 1989a) and *Working for Patients* (DoH 1989b), led to the creation of 'purchasers' and 'providers' in health care further increasing skill mix changes. This was possibly due to the fact that HCA's were 'cheaper' than RN's. Chief Executives of the then self-governing NHS Trusts were constantly required to deliver 'more for less', with the staffing budget rapidly eating into funds available. Ranade (1994:32) identified that in 1990-91 there were 15,400 RN's to 137,400 HCA's, representing a 5.2% reduction

in qualified staff and a 17% rise in unqualified staff. Although the Labour government upon their election attempted to remove the competitive nature of internal market policies and develop a 'modern dependable NHS' (DoH 1997) considerable workforce issues have remained.

Bradshaw (1995:976) suggested that the clinical grading structure introduced in 1988 influenced job insecurity, with Chief Executives of NHS Trusts being advised by the government to set up local pay bargaining. Qualified nurses are an expensive luxury. Whilst it may be considered that quality is worth paying for, when there is a limited budget the natural response is to select a cheaper 'version' of the goods required. Only time, and research, will tell whether the risk was worth taking. Ranade (1997:129) suggested that the rewards for nurses were inadequate. She identified that factors such as poor pay, lack of power, lack of career prospects, short-term contracts, increased use of bank nurses and cutbacks had resulted in low morale.

Economic cost has a significant effect on the delivery of health care. In particular the rising number of elderly to be cared for has tremendous implications. Ranade (1994:29) quotes the annual cost of caring (hospital and community services only) in 1988 as averaging £1087 per person in the 65-74 age group and £1995 for the 85+ age group compared to a cost of £85 for the 16-64 age group. It is, therefore, unrealistic to expect the trends in skill mix to be reversed, indeed the Community Care Act (DoH 1990) transferred responsibility for some health care to social services. Hence many elderly found themselves being means tested and having to pay for care delivered by social service carers, or having to be cared for by their own family instead of accessing health or social carers. The current debate on how care for the elderly is funded in England, aggravated by the decision published in Scotland (SEHD 1999) to fund all care for the elderly, continues to highlight differences in the delivery of care.

The initial changes in care delivery may be accounted for by the proposals made in the two major Conservative government papers. *Caring for People* (DoH 1989a) stated the following main objectives:

- Services which allow people to remain in their own homes whenever possible
- High priority to supporting carers
- Quality care to be based on needs assessment and good case management
- To promote a 'mixed economy' of welfare
- To clarify responsibility
- Better value for money

Working for Patients (DoH 1989b) had the following main aims and key features:

Main Aims

- Extending patient choice
- Devolving responsibility
- Securing better value for money

Key Features

- Devolution
- Management changes
- Money following the patient
- Self-governing Trusts
- GP fundholding
- Creation of a Purchaser-provider split
- Medical Audit

The radical changes in managing health care that resulted from these two papers resulted in nurses constantly being involved in managing change. This created a demand for a new type of practitioner to be prepared through nursing education programmes. The major problem for nurse educators was to prepare this different kind of practitioner, who would have the knowledge and skills to cope with the dynamic state of health care delivery, and to do this whilst being aware

that the role models the students would meet in practice held traditional beliefs and values.

In addition to all of these organisational and demographic changes there were also changes in illness patterns and medical care to be considered. Ranade (1994:37) stated:

> *... medical advance not only enhances clinical capability, it carries with it profound ethical, legal, social and economic implications.*

While significant advances in genetic screening make it possible to diagnose abnormalities in the unborn baby, with this comes the ethical dilemma of whether or not to abort the foetus. Advanced technology is expensive to utilise, patients are aware that CAT scans (computerised axial tomography) and MRI (magnetic resonance imaging) can aid diagnosis. These are costly investigations and their availability to all has been questioned. Newspapers frequently report emotive dilemmas, where NHS Trusts or GP fundholders have withheld investigations or treatment because the budget does not allow for it. However it may be argued that rationing of health care is not new, but instead more overt than in the past.

Personal experience, as a theatre sister, included contact with many patients who had spent long periods of time on the 'waiting list', a useful strategy for rationing care. Bradshaw (1995:975) suggested that rationing of care is an 'inevitable consequence' of health demand which has been managed through making patients wait for treatment, failing to supply treatment or charging for it.

Patterns of health and illness are also changing. The government consultative paper, *'Health of the Nation'* (DoH 1992), identified five key areas for health gain. These were:

- Coronary heart disease and stroke
- Cancer

- Mentally ill people
- HIV/AIDS and sexual health
- Accidents

These areas reflect illnesses that are endemic in westernised countries today, often brought about by stressful occupations and pressurised social lives. Changes in nursing and medical care are evident as new advances are made in diagnosis and treatment of such illnesses. Health has become a key focal area of the nursing curriculum, and the need to develop knowledge and skills in health promotion and disease prevention are vital.

It is against this background of constant change that nurse preparation programmes take place. The focus of preparing practitioners for the new millennium was to develop knowledge and skills for lifelong learning, the ability to manage change and to develop personal coping mechanisms.

The Nursing Degree Programme

Three Year Nursing Degrees

The past two decades have witnessed a significant growth in nursing degree courses. The ENB (1992) identified that in July 1988 the University Grants Committee presented a case, from the committee on studies allied to medicine, for an expansion in nursing degree courses. At this time the nursing degree courses in existence were typically 4 year degree courses and based in traditional universities. The growth in nursing degree courses corresponded to a growth in the number of Polytechnic Institutions of Higher Education, later to be known as the 'new' universities. The Polytechnic and Colleges Funding Council (PCFC) supported the growth of nursing degree courses but on the condition that they were three years in length. This argument was based on a variety of factors (Table 2:2).

- Increased throughput would be gained if courses were 3 years in length
- Practice based learning was now recognised as academic in nature
- Collaboration between HE and Colleges of Nursing & Midwifery had been strengthened.
- Success of the ENB Pilot Schemes as a precursor to Project 2000 style courses
- Increased recognition of modular structures and credit accumulation as a feature in degree courses
- Increased experience in joint validation of courses by HE and Professional Bodies
- Three year courses would increase cost effectiveness

Table 2:2 Factors Influencing the Growth of 3 Year Degree Courses (ENB 1992)

The Policy Committee of the ENB agreed to approve 3 year nursing and midwifery degree courses (ENB 1992) and between 1989-1992 ten institutions of HE either had courses approved or received approval in principle which is the first stage of the validation process. The first 3 year nursing degree course commenced in 1989, two nursing and one midwifery courses commenced in 1990, four nursing and one midwifery courses commenced in 1991, one nursing degree course commenced in 1992 and another received approval in principle.

The ENB in October 1991, having received a report from the ENB Specialist Committee, decided that no further approvals would be given and that only those already going through the approval process would proceed (ENB 1992). In January 1992 the ENB instituted an evaluation project to review 3 year degree programmes as compared to 4 year courses. The programme from which participants were drawn for this research was approved in 1990, and staff and students were willing participants in the ENB's evaluative study.

The first report from the evaluation project was received at the July 1992 meeting and identified the following key conclusions:

- Para 12.6 : Comments from external examiners indicate that the courses compare well with other honours degree courses
- Para 13.4 : Any misgivings that the very demanding course might lead to marginalisation of the practical components have so far proven unfounded
- Para 13.5 : Evidence supports that the three year courses provide a welcome and valuable addition to undergraduate programmes of study

The final recommendation was that when the current approval for existing courses expired, prior to the final outcomes of the research project, 'institutions should be supported in seeking re-approval or extensions of approval' (ENB 1992).

The preliminary findings of the research project were supported throughout the remainder of the study. An Interim report (ENB 1995a) identified the issues that had confronted teachers of nursing and midwifery 'in trying to satisfy the requirements of both higher education and their professional bodies' stating that they had been 'stretched to the utmost' (ENB 1995a:1). In particular the report contained comments on the need for negotiation with multiple stakeholders and the requirements to relocate healthcare intellectually with the related fields of medicine, health sciences and related professions in higher education.

The researchers concluded that (ENB 1995a:2):

> *Despite being caught up in multi-layered innovation over the past decade and - like other professional educators - being sent spinning from time to time by the many and complexly-related currents which criss-cross at different levels in their particular professional 'ocean', nursing and midwifery educators have successfully charted a course through unsettled and unpredictable waters.*

Recommendations arising from the research (ENB 1995a:5) identified the need to emphasise:

- organisational sensitivity to internal and external constraints
- communication to all levels in the system and at all key stages in the process of education
- the structuring of 'voices' to facilitate dialogue
- a clear link between dialogue, feedback, and resultant action, development and learning.

The research findings and recommendations were considered by the ENB in 1994, prior to publication of the interim report, and used by them to shape curriculum development. The Board also identified that all three and four year degree programmes had met the UKCC and EC requirements and lifted the moratorium on three year degree programmes (ENB 1994b)

Course Structure

The participants in this research were undertaking a three year Bachelor of Science (Honours) nursing degree course, from which they would graduate with both an academic and a professional qualification. It had a typical Project 2000 style structure (Fig 2:1).

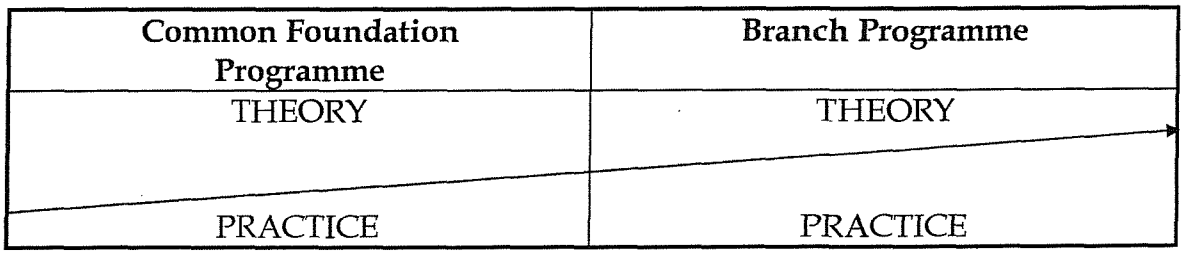


Figure 2:1 Project 2000 Course Structure

The two major component parts of the course, the Common Foundation Programme (CFP) and the Branch Programme were each 18 months in length. There were two Branch Programmes, one for adult and one for mental health nursing. Each major component of the course was divided into three semesters. Professional regulations (ENB 1993a) required that each of the CFP and Branch programmes were to have a minimum of 2,300 hours of student study.

The balance of theory to practice altered as students progressed through the course, overall there was 50% theory and 50% practice, with the CFP being two-thirds theory and one-third practice, and the Branch Programme being one-third theory and two-thirds practice. The structure of such programmes attracted much criticism and the Education Commission set up by the UKCC to review pre-registration programmes in its report (UKCC 1999) recommended that the CFP should in future be one year in length with the branch programme being extended to two years. The balance of theory to practice remained at 50% for each. Implementation of programmes with this revised structure commenced in September 2000.

It was also necessary to meet requirements agreed with the European Community (EC) regarding the nature of preparation of nurses, and the clinical placements experienced in the course (ENB 1993a). The UKCC rules related to the EC directive required students to have a minimum of 150 hours experience in each of community, maternity, paediatrics and mental health, and 300 hours each in a variety of adult nursing specialities. This rule has subsequently been changed to remove the requirement for specific hours (UKCC 2000b) in response to increased student numbers resulting in practical difficulties for education institutions meeting the requirements. However the requirement for the types of experiences as identified in the EC directive has remained and the defined outcomes have to be met.

The course was therefore organised to provide the opportunities for students to meet the short EC placements in the CFP and the longer ones in the Branch Programme. Students were divided into 5 groups in the CFP and 3 groups in the Branch Programme to avoid 'flooding' clinical areas with too many students. They undertook the same placements but in a different order (Figs 2:2 & 2:3).

Semester 1		Semester 2		Semester 3
Maternity	Paediatric	Adult	Mental Health	Community
Paediatric	Adult	Mental Health	Community	Maternity
Adult	Mental Health	Community	Maternity	Paediatric
Mental Health	Community	Maternity	Paediatric	Adult
Community	Maternity	Paediatric	Adult	Mental Health

Figure 2:2 CFP Clinical Placements

Semester 4	Semester 5	Semester 6
Accident Department	Medical/Coronary Care/Intensive Care	Elderly Care
Trauma Ward	Surgery/Operating Theatre	Oncology/Palliative Care
Community	Community	Community

Figure 2:3 Branch Placements

Semesters were equal in length in the CFP (20 weeks each), but variable in the Branch Programme (being 24:34:20 weeks respectively). This was to allow students a longer period of time in semester 5 when they were expected to carry out a research project. The planned course exceeded the minimum number of hours required by the regulatory body, being a total of 5,175 hours as opposed to the minimum of 4,600 hours. The branch programme was longer than the CFP, but both components met and exceeded the minimum requirements of the regulatory body.

The course had five major themes (Table 2:3).

THEME 1 **Biological Sciences**	1a. Physiology (with anatomy) 1b. Pathology 1c. Pharmacology 1d. Microbiology
THEME 2 **Behavioural And Social Sciences**	2a. Individual Development 2b. The individual as a group member 2c. The individual in society
THEME 3 **Professional Studies**	3a. Nursing Ethics 3b. Legal Issues 3c. Strategies for study, enquiry and research
THEME 4 **Nursing Theories And Process**	4a. Nursing Process 4b. Nursing Theories and Models
THEME 5 **Nursing Practice**	5a. Communication and Interpersonal Skills 5b. Technical Nursing Skills 5c. Nursing Practice Placements

Table 2:3 Themes of the Nursing Degree

Student experience

Students studied a longer academic year than is the norm in HE. Each week of the course counted as 37.5 learning hours and students studied for 46 weeks each year. This was necessary firstly to meet all the requirements of the professional regulations (ENB 1993a), secondly to ensure sufficient theory time to develop the academic craftsmanship expected of undergraduates, and finally for the pragmatic reason of enabling students to obtain an extended year's grant from their Local Education Authority (LEA).

Undergraduate nursing students, as other HE students, were funded at that time through a means tested grant system. Whereas Diploma nursing students were funded, via the Department of Health NHS Executive, through a non-means

tested bursary that was significantly higher than an educational grant. In consideration of the need to meet the hours required by the regulatory body, which reduced the opportunity for students to work in the holiday periods to supplement their grant, the course team ensured that students met the LEA criteria for an extended grant.

The student experience of the course was of alternating theory and practice experiences. During the CFP the clinical placements, each of 4 weeks duration, were spread throughout the 18 months. This meant that students varied from intensive theoretical study, with access to academic support and resources, to intensive clinical work where support was variable and there was little time to use academic resources such as the library. The nature of the clinical placements was that they were very different, making if difficult for students to transfer learning from one area to another. As the length of the placement was short students typically commented that they were only just beginning to 'know' what they were doing when it was time to leave.

Branch placements were longer as the amount of theory input was reduced. In semester 4 students had a combined accident department/trauma ward/community experience of 12 weeks. This was divided into 6 weeks each in the accident department and trauma ward. One week from each of these placements was spent in relevant community experience, working with the ambulance service from the accident department experience, and in a home for long term disabled people from the trauma ward.

Semester 5 had two placements of 8 weeks each in medical and surgical wards. One week of each of these placements was spent in relevant speciality experience, in either the intensive or coronary care unit from the medical ward and in the operating theatre from the surgical ward. There were two

experiences, each of four weeks in length, in the community where students took a small caseload of patients under the supervision of a District Nursing Sister.

Semester 6 had two placements, each of eight weeks in length, one in care of the elderly and the other in oncology or palliative care. Two weeks from each of these placements were spent in community settings, with the Health Visitor focusing on elderly assessment, and in a home for young chronic sick when in oncology or palliative care.

Concern over falling theoretical hours as the course proceeded, related to increasing academic demand led the course team to consider how best to support students in meeting the academic requirements of the course. Firstly the balance of the themes taught was varied throughout the course. Themes (see page 36) 1 and 2, which were largely foundation knowledge for nursing, were mainly taught in the CFP. Theme 3 remained fairly constant, whereas themes 4 and 5 increased in capacity throughout the branch programme, in recognition of the student's need to have clinical practice in order to make sense of the theory taught.

Secondly a decision was made to bring students back to the university for one 'practice focused' study day a week during clinical placements. These days used reflective learning strategies to integrate theory and practice. Finally during semester 5, when students were undertaking their research project, study days from clinical placement were made optional. This was to allow for research supervision when relevant, but also to allow students to manage their own learning in undertaking this project.

Student Support

Students were supported by a variety of people throughout their course. The two key roles in student support were those of the Personal Tutor and the

Mentor. The Personal Tutor was a member of the academic staff who related to the student throughout the whole of their course. The original student handbook (Bournemouth University 1990) identified that this tutor would:

- be a nurse who is also a member or honorary member of the Polytechnic teaching staff
- endeavour to cultivate a relationship of trust and mutual respect
- act as a resource person for both academic and practical aspects of the course
- offer one to one or group tutorial seminars on a particular subject relative to the course
- take part in the marking of assignments as appropriate
- visit the student during practice placements to nurture the mentor/student relationship. to assist in ensuring a clinical climate conducive to learning and to perform pre and post conferencing

At the time that the handbook was written the university nursing team was small in number, and relied on support from colleagues from the local College of Nursing and Midwifery in order to meet course requirements of teaching and student support. By the time this research was carried out the College had merged into the university, vastly increasing the size of the nursing team. One of the effects of this merger had been a rationalisation of roles. All nursing and midwifery teachers had taken on a role as a Link Tutor, a teacher with specific responsibility to support staff and students in particular clinical areas. Thus an additional support person was provided for students when in clinical practice, reducing the need for the Personal Tutor to take on this element of support.

The mentor was described in the original handbook as a 'wise and reliable advisor'. This person was a qualified practitioner who had responsibility for the student for the duration of a practice placement. Therefore many different mentors supervised students in practice as they made their way through the programme of clinical placements. Whilst ideally the course team would have liked students to be able to choose their own mentors this was not a practical option. The number of practitioners in each clinical area who met the criteria

identified for a mentor was small, and the short placement time limited the opportunity for students to get to know staff in order to make an informed choice.

The original requirements state that the mentor would:

- be a registered nurse who is working within and experienced in the clinical area of practice
- have completed a course of teaching and learning in the clinical area, i.e. ENB 998 or the Mentor Training Course
- be motivated to continue life-long education
- be aware of the nature of the students and the course aims and objectives
- help the student use the 'log book' study guide to collect and understand data collected in preparation for problem based learning days
- demonstrate and supervise the psychomotor skills pertinent to the clinical placement
- act as a professional role model by carrying out nursing care skilfully, competently and efficiently having the patient/client as the centre of the process of nursing
- use the practice profile to formatively and summatively assess the student
- encourage the student to self-assess and become 'reflective' in her performance
- maintain an effective relationship with the student which is based on mutual trust and respect

In respect of supernumerary status of degree students the course team proposed that students should work the same 'duty hours' as their mentor. This was to ensure maximum contact between them and also to enable students to gain a realistic view of practice by working 'normal' shift patterns. Inevitably the theoretical ideal did not translate into practice, sometimes because students did not want to work the shifts their mentor was working, and sometimes because the mentor disappeared on to night duty or annual leave. This support process has now been reviewed and is discussed more fully in chapter 7.

Teaching and Learning Strategies

Students were exposed to a variety of teaching and learning strategies throughout the course. In academic study these included teacher centred strategies such as lectures, teacher led discussions and supervised practical work in biological and the clinical skills laboratories. Student centred strategies such as problem based learning days, reflective discussions and student led seminars were more evident in the remaining themes of the course. The focus of all strategies was on the integration of theory with practice and in all themes there was an emphasis on experiential learning.

The more traditional themes of the course, biological, behavioural and social sciences were integrated through 'link seminars' in which students were encouraged to view a particular issue from each of the scientific perspectives and integrate them in a nursing care approach. An example of this is 'stress', one of the earliest topics in the programme. Students would study the biological basis of stress and stress response, collect evidence on their own stress by recording their pulse rate and describing their feelings and coping mechanisms in relation to particular activities over several days. Ultimately they would lead a seminar on stress and relate the findings of their personal study to how to care holistically for patients who might experience stress as a result of illness, hospitalisation or treatment.

Case studies were used in the theme of professional studies, allowing students to learn from 'real' incidents. Clinical experiences were used in learning nursing theories. Students would be encouraged to collect evidence when in a placement, such as assessing a patient's needs and problems, and use this information as a basis for exploring nursing theories and models when back in the university. Occasionally team teaching, by adult and mental health teachers, allowed for shared professional learning between students from different branches of

nursing. This enabled them to view issues from different perspectives and gain an understanding of the roles of nurses in other specialities.

The most difficult area for which to define teaching and learning strategies was that of clinical practice. Learning in practice is largely opportunistic, whilst a student may be expected to have certain experiences in a clinical area these cannot be accurately predicted. Learning is mainly from role models, these may be either good or bad. Earnshaw (1995) identified that both can influence the student's behaviour and attitudes. In his study on student's views of mentorship he found that although students may have a designated mentor they actually regarded all members of the nursing team as fulfilling aspects of mentorship role, rather than just one person doing this. Campbell et al (1994) in their study on student socialization into nursing found that the role of the teacher (Instructor) in clinical practice was significant. They identified that 1st and 2nd year students, from a 4 year baccalaureate programme, often felt unsupported and undervalued by practitioners. The effective teacher was able to function at various levels in different situations, providing a positive role model for the students. Students tended to avoid teachers who were regarded as poor role models. They quickly assessed who the good role models were and tended to access these people even if the person was not their designated mentor.

Academic strategies were used to integrate theory and practice to some extent. Problem-based learning days, which took place for one day of each week of CFP placement, had a defined topic for each of the 20 weeks (Appendix 3). These days were based upon Steinaker and Bell's (1979) experiential model of learning; encompassing the five phases of exposure, participation, identification, internalisation and dissemination. Students were guided to collect information in practice and to read around the defined topic which would then become the focus of the study day, which culminated in them leaving with an action plan to meet their defined learning needs, identified as a result of personal reflection

and peer discussion. These days were perhaps not as successful as they could have been in the early years of the course, due mainly to the inexperience of teachers in facilitating reflective learning. Students appeared to have difficulty in managing their own learning and were constantly seeking guidance from teachers.

This in itself may have been a reflection of the learning strategies to which they were being socialised in clinical practice. Taking into account the fact that their role models were largely traditionally prepared, and therefore more used to teacher-centred teaching and learning strategies, it is reasonable to conclude that students were experiencing some conflict in the approaches taken by their teachers in practice to that taken by their teachers in the university.

Palmer et al (1994:10) identified reflection as an appropriate tool to facilitate learning from practice. They acknowledged that the focus of professional education was that of developing competence, but stated:

> *Central to competence is the need to prepare practitioners who are capable of responding to and learning from unique situations in practice and who are able to develop further their professional expertise.*
>
> *Palmer et al (1994:11)*

It may be argued that reflection in and on action is an effective strategy for self-directed learning, facilitating the ability to learn how to learn. The course team believed that if students were able to develop self-directed learning abilities in the CFP, through developing reflective learning skills, they would be better able to manage their own learning in the branch programme, when theoretical input was significantly reduced.

Consequently, as well as problem based learning days, students were also asked to compile a log book which contained guided reflections, reports relating to the topics studied on problem based learning days and their personal action plans. The stated purpose of this log book was:

> *For reflection on the quality and quantity of nursing care you have been involved in, in order to assess and evaluate your own performance, increase problem-solving skills; foster an attitude of enquiry, self-awareness, self-reliance, self-confidence, responsibility and autonomy.*

Students also had reflective discussions with their peers, as part of the problem-based learning day, facilitated by a teacher with expertise in the related clinical experience that they were currently undertaking.

Once again there was a gap between the ideal and the real as the university did not have teachers with all of the relevant expertise. As an example it was necessary for me to facilitate reflection for students undertaking the paediatric placement, personal expertise having been mainly gained experientially through being the mother of two children! However as, at that time, the university did not employ a paediatric teacher, this was a case of necessity dictating action. My own self-directed learning skills were challenged in that I had to rapidly learn elements of paediatric nursing. In part this was achieved by becoming the link tutor to three paediatric wards, allowing some practical experience to support an expanding theoretical knowledge. I was reassured by the knowledge that the students were, after all, studying to become adult nurses not paediatric ones. Their experience in this area was specifically to meet EC directives, and was intended to give them an insight into paediatric nursing not to develop expertise in these areas of care.

Through reflection students were able to resolve 'problem issues', discussing with their peers their own response to a particular situation and exploring alternatives. They were also able to identify transferable skills and knowledge that they could take forward with them to future placements. These sessions had a variable success rate, when an appropriate teacher was available to facilitate them student evaluations indicated that they were valuable sessions. However at other times when expert teachers were scarce students found the sessions unhelpful.

A particular reflective strategy utilised in the branch programme was developed from pre- and post-conferencing as described by Iwasiw & Sleightholm-Cairns (1990), which followed the experiential learning cycle described by Kolb & Fry (1975). This involved the teacher, either university or practice teacher [mentor], in having a short discussion with the student at the beginning of a shift of duty to identify potential learning opportunities and action to be taken by the student to access these.

The student then carried out normal nursing duties *(concrete experience)* for the remainder of the shift. Towards the end of the shift the student and teacher met for a reflective discussion. This involved the student in looking back on the experience *(reflective observation)*, and relating this to previous knowledge or deducting knowledge from practice *(abstract conceptualisation)*, in order to identify future learning needs and plan action to meet these *(active experimentation)*.

Once again student evaluations identified that when appropriate teachers were available to facilitate the process it was successful, but when carried out by teachers [mentors] who did not themselves understand experiential learning the strategy was doomed to failure.

It is against this background of experimentation by teachers, in teaching and learning strategies with which they were inexperienced, that the idea for this research was generated. As identified in chapter 1 the development of the nursing degree programme had mainly been focused upon the academic component of the course to meet requirements of validation, and the need to justify teaching and learning strategies for this event. Learning in clinical practice, whilst vital to demonstrate the acquisition of competence for the professional qualification, was perceived to be of less value at academic

validation. This was possibly because it belongs to what Schon (1983) calls the swampy lowlands, being messy but important.

Preparing for the Research Project

The research project was developed as a result of personal interest, personal experience as the nursing degree course leader, academic responsibility to encompass the changing world of nursing and nurse education and a belief that nursing is best learnt in practice not in the classroom. Whilst the latter is fundamental in developing nursing knowledge and academic craftsmanship, it does not 'come to life' until integrated with the experience of caring.

Having identified a personal philosophy I needed to explore this through entering the world of nursing students. Research methodology should be guided by the nature of the research questions. An ethnographic approach was selected which would allow me to experience this world. The issues of the methodological approach are considered in depth in chapter 3. Personal views held of learning to nurse had largely been gained in the role of a teacher, it was therefore necessary to gain experience, which would enable understanding of this experience from the perspective of a student nurse. This was achieved initially through undertaking a preliminary stage to the study using focus groups, one of CFP students and one of Branch students. The results of this preliminary study are discussed in chapter 4.

Finally, in preparation for undertaking the research, I needed to address my confidence as a practitioner, in order to be an effective participant observer. My concern was to not be distracted from 'observing' the participants by my own fears of 'doing something wrong'. I negotiated practice experience for myself, on a surgical ward where I felt confident in my own knowledge and skills, under the supervision of a qualified nurse. This enabled me to experience 'being a student'.

Whilst professionally up to date through reading and discussion I had not practiced in an adult surgical area for four years. I discovered that although nursing practice had changed little the equipment with which it was carried out had changed considerably. This resulted in a realistic 'student' experience as I discovered that things I thought I knew were no longer valid, and had to seek help from my supervisor in order to carry out delegated care. An abstract from my reflective journal after my first day in practice states:

> *By the end of the shift I really knew what it was like to be supernumerary - frustrating. I asked as many questions as I felt I could but was conscious that the staff were busy and I didn't want to be a burden.*

This experience subsequently proved to be useful in understanding the actions of students. I observed them behaving in the same way as I had, searching drawers and cupboards for information rather than troubling the busy staff.

Clinical experience achieved the main objective of developing personal confidence to behave as a practitioner, enabling me to take on the participant role that was necessary for the research. This, combined with knowledge gained from the preliminary focus group study, enabled design of the main study in such a way as to be able to address the research questions posed.

CHAPTER 3

CRITICAL CONVERSATIONS
The methodological approach

The choice of research method is probably one of the most significant decisions a researcher makes. Selection of an appropriate strategy, that will enable collection of relevant data to answer the research questions posed, is vital to the ultimate quality of the research carried out. Data for the questions posed for this research (chapter 1) could have been collected by a number of methods such as survey, interviews, focus groups, observation, biographical analysis, action research, case study or a combination of methods.

An ethnographic approach was selected as being the most appropriate to answer the questions posed. In this instance ethnography is defined broadly as an approach which involves entering the culture, participant observation, interviewing participants, writing field notes, collecting other biographical and environmental data, analysing data and writing a convincing account of undergraduate nursing student's experiences. These steps, and ethnography as an approach, are discussed in this chapter.

Ethnography

Ethnography is generally recognised as having its roots in cultural anthropology (Berg 1989, Gilbert 1993, Morse 1994, Hammersley and Atkinson 1995, Holloway and Wheeler 1996, Mason 1996, Silverman 1997, Streubert and Carpenter 1999). There are many definitions of the term, either as a generalised approach or as specific method (Field and Morse 1985, Morse 1994, Hammersley and Atkinson 1995, Holloway 1997, Streubert and Carpenter 1999). Whilst these definitions vary, mainly in their level of specificity, there does appear to be reasonable consensus as to the characteristics of ethnography.

Hammersley and Atkinson (1995:1) provide a typical description stating that ethnography:

> *... involves the ethnographer participating, overtly or covertly, in peoples lives for an extended period of time, watching what happens, listening to what is said, asking questions - in fact collecting whatever data are available to throw light on the issues that are the focus of the research*

The significance of the researcher entering the culture to be studied is clearly recognised by research theorists (Morse 1994, Hammersley and Atkinson 1995, Parahoo 1997, Silverman 1997). Historically anthropologists lived in the culture they were studying in order to understand it. However current ethnographers do not always totally enter the culture. Baszanger and Dodier (1997:8) state that a critical reassessment of ethnography has resulted in new definitions that 'reassert the value of fieldwork'. They suggest that recent definitions focus more on the relationships between forms of actions rather than identifying the culture as a whole.

This, perhaps, typifies the ethnographic approach in health care. Holloway and Wheeler (1996:83) identify that ethnography in nursing is different from that in anthropology in that researchers spend only the working part of their day with the participants. Their private lives remain separate and they live away from the site of the phenomenon that they are studying. This definition recognises that both researchers and participants have many social roles in their lives. The contact that occurs in research is likely to be only one aspect of their lives, although experiences that occur in other roles may shape the behaviour of the role observed in ethnography.

Originally anthropologists studied cultures that were new to them, however today it is acceptable for ethnographers to study a culture they are already familiar with. This brings with it a challenge to treat the culture as 'anthropologically strange', to view it through 'new eyes' rather than impose previous assumptions upon it. This in turn requires some form of preparation for

the ethnographer to raise self-awareness of the assumptions they hold and take action to distance these from the participant observation they carry out.

Ethnography has been redefined as it has developed methodologically. The impetus for this appears to have arisen from the different philosophical stances of positive and naturalist approaches to research. Whereas these may once have been perceived as opposing stances it is now possible to perceive them as ends of a continuum, with ground for overlap in the middle of the continuum. Hammersley (1992:11) suggests that:

> *The rationale for ethnography is based on a critique of quantitative, notably survey and experimental, research.*

In advocating a qualitative approach he goes on to assert that participant observation in natural settings is vital in discovering the social world. Lipson (1989:73) suggests that when taking an ethnographic approach the researcher becomes the prime data collection tool, using strategies such as participant observation and interviewing. She identifies the importance of recognising the impact the researcher has made on the research.

This is quite different from the positivist stance where all attempts are made to remove researcher influence on the data collected. Hammersley and Atkinson (1995:15) question the ability of the qualitative researcher to hold neutral values, arguing that the researcher must be aware of their value commitments, and adopt a reflexive approach to research which recognises and interrogates these. They also identify that in carrying out participant observation the researcher selectively observes the phenomenon, thus the end product is influenced by what the researcher sees or is aware of seeing.

Parahoo (1997:151), on the other hand, suggests that the purpose of participant observation is to gain a holistic view of the participant's behaviour. He feels that this may be achieved through the researcher sharing the experience with the

participant. Conclusions drawn from personal reflection of experience gained in this study suggest that the researcher's perceptions provide an additional dimension for thematic analysis. However this does not necessarily mean that participant observation is the most effective method. Preconceptions and affective response to situations may 'blind' the researcher to some aspects of it. Reflective analysis may raise awareness of issues that are not readily apparent at the time. In this research engagement between the participants and myself, in reflective discussion, may be perceived as enhancing our ability to perceive the situation as a whole.

Boyle (1994:162-9) identifies four major characteristics of ethnography. Firstly she considers that it is holistic and contextual in nature. In order to achieve this data gathered through fieldwork is set within the wider theoretical framework and social context. Secondly she identifies the reflexive character of ethnography resulting from the fact that the researcher becomes part of the culture being studied, thus both affecting this culture and being affected by it.

Thirdly the use of emic and etic data is a typical characteristic. Holloway (1997:53). defines the emic perspective as the view of the insider or 'native', whereas etic is the view of the outsider, in this case the researcher. Dreher (1994:158) suggests that these definitions are often misused, and proposes a theory that emic is what people say they do, their espoused theories, and etic is what they are seen to do, their theories in use. Boyle's final category (1994:167) is the end product of ethnography. She questions whether this ethnography is merely descriptive of the findings, or whether it does in fact offer a cultural explanation. The latter can provide knowledge that is applicable to the culture as a vehicle for change. She concludes (1994:169):

> *The value of ethnography or even ethnographic methods in nursing or other health professions lies in the pragmatic outcomes for both theory and practice.*

This view demonstrates a reconstruction of ethnography. Initially it was perceived as a descriptive account of social worlds, today it is more acceptable to use ethnography in an applied manner. Thomas (1993:4) discusses the difference between conventional and critical ethnography as the purpose of the former being to describe a culture, and the purpose of the latter being to change it.

Whilst there was no intention to undertake critical ethnography it was expected that the findings would be useful in changing nurse education, within the locality, to make learning experiences more effective for students. The main purpose was to investigate how undergraduate students controlled their own learning in clinical practice; a secondary purpose was to influence curriculum development in order to enhance self-directed learning. Thus, the research had pragmatic outcomes for both theory and practice. The characteristics of ethnography are summarised as Table 3.1.

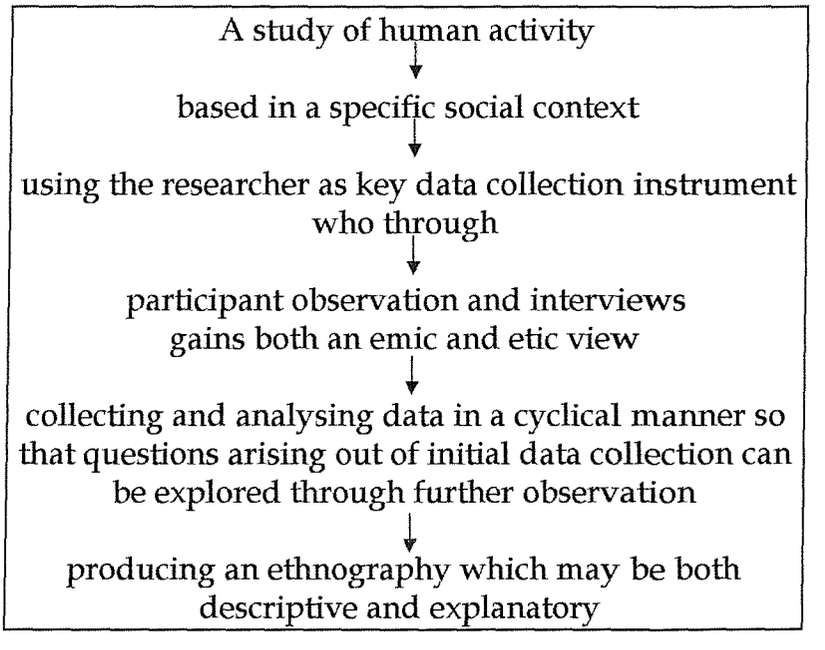


Table 3.1. : Characteristics of Ethnography

Parahoo (1997:152) discusses the limitations of ethnography, identifying four points (Table 3.2).

1. Immersion in the culture may prevent the researcher from being objective
2. It is not possible to be in all places at all times
3. The large amount of data gathered is laborious to analyse
4. There are ethical implications of collecting data when individuals are not aware of this

Table 3.2: Limitations of Ethnography (Parahoo 1997)

Possibly not being totally immersed in the culture, only having contact during the working day, does allow researchers to distance themselves from it. In this study the emotional involvement of being an active participant did at times interfere with the ability to see what was happening. On occasions during reflective interviews there was an awareness of both participant and researcher being sidetracked, following up issues of interest rather than those related to the purpose of the research. Critical reflection enabled us to clarify issues and become more objective about them.

In the broad context it was not possible to be with all students at all times throughout their clinical placements, due to the number of students, clashes with their duty times and work demands outside of the research. In specific observations participation was limited by the need to gain permission from 'gatekeepers', the student, patients and their visitors, nursing, medical and paramedical staff. Personal knowledge and competencies had a limiting effect in some areas, especially in mental health and maternity care. At other times the nature of the situation was such that despite permission and competence it was not appropriate to be present for ethical and moral reasons, such as during bereavement counselling.

The outcome of undertaking participant observation for a year was four large files of transcripts, bibliographic data and field notes, plus recordings of interviews. The amount of data collected was extensive and laborious to analyse. Experience gained from the focus group study was helpful in speeding this process. Ultimately a large amount of material was accumulated that was not relevant to this particular study, as a result of exploration of issues that were not related to the purpose of the study but were relevant to the actual experience of the day.

Finally ethical considerations were vital. Formal permission had been gained from official gatekeepers, however each observation required permission from those with whom there was immediate contact. This was easily negotiated with supervising nurses and doctors, but impossible to do for every point of contact. Permission from patients was sought through a group protocol. Initially the student would introduce me to the patients they were caring for as a researcher who was working with them, and explain what the research was concerned with. Patients were given the opportunity to ask questions about this and their part in it.

However patients and staff quickly forgot the research role due to my active participation in nursing care. Patients would accept me carrying out nursing activities and treat me as one of their carers, asking questions about their care and medical treatment, as they would do to any nurse caring for them. Staff would ask me to carry out nursing duties, taking my participant role at face value. This was particularly obvious when they were short staffed, nurses would delegate me to work in a bay of patients where the students was working. On a couple of occasions I was mistaken for an agency nurse by nurses or medical staff. When 'acting as' a nurse did not impede the nature of the research I would accede as such action supported my participant role, however if it interfered with collection of data related to the purpose of the study I would decline. Thus

data may have been accessed that if informed consent were sought would not have been available.

This raises issues related to the ethics of presence, the effect that researchers have when they take a participant role. On one occasion there was a dispute between a social carer and a doctor regarding a case of child abuse. The details of this cannot be included in the ethnography for confidential reasons. However it caused a considerable amount of personal conflict between the roles of researcher, nurse and mother. The result was several sleepless nights until the following week when the issue was satisfactorily resolved for all concerned. In this example I may have accessed data that would not normally have been available to me. It was evident during the incident that the doctor, social worker and others present 'forgot' that I was there in a research capacity. They appeared to perceive me as a nurse and a team member.

Research Design

The research was planned in two main stages, an initial stage using focus groups as preparation for entering the culture, and a subsequent stage of participant observation and reflective interviews. The first stage (June-July 1995) almost immediately preceded the second, leaving very little time for analysing data. Concurrently with the first stage personal experience was gained in clinical practice to refresh and regain confidence in clinical skills. This was to enable me to 'feel comfortable' in clinical practice so that I would not be distracted by personal anxieties once the second stage commenced.

The second stage, involving participant observation and reflective interviews, commenced in September 1995 for a period of one year. Planning how to work with students was complex as they were not all in practice at the same time. Clinical experience increased as they progressed through the programme. Priority was given to first year students who only had twelve weeks in practice

throughout the year. Second year students had twenty weeks in practice, and third year students forty weeks in practice.

Participant observation was planned in clusters of four weeks This allowed me to work with only one group of students at a time, rather than mixing first, second and third year students. (Appendix 4). This allowed familiarisation with typical experiences for each year group, and enhanced the ability to become part of their culture in that placement. Normally students would be spread throughout a variety of placements coming together on study days. The culture was therefore more one of sharing similar experiences rather than being together in one experience. This pattern allowed short breaks between observations to begin to transcribe interviews and carry out preliminary data analysis. Sources of data for the study were reflective interviews carried out at the end of each shift of duty, personal fieldnotes and biographical information collected from the environment.

Sample

Determining the sample for the study involved identifying a sampling framework (Mason 1996), the population available who could provide the information that would answer the research questions posed. Firstly it was necessary to identify relevant cultural experiences that would provide appropriate data. The key characteristic was the clinical experience being undertaken rather than the academic aspect of the programme.

The sample may be described as a purposive sample (Gilbert 1993, Robson 1993, Cohen and Manion 1994, Holloway and Wheeler 1996, Parahoo 1997). This is generally described as a sample where the researcher uses their judgement to select cases to be included on the basis of their relevance to the research question. In this instance the cases related to the clinical experiences available rather than to the representativeness of the individuals involved. The identified

need was to sample all of the clinical placements to which students were exposed during the course of the programme. It would have been impracticable to sample every placement area and therefore a decision was made to sample the types of experience available throughout the programme (as described in chapter 2).

Inequalities were recognised, such as not working in every placement area but instead sampling types of placement. It was not possible to work an equal number of occasions with every participant due to his or her placement pattern. Assumptions were made that the individuals experience was typical of their peers and therefore requirements for the purpose of the study were met.

The sampling framework for the second stage was therefore considered to be all of the students on three cohorts of the nursing degree course, with the exception of branch students following the mental health speciality. The first stage, using focus groups, required access to students who would have experienced these placements. The framework sample for this part of the study involved two cohorts of students, one nearing the end of the CFP and one nearing the end of the adult branch programme. The structure of placements in the CFP meant that there was a reasonable chance of students in the sample having had experience in each of the five areas of placement. Once again the branch group did not include students following the mental health speciality.

Individuals were not personally selected. The criteria for participation were that they were following the defined undergraduate nursing degree programme, were undertaking the planned clinical placements for this programme, were not undertaking the mental health speciality for the branch focus group or participant observation with second and third year students, and were willing to volunteer for either focus group participation or participant observation and interviews.

The sample was purposeful in that it was identified that there would be representatives of the CFP and adult branch for the focus group study, and representatives of first, second and third year students, with branch students following the adult programme, for the main study. The latter would cover, between them, all of the types of clinical placements in the programme.

Participants were not considered to be representative of the population from which they were drawn, as there were too many variable characteristics for this to be achieved. However they were considered appropriate 'cases' for research, as they would be undertaking the clinical experience required for students on the nursing degree. Previous experience, as nursing degree course leader, had enabled construction of a typical profile of an overall cohort of students (Table 3.3).

Characteristic	Description
Age	18-45 (mainly 18-25)
Gender	predominantly female (5-10% male)
Academic Level	Minimum 2 'A' Level @ A, B or C grade (minority of exceptional entrants)
Previous Nursing Experience	Majority have some care experience - paid or voluntary

Table 3.3: Typical Student Profile of Cohort of Nursing Degree

The sample of students obtained for the study demonstrated these typical characteristics and to this extent were representative of the whole population. Their age ranged from 18 to 43, with two males and twenty females. The majority met the minimum requirement of two 'A' levels at grades A, B or C. There was one exceptional entrant who had passed the UKCC's entrance test, one with a BTEC qualification and one with open university credits. Most had

previous experience as a Health Care Assistant (HCA), voluntary work experience in health care or work experience in health care from school or college.

All participants were asked to complete an individual learning styles questionnaire to see if they met the norm for nursing students of being either and activist or a reflector (as described in chapter 1). One student chose not to complete this questionnaire. Of the remaining twenty-one students, twenty were activists or reflectors or combined these with one other learning style; the remaining student was a theorist. The two predominant learning styles relate to concrete learners (Honey and Mumford 1986), learning best by doing and then reflecting on what they have done. These styles were appropriate to learning to nurse because of the applied nature of the programme.

The size of the sample was relatively small, which given the richness of the data generated is appropriate in qualitative research. Mason (1996:96) identifies that this is usually necessary for pragmatic reasons to do with costs, especially time and money. In this instance there was a defined time limit on data collection, and a personal limit related to how many students could be realistically worked with in clinical practice in the time available. The initial aim was to recruit five students for each focus group, and four students from each year of the degree course for participant observation. Ultimately four students volunteered for each focus group, five students each for the first and second years of the programme, and four third-year students for participant observation.

Participants were recruited by sending a letter to all students in the relevant cohorts explaining the research and asking for volunteers (Appendix 5). This was followed up by a short presentation to each cohort to explain the research further and answer any questions. Finally the students were reminded how to volunteer if they wished to participate. In both the written and verbal

presentations it was made clear that contribution was voluntary and that they had the right to withdraw at any time.

A personal concern was that students who volunteered might only be the extrovert, confident students, and thus it might not be possible to observe a variety of approaches to self-directed learning. This fear proved unfounded as in both the focus groups and main study there were participants who demonstrated shyness and lack of confidence. As our relationships developed throughout the research I was able to ask them why they had volunteered, typically the response was '*I/my friends thought it would be good for me*'. The driving concern for them seemed to be a personal concern at needing to take on the role of qualified nurse and therefore act with confidence in front of others. One student stated that she never saw a teacher on the ward and thought that volunteering to be in the research sample would be one way of getting some input to help her make sense of theory and practice.

In conclusion the sample obtained is not representative of the population from which they come in terms of specific student characteristics, but is representative of the population in terms of undergoing the defined clinical experiences of the course. The latter related appropriately to the purpose of the research enabling observation of relevant experiences in order to collect data. The sample was also typical of the overall student population for the course in terms of general characteristics. They were therefore deemed to be appropriate 'cases' for study to gain information that would answer the research questions posed. Streubert and Carpenter (1999:22) identify that:

> *Individuals are selected to participate in qualitative research based on their firsthand experience with a culture, social interaction or phenomenon of interest.*

The participants in this study were having first hand experience that was relevant to the topic of the research.

Ethical Considerations

Formal Consent

Prior to commencing the research formal permission was obtained to carry out the study. This was gained firstly from the Dean of the Institute of Health and Community Studies within the university responsible for the student's educational programme. Secondly permission was gained from the Directors of Nursing in each of the NHS Trusts in which students had clinical placements (4 General Trusts, 1 Mental Health Trust and 1 Community Trust). Finally, although the research was concerned with educational experiences, an approach was made to one of the two District Ethics Committees for approval.

The grey area related to the research was that although the topic was an educational one, and the participants were undergraduate students, there would be contact with patients because of carrying out observation in clinical practice. Conflicting advice was received from supervisors, managers and colleagues regarding the need to gain ethical committee approval. The ethics committee chosen was concerned with the Trusts where the majority of the participant observation would take place and was a 'test case'. It was decided that if they required formal consent then the other ethics committee would also be approached. The response from the first ethics committee was 'it is not necessary to submit your proposal to the ethics committee'. They advised that permission be gained from the Director of Nursing - this had already been obtained.

Formal consent allowed progress past the high level 'gatekeepers', but clinical staff who would be involved also needed to consent to my presence and participation. Hammersley (1992:147) states:

> *When (as is common) an ethnographer negotiates access to a setting via a gatekeeper who is at the top of an authority hierarchy within the setting, people lower down that hierarchy may feel pressure to cooperate lest they suffer sanctions from the gatekeeper.*

The NHS is renowned for its hierarchical structure. It was necessary to work through the hierarchy in order to pave the way for successful participant observation. This was achieved initially by negotiating time at unit meetings. These are meetings of Sisters and Senior clinical staff within a defined clinical area such as medicine, surgery, care of the elderly. At these meetings the planned research was presented and questions answered. Although personally time consuming this was a beneficial action as once participant observation was commenced the staff in charge of wards were aware of the research and the reasons for my presence to work shifts with students.

Informal Consent

Specific experience was accessed through the process of introducing myself and agreeing ground rules with clinical staff and the participant. These related to the role to be adopted in practice. Trust identity badges stated that I was a nurse researcher, and personal explanation clarified to staff and patients that I was there to 'work with' the student. I offered to be a 'pair of hands' providing that I was with the student, but clarified that I was not there to act as a teacher or a trained nurse as this would detract from the information I was trying to gather. I explained that staff, participants and patients all had the right to ask me to leave if they did not want me present at any time.

One factor that assisted in gaining entry was stating my belief that practice was where students really learnt nursing, and that the research was aimed at helping them to do this more effectively. Finally an explanation about the need to carry out a reflective interview at the end of the shift was given, and a time and place to do this was negotiated. This was within the shift if possible but at the end of the shift when the workload was high.

Role Conflict

I was aware that in entering the culture as a researcher I would take with me knowledge and skills gained through practising as a nurse and a teacher, and that at times I might experience role conflict. Selecting participant observation as a method meant using personal nursing skills to participate and it was necessary to define personal and professional boundaries with respect to this. The UKCC Code of Professional Conduct (UKCC 1992; Appendix 6), served as a guide, ensuring that the ethical principles, defined by Beauchamp and Childress (1994), of non-maleficence (doing no harm) and benificence (doing good) were met. A decision was made that if at any time a patient's life or well being was at risk by my not acting in the role of qualified nurse I would change roles. Equally if ever asked to undertake something in which I did not feel competent I would refuse, being both accountable and responsible as a registered nurse.

It was also necessary to consider the principles of autonomy and justice (Beauchamp and Childress 1994), ensuring that the rights of participants, patients and clinical staff to withdraw for all or any part of the observation were respected. There was potential conflict with being a teacher to take into consideration. Whilst the intention was to take a 'back seat', observing how students learnt from other practitioners or for themselves, I was aware that at times I might be the 'expert' in a particular situation and had to decide whether to keep my knowledge to myself or to act as a teacher and guide others. These issues are explored further in chapters 4, 5 and 6.

Koch (1994:980) identifies similar role tensions, particularly in relation to observing poor standard nursing care. She describes conflicts in the decision-making process, regarding 'whistle blowing', identifying her ultimate decision to keep quiet in order not to contaminate her research. As a result of her experience she recommends researchers to plan ahead regarding their behaviour in predictable situations, advice which was personally very helpful. At times in

this research I similarly chose to keep quiet; at other's I consciously changed roles, but only after careful consideration of the consequences. The Code of Conduct, and adhering to the principle of justice, helped the decision making process in these instances.

Validity and Reliability

Holloway and Wheeler (1996) argue against using the terms validity and reliability, as these are normally related to quantitative research and have a specific meaning in that context. Instead they suggest using the term trustworthiness, (as identified by Guba and Lincoln 1985), which relates more appropriately to 'when the findings of a qualitative study resemble reality'. Other alternatives are the terms credibility, transferability, dependability and confirmability (Guba and Lincoln 1985 & 1989, Koch 1994).

Credibility may be deemed to refer to the internal validity of the research where the participants recognise the truth of the researcher's findings. Transferability corresponds to external validity, where readers recognise the truth of the research in relation to social contexts known to them. Holloway (1997:160) suggests that this arises from thick description included in accounts of qualitative research. This allows the reader to form their own judgements and compare them to the conclusions of the researcher.

Dependability may be said to equate to reliability. Many methodologists stress the importance of laying an audit trail. In particular Streubert and Carpenter (1995:265) suggest that this is one way in which qualitative research may be replicated. They consider that other researchers would be able to undertake research in similar settings, using similar strategies, and thus obtain similar results.

This conclusion could be argued with on the basis that the environment of clinical practice is so dynamic. The combination of staff, patients and clinical situations exists only at that moment in time. However it is reasonable to suggest that other nurse practitioners, students and educators may read this research and 'recognise' situations as similar to their own experience. Their personal judgements, on the 'fitness' of conclusions in this research, is what will make it reliable. The audit trail maintained for this research enables others to follow the decision trail and draw their own conclusions.

Koch (1994:977) argues the importance of keeping an audit trail, an account of how the researcher has gathered and interpreted data and made decisions with regard to this. She suggests that:

> *One way of increasing self-awareness is to keep a journal in which the content and the process of interactions are noted, including reactions to various events.*

Throughout this study a reflective journal was maintained which provided such an account, as well as paper copies of all transcribed interviews, the process of analysis and the original tapes. Where relevant comments from the reflective journal are used to enable the reader to follow the decision trail throughout the study. Once the study is completed all identifiable evidence would be destroyed to protect confidentiality.

Finally, confirmability relates to the objectivity of the research. Once again the audit trail allows readers to access the data and decision-making process, and thus determine its objectivity. Utilising a reflexive approach is an attempt to expose known bias and account for personal influence on the findings. Mason (1996:146) identifies the importance of ensuring that data is not misinterpreted. Once again the use of thick description allows readers to access original data and form their own conclusions.

Hammersley and Atkinson (1995:228) discuss the value of respondent validation. They identify that this may have a positive value, in that the respondent may have access to additional knowledge of the culture; but also that it may have a negative value in that the respondent may disagree with the interpretive analysis that the researcher has made.

The focus group report from this study was published to participants and they were asked to comment on the findings. Their response confirmed the analysis made and assisted in preparation for the second stage of this study. During the latter preliminary analysis was shared with participants as the study progressed. This led to interesting discussions when they questioned how conclusions had been reached. Interim reports have also been presented to student cohorts on the nursing degree and generally there has been a high level of agreement with the conclusions reached.

Ultimately this ethnography is a personal interpretation of the data collected. Readers must determine for themselves whether the account is credible, transferable, dependable and confirmable on the basis of the evidence provided. Robson (1993:66) identified that research accounts, which are supported by evidence, tend to be open, unbiased and honest. He states that common causes of unreliability are subject [participant] bias and observer error. This ethnography includes as much evidence as is appropriate to open the research to the reader. Throughout data collection fieldnotes were written immediately and the use of recorded reflective interviews at the end of each shift allowed for accounts of experiences to be made whilst they were fresh in the minds of both participants and researcher.

Focus Groups

Morgan (1988:12) identified that the purpose of focus groups is to use group interaction in order to access data and insights that would be less available on an

individual basis. An important aspect of my role was to facilitate group interaction so that rich data would be forthcoming, creating a student centred environment for the focus groups. This posed both practical and personal difficulties.

The venue had to be my office as there were no suitable informal rooms available to me. Informality was achieved to a degree through comfortable chairs, the coffee machine and a tin of biscuits. Students were asked to imagine that this was a coffee time conversation with colleagues rather than an interview. Focus group interviews were recorded using a small dictaphone that was relatively unobtrusive at the side of the biscuit tin.

Perhaps for me the hardest problem was to not lead the ensuing conversation, as I am by nature gregarious and stimulated by the conversation of others, always wanting to 'have my say'. In my reflective journal after the initial CFP focus group I wrote:

> *Some good information is coming out, I kept wanting to join in so had to be very disciplined, confined myself to nods and mmm's on the whole.*

I was aware that students might perceive me as 'acting out of character' and found this first experience to be a personal learning one. My inexperience also showed in a comment I wrote after the second CFP focus group when I wrote:

> *I felt that we were covering a lot of the same ground - however perhaps that's how it should be.*

My journal also reflects feelings, excitement that I was actually getting started on the fieldwork, worry that the students wouldn't arrive, anxiety in case the students didn't say anything resulting in an overall feeling of stress. This subsided as the interviews progressed and I began to feel more comfortable in role.

I was also reassured that my perceptions of learning in clinical practice were not unrealistic, after the first branch and the third CFP focus groups (they occurred on the same day) I wrote:

Overall I'm finding that my 'teacher perceptions' don't seem too far out.

Whilst this made me feel comfortable it also made me realise that it would be easy to put personal interpretations upon what was happening.

Morgan (1988:48) proposes a continuum of focus group interaction (Table 3.4) that is useful in determining the way in which the group was functioning.

LOW ———			**HIGH**
Non-directive self-managed group	Participant dominated	Moderator dominated	Control topic & group dynamics

Table 3.4 Continuum of Focus Group Interaction (after Morgan 1988)

As the purpose of the interviews was to gain the student's perspective my intention was for the group to be participant dominated, overall I believe that this was achieved as transcriptions of sessions (sample of CFP group Appendix 7, and branch group Appendix 8) indicate that after the initial introduction my contribution was minimal and the groups interacted with each other.

A focus for the interviews was provided on the first occasion by asking them to 'talk about how they learnt in practice', on the second occasion to 'discuss what it's like to be a degree student in practice' and on the final occasion to 'identify how they thought they managed their own learning in practice'. Their responses are discussed in depth in chapter 4.

The size of the groups was also an issue to consider. All students from two cohorts of the BSc (Hons) Clinical Nursing programme, who would meet the criteria of being in either the CFP or Adult Branch, were approached for volunteers. Five volunteers were sought from each group. Morgan (1988:44) had indicated that four was the smallest number to be effective. Ultimately four CFP and four Branch students volunteered to take part. The experience of running the groups subsequently led me to feel that this was an appropriate number as they quickly settled down and talked easily to each other, a larger number might have resulted in some students not participating. Gilbert (1993:137) suggests that:

> *The strength of group discussions is the insight they offer to the dynamic effects of interaction as expressed opinion.*

Individuals within the group reacted to statements from each other by agreeing; contradicting and challenging with the result that clearly expressed opinions were identifiable.

Kitzinger (1994:105) identified that established groups are more likely to be able to 'relate each other's comments to actual incidents in their shared daily lives'. The students were familiar enough with each other to be considered established and shared much of their daily lives especially the university experience, although in practice were not all in the same placement area. This latter issue was compensated for by the fact that in university they had shared reflective learning sessions, on Problem-Based Learning Days, where they could raise examples of issues from clinical practice with their peers for discussion. Through these they had gained experience in sharing and discussing clinical learning experiences. A full account of the focus group study is provided in chapter 4.

The utilisation of focus groups as a preparatory method for carrying out participant observation for the second stage of the study was invaluable. This strategy was useful in four ways. It provided experiences in carrying out

qualitative interviews, transcribing them, using qualitative analysis and most importantly enabled insight into a student's perspective of learning in clinical practice.

Participant Observation

Spradley (1980:53) relates participant observation to the behaviour of an individual when entering a new environment. He identifies that initially the individual watches what others do and takes cues from them to then copy their behaviour. This enables them to fit into the new culture, and is typical of the behaviour observed in this study when participants were new to a clinical environment.

Field and Morse (1985:76-77) identify four approaches to participant observation (Table 3.5).

- Complete Participant
- Participant as Observer
- Observer as Participant
- Complete Observer

Table 3.5: Types of Participant Observation

The role selected was that of 'Participant as Observer' in order to enter the culture as much as possible. This was considered to enable collection of more data than the other roles, with the exception of being a 'complete participant'. The latter may be deemed to be unethical as participants would be unaware of the observer's role. On occasions where personal [professional] competence did not allow participation the roles of 'observer as participant' or 'complete observer' were taken.

Spradley (1980:54-58) identified significant differences in the behaviour of a participant observer to an ordinary observer (Table 3.6). The dual purpose of participant observation in this study was to engage in the delivery of nursing care, whilst at the same time observing the student, other clinical staff, and patients and collecting biographical data relevant to the environment.

- Dual purpose
- Explicit awareness
- Wide angle lens
- Insider/outsider experience
- Introspection
- Record keeping

Table 3.6: Characteristic Behaviour of Participant Observers

An ordinary observer develops selective awareness in order to avoid information overload. This was a trait that had to be overcome. During shifts at times the role of 'complete observer' was taken to enable observation of detail to occur. At times such behaviour was overt, with the participant being informed of what was happening. Brief notes would be written at such times to ensure that potential learning opportunities were identified for discussion during reflective interviews. At other times it was done unobtrusively, for example undertaking an activity such as bedmaking, therefore appearing busy but being able to observe.

Spradley (1980:56) explains a wide-angle lens as being a broad view that the observer takes to gain knowledge of the culture. Collecting biographical data such as examples of care plans (without patient information on them), patient information sheets, drawings of the general environment (ward layout), observing staffing levels and the behaviour of staff and patients all contributed

to data gathering. Observation was also made of routine discussions between clinical staff such as report time, multidisciplinary meetings and conversations between mentors and participants.

Insider experience was gained by active participation, whereas outsider experience was though taking the 'complete observer' role. At times others imposed this role such as the participant or practitioner asking me to withdraw. This mainly happened in midwifery and mental health settings where I was not qualified to participate.

Introspection concerns the use of the observer as a research tool. In this study the reflective approach allowed introspection to occur, and findings to be confirmed by the participant who had shared the experience. The immediacy of carrying out reflective interviews facilitated such introspection. A record of these interviews was kept in various forms, as a tape, a transcription and through personal fieldnotes. Towards the end of the study participants were asked to write a critical reflection of one shift to confirm that their perceptions of learning opportunities matched researcher perceptions.

Personal Clinical Experience

As identified previously a strategy used for personal preparation was to undertake clinical practice prior to commencing the main study. Permission for this was negotiated from a local Director of Nursing, and her permission also gained for supervision by an experienced qualified nurse during this period. The latter provided a preceptor (a qualified nurse who supervises newly qualified or returning nurses) who was able to give feedback on my performance in clinical practice, and also teach new knowledge and skills appropriate to adult nursing. Time available and other commitments limited the refresher period to one day a week for four weeks. Additionally, prior to this supervised practice, I was able to attend the new staff 'Induction Course' for 3 days, enabling refreshment of key

health and safety knowledge and skills such as resuscitation procedures, manual handling and prevention of cross infection.

Clinical experience was mixed, I learnt quickly and my preceptor soon felt confident enough to leave me looking after patients with distant supervision. At times the wealth of knowledge acquired over the years enabled an insight which less experienced nurses did not have. As an example on one occasion I discerned from the history a patient was recounting that she potentially had an eating disorder. This had not been recognised by the qualified nurse caring for her. Medical staff listened to my rationale and followed this assessment up.

On other occasions, whilst I knew what to do, I found that I was unable to carry out care because the equipment had changed and I did not know how to use it. I found it very embarrassing to have to ask for help in such situations. There were occasions when I knew how to do something in theory but had never done it in practice, for example patient controlled analgesia. My preceptor taught me how to use the equipment, supervised me for the first two occasions and then left me to carry out care without supervision, as she was happy with my level of knowledge and skill. After the fourth day in practice I wrote in my reflective journal:

> *I've met my objective of feeling comfortable in clinical practice again, but realised how out of touch I am, so much to learn.*

One aspect that was important was I gained empathy for students in clinical practice. When undertaking participant observation I often recognised students behaving exactly as I had. This helped me to understand the strategies that they use to control their own learning in clinical practice.

Observing Participants

Participant observation was carried out over a one year period from September 1995 to August 1996 in four week periods as previously described (page 55).

Observations were carried out during the participant's normal working hours. These included both early and late duties. Night duty and weekend shifts were not utilised due to conflict with needing to fulfil an academic role on other days. The nature of participant observation varied according to the access negotiated with various gatekeepers. On the majority of occasions I was able to take the role of Health Care Assistant, being a 'pair of hands' but not guiding or explaining the care being delivered. Through this process it was possible to observe how students coped when they came across unfamiliar experiences, and to see how they managed their own learning in relation to these.

Participants were advised to tell me if they wanted a break from being observed. This would be achieved by asking me not to accompany them, taking a different meal break or occasionally by qualified staff asking me not to observe. Such requests, from participants and staff were rare. Participants quickly learnt to use 'my hands' to make their own workload lighter. Occasionally staff mistook me for an agency nurse and 'told' me to go and do something. I usually complied, providing that observation of the participant could be maintained, as it helped me to blend into the culture.

Reflective Interviews

Current nurse education makes extensive use of reflective learning strategies. Reflective interviews were used because they allowed immediate collection of data, limited note writing during the shift therefore enabling participation and because participants were familiar with reflective models as a strategy for analysing their experiences.

The model selected to structure these was Gibbs (1988) Reflective Learning Cycle (Figure 3.1). During the interview the cycle was used several times. Initially participants would be asked to 'talk about the day', exploring issues as they

brought them up. When they began to dry up I would use the notes recorded during the day to remind them of particular incidents. As they became familiar with this technique they would sometimes ask for my notebook themselves to jog their memories. Occasionally, during a shift, they would tell me to write something down - in this way the notebook became joint property.

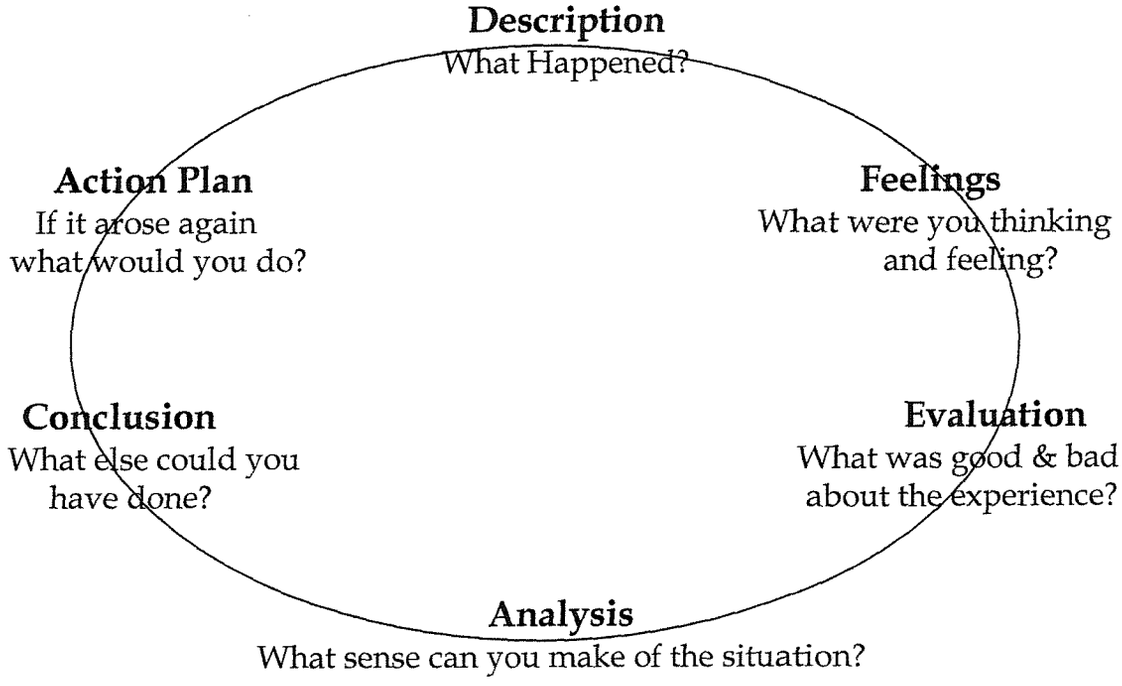


Figure 3.1: Reflective Learning Cycle (after Gibbs 1988)

Questions during the interview were based on those in the cycle. We would move backwards and forwards around the cycle, particularly when experiences provoked an emotional response. On average interviews lasted 40 minutes.

Rubin and Rubin (1995:129-139) identify seven stages to qualitative interviews (Table 3.7.). The interviews took place in the ward environment, a natural working environment but not necessarily appropriate for an interview. Occasionally we were able to access a quiet room, one used for talking to patients or visitors. More often we sat in coffee rooms (often interrupted), treatment rooms and on one occasion a bathroom.

- Creating a natural environment
- Encouraging conversational competence
- Showing understanding
- Getting facts and basic descriptions
- Asking difficult questions
- Toning down the emotional level
- Closing while maintaining contact

Table 3.7: Seven stages of qualitative interviewing

Strategies used to encourage conversation were acting in a reassuring manner, showing empathy and sharing personal perceptions of what had been going on.

Getting the facts and asking difficult questions were dealt with by reiterating what the participant had said, asking probing questions to gain more information and trying to be aware of when participants were avoiding talking about an issue. In the case of the latter I would try rephrasing questions, or asking them how they felt about the issue. Usually if emotional responses were made explicit it was possible to move on and discuss the issue more factually. On occasions where emotional responses were unpleasant I attempted to tone these down by reassuring the participant that their feelings were a normal response and agreeing an action plan to cope with similar situations in the future.

Usually interviews came to a close when the participant ran out of issues to talk about. However I left an opening for further dialogue by saying that if

they thought of anything else then they could ring me or tell me next time we worked together. I was surprised at the ease with which participants discussed issues with me. Berg (1989:39) identifies:

> *One interesting and fairly common assumption novice interviewers make is that subjects will not discuss certain topics with them. Interestingly, however, once subjects have been persuaded to participate in an interview, they often tell interviewers far more intimate details than they may desire to know.*

Whilst I did not necessarily hear anything that I would not have wanted to I was conscious that participants might provide information that could cause me professional conflict, and if they did that I would have to make a conscious decision to either act as a researcher, and keep quiet, or act as a teacher, and take action.

Transcribing Interviews

Interviews were personally transcribed to enable exposure to the data being collected, allowing immersion in it. The process was a slow one as not only was I new to transcribing but I also kept stopping to think whilst doing so. This was not wasted time as I frequently wrote 'memos' which contributed to preliminary analysis of the data. Some of the difficulties met were anticipated, such as students with quiet voices or in focus groups more than one student talking at the same time. However one problem had not been foreseen, I wrote in my reflective journal:

> *I have discovered that we don't speak in sentences; just one continuous one with ands, buts and so's which makes transcription difficult.*

It took some time to decide how to write these continuous sentences and inevitably the final transcription bears a personal version of punctuation, using the tones of voices and pauses to decide where breaks came. I developed my own version of shorthand, for example three dots at the end meant the student was interrupted and was going to carry on, six dots in the middle meant the student had paused to gather their thoughts. Initially progress was slow, I wrote in my journal:

I find I get tired and need frequent breaks but at the same time frustrated at my slow progress.

As more interviews were transcribed I became both faster and more able to make sense of what was being said. Examples of transcriptions are included from year 1 (Appendix 9), year 2 (Appendix 10) and year 3 (Appendix 11).

Data Analysis

When the study commenced the intention was to use a modified grounded theory approach. This theory was first described by Glaser and Strauss (1967), and has its foundations in symbolic interactionism. The approach uses constant comparative method to analyse data. Glaser and Strauss (1967:105) identify four stages to this method. The first stage requires coding of incidents into categories that are then compared to determine similar and different properties. The approach was used for analysing focus group interviews, to identify concepts that could be explored further in the main study. This was achieved by reading transcripts to identify incidents that related to learning, particularly control of learning. Notes were written in a large margin that had been left for this purpose. Strauss and Corbin (1990:61) label this first stage open coding, which identifies the categories emerging from the data.

The second stage was integrating categories and their properties (Glaser and Strauss 1967:108). Through constant comparison categories were grouped together and given a conceptual label. Ultimately the relationship between categories reveals an emergent theory. Glaser and Strauss (1967:109) suggest the use of theoretical sampling, a process of analysing data and then returning to the culture to explore emerging categories further.

Stage three, which Glaser and Strauss (1967:109) label delimiting the theory, is achieved in two ways, firstly delimiting the theory which' solidifies', and

secondly reducing the number of categories. Further constant comparison is used to reduce the number of categories into major conceptual themes, with some of the original ones becoming sub-categories. This enables the theory to be clarified and emerge from the data. They suggest this should be continued until saturation is achieved, where no new evidence is emerging. This was only partially achieved in this study in that categories emerging from the focus group study were explored in the main study and preliminary analysis of data from the latter was explored as the study progressed.

Additionally the fact that sampling was identified at the beginning of data collection was an influential factor. Normally with theoretical sampling data analysis guides the selection of further sampling. This was possible with regard to following up theoretical concepts, but it was not possible to change the environmental samples as these had been negotiated previously with the relevant gatekeepers.

The final stage is writing the theory (Glaser and Strauss 1967:113). This comprises of a discussion of the theory, supported with evidence from the data and analysis carried out. The theory is therefore 'grounded' in the data, thus justifying the name given to this approach.

In this study categories emerging from the focus groups were further explored in the second stage of the study, resulting in some being subsumed into others, and the production of some new categories. These are discussed in detail in chapters 4 and 5. It quickly became evident; when analysing data from the main study that a grounded theory approach was inappropriate. The wealth of data combined with a lack of time to further explore concepts that might arise, meant that the approach to analysis needed to be reviewed. Miles and Huberman (1994:8) suggest that because of the descriptive nature of ethnography:

> *The task is to reach across multiple data sources ... and to condense them, with somewhat less concern for the conceptual or theoretical meaning of these observations.*

Transcripts from the CFP participant observation were analysed using comparative analysis, influenced by Miles and Huberman's approach of data reduction, data display and conclusion drawing and verification. This made it possible to identify patterns and draw conclusions.

Branch transcripts from participant observation were analysed using Buzan's (1995) mindmapping approach. Such an approach requires a visual interpretation of data in diagrammatic form. The central concept of self-directed learning was written in the centre of a page, encapsulated in a circle. Through listening to tapes of interviews data emerging was captured in further 'bubbles', using different colour pens to identify related ideas. Ultimately a complex diagram was built up from each tape that mapped the information given by participants. Further analysis using constant comparison resulted in the identification of sub-categories. This method proved an efficient way of dealing with large amounts of data. It was possible to listen to tapes, whilst reading the transcripts and map key items. This technique was then applied to a sample of the CFP transcripts to check for reliability.

Ultimately it became apparent that the data from the focus group interviews needed to be combined with that from the second stage of the study to identify the findings. Additionally fieldnotes and biographical data fed into the final analysis, making full use of all strategies for data collection.
It took some time to determine the findings, and in analysing data to decide which of the many quotes to include in the text and which to leave out. Johnson (1995:31) identified:

> *It is important to take the difficult decision about what to leave out, and to accept that the most useful data might address a different issue to the one you perhaps had in mind originally.*

Burawoy et al (1991:5) discuss the relationship between theory and data when the goal is explanation. In exploring this dialogue it became clearer which were relevant quotes to illustrate the findings. The sheer volume of data from the study added to the complexity of analysis.

It was important that the voices of the participants were clearly heard. However it was also important to recognise the influence that my presence had made on what was said in the interviews. In the focus groups, whilst I had attempted to stay quiet, I was aware that my mere presence would have an influence on the group. Carey (1994: 234) identified that:

> *When using transcripts of a focus group session, the researcher needs to be mindful of the total group setting, the non-verbal data, and changes and discrepancies in member's contributions.*

I was aware that the interaction between group members also included me, noticing in the early interviews that students had a tendency to direct their contributions towards me, even if I was not replying verbally, and that it was only as they became used to the activity that they directed comments more to each other. The social context of the setting was such that I could not be outside of the group and thus had to be aware that comments made might be 'tailored' because I was there.

Carey (1994:236) suggests that the potential impact of censoring and conforming could be a pitfall of focus group interviews. I was aware in this stage that comments might be censored by students because of my presence, and also that suggestions made by one student might trigger another into agreement, even if the individual did not necessarily believe in what they were saying. The need to be accepted by the group might have been greater than the need to stand up for the individual's own beliefs.

At the end of analysing the focus group data I believed that I had uncovered the student's perspectives of learning in clinical practice, at least sufficiently to guide my future actions, achieving the 'open' but not 'empty' mind that I required. Analysis at that time was broad in nature; further induction could have been carried out which may have reduced the categories for further exploration. Carrying out the focus group interviews prepared me well for reflective interviews. Sometimes in these we just followed our own interests, discussing issues that were of personal interest rather than useful to the research. As these were on a one-to-one basis my voice is heard more. Following the reflective cycle provided a structure for interventions and space for participants to talk. Both strengths and weaknesses may be identified in reflective interviews (Table 3.8).

STRENGTHS	WEAKNESSES
immediacy of recall of experience	little time to reflect - would the situation seem the same after a longer interval
clarification by describing the experience in words	easy to go off the point and be distracted by non-relevant issues
shared experience of participant and researcher	power relationship may alter perceptions
critical discussion to explore each others perspectives and agree interpretation	emotional involvement which can 'cloud' perception
capitalises on opportunistic learning	inappropriate learning opportunities may be accessed
enhanced learning through increased awareness, questioning and clarification by critical discussion	lack of readiness to learn may result in confusion

Table 3.8: Strengths and Weaknesses of Reflective Interviews

The immediacy of carrying out the interview at the end of the shift was an advantage in that the experiences were fresh in our minds, but a disadvantage in that we were, at that time, perhaps too close to them to be objective. Recency enabled easy description in words, but it was difficult to

separate relevant incidents from others that had occurred. At times it was necessary to explore these other incidents, especially if they had evoked an emotional response that was interfering with ability to focus on learning incidents.

The fact that we had shared the experience was an advantage; we were able to explore the similarities and differences of our perspectives. However I was aware that I had a powerful position that might influence the participant. This was specifically as a researcher, which perhaps gives informational power, the perception by the participant that I had a superior knowledge. Also formal power perceived from my role as a senior education manager at the university. This meant that building relationships was of vital importance to be accepted by the participant as a fellow worker, and for the reflective interviews to be on a peer basis.

As the study progressed I observed that participants settled into the interview situation more readily, and that there was a subtle shift in power basis, with the participants beginning to control the interview rather than me. They would define how long it was going to last, where it was going to take place, introduce their own agenda and take my notebook from me to see what I had written and then talk to it. This power shift did not detract from the quality of data obtained, merely shifted the locus of control.

Initial interviews tended to be fairly superficial and shorter, as we settled down with each other and 'learnt the rules of the game'. Subsequent interviews became more critical and of greater depth. We felt safe in questioning each other, and disagreeing. Debate became more evident and we would explore each other's comments to reach agreement on an explanation. At times emotion interfered, when we had shared a 'bad' experience we would console and support each other, but not always discuss

critically. Incidents such as these needed revisiting when we next met and were more able to be objective about them.

Participant observation allowed us to make the most of opportunistic learning. It was not possible to predict all of the learning opportunities that the participant would have during a shift. Reflective interviews allowed us to explore the unexpected opportunities that had arisen. However on occasion these would be inappropriate, such as the occasion when a first year student was asked to 'talk to' a patient threatening to commit suicide immediately, without any supervision from an appropriately trained mental health nurse. An assumption was made, by the nurse who directed the student [and who was rushing off to a meeting], that I would act as supervisor. However I was not qualified to do so. We tried to find an appropriate supervisor but the ward was short staffed and there was no one available. We handled the situation guided by common sense knowledge rather than by formal knowledge.

Ultimately reflective learning enhanced awareness of achievements and identification of future learning needs. Occasionally it was evident that the participants were being required to undertake learning for which they did not feel ready, but at least they were able to verbalise this and plan future learning accordingly.

Writing an Ethnography

In writing this ethnography I have deliberately chosen to be 'present' in the script, using the first person whenever I am personally involved in actions or thoughts. Lipson (1989:73) discusses how, in nursing, the dominance of empirical (positivist) research has resulted in authors removing themselves from the text. She debates the conflict between new paradigm and positivist

research, identifying that in the former it is the researcher who is the main tool of research. With regard to writing up such research she states:

> *... reports often contain methodological remarks about the impact on the researcher of conducting research.*

In this ethnography the reflexivity is recognised and the following chapters include the dual perceptions of the impact of the researcher on the researched and the research on the author.

Ultimately this ethnography is a personal construction of the social world of undergraduate student nurses in clinical practice. In representing and analysing their world, I have been guided by the thoughts and actions of the participants. These together with personal observations and perceptions form an eclectic whole. The final product is a reflexive account, focused on how undergraduate student nurses attempt to control their own learning in clinical practice, but additionally recognising that this is just a part of their social world. Inevitably the wider social world has to be considered to provide the context in which focused activity takes place.

CHAPTER 4

BECOMING A 'CULTURAL STRANGER'
Gaining the perceptions of student's learning in clinical practice

This chapter reports the first stage of the research and focuses on the major strategy used in preparing to 'enter the field'. Complementary strategies included a period of clinical practice for professional updating, and reading ethnographic research reports and methodology books to assist in identifying potential problems that might occur.

Having decided that an ethnographic approach would provide the best quality of data to answer the questions posed, the main task was to prepare for entering the culture of clinical practice as experienced by adult nursing students. Focus groups, as explained in chapter 3, were selected as an appropriate strategy to gain a student's perspective of clinical practice.

The Focus Groups

Two focus groups were set up, which represented the major component parts of the programme, one of Common Foundation Programme (CFP) students and one of Adult Branch students. It was recognised that the focus group interviews would provide students views of learning in clinical practice and that these might differ from reality. When designing the research it was anticipated that the focus group interviews would discover issues that were relevant to the students. In turn these issues would provide a structure for exploring the research question of how students managed their own learning in clinical practice. The main aims were, therefore, to prepare myself for participant observation in the main study and to identify a student's perspective of learning in clinical practice.

Topics for discussion by the focus groups were broad in nature to encourage general discussion, and to allow participants to set their own agenda. Issues identified by both the CFP and the Branch groups were similar, although the examples varied. Guidance given at the commencement of each session was the same for both groups. On the first occasion they were asked to 'talk to each other about learning in clinical practice'. Transcription of these interviews identified two broad themes emerging from both groups - degree level practice, and integrating theory into practice or practice into theory. These formed the focus for the second meeting. On the third occasion they were asked to focus on 'what control you feel you've got over the learning situation'.

The issues raised seemed very familiar, reflecting knowledge gained from past experience in a variety of teaching roles. However my need was to be able to interpret these experiences as a student would, and not to put personal meanings to them. Hammersley and Atkinson (1983:7) stated that:

> *Even where he or she is researching a familiar group or setting, the participant observer is required to treat it as "anthropologically strange" in an effort to make explicit the assumptions he or she takes for granted as a culture member.*

Transcription of the interviews and analysis, as discussed in chapter three, enabled an understanding of the student's perspective that could not have been acquired by just a group discussion or individual interviews. Morgan (1988:15) suggested that:

> *Focus groups combine elements of both individual interviews and participant observation, but also have a distinct identity of their own in that they can provide access to forms of data that are not obtained easily with either of the other two methods.*

This was found to be true in the experience of using focus groups to prepare for undertaking participant observation for the main study. Group dynamics resulted in the generation of student-centred debate that could not have been accessed through a researcher led interview.

The Participants

Volunteer students came from cohorts of the nursing degree course. The letter sent to all students (see chapter 3) in the selected cohorts, explaining the research study and asking for volunteers, was followed by an information session with each cohort to further explain the nature of the research, the main aims, methodology and the potential outcome, and also to allow students to ask questions before they decided to volunteer.

Ultimately eight students volunteered, four from the CFP (3 female and 1 male) and four from the adult branch (all female). They were asked to choose a name that they would like to be known by in the research, so as to protect their identity from the majority of readers. It was acknowledged that students would be able to recognise themselves, and indeed may have shared their name with others. However as one of the concerns was for the students to be able to verify interpretation of the data it was justifiable for them to be able to recognise their own contributions. Once students had verified the interpretation made their names were changed once more to maintain confidentiality.

The CFP students had commenced their course in September 1994 and were about to commence their third clinical placement towards the end of the first year (June/July 1995). Branch students had commenced their course in September 1992 and were about to commence their final placement towards the end of the third year (July/August 1995).

In the CFP group meetings one student was unable to make the first meeting and another was sick for the third, and in the Branch group one student was sick for the third meeting. However the sessions produced a wealth of data even when only three students were present, although it was recognised that the group interactions may have been affected by changing membership and that the group size may have been too small to be truly effective. As the main purpose of

the meetings was to prepare for participant observation for the main study it was not felt that size inhibited the collection of students' perspectives unduly.

Analysis of Focus Group Data

Constant comparative analysis, starting with open coding (Strauss and Corbin 1998) was used to analyse the focus group interviews. Many sub-categories were identified and reduced into seven main categories that were common to both groups, although the nature of experience varied within each group. Categories identified were:

- Bringing theory to life;
- Building experience;
- Levels of learning;
- Bargaining;
- Safety net;
- Self-centred practice and
- Expectations.

There were many sub-categories identified and further analysis may have reduced the above to a smaller number of categories. However these categories were deemed sufficient to provide a focus for gathering more data through participant observation.

Bringing Theory to Life

This category related to how clinical practice made sense of theory gained previously in the university or through prior educational experiences. Initially this tended to relate to how to use new knowledge gained when going into practice, when students began to identify varying knowledge bases in the qualified staff that were supervising them and tried to make sense of the situation. A CFP student stated:

> *... there is a balance somewhere between theory and practice that's got to be a working balance, I suppose as more and more - you know theory comes into nurse training - it will rise won't it?*

At this time the student was coming into contact with qualified staff who had been prepared for nursing through both traditional and more modern routes, and becoming aware of inconsistencies in their knowledge bases and application of theory in practice.

Other students were trying to use knowledge presented to them by their university teachers to understand their practice experiences, for example a CFP student identified:

> *I tend to stick to the guidelines (um) on paediatrics ..... so I've taken say four each day or whatever, be it something like language development whatever and (um) potty training, and then I suddenly thought well I don't know what age children should be speaking 'cos you don't unless you've got your own, I'm thinking well I kind of know what to expect but I just would say go home and read or ask them if they had anything ..... or ask somebody say what age should people be speaking at?*

This realisation that knowledge gained in formal study either wasn't sufficient, or needed to be revised when it became relevant to use it, was common. Most students identified the need to go away and read books or journals, or to ask questions to gain a greater depth of knowledge. Interestingly this student was also identifying the need to use her life experience, and perhaps reflecting the words of many a new mother who once she has a baby realises that she doesn't know what the normal milestones of development are.

Although the student had received this information in theory she had not needed to use it until her placement and thus had not retained the information. This behaviour relates to the Knowles (1984:55-61) characteristics of adult learning in that she brought her previous experience to the new learning situation, was demonstrating a readiness to learn and needed immediacy of application.

However reading wasn't always sufficient, a branch student stated that:

> *You can't just swallow what's in a journal - see if that's right, if that's the way to go, you need to sort of investigate it I think.*

Her feeling that knowledge had to be tested in practice to see if it fitted was echoed by other students. Another branch student recounted how her reading had been useful in practice saying:

> *I was discussing (um) articles to do with hydration and terminally ill patients and she was asking which articles I'd read and you know she was saying there's only one disadvantage, no what did she say, there's only one advantage and that's because hydration prevents thirst and then I was saying no there's others as well and according to this article ...*

As she tested out her knowledge on a more clinically experienced nurse, she was also clarifying, extending and making sense of it. Confidence in her knowledge base, and the respect shown for this by the qualified nurse, enabled her to share it with a more clinically experienced colleague.

More commonly it was practical experiences that achieved this, such as that recounted by a branch student:

> *Somebody came in and arrested just as he went through the doors of the resus room so the Registrar and my mentor and everyone told me to take over with (um) cardiac massage and (um) so I did it and I was watching everything that went on and somehow the knowledge just seems to just - you know what you're doing but you sort of need prompting to do it [laughs] you feel like an idiot, well I know how to do this, and then my mentor took me aside afterwards and said well would you like to go through it and shall I show you how to put on an ECG tracing and things like that and he said to me you know how much do you want to know, how much do you want to do when you're in the situation and I feel then I had a lot of control over it because he was sort of empowering me.*

The response of her mentor was critical to this student being able to learn effectively, from a situation that could have been quite a frightening one if not handled well by him. The opportunity to reflect afterwards and clarify what had happened, as well as to gain further knowledge and skills to prepare her for the next time it happened made this a very positive learning situation, as she identified with her feeling of empowerment. Palmer et al (1994:53) have

suggested that reflection is a 'valuable part of [the student's] development towards providing therapeutic care'.

Not all of this student's experiences were quite so positive, for example she stated that:

> *We come to the ward and a real patient with a real problem, and maybe if the staff nurse is good enough to say to you well what's going on here then or can you tell me about - and I don't know about you but I stand there blankly for a minute thinking well I don't know I'm only a student and then common sense sets in and I think well I do know but putting theory into practice is ... (goes quiet).*

The pressure of being put on the spot is one that requires experience to be able to handle. The student's experience of going blank, or hiding behind her student identity was not unusual. Without practice experience to make sense of theory students tended not to have the confidence to demonstrate their knowledge, finding it safer to say 'I don't know'. Her phrase of 'if the staff nurse is good enough' is pertinent; the issue of being allowed to learn is addressed later in the 'bargaining' category.

Some students found it necessary to put distance between theory and practice in order to understand it. A branch student stated:

> *When I was working in the community - you become obsessed with single patients and how it is on ground level, whereas if you sort of step back out of it and you look at the theory and then talk to nurses about how it is in practice as you were just describing [said to a colleague] and you sort of think about how it, how you could improve it, how you could improve your own practice, perhaps how good practice is at the moment.*

This movement backwards and forwards between theory and practice is an important one, in order to integrate knowledge into practice there appeared to be a need to gradually mix the two together, combining knowledge gained from experience with theory in order to develop practice, constantly re-evaluating each component.

It appeared to come as a surprise to students that they had gained a depth of knowledge; a branch student who recounted her experience of discovering personal knowledge illustrated this:

> *Yesterday I was assessing a patient's knowledge of her diabetes and after I thought gosh (laughs) I must have some knowledge to have been able to have done that. I hadn't quite realised I had all this knowledge but it's - I was quite pleased with myself really that I seem to have you know I was able to answer the questions and explain what she didn't know, and I felt quite proud of myself really.*

The active experience of using knowledge in practice helped students to develop confidence in their own abilities. This student's comment that she felt proud of herself demonstrated the intrinsic reward that students experienced when things went well.

However sometimes their knowledge resulted in their experiencing conflict, for example a CFP student identified:

> *You can easily see again how theory and practice don't quite work the same. For instance they're on a primary nursing thing (um) group regime and (um) but they've lost the theory. I like to think that I know the basic theory of primary nursing as opposed to others, and the theory is lost in practice you know. They're practising primary nursing in their way to fit their own regime; they're not actually following if you like the rules of primary nursing. It's really a sort of we'll give everybody a colour and we belong to different teams but the way the ward's actually working it's no different to really many of the other wards where you get everybody working together really for the sake of the patients you know.*

This student was trying to make sense of the complex concept of primary nursing, but experiencing conflict between theory learnt in university and experience gained in practice. Inevitably the student was making sense of the unknown by referring to previous knowledge and experience gained in other contexts. The description of the way the ward staff were interpreting theory appeared to be rule governed behaviour that Benner (1984:20) relates to a novice nurse. The student's knowledge and understanding of the theory seemed to be greater than the qualified staff acting as practice teachers, allowing a critical view to be developed.

The notion of working together for the sake of the patient was also described by a CFP student who stated:

> *Where I was in care of the elderly the staff were not interested, they weren't happy people and that's reflected in how they treat others. But on my paediatric placement we were all working to the common good and I really felt quite accepted and part of the team up there. So if I wasn't with my mentor then I would go and watch and participate with another trained member of staff, and (pause) very good for the parents I think and the children.*

Her notion of the common good was important, although she identified that it was good for the parents and children it was obvious that she had benefited from it as she felt able to learn in this environment, meeting her own needs. In comparing the two environments she was using a general strategy for making sense of any experience, by comparing one to the other it became easier to identify the characteristics of each.

It can be seen from these examples that clinical practice brought theory learnt in the university to life, it took on qualities of reality that made it easier to assimilate and develop. Theory generated from practice experience enhanced the student's knowledge base. Neither theory nor practice can stand alone, each needs the other to make a comprehensible whole.

Building Experience

The value of both life and educational experience was significant; students used their experiences and those of others to develop knowledge and skills in practice. They also perceived the necessity for lifelong learning, both for themselves and their colleagues, recognising that learning would continue long after the course was completed. They built experience adding new knowledge and experience to that already in existence.

Initially they had a concern to gain the foundation caring skills fundamental to nursing practice, recognising that there were a variety of sources for learning. Two CFP students in discussion exemplified this:

> *Lesley: It's not just what you've learnt in exams though it's what you've learnt in other practice and other fields of work that we've done ...*
>
> *Frances: Yes I think so ...*
>
> *Lesley: ... quite a few of us have worked on care work and other types of things that we can draw on ...*
>
> *Frances: ... yes experience right ...*
>
> *Lesley: ... that's useful.*

The value of working both with and as a Health Care Assistant (HCA) was a recurring topic, although this experience was not always a good one as a CFP student identified:

> *It's very easy for the trained staff to let you just go on and become an HCA, it would help them 'cos the big onus is on getting everything done by lunch time, 'haven't you finished your patients yet', well, what's the big deal you know you spend an extra five minutes talking to them and they're happy, all right they're not dressed till half past eleven - does it matter?*

This statement demonstrated her perception of the difference between being an HCA and being a student in clinical practice, a difference that was not always recognised by the qualified staff supervising the students. Many students worked as HCA's on their days off to earn a little extra money and were able to compare the experience of being an HCA with that of being a student, identifying differences in their expectations of learning situations.

The problems of meeting academic needs and thus having less time in practice to learn clinical skills was one that caused concern for many students, as a group of branch students discussed when evaluating the benefits of doing agency work as a way of gaining extra clinical experience:

> *Ursula: I think that everybody should, that every student should be encouraged to do some agency nursing ... definitely because that gave me sort of a lot of confidence, for basic nursing care - for emptying commodes and just handling of patients as well. I'm not scared*

anymore, before you know when I went on a ward I thought 'I've really got to wash this person' and just feel, lightly, but now I'm not scared to touch people and handle people and talk to people, and I think sort of agency nursing gave me a lot of confidence and now I can perhaps concentrate on more specific tasks that I haven't done yet

Teresa: And working on the agency, working with other auxiliary staff as well 'cos you know the auxiliaries get on with ... I learnt a lot from the other auxiliaries

Ursula: Yeah definitely

Wendy: You can learn a lot from other health care people can't you, it doesn't necessarily have to be a nurse, like the physio's they'll teach you how to handle people ...

Ursula: Yeah

Wendy: ... occupational therapists, and doctors sometimes teach you about drugs whatever

Teresa: Oh yes some doctors, if it's not beneath them of course because there's the hierarchy to be seen to [laughter].

Having progressed further in the course these students were clearly identifying alternative sources of learning skills and knowledge, by examining the roles of paramedical and medical staff they were able to build knowledge of their own role as a nurse. However the strong need to have actual experience of care appeared paramount to their being able to progress further in acquiring the professional skills of a qualified practitioner.

One of the issues of placing nursing education courses within higher education has been to develop the academic focus of such courses and establish the identity of 'nursing students' to replace the previous apprenticeship image. The students themselves perhaps perceived this more easily, as one CFP student stated:

Everyone is sort of saying you know that we all want to learn, I know that's our job at the moment - we're students ...

The phrase of 'that's our job' related to learning demonstrated a clear identity as a student, however the practice teachers [qualified practitioners as opposed to university teachers] appeared to lack a clear understanding regarding what the

students were there for. Two branch students expressed their concern about qualified staff as teachers saying:

> *Wendy - ... it's a bit worrying really if these people are supposed to be teaching us how to be a nurse and we're supposed to be learning from them and they don't know where we're at ...*
>
> *Teresa: I say to them 'I want to learn to do the job' you know what I mean, then they look at me a bit vague then you know, what do you mean, you know.*

This comment reflected the difficulties some qualified staff experienced in trying to teach students who were undertaking a very different kind of preparation programme to the one that they experienced. It also identified a potential problem with the role models available to the students. Traditionally trained practitioners were more likely to try to make students conform to their image of a student nurse, rather than respect the educational changes that had occurred and also understand the different type of role that these students were being prepared for.

One of the most commonly utilised strategies for learning was to observe role models in practice. A branch student described how she made sense of what she saw by stating:

> *I tend to like constructively criticise someone else's performance in my head if I'm watching. I think how would I do that differently, why is she doing that?*

She was demonstrating how her experience to date enabled her to interpret what she was seeing, and enabled her to compare it with other experiences in order to determine the best approach and thus shape her own performance. In this way she was using the experience available to her, but adapting it to prepare herself for the role she was aware that she would do rather than unthinkingly accept the standard of practice modelled. Similarly another branch student commented:

> *It's quite useful to be able to talk to nurses who've had a lot of experience in that area and from the research it has helped you to be able to talk a little bit more on their level and to understand ...*

Here it was possible to see how she was building on the experience she had gained through her personal course research project, as well as using the qualified nurse's experience in order to increase her understanding and prepare herself for her role as a qualified nurse.

Many students recognised that they would need to carry on learning once their course had finished, and were conscious of the need to increase their care experience to become both competent and confident in their nursing skills. They realised that academic knowledge was not enough as two branch students identified, saying:

> *Wendy: with a degree or not I need the experience, it's not my course it will be the experience that gives me the authority and competence and confidence to ...*
>
> *Ursula: Be assertive yeah.*

Three branch students used their current learning experiences to try and make sense of how they would continue to develop once they were qualified saying:

> *Veronica: I think if it's a particular skill that you want that you're worried about there's no point in avoiding it when you're qualified 'cos it's like at the moment if you know that there's something that you're not very good at (um) people have been saying to me that the only way that you're going to overcome that is by practice and experience, and it's the same when you qualify if you're not sure of something then you've just got to admit it and it's through practice and experience that it's going to improve*
>
> *Teresa: That's right*
>
> *Wendy :It's up to us isn't it; to make sure we carry on.*

This was further demonstrated in a discussion between two branch students when thinking how it would be as qualified nurses:

> *Teresa - Well I think it's going to be - I mean as that staff nurse who's been qualified six months said to me the other day 'what you learn in the first six months bears no relationship to what you've learnt in the last three years. Really, there's so much more' and you know I just can't wait for the next six months to go by*
>
> *Veronica: Yeah it's like a continuation of it really.*

Throughout the interviews students gave many examples of how they added one experience to another, gradually increasing their knowledge and skill base, and also made use of other peoples experiences to make sense of the 'job' they were trying to learn. They clearly valued practice experience and needed it to develop confidence in their own ability to become qualified practitioners.

This strategy of building experiences, one upon the other, may be compared to Ausubel's principle of integrative reconciliation (1978, cited in Oliver and Endersby 1994: 60), an aspect of his assimilation theory of learning, which describes how new knowledge is consciously related to previous knowledge to create a more comprehensive picture. However a sufficient amount of experience is necessary if this picture is to make sense to the student.

Levels of Learning

This category relates to a variety of levels both of academic experience and clinical practice, recognising differences and similarities between different types of students and qualified staff. The initial level is concerned with gaining survival skills, those that enable the student to 'fit in' to the environment they have entered. Two CFP students discuss this:

> *Olivia: I think you have to use your initiative a lot more in placements, it's down to you really ...*
>
> *Frances: that's what I meant earlier ...*
>
> *Olivia: to look for information*
>
> *Frances: (mmm) that's what I meant, using your initiative and trying to gain it, and knowing when to be quiet and humble (laughs)*
>
> *Olivia: I mean well they're trying to carry out their work aren't they, and you've just got to try and fit in around them and sort of find things out for yourself because they haven't really got the time, well!*

Many students described how they would rummage through cupboards to search for information that would tell them about the nature of the ward, it's clients and the ward routine. This was a strategy that I was able to personally

identify with, as it was reflective of my behaviour in clinical practice when preparing to undertake participant observation. As a supernumerary member of staff, supervised by a preceptor, I was aware of constantly asking questions of very busy people. Strategies of trying to find information from other sources that would enable me to 'fit in' with the ward environment without causing too much trouble to those looking after were similar to those later observed with participants.

A CFP student elaborated on this issue stating:

> *What I tend to worry about is how people consider me; you know how they consider my actions as a student on the ward. I want to do it their way so that I can fit in firstly and then learn from that way - do some of the basic tasks first and just learn their way and fit in their little system.*

The need to fit in was strong enough that students would accept doing lower status work until they had found their feet as a CFP student identifies:

> *On the first placement on maternity you're a great pair of hands for the midwife I felt, a gopher - fetching and carrying, which wasn't a bad thing because you're learning where things are and you still feel involved.*

The student's acceptance that learning continued whilst fetching and carrying was generally the case amongst students. It appeared reassuring to be asked to do relatively simple tasks until familiarity with the environment was established, at which point they desired more challenge.

However although this student may have had a clear self-image and awareness of the need to learn in clinical practice, even from simple tasks, not all experiences were so straightforward. A CFP student described a case of mistaken identity:

> *I got messy on maternity and I put a green surgical top on and I had a doctor sitting in the coffee room happily talking to me for half an hour and then somebody came in, a midwife came in and asked me to go out with her, and he looked at me, he said 'oh what are you then' and I said 'oh just a student nurse', I didn't say just I said 'a student nurse', that was it he never spoke to me again (laughter), I think he thought I was a student, a medical student you know ...*

Although the student had no problems learning from a doctor, it appeared that the doctor did not perceive it as his place to discuss issues with a student nurse.

This lack of understanding extended to the debate between Diploma and Degree students, not even the students were clear as to what the difference in level was, as illustrated by this group of CFP students:

> *Olivia: I don't think that degree students should know any more than (um) Project 2000 students basically, you should all be at the same level*
>
> *Susan: you're talking about just in practice?*
>
> *Olivia: in practice yeah because that's .... patients should get a reasonable standard of care and having ...*
>
> *Susan: at the same level*
>
> *Lesley: yeah they are aren't they?*
>
> *Olivia: ... worked with them they're saying that you're going to get (ah) better care if you get a degree student than if you get a Project 2000 student, I don't know*
>
> *Lesley: I think the only difference is in the qualification that you get at the end, the academic qualification ...*
>
> *Olivia: that's right, even research*
>
> *Lesley: ... your registration's going to be the same so therefore the amount of practice that you'll have done would have been set by the Board [ENB] and should be the same.*

There was much debate about the difference not only between Diploma and Degree, but also the differences between newer education courses to more traditional ones. A branch student appeared clear about the difference in the course she had followed stating:

> *Which is why our course I suppose in a way ... is to go off to do, to have the knowledge to go off and adapt to new situations, whereas before you had to learn all the tasks and then you know exactly what you're doing whereas you probably couldn't adapt to new situations could you?*

Her point about having the knowledge to 'go off and do' demonstrated the student's perception about knowledge based practice, one of the major differences they perceived in their preparation course.

They took ownership of their responsibility to learn as two CFP students discussed identifying the need to establish their learning levels:

Susan: I think that's what you have to do as a student; you have to be there all the time ....

Frances: find your own learning level

Susan: Yeah

Frances: I've found that.

Despite their relative lack of experience they clearly thought that they should be self-directed in learning, taking responsibility for their own achievements in practice and setting their own standards.

Different levels did not only relate to academic issues but were also evident in relation to practice. Two CFP students identified the response of patients to their status saying:

Lesley: patients don't really differentiate between you as a student nurse ...

Susan: no

Lesley: or say a more senior nurse and they're likely to ask you just as they would anyone else, the only person who stands out for them is Sister, they know the Sister, all the others - the auxiliaries are nurses, they'll ask the same question to any of us who may or may not be able to answer.

This recognition that to the users of health care they were just one of a number was a potential source of conflict. The students were aware of differences in the way they responded to practice situations and tended to compare themselves with Diploma students as two CFP students illustrated:

Frances: I don't discuss things like this with Diploma students who, a lot of them are my friends; I think we're very quick to pick up the ethics ... when we're on placements

Lesley: (mmm) and on right practice as opposed to bad practice.

Their concern to succeed was also demonstrated in relation to personal achievement in clinical practice, their information coming from the practice profile (described in chapter 1) that was used to assess their progress. This was

also the cause of some competition between the students as a CFP student demonstrated:

> *It does show in the practice profiles doesn't it? I mean we know that we've only got to reach level 2 and that but I mean the first two placements we're all charging around saying I've got a 4 or God they've only given me a 3 for that surely I deserve a 4 for that one, trying to push it up you know, and everybody's trying to show off their 5's, you know I've got a 5 you know and it shows doesn't it that we're all trying to sort of be there ...*

At this stage in their programme they were not realising the relationship between 'gaining their levels' and being competent to practice. Achieving level five was their goal but they failed to understand the implication of subsequently being accountable for their own practice once they had been assessed as able to function at a particular level.

The need to control their own level of learning in clinical practice continued throughout the course and was described by a branch student:

> *Well at my stage I prefer my learning to be a bit more self-directed and if I had any trouble then I would go to my mentor and say I've done this or if I need any questions answering that I couldn't find out for myself. I quite enjoy finding out for myself and I think it sticks rather than someone telling you this is this and that is that.*

However despite wanting to take control the students continued to need feedback on their performance levels. A group of branch students related their need for feedback to that gained from academic assignments saying:

> *Wendy: like the assignments, I only know if I've learnt some theory if I get a mark back that's good, and in practice I only feel that I'm getting anywhere and I can give myself a pat on the back if somebody else comes along and says 'you did that well' I'm just one of those people who can't ...*
>
> *Teresa: you've got no perception of your own ... yeah*
>
> *Wendy: I can assess my own performance but I'm still worried that you know I've got a different perception than other people ...*
>
> *Veronica: (mmm)*
>
> *Wendy: and I definitely need feedback from my mentor.*

Their difficulty in determining the levels at which they should be practising may have related to the role models that they had in practice having undergone different types of preparation courses to the one they were on. This potentially influenced the expectation each had of the level of performance that the student should be demonstrating. The role model may have expected behaviour similar to their own when they were a student, or to more traditionally prepared students of whom they had experience. Whereas the student had a different expectation due to the visions created for them by their university teachers.

Some role models tried to help the students to self-assess their performance although this caused a degree of stress for some students. Two branch students described this:

> *Wendy: on the last placement ..... when it came to do the final profile as it was on my second to last day and we sat down to tick the boxes for the final time and I was terrified that I wasn't going to get the levels, and as we were going through - they usually go down the list don't they in turn - well she left a couple of sections out and she said 'I'll come to those later' and the look on my face, my mouth must have just dropped down and I was, I was you know I wasn't quite trembling but my heart was beating faster and I thought 'I'm not going to get the levels, she doesn't think I'm a good enough nurse' and (um) she made me go back and evaluate them, justify myself - how I'd achieved level 5 in each of those and (um) I said ...*
>
> *Teresa: really?*
>
> *Wendy: I thought perhaps thought that I'd achieved level 5 in each of them and I said why and she said at the end 'yes I think you have achieved level 5 as well but if you hadn't have said that you had I wouldn't have given you the levels because you need to say that you've got confidence in your own competence as a nurse, there's no point in me sitting here telling you that yes you're going to make a good nurse, you need to know it yourself, you need to be able to evaluate your own performance'.*

Having to justify her level of performance helped this student to recognise her personal and professional development, and was a useful strategy in assisting her to take on the accountability necessary to practice as a qualified practitioner.

However it was clear that she did not necessarily find the experience an enjoyable one.

Some students responded well to recognition of their knowledge base, as one branch student identified in discussion with another:

> *Ursula: I get quite excited actually when like you've got a situation on the ward (um) a bit sort of something on mouth care or terminally ill and (um) chemotherapy and (um) the nurses, The Sister's very into you know research for mouth care and (er) she was trying to find the best mouth wash and stuff to use and (er) I got quite excited about it because it was like a little project for me to do and I said 'well I'd like to get involved with that' so I went off and I'm currently looking at ...*
>
> *Wendy: doing your own research*
>
> *Ursula: yeah yeah it's nice because I'm actually working with her as well because she's interested in the subject as well so it's going to benefit the ward ... and it's interesting for me to find out.*

This experience perhaps suggests that one dimension of the new role of students should be to contribute to the development of evidence based care.

Students demonstrated the need to integrate their knowledge in practice and by the end of the course had developed clear identities of themselves as nurses, as a branch student stated:

> *... but now we're definitely nurses first, definitely but with the theory to back it up I like to think.*

They had also developed a view that learning would continue and saw themselves as potential change agents in practice. This was demonstrated by a branch student, who stated:

> *I think we realise that we're sort of at the forefront of this change, I mean we've had it sort of taught to us and you realise, especially when you see people who've been traditionally trained some time you do see a difference. It's not their fault but there is a big difference.*

Thus as their course progressed the students saw themselves moving through various levels of performance, both in theory and practice. They made sense of

these by comparing themselves to fellow students from their own and other courses, and to the performance of the qualified staff they met in practice.

These comparisons helped them to form an identity of themselves as 'knowledgeable doers' as the UKCC (1986) described the outcome of the Project 2000 style courses. However they were able to extend this identity to encompass the qualities of graduate practice and thus determined their future role and developmental needs. Glen (1995:91) suggested:

> *What counts for higher education is the student's ability to understand what is learned or what is done, to conceptualise it, to grasp it under different aspects, and to take up critical stances in relation to it.*

In identifying levels of learning the students were demonstrating how they were progressing through those levels that would previously have been relevant to more traditional preparation programmes, to the higher order levels appropriate to new preparation programmes that enabled them to 'take a critical stance'.

Bargaining

The strategies students employed to gain learning experiences were identified, in particular the need to utilise 'tit for tat' processes in which they recognised that they must 'pay in kind' in order to access the learning opportunities available in practice. This was called bargaining. Initially students found this acceptable, perceiving that they needed to contribute to the working environment and that their teachers in clinical practice were not there just to look after students. A CFP student stated:

> *I think if you're prepared to muck in as the expression goes and help then they'll, when they've got some time they'll show you things which you persistently ask all the time.*

She further identified her own responsibility for learning in clinical practice, the need to respond to the learning opportunities available saying:

> *If you're willing to ask you can learn as much as you want really and you're in control of what you learn, if you read what they give you and*

> *find out exactly what happens, what goes on there, you're really in control to learn as much as you want or as little as you want.*

However there was conflict for the students in trying to meet their own learning needs and meet the expectations of practitioners who were responsible for teaching them. A CFP student identified an awareness of this conflict, for both students and practitioners stating:

> *You've got the personal thing where you're trying to get on with people and you're trying to learn and you're trying to witness but you don't want to feel you're badgering them you know.*

The need to form good working relationships was seen as paramount to being able to learn in practice.

A group of CFP students discussed how carrying out menial work helped them to be accepted in practice and thus access learning opportunities:

> *Susan: I think that goes with the old if you will, when they're really busy, you (um) sort of make yourself available to do all, everything don't you ...*
>
> *Frances: That's right*
>
> *Susan: all the chores and ...*
>
> *Frances: Take the tea trolley round, mop the floor or ...*
>
> *Susan: help them or stay a bit later and then they'll sort of help you that way, or that's what I've found anyway - it's give and take isn't it?*

Students rapidly learnt this form of negotiation, realising that if they contributed to the work to be done, even when it did not have a great deal of educational value, they would ultimately benefit. It also reflected the reality of the working environment where not every aspect of a nurse's role was stimulating and interesting, but that all aspects together perhaps made it a rewarding experience.

Conflict emerged in that, although students were clear that they were in practice to learn, they encountered different responses from their mentors, some facilitating learning and others denying it. Two CFP students, whilst recognising

the need for them to contribute to the work to be done, discussed the difficulties in ensuring that they got the learning experiences they needed:

Lesley: you go in as a junior nurse then ...

Susan: but you're still responsible aren't you?

Lesley: at the end of the day we're responsible now aren't we, it's a very big weight on our shoulders ...

Susan: but not to the same extent because nothing - like drugs you wouldn't give out drugs without your mentor double checking it or you shouldn't

Lesley: yes, some of us have never given out any drugs at all

Susan: why?

Lesley: well on my first placement I was told it wasn't anything I needed to know about on first placement so I couldn't even ...

Susan: didn't you pursue it?

Lesley: well yeah but then they usually found something else for me to do like (um) commode round or something

Susan: you see I would have to question that, I would have to say something, I would do the commode round but I would say ' look I know I'm doing all this and I'm not here just to empty commodes, I'm here to learn and I already know how to empty a commode ' and you know it's like the give and take thing, I would have to say something.

Once again it was evident that students saw learning as their responsibility, but identified the need to bargain with clinical staff to access learning opportunities. At times their perception of how rapidly they could progress could be unrealistic, but at the same time they were gaining a holistic perspective of care, which was valid, rather than the fragmented view that traditional 'task orientated' preparation programmes produced.

The 'give and take' theme continued to emerge as students progressed into the branch programme, as did the need to prove themselves capable of contributing to the work to be done in order to gain learning opportunities, which were seen as a 'prize' by these branch students who stated:

Teresa: then once you can go on the ward and show them that you can do the basic care then they seem, you know it gives you confidence 'cos you

can sort of contribute something to the work of the shift and I think they also then think 'oh she can do that so now we'll show her how to - now she can do the drugs and' you know 'change bags' and ...

Wendy: it's like you have to contribute something to their work before they give you the prize that (laughter) of being able to learn

Teresa: yeah yeah

Wendy: now that you've emptied some commodes you can learn how to be a nurse.

It is possible that the students' experiences were a result of qualified staff's perceptions of what students were there for, reflecting their past personal experiences of nurse education. The conflict of education or work surfaced again, with the students and practitioners clearly having different priorities.

Having moved into the branch programme students demonstrated evidence of their socialisation into the clinical culture and acceptance of the values to which they had been exposed regarding practice-based learning. A branch student identified that:

It seems that you have to earn your respect first and sort of get into the ward culture and then, then you're able to start looking at ideas and giving suggestions.

It was apparent from this statement that this student saw herself as having a degree of control over her learning in that she could contribute to learning experiences through suggestion and offering her own ideas.

However CFP students did not find that so easy, in fact discovered that at times they met 'blocks' in learning because practitioners perceived them as belonging to the university and therefore did not feel they had a responsibility to teach them. This lack of commitment was demonstrated in discussion by a group of CFP students:

Frances: I would say, again going back to mental health, they certainly felt totally detached you know, or felt that we were totally detached from them, that we belonged to the university and we were just there ...

Olivia: not part of it

Lesley: yes

Frances: because we had to be and they would tolerate us

Olivia: yeah and when you told them you were doing adult nursing and you were a degree student that was it you know, they didn't want to know you particularly, it felt awful you felt guilty almost ...

Frances: I was a bit naughty ...

Olivia: being adult adult

Frances: yeah I was a bit naughty actually I felt I couldn't say I was actually an adult nurse I just said I hadn't decided yet until I branch ...

Lesley: what!

Frances: because (laughs) ...

Lesley: veracity and all that ...

Frances: you know I must be honest I felt I had to I really just felt I had to you know.

Frances' behaviour perhaps showed the lengths to which students were prepared to go in order to bargain for their learning opportunities. Whilst it was criticised by the other students they also understood why she had behaved in this manner.

Practitioners were not always motivated to teach and some would take action to avoid it, a branch student highlighted this in discussion:

I remember a senior staff nurse, we were really quiet, the ward was actually closed because we had (um) MRSA actually all over the place and (laughs) so it was really quiet and (um) we'd been round tidying up everywhere and everywhere was tidy and all the patients were happy and nobody wanted to go for a walk or anything and we could, well nobody wanted to do anything. So there was myself and another couple of students on and we were saying this would be an ideal opportunity to, for somebody in the staff nurses to give us some sort of teaching, so we were just going to suggest it and say 'what do you think we could learn, what do you think you could teach us, what could we go through' when she sets us to work cleaning out all the cupboards and cleaning out all the linen cupboards and the kitchen, and we said that the domestic's coming on later to clean up the kitchen and she said 'well she isn't here now' and no amount of being assertive in that situation I don't think would have changed her attitude.

The difference in perspective between the students whose major role was to learn, and the practitioners whose major role was to care, may account for the perceived denial of learning opportunities. Many of the practitioners who acted as mentors to the students had undergone a more traditional preparation course and were having to learn to deal with a new type of student with different demands.

The clear identity as a student probably reflected the higher education environment into which the students had been socialised. Whilst nearing the end of their branch programme they conjectured what they would be like as trained staff and how their learning would continue. A branch student stated:

> *Identifying what you need to learn and who you want to learn it from and suggesting to people 'well how about I' like you say 'how about I have such and such as a preceptor, how about I do such and such as a project' or 'do you think we could do this for students' or 'do all of us staff nurses know this'.*

She appeared to be transferring the negotiating skills she had learnt as a student into her future role. Thus the perception of the need to bargain continued, in order that learning needs could be met at the same time as fulfilling work expectations. It was at least reassuring that she saw herself working in partnership with her peers to continue learning both to meet her own needs and those of students. Melia (1987:161) identified that:

> *Much of what the students preparing to join an occupation learn, then, comes to them in subtler, complicated and negotiated ways.*

In this respect it would appear that little had changed since her study with regard to what she identifies as:

> *The uneasy compromise which has to be maintained if nurses are to be trained and patients are to be nursed.*

This compromise was evident in the issues that students raised, and to an extent was exacerbated by the practitioner's awareness that they too needed to change their role. The one for which they were prepared no longer being sufficient to meet the needs of health care today. Many practitioners themselves were

experiencing conflict in trying to work and study at the same time in order to meet the new demands being made of them.

The issue of being allowed to learn remained despite the move of nurse education to higher education institutions, and despite the supernumerary status of students. This created the need for students to bargain and develop negotiating skills in order to get the learning experiences that they needed, skills they were likely to use throughout their careers to meet lifelong learning needs. The need to 'bargain' for learning experiences perhaps also reflected the failure of qualified staff to perceive the changes in nursing roles, and therefore the need for a different type of practitioner who has been educated differently.

Safety Net

The need for a safe learning environment was vital to the success of learning in practice where students recognised that they were a potential danger to patients and colleagues. The main factor in creating safety was their mentor, a practitioner who acted as friend, supporter, guide, advisor, supervisor and assessor in practice. The latter aspect of this role was sometimes disputed; Morton-Cooper and Palmer (1993:123) identified that:

> *The concept of support (which is to be open, non-judgmental, and enabling) is in direct conflict with that of assessing a person's performance.*

However it is difficult to see how a mentor could guide, advise and supervise without inevitably assessing what was going on and providing feedback. It was perhaps more useful to see assessing, in this case, as a way of facilitating learning. In this category the facilitative function of mentors was reflected, particularly the strategies which provided a 'safety net' for students, allowing them to 'do' without being in danger.

In the CFP students were seeking a supportive relationship, a mentor who would be friendly and help them to feel at home in clinical practice. They

wanted to be valued but at the same time recognised their inexperience and so were looking for a relationship that would allow them to practice their developing skills in safety. Two CFP students discussed how they approached a new environment:

Lesley: it's nice to be shown the ropes of the ward, go along with your mentor or another experienced nurse who will explain what she's doing and let you have a go as well, rather than just observe all the time

Frances: yeah then be left to get on ...

Lesley: yeah

Frances: left to (pause) like develop ...

Lesley: (mmm)

Frances: without being (um) considered a minion you know

Lesley: yeah

Frances: being given credit for your ability but at the same time being ...

Lesley: allowed some initiative

Frances: initiative yeah and being watched over.

Students frequently cited explanation as being necessary to enable them to know not just what they are doing but also why, so that they could link theory with practice. Mentors who provided explanations were seen as good.

There was a realisation that the mentor had a responsible position and took risks in allowing students to practice their developing skills. Having access to a good mentor allowed them to judge the standard of their own performance as these CFP students discussed:

Olivia: if you do make a mistake and react wrongly that's down to experience but you know the next time ...

Lesley: seeing how other people react to certain situations as well, this is where a good mentor is really valuable

Olivia: yeah you can learn a lot just watching your mentor you know it's important ...

Lesley: there's some mentors don't really want to be mentors, they get that sort of put upon them and although they do a very good job (um) they - one of the ones I asked that when I was doing paediatrics, she was

> *very good, I said 'would you rather not be doing it' and she agreed she would rather not be a mentor you know, not so many students traipsing through ...*

Their appreciation that being a mentor was not necessarily a voluntary function was interesting. As they progressed through the course they made comparisons between one mentor and another, finding a difference in the approaches of mentors towards teaching students. A CFP student observed:

> *My mentor she's taught me how to do the admissions and everything, and I've been doing all the obs and I think she quite likes it because she can sit down and have a cup of coffee or catch up with her paperwork and send me off to do the obs, the admissions, so in some ways it can be a benefit for the mentor, it takes the workload off their shoulders a little bit. Maybe not at first while they're teaching you but later on you know in the long term.*

Her observation that being a mentor was a two way process was an indication of the knowledge she was gaining of mentoring, which may influence her future attitudes as a qualified nurse. It was also clear from her statement that she enjoyed being trusted to 'go off and do', evidence that she felt safe to practice without direct supervision, but in the knowledge that her mentor was within reach if necessary.

The guiding function of mentors was important to students who were trying to make sense of the learning opportunities that were available to them. Two CFP students discussed this aspect:

> *Frances: I've found that on my ward because it's medicine as well so it's a whole new thing to take in, and I found that I was struggling you know all these various drugs they use, I didn't know what they were for I think but luckily my mentor sat down and wrote me a list of the main drugs that are used on the ward, gave me the BNF to take home and so it's up to me then to, you know with her help - she was very helpful, to look up and find out basically what they're for you know what sort of doses. I don't remember it all instantly but reading through it I mean it's a help, it'll all, it's gaining experience*
>
> *Susan: I think that really with drugs and things on occasion you don't tend to remember them until you've actually worked on a ward that uses specific drugs do you? I find it really helpful to actually to work, you know to do the drugs with the trolley and go round with your mentor.*

The need to have experience to make sense of theory was apparent, as was the need for guidance to know what it was they needed to know so that they could focus their learning appropriately. These branch students described a similar need:

> *Veronica: all this talk about (um) you know being responsible for your own learning ...*
>
> *Teresa: you need their help don't you*
>
> *Veronica: yeah I know that's what I mean*
>
> *Wendy: I find it difficult sometimes, not so much now we're near the end of the course but at the beginning of the course in the CFP there seems to be an awful lot to gain from this placement and I find it difficult saying what I need to learn if I don't know what there is to learn ...*
>
> *Teresa: yeah*
>
> *Wendy: 'cos you don't know it in the first place, you need somebody to guide you through it don't you, but they can't guide us through if they don't know how our course works.*

As these students were further on in the course they had learnt that not all mentors understood the demands being made on students. This resulted in some insecurity, as the students were unsure if what they were being taught in practice was what they needed to know to meet the requirements made of them.

The supportive function was seen in the way that mentors encouraged students to try out skills, A CFP student identified the importance of this aspect:

> *It depends on your mentor as well you know, 'cos I've always maybe I've just been lucky but I've always had mentors who would push me into doing it, even if I'd said 'oh I don't know if I'm quite - oh I feel a bit nervous' and they've said 'oh if you never do it you'll never learn, come on I'm here, it doesn't matter if you make a mistake.*

The mentor 'being there', making it possible for the student to try something in the knowledge that her mentor could help if things went wrong provided safety in this situation.

As the students progressed through their course their comparisons of mentors led them to draw conclusions about the quality of mentorship, they realised that

their learning opportunities might be affected by something that was outside of their control. A CFP student clarified this saying:

> *We keep going back to the question of mentors, we had this discussion again this morning in our reflective session and there seems to be three types of mentor, the very good, the mediocre and the downright rubbish [laughter] and it's the luck of the draw which one you happen to have, so (um) one of our colleagues this morning said when we evaluate our placement shouldn't we be evaluating our mentors as well, so maybe a questionnaire type thing, a quality thing with mentors might be a good idea.*

Students had experience of evaluating taught theory units at university, and had been able to comment on their placement experience in general terms, but it was interesting that this student had begun to see the process of evaluation extending to mentoring as well.

Further progress was seen as students in the branch programme discussed the value of critically reflecting on their actions with an experienced practitioner:

> *Teresa: it's getting a balance isn't it really? I mean that I find my best learning experiences have come out of mistakes I've made ...*
>
> *Ursula: oh definitely*
>
> *Teresa: I don't mean horrendous life threatening mistakes, just little things and where they've noticed you've done it and they put you right and you know and explained*
>
> *Wendy: that's it isn't it, having time to talk to someone afterwards who understands what you've been through and can support you to make it better.*

Structured reflection was a useful strategy to help students to learn from their practice experience. Parker et al (1995:112) identified that:

> *Practice-based experience is the major type of planned experiential learning for student nurses. Experiential learning is based on real life experiences and presents learning as a holistic, adaptive continuing process.*

Mentors who employed reflective techniques with students helped them to learn both in and from practice experience. The simple strategy of discussing action

with students enabled them to clarify and extend their knowledge, adapting it to meet new situations.

Another strategy that students found helpful was questioning, but again within a safe environment. A branch student identified this:

> *I think you learn more when they question, my best mentors have been sort of, not threatening exactly but the more questioning ones who, you know.*

The need for challenge was important although some students were less able to cope with this than others. Another branch student discussed with her peers the assessment made of her by a mentor at the end of a placement and how she would use this in her final placement:

> *Veronica: I know going into my last placement that's something I've really got to work on and I know that myself, and that's like a challenge to me in that I won't be able to do that (um)*
>
> *Teresa: so you'll tell this mentor will you that that's your area, otherwise she won't know will she?*
>
> *Veronica: no I know*
>
> *Teresa: because it's something in yourself you mean?*
>
> *Veronica: yeah it's something in myself as well but I sort of - I suppose I'll tell her part of it but I don't want to tell her that, my weakness because (um)*
>
> *Wendy: it makes you feel vulnerable?*
>
> *Veronica: yeah*
>
> *Wendy: you do feel sort of exposed but I find the only way I can get some confidence in my competence as a nurse is by having feedback and usually that's from the mentor isn't it?*
>
> *Veronica: yeah.*

It appeared that more confidant students responded well to challenges but those lacking self-confidence were more likely to feel threatened by it. While this might reflect personal characteristics it may also have resulted from learning experiences the students had. Not all mentors made students feel safe in learning their role as a nurse. The system of assigning mentors might mean that the

preferred teaching style of the mentor did not match the learning style of the student.

One branch student thought that a system of selecting her own mentors might be more useful as she could then identify whom she wanted to learn from. She stated:

> *I think it's a shame that as qualified nurses with all their experience they have so much to teach us and I think if they concentrate enough on teaching us what they know then we could perhaps pick out the ones that we want to be our role models and pick out the bits of knowledge from different people that we meet and we feel is useful, and anything that they tell us that we think well that sounds good, bit traditional, bit sort of ritualistic, we could go away and think about another time, but they seem very reluctant sometimes don't they to tell us anything 'cos they think it won't fit in with our course or something.*

It was apparent that the amount of clinical practice she had enabled her to discriminate between knowledge and skills that were appropriate to the role she would perform and those that were not. She was able to learn even from poor quality role modelling, analysing the behaviour of her role models and synthesising knowledge from other experiences to determine what knowledge to make use of and what to discard.

Mentor's attitudes were another influencing factor in creating a safe learning environment. A branch student commented:

> *My mentor had just come back from holiday and she's, she seems interested and she said to me 'Teresa have you done much going through the cardiac arrest trolley' and I said 'no I haven't' and so you know because she was interested it was really nice 'cos we had time and we went through it all and that was really nice but - some people aren't that interested and if you ask them to show you something you can sort of see that you're just putting a burden on them and it's busy, so you know although you try you can't really control it but you have to be quite assertive otherwise you get nowhere.*

Teresa's awareness of the time element of being a mentor identified another factor in creating a positive relationship. Students were aware that the demands

they made on their mentors were high, and that a mentor who responded to these demands made her own workload greater, increasing the pressure under which work was carried out.

This issue of the mentor's confidence in being a teacher was also important. Most practitioners were prepared for their role through attending the English National Board approved programme (ENB 997/998[1]: Teaching and Learning in Clinical Practice), which tended to be a modified version of a teaching course. A revalidated version of this programme is discussed in chapter 7, identifying how a change has been made in the way mentors are prepared to correspond with new strategies introduced to the degree course.

It may be argued that the skill that mentors really required was that of facilitating learning, something that is quite different from planned teaching. The reality of learning in practice was that mostly it was opportunistic rather than planned. Mentors needed to be able to identify learning opportunities and help students to access and make sense of these. Sharing their knowledge and critically discussing care delivery was likely to be more effective than planned teaching sessions in practice.

Students were aware that learning would not finish when they qualified, and continued to seek a 'safety net' to carry them forward into their role as a qualified nurse. A branch student suggested that this need might be met by maintaining contact with teachers at the university:

> *Well what I think is quite valuable is not to feel you're sort of out there on your own, even if you have a preceptor you sort of - there's just you and the ward and that's it. I think it's quite valuable to still have contact with, I mean even if you're not in the area, I mean obviously I won't be in this area when I qualify, but if I was here just to have contact with the same tutors, and to know you can go to the university for advice or contact the*

[1] ENB 997 for midwives and ENB 998 for nurses

> *careers office, and to use the library and things like that, as you have as students ... because you've established a sort of way of learning haven't you, discovering things and to have that cut off I think you'd feel very left and out of control really.*

It can be seen that both during their preparation for role and afterwards students sought a safe learning environment in order to gain the maximum value from learning opportunities that were available. Mentors were able to provide safe learning conditions by supporting, guiding, advising, supervising and challenging in a non-threatening manner. However they needed confidence in their own abilities to achieve this. Maeve (1994:14) suggested that:

> *Bedside nurses are not encouraged to behold themselves as experts.*

She claimed that the role of expert had been claimed by academics and thus that the nursing knowledge passed from one practitioner to another was devalued. However she went on to assert:

> *Bedside nurse are empiricists who observe what works and what does not; we learn what soothes and heals and what does not; we show each other, and we tell each other.*

Making use of critical conversations, reflective discussions between mentors and students about what had been happening, was one way of valuing the knowledge gained in practice.

Self-Centred Practice

This category refers to the influence that traditional practice had on the learning opportunities available to students. Sometimes these were selfishly denied to students and at others qualified staff perceived no need to consider the needs of students, behaving in a self-centred manner and meeting only their needs. In this category the negative side of mentoring was portrayed. This aspect was perceived more by CFP students, possibly because of their greater need for support in practice due to their lack of clinical experience. Branch students who had more experience appeared to be either more independent or more impervious to the influence of traditional practice. Self-centredness did not only

apply to practitioners but also to students who put their own learning needs first before meeting other requirements made of them in clinical practice.

One of the major problems that students expressed with regard to learning from qualified staff related to those who had not updated their knowledge and skills since registering. A group of CFP students discussed the difference in their mentors and how it effected learning in practice, saying:

Lesley: so unless they've had continuing education

Frances: (mmm)

Lesley: you could be stuck with some sort of procedure from the dark ages that's no longer relevant

Frances: I didn't mean the whole procedure I just meant the little

Lesley: but it is the little things though, some people are interested in them

Frances: (mmm)

Lesley: sort of keeping up with (um) modern practice and client-centred practice and other people are sort of stuck in the same sort of practice they had when they first qualified and nothing's going to shift them from that practice

Olivia: Self-centred practice

Frances: (mmm)

Lesley: yeah so that's definitely the difference between the sort of mentor or team that you might work with.

Despite the early stage the students were in on the course they were realising the importance of continuing to learn, knowledge that would stand them in good stead once they qualified. It was interesting that traditional practitioners were seen as self-centred, this selfishness arose in other examples. A CFP student related this to age, a fact that may be contested, saying:

I find that the younger nurses that are sort of maybe out of (um) nursing, nurses who've been here say two or three years ago then they sort of tend to help more and they know what it's like to be a student nurse. Ones that trained about sort of 50 years ago (laughter) or more well you know they just sort of you know they just expect you to learn yourselves, on the ward yourself.

In reality it is the time that had passed since qualifying that appeared to be the influencing factor rather than chronological age. This however was not a generalisable statement, but represented her perception of the situation.

Selfishness also related to the students in acquisition of learning opportunities as another CFP student illustrated:

> *For instance in the first placement on maternity if I hadn't have said can I can I can I, for instance giving pethidine injections or things like that, if I hadn't have asked I wouldn't have been allowed.*

The concerning factor was that the student felt that learning opportunities would have been denied if an assertive manner had not been adopted. The student emphasised this again later by saying:

> *... yeah it's entirely up to me to teach myself and to ask to be taught.*

This statement may be interpreted as the student becoming aware of the need to be self-directed in learning, however to meet this requirement an element of selfishness was required, putting the student's own learning needs perhaps before the needs of others.

The development of assertiveness skills was vital to students being able to ask to be taught. A branch student identified:

> *I wasn't as assertive as I should have been so ... so I didn't make as much effort as I should have done to learn or to gain the most experience from the ward, whereas another place where maybe you're enjoying it more (um) I found that I sort of, I do try and be more assertive 'cos I'm not generally as a person that assertive but (um) yeah.*

She clearly responded to the friendliness or approachability of learning environments, getting more out of an experience where she felt happy. In her earlier statements related to 'safety net' it was apparent that a lack of confidence and associated lack of assertiveness had impeded her personal and professional development. Assertiveness, then, may be seen as a positive form of self-centredness in learning situations.

The supernumerary status of students should have facilitated them meeting their learning needs but too often they were seen as a useful pair of hands in practice, especially in placements with a high workload and low staffing level. A CFP student identified:

> *Well I was more or less left to my own devices on my first placement (um) some of the staff just referred to me as the student (um) and I wasn't really involved, unless I was with my mentor I wasn't really involved, nothing was explained to me, I was just left to fetch and carry, and if I did ask something like one time I couldn't get this gentleman's blood pressure and (um) when I asked for help I was given the reply 'oh there's a machine in the linen room use that' ..... but not shown how to use this particular machine so I didn't learn anything at all.*

This example illustrated the lack of commitment that some mentors demonstrated towards teaching, seeming to be unaware of the student's learning needs.

Two branch students discussed the attitudes of mentors towards facilitating learning in practice:

> *Wendy: so even though it was our learning opportunity we had absolutely no control over it because she was just denying us that opportunity basically. I don't think that happens very often thank goodness, basically I think if you say to them, well what you're really saying when you say 'tell me about this' is 'I really value your knowledge' and 'could you teach me 'cos I don't know anything', we do but perhaps it gives them a confidence boost, as long as they've got the confidence I think*
>
> *Teresa: and it does make such a difference when they're interested in you and in teaching and happy to share their knowledge with you, it just makes such a big difference, it's hard to put into words really.*

Qualified staff who did not recognise and use learning opportunities for students were also denying their own developmental needs. As Wendy identified they have a wealth of knowledge and experience but if this was not shared then their practice may have been carried out unthinkingly and they would not develop their own quality of care provision.

Students also demonstrated concern when qualified staff did not value the knowledge that they had. Two CFP students illustrated this:

Lesley: when you try and apply something that you've learnt and that you know to be right and you get people laughing at you

Frances: (mmm)

Lesley: well that happened when I offered a patient that had been on the commode the hand washing facilities and they just scoffed at it

Frances: (mmm)

Lesley: they thought that was hilarious you know - this is the real world love get on with it (laughter from group)

Frances: shocking

Lesley: yeah

Janice: how did the patient feel?

Lesley: the patient was surprised, she'd never been offered hand-washing facilities before and she probably never was again.

One of the implications of the structure of Project 2000 style courses was that in the common foundation programme students gained a great deal of knowledge, but had little opportunity to apply this in practice due to the programme's structure of two thirds theory one third practice split in experience. The need to have practice experience to make sense of theory has already been discussed in 'bringing theory to life'. Thus in situations such as that described students lose confidence in their own knowledge because of the negative response of practitioners.

Fortunately not all mentors responded in a negative manner, although many remained guilty of carrying out care without being able to justify it. Two CFP students discussed this issue:

Lesley: it definitely helps if the person you're with knows why they're doing something, sometimes they don't. I mean I asked a question (um) why (um) is the backrest not allowed to be out if somebody has had a stroke?

Frances: (mmm)

Lesley: and 'oh I don't know we just do it like this' so I still to this day don't know don't know, you can prop them up on pillows but you can't put the backrest out, so they're doing something that they've never bothered to find out why, so I'm just as ignorant as they are. I suppose I could read it up, check it out but I haven't done.

Lesley made an important point in that she had copied the behaviour of the qualified nurse and not bothered to find out for herself, but at least she demonstrated self-awareness in identifying this. Students needed motivating to go and look up for themselves and responded better to enthusiastic mentors than to those who did not demonstrate an interest themselves. I was sufficiently disturbed by her comment to change into 'teaching mode' at the end of this particular interview and help her to work out the answer to her question.

The motivation of qualified staff to facilitate learning was a recurrent issue; a CFP student raised an interesting point:

On my first placement the green mentor handbook was taken and then filed away and it was never seen again, never referred to at any time and (um) never sort of had the time to sit and look at the log book either, so they see it as something that we have to do out of their time.

This issue of student's learning being 'out of their time' for qualified staff was another indication of self-centredness. Another incident described by this student was:

It was a bit like trying to do the admissions forms and that sort of thing, you ask and you ask and they'll conveniently wait until you've gone home to admit the patient, things like that, you get kept at the level they want you to be, to stay at.

Although students appreciated that trained nurses had their own job to do they also expected them to have some commitment towards enabling them to learn, and not to deny them learning opportunities.

This lack of commitment caused students to wonder what had happened to the staff since they qualified as this group of CFP students discussed:

Frances: because some do actually put work into it, make it a specific task on top of their other work, when others don't

Lesley: because they've all been students, they must know what it's like for us and you automatically think 'oh they'll be receptive to our needs and they'll want to help us' but it isn't always the case, it's almost like 'well I've had to do it' you know 'trial by fire' so therefore you're going to do the same sort of thing and come through unscathed at the end of it

Susan: (mmm) it's their problem though that isn't it. I think that should be because they should use it as a learning experience themselves, because if they've been out of (um) the training there's perhaps things that we've learnt or things that we've read, perhaps up to date material that we can share with them and they should take advantage of that.

It would appear that self-centredness caused qualified staff to forget the experience they had in learning to nurse and thus they failed to recognise that they were not facilitating learning for the students.

However self-centredness did not only relate to practitioners but was also applicable to nurse teachers. Clare (1993:282) identified that:

> *Nurse teachers and clinicians have socially constructed and legitimated power over students which acts to constrain the development of critical consciousness.*

The potential conflict arising from diversity between academic knowledge and clinical practice might result in confusion for students. Both teachers and practitioners were likely to be perceived as powerful, the students adapting their behaviour according to the environment that they were in. Clare (1993:283) suggested that:

> *Teachers want students to 'fit in' with as little disruption to the clinical setting while at the same time demonstrating their new and often different educational ideals.*

She argued that it was necessary for both teachers and practitioners to reconstruct their own working worlds before trying to get students to practice differently. This requires both groups to stop being self-centred and to ensure that the rhetoric of modern practice matches the reality that student's experience.

Expectations

This category explored the expectations held by students, their teachers and practitioners. These expectations could influence perceptions of what was happening. Firstly students had expectations of what practice placements would be like, these were shaped by the information, or lack of it, that they had. They appeared to expect that their mentors would perceive the student's learning as important and not let it be affected by personal issues. A CFP student identified the difference in approach when mentors were undergoing continuing professional development themselves saying:

> *... like you say they're generally happy people (um) they're generally all right in their own private lives (um) so they're not bringing their own problems to work and they're very (ah) education orientated in that they know, they're all doing education, we're together, they're all qualified but they're all taking study days so that's reflected in how they view you.*

The student's observation that when mentors were involved in education themselves they had more understanding of the student's learning needs was an important one. Problems when they arose tended to come from conflicting expectations of each other's roles.

Two CFP students compared information they had, or would like to have received, prior to or immediately on commencing their placements that led them to have expectations of what it would be like:

> *Frances: Do you feel, because some of the mentors don't get it across very well - it's not explained that well, or that you can't get it from them initially, especially in the first few days; but before you go on a placement do you think it would help if there were some printed literature about that ward? Not the sort they give to patients, you know that ...*
>
> *Olivia: I've got that*
>
> *Frances: ... like I've read yours ...*
>
> *Olivia: I've got a learner pack*
>
> *Frances: but it's very (um) I haven't read it all, I've read your - the papers that they give out to the patients explaining the wards and the colours of the uniforms and the staff and etc. but wouldn't it be nice to have*

> *one which not extensively but briefly (um) explains what they deal with on the ward - the diseases, all the surgery (um) how it may affect, and then if you had that you could at least pick up some basic books and have a little bit of knowledge when you go on, or have some of the abbreviations that they use perhaps on the ward.*

Their need to understand what they were experiencing came through; the information they received caused them to have particular expectations of a placement. Frances' point that this information needed to be different from that given to patients was a relevant one, information should to be written for its audience and to receive the wrong sort of information could be as useless as receiving none at all.

Students demonstrated an expectation that they would have to quickly 'fit in' with the clinical environment in order to be able to progress, but a CFP student, identified that there was a need to pace themselves:

> *I think like any placement when you first get there you want to fit in too quickly, you want to be part of it too quickly and you've got to just take a little bit of a back seat, an interested back seat until, you know, until you see the routine and the way it works and the who's who and then pick up when things tend to slowly, slowly work quite well, and you're reasonably positive it's going to be all right.*

The phrase 'interested back seat' indicated the student's consideration of the practitioner's expectations of students. Another CFP student clarified this further saying:

> *... but don't you think. probably (um) because of this you know we're degree students that maybe we're expected to do that ourselves?*

This was a student perception and did not necessarily represent the practitioners view, however as she was in her third placement it suggested that she had come across the attitude that degree students should manage their own learning in her practice placements to date.

Students also had expectations related to being taught in practice, but their experience led them to question whether practitioners and university teachers shared these expectations. Two CFP students discussed this:

> *Lesley: do you think also because we're university based that a lot of staff see us being under the jurisdiction of the university in terms of what we're taught so they don't go out of their way (um) for the teaching process. 'Oh it's not really our job, they belong to ... whatever'. Whereas previously I went to work on an orthopaedic ward as an auxiliary years ago and I was taught everything I know by the staff on that ward who took responsibility for me ...*
>
> *Frances: yeah*
>
> *Lesley: ... from the Sister down to the staff nurses and other auxiliaries. They were all active teachers all the way through. They didn't seem to think 'oh well, you know, she should be learning it from somebody else.*

Lesley raised an important issue in comparing her experiences as a nursing auxiliary and a student. In the former role there was a clear commitment from practitioners to helping her to learn the role, whereas although she could reasonably expect this to be the same for students her actual experience contradicted this expectation.

A branch student. demonstrated that the attitude towards who should teach the students did not change as students progressed through the programme, saying:

> *... and some days 'oh we'll teach the students now shall we' but they seem to assume that we've been taught how to do this and how to do that in university whereas we aren't now are we, not how to do certain tasks because they [university teachers] assume we'll learn how to do it in practice, whereas in practice they [practitioners] assume we'll learn how to do it in the uni (laughter from group).*

This identified the conflicting expectations of students, practitioners and university teachers. raising the importance of a collegiate approach towards the preparation of future practitioners. Students cannot be expected to integrate theory and practice if practitioners and university teachers do not have shared dialogue and facilitate student learning in practice.

A group of CFP students in discussing their expectations of being in the branch programme identified:

Frances: I want to feel confident and competent in nursing skills, you know practical nursing skills (um) the whole range you know, and at the moment I feel that I'm lacking somewhat

Susan: I tend to think ...

Lesley: we all though I know I tend to feel that

Susan: I think even after you're qualified that's something that you just learn as you go along isn't it because you can't do everything in three years and do the theory as well, I mean even people I've met when I've been on placement. people who are qualified, recently qualified, they don't you know there's still things that they have to learn. I'm sure you continue to learn forever

Frances: oh of course yeah, yeah

Susan: I think you know I don't think I would worry about that

Lesley: some of the confidence will come with experience, I think, it has to.

It was interesting to see that they were trying to put their learning needs into perspective and realised that they needed experience to gain confidence in their abilities, and that they would continue to learn after graduating. Two of the CFP students raised the issue of what it would be like to be qualified:

Susan: ... and on the other hand I think it must be really, I've always thought, when you actually do qualify it must be a real bitch really because suddenly you've always had a mentor there to help you and really you're not responsible but suddenly you've got this huge amount of responsibility and it's your fault, you know if you do something wrong but 'oh yeah I got a 5 in that' you know and you do it wrong ...

Lesley: but you go in as a junior nurse then

Susan: but you're still responsible aren't you?

Lesley: at the end of the day we're responsible now aren't we, it's a big weight on our shoulders.

This debate perhaps gave an indication of their fears as well as expectations, the worry that they may not know enough or have enough support in practice, either at that time or after they have qualified.

A similar issue was raised by a group of branch students in discussion:

> *Ursula: I mean one of my mentors asked me my strengths and weaknesses and you don't want to appear big headed and you don't want to appear ... it's very difficult ... so I immediately went on to my weaknesses ... the trouble is who's going to be there in 6 months time when we're staff nurses?*
>
> *Teresa: but it's so much better, I think it will be easier in a way when you're taking the decisions and you're not worrying, not worrying but you haven't this got thing that you've got to do it their way and you know I think it will be much easier when we're - harder but easier to take the ...*
>
> *Wendy: who will assess our performance apart from the yearly or however often they are appraisals?*
>
> *Ursula: I think you assess yourself don't you, I think you can continually.*

These students clearly expected to take responsibility for their own learning but identified the need to have feedback from others that they were doing the right thing. They were correct in their assumption that they would assess themselves from the point of view that nursing is a self-regulating profession. Once they had become Registered nurses they would be responsible and accountable for their own practice. However the need for continued support is recognised. Clinical supervision may provide the support that they were seeking. Butterworth and Faugier (1992:12) have defined this process as:

> *An exchange between practising professionals to enable the development of professional skills.*

The UKCC's policy that newly qualified nurses would undergo a period of 'preceptorship' following qualification (UKCC 1993a), and the recommendation that all nurses should have access to 'clinical supervision (UKCC 1996) demonstrated the concern of the regulatory body for support in the continuing development of nurses in practice.

Two branch students questioned the validity of expectations held of them by practitioners saying:

> *Wendy: The management sessions that we have I understand the diploma students don't have them and I know that ...*

Teresa: oh don't they

Wendy: no, very little management input. Some of the nurses that I've been talking to have said 'oh you're doing the degree course are you, well you're just training to be managers aren't you, you don't want to be a proper nurse' whereas they've been using the same management skills as we're being taught for years but because they have a specific name now - like interpersonal skills that we have and the research that we have, because we give it a specific names and we're taught in a classroom they think we want to take it away from practice sometimes.

In comparing themselves, to diploma students and practitioners, they were making sense of both theory and practice, and clarifying their own expectations. Their realisation that the current curriculum had formalised some of the learning that previously was more covert was a good one. Nursing curricula need to be dynamic in order to meet the rapidly changing scenario of health care delivery.

However the tendency, on the part of practitioners, to assume that students were not learning nursing as they did and to forget what they have learnt since qualifying in response to health care delivery changes was a common one. It is natural to make sense of the world by comparing new information to that which we already know, and practitioners are therefore likely to make sense of current nurse education by comparing it to the experiences they had as a student nurse.

The experiences that branch students had led them to think that they were being prepared for a different approach to care delivery and therefore they expected that once qualified they would not 'fit in' with more traditional environments, as one branch student identified:

I think the thing is we'll all go, you know, we'll hope to find an area where we feel comfortable, where they ... you know, I can't see any of us going into a traditional ward where ... you know, not for long anyway.

They perceived the changes as being long lasting, with nursing moving toward an all degree qualification as another branch student stated:

Well I think that's the way that nursing's going isn't it? I think it's going to be degree orientated eventually, the same as teaching.

This expectation perhaps indicated that these students felt that they were in a position to lead and shape care delivery, and indicated that nearing the end of their course they felt that they would be in a position to influence nursing. This view, hopefully, suggested a contradiction to the finding of Smith (1992:141) who identified:

> *Students describe trajectories where they begin fresh and enthusiastic with an 'uncanny way' of getting to know their patients, but arrive at the end of three years' training 'cynical and disillusioned'.*

However whether the student's expectations would become reality remains to be seen. Their feeling that they would not remain for long in a traditional environment may be an expression of their fears that they too might become 'cynical and disillusioned'.

Conclusion

The conclusions reached were sufficient to focus my attention for undertaking participant observation. The validity and reliability of these conclusions might be debated; Robson (1993: 402) identified that:

> *Many pitfalls centre on representativeness being assumed when it is suspect. There are tendencies for over-reliance on accessible informants (informants may therefore be non-representative); on accessible events (which may well be non-representative); and on plausible explanations (inferences may be drawn from non-representative processes).*

As the students who participated in the focus groups were volunteers I could not say they were truly representative of their cohorts. They may have had certain personal characteristics that caused them to volunteer that were not shared by other members of their cohort. They selected the events that they chose to discuss and thus I had no way of knowing if these were typical experiences. Inevitably I was aware of making sense of their experiences by using my own experience of learning in clinical practice.

In an attempt to verify my perceptions the original report from these focus groups was issued to all participants for them to review and give 'respondent

validation' as they saw fit. They confirmed my perceptions as being representative of their own views, stating for example:

> *'Your analysis seems logical and accurate' (Lesley).*

and

> *'Your analysis of the various comments shows an understanding of what it is like to be a student nurse in the clinical environment' (Teresa).*

These were reassuring statements and confirmed my feelings that I had now gained a students view of learning in clinical practice.

The focus groups had served their purpose. I had been able to listen to the student's voices, to hear their accounts of learning in clinical practice, and to analyse these to determine conceptual categories which were then used to focus attention in carrying out participant observation to discover how undergraduate students took responsibility for their learning in clinical practice. Carey (1994:225) stated that:

> *Focus groups provide insight into beliefs and attitudes that underlie behaviour.*

In this case the focus groups provided such an insight, and thus can be accepted as true accounts of the students perceptions of learning behaviour in clinical practice. The data gathered resulted in categories to be explored further through participant observation, and also contributed to the final analysis carried out. These are described in chapters 5 and 6.

CHAPTER 5

BRINGING THEORY TO LIFE
The reality of learning in clinical practice

This chapter provides a descriptive analysis of the data gathered in the second stage of the research, giving an in-depth account of the participant's experiences of learning in clinical practice. Data is presented in relation to the whole sample, rather than each individual year group. There was no intention to compare each of these groups, rather to determine if there were common issues related to students managing their own learning in clinical practice.

Data Collection

As described in chapter 3 participant observation, reflective interviews and field notes were used to collect data. Categories identified from analysing focus group data provided a framework for interpreting observations. Processes of constant comparative analysis and mind mapping were used to determine if the characteristics of the focus group categories were reflected in the reality of practice. This was in recognition of the fact that the participants in the focus groups were describing their perceptions of practice, making their own interpretation of experiences, whereas participant observation would provide the opportunity to 'see' if such perceptions experiences occurred in the reality of clinical practice.

Constant comparison of the data gained from different methods of collection enabled similarities and differences to be identified. Ultimately all of the focus group categories were found to be present in the data collected from

participant observation, although some were subsumed and a few new categories emerged.

The final analysis therefore combines data from both stages of the study, with categories from both being used to identify sub-themes and an overarching core theme. At the end of data collection group interviews were held with each of the first, second and third year participants, to gain their views of how they had managed their own learning over the year. Comments from these interviews served to supplement and validate the analysis of data gained from participant observation.

Placement Sampling

Participants from year 1 had experience of three placements, each of four weeks duration (see chapter 2). Typically these students felt that they were just learning how to care in a particular area when it was time to leave. One stated:

> *The first two weeks were quite daunting, you didn't know what to do and you have to learn off your own back - then the last two weeks you built your confidence and then it was hard to leave the ward.*
>
> *Year 1 student (End of Year Group Interview)*

Their ability to transfer learning from one area to another appeared to be minimal, they identified that it was like starting all over again each time they went to a new placement. This might be attributed to the long period between placements; and the fact that new theory that they learnt between placements interfered with previous learning.

The different nature of each placement meant that they were learning a new approach each time, for example the care of an adult is different from the care of a child, the care of a patient in hospital was different from that of one in the community, the care of a healthy woman in pregnancy or healthy baby after

birth was different to that of a sick woman or child in hospital. The students learnt theory relevant to each placement prior to and during the placement. However some theory and practice was transferable such as principles of confidentiality, the philosophy of patient centred care and many practical skills.

By the end of the period of participant observation all participants in the year 1 sample were identifying increased confidence. There was a general feeling of looking forward to the branch programme. All five students identified that they learnt 'more in practice than in theory'. This statement related well to their predominant concrete learning styles of activist and reflector (Honey and Mumford 1986). They also felt 'safe with routine' fitting Benner's (1984) description of the novice nurse who demonstrates 'rule-governed behaviour'.

Year 2 participants were at an important stage in the course as they changed from the CFP to the Branch Programme. They had two placements of four weeks and one longer placement of twelve weeks. The latter included four weeks of community care and speciality visits (see chapter 2). Initially they appeared confident in practice, with three placements behind them. They were more able to adjust to entering a new environment although identified concerns related to the short length of the CFP placements saying:

You just start to feel confident and then you're whisked away.

Year 2 student (End of Year Group Interview)

At the end of the year they commented on how much better the longer branch placement had been.

Their approach to learning changed as they entered the branch programme, particularly related to accessing learning opportunities. They used their initiative more, realising that they were no longer observers who participated

but that a level of competent practice was now expected of them. Some found it easier to ask for learning experiences than others. Assertiveness skills were seen as being important to this aspect. One student identified:

> *You've got to feel in control of yourself, know what you want and be able to justify what you know and what you can do.*
>
> *Year 2 student (End of Year Group Interview)*

They appeared much more aware of their learning needs than the first year students and more able to negotiate for learning opportunities. Conflict arose when they experienced a gap between theory and practice, one student said:

> *They're not practising what we are taught.*
>
> *Year 2 student (End of Year Group Interview)*

However they were able to identify that as students they were practising from a knowledge base, whereas many trained staff were acting ritualistically - doing it the way it had always been done. They thought that having students to teach must be 'quite threatening to the staff' and were able to discuss the effects of different approaches to mentoring.

Year 3 participants were well established in their branch programme. They had two twelve week and two eight week placements, each of which included some time out for specialist care (see chapter 2). They demonstrated a greater ability to manage themselves in practice. However this was not necessarily the perception of the staff they worked with who continued to expect them to behave more like traditionally trained students. Their supernumerary status seemed to cause some conflict for them. One student said:

> *Traditional students didn't have to do battle to get on a drugs round whereas this supernumerary label interferes.*
>
> *Year 3 student (End of Year Group Interview)*

This statement reflected the many different interpretations that both practitioners and students gave to the term 'supernumerary'.

Others identified that they were used as Health Care Assistants (HCA's) causing one student to say:

> *You have to assert yourself, once you let them treat you as an HCA they will carry on doing it.*
>
> *Year 3 student (End of Year Group Interview)*

More assertive students were able to achieve this, but observation identified that less assertive students let themselves be used and missed out on valuable learning opportunities. They would cede control of their learning experiences to others even when they knew what they wanted to learn, not having the confidence to assert their needs. Such behaviour was reminiscent of the passive attitudes that students undergoing traditional 'apprenticeship style' training were expected to demonstrate. This was particularly evident with one of the third year students.

Overall students identified that their increased knowledge and skills gave them confidence to access learning opportunities. It was clear that these students were using knowledge they had gained to support their practice, and actively sought to increase their knowledge base. They discussed using questioning as a means of increasing their depth of knowledge; both asking others and being questioned themselves. They described how they would keep questioning until they got the information they needed. One student stated:

> *You have to assert yourself to question so that you get a decent explanation.*
>
> *Year 3 student (End of Year Group Interview)*

They recognised that sometimes their questions were not answered due to a lack of knowledge on behalf of the staff they questioned.

An audit trail of sub-categories, categories, sub-themes and a core theme is presented as Table 5.1.

Emerging Themes

CORE THEME	SUB-THEMES	CATEGORIES	SUB-CATEGORIES
SAFETY NET	Self Directed Learning	- Reading up	- theory into practice
			- searching the environment
		- Planning ahead	- thinking it out
			- writing a plan
	Learning from People	- Learning from patients	- reading patient's notes
			- talking to patients
			- learning from Physio's
		- Learning from PAMS	- learning from Doctors
			- learning from OT's
			- observing experts
		- Expert Practice	- copying experts
	Being Supported	- Risk Taking	- sharing the blame
			- being allowed to try
			- fitting in
		- Self Centred Practice	- doing it 'their way'
			- 'forget the university'
			- getting the work done
			- no time to help
		- Talking to the House	- talking to friends
			- sharing experiences
			- being able to cry
	Active Learning	- Bargaining	- doing a share of the work
			- knowing when to ask
		- Assertiveness	- knowing own limits
			- asking for experience
		- Questioning	- knowing who to ask
			- questions to 'find out'
		- Doing	- silent questions
			- gaining confidence
			- learning from experience

Table 5.1. Themes and Categories

Four major sub-themes emerged - 'self-directed learning', 'learning from people', 'being supported' and 'active learning'. These led to a single co-ordinating theme of 'safety net' related in particular to the nature of support available to enable students to manage their own learning in practice, but also reflecting the quality of learning experiences in clinical practice. This significant theme is discussed in depth in chapter 6. The contributory sub-themes and associated categories form the framework for analysis in this chapter.

Self-Directed Learning

This sub-theme has two major categories, 'reading up' and 'planning ahead'. These were activities that students employed to make sense of the experiences that they had or to prepare themselves for practice. A variation was observed in the ability of participants to be self-directed (as discussed in chapter 2). Whilst their experience in university was planned to develop such skills, through the use of independent learning strategies, it became evident that some of them had a natural ability to manage their own learning and others waited to be instructed to 'go off and learn'. A relationship was identified with this sub-theme and the focus group categories of 'building experience' and 'bringing theory to life'.

Reading Up

There were many examples of students managing their own learning by taking the initiative to read up articles, books and commercial literature in order to extend their knowledge [building experience] and transfer theory into practice [bringing theory to life]. Often they would say *'I must read that up'* or write down issues to follow up when they went off duty. Frequently I observed them 'searching the cupboards' to find information that would tell them how to do a certain procedure or explain why a procedure was done. In

these instances much of the literature they accessed was written for patients, such as health information leaflets. Some papers were of a more formal nature such as guidelines for investigations. Students identified that they felt there was a limit to asking staff questions and that searching for answers to their questions in drawers and cupboards often gave them the information they wanted.

This corresponded with personal experience when preparing to enter practice to collect the data, as described in chapter 3. The wealth of information available in policy books, patient information materials and formal forms and guidelines provided a valuable resource for self-directed learning.

Planning Ahead

There were many instances when I observed students planning their work in advance, both mentally and in written form. A CFP student, in the 4th week of a mental health placement, who was asked to *'go and talk to Mr ... because he's feeling very suicidal'* stood still for several minutes before complying with this request. When interviewed later the participant explained:

> *You can't go running in, jumping with two feet over your neck because you've lost it then, you don't know what you're going to talk about - particularly if it's a very open ended interview where anything could go wrong either way, you need to know where you're going, you've got to focus things.*

This participant had thought through an approach to the patient and had been able to apply previously learnt theory and knowledge gained from current experience to manage the situation [building experience and bringing theory to life]. In this instance the previous experience was gained both during and outside of the programme, the participant having worked as a paramedic prior to entering nurse education.

Other participants would look ahead to potential learning experiences and prepare to get the most out of them. A CFP student, on the 1st week of a paediatric placement, explained how she had agreed many learning objectives with her mentor in order to get the most out of the placement. She had written the objectives before coming to the ward and then discussed them with her mentor. Together they had identified possible learning opportunities that would enable her to meet the objectives [bringing theory to life]. Such an approach relied on the participant being appropriately supernumerary so that she could be free to leave the ward to follow children through investigations and surgery.

This participant was able to holistically care for a child having corrective surgery for a cleft palate by caring for the child on the ward, pre- and post-operatively. She was also able to discuss the surgery with the Consultant, and study pictures of other children taken before and after surgery, prior to observing the actual operation. Whilst in this instance the mentor met the requirement for supernumerary status there were many experiences where participants were used as 'pairs of hands' to 'get the work done'.

The holistic approach was found to be a common one, used by several other participants. The approach had been initially proposed by a teacher at the university but left for students to choose whether or not to follow it up. The participants who did use it tended to be the more assertive ones who felt 'safe' when asking for learning experiences.

Learning From People

A common source of learning was the people to whom participants were exposed. These acted as role models and resources, helping participants to gain both knowledge and skills in health care delivery. The use of role models

is a well established strategy and is discussed further in chapter six. Three categories emerged from this sub-theme 'learning from patients', 'learning from professionals allied to medicine' and 'expert practice'. A relationship was identified with this sub-theme and the focus group categories of 'building experience', 'levels of learning' and 'expectations'.

Learning from Patients

Patients were excellent teachers of the participants; they readily answered questions without realising that they were helping participants to learn. Typically CFP students had more time to talk to the patients but were less able to structure their questions, not knowing what they did not know. Branch students were more knowledgeable, and more able to ask discriminative questions, but had less time to talk to their patients. Learning from patients helped participants to develop a holistic view, which enhanced understanding, but also gave rise to conflict [building experience].

A third year student was involved in a situation where a patient did not want her daughter to know about the poor prognosis for her condition. The staff nurse in charge wanted to tell the daughter, and in fact subsequently did so. The participant, having talked to the patient ended up caught in the middle of an unpleasant situation. She was able to appreciate the patient's view but felt compelled to support the staff nurse because she was a registered nurse. We spent much of the reflective interview exploring the ethical dilemmas, related to confidentiality and consent that had resulted from this situation. The participant stated:

> *You can't force care on patients ... I mean you can advocate care for patients but you can't force it upon them.*

She appreciated the fact that the staff nurse had spoken to the mother and daughter together but felt that the patient's views should have been respected in this instance.

Learning from Professionals Allied to Medicine

Many participants accessed learning opportunities by attaching themselves to doctors, physiotherapists, occupational therapists and dieticians [building experience]. Paramedical staff were able to provide them with a multi-professional dimension to the care being delivered. A second year student was able to observe a child having a barium meal investigation and compared the approaches of two doctors involved in the care of the child saying:

> *There was a difference between the doctors ... and I noticed that he was much more child friendly ... whereas the other one was more adult friendly ... I mean [the child's] mum was saying one of the doctors is very good because he actually looked at him [the child] and talked to him.*
>
> *Isobel, year 2*

In this instance she was learning a valuable lesson about communication, and how to adapt language according to the person you are talking to. She commented about how another doctor ignored the child and spoke only to the parents, or else used adult language that the child could not understand [levels of learning].

Other therapists provided learning opportunities that participants accessed. A third year student commented on this:

> *There was a speech therapist who came in and I was trying to listen in to what she was saying to the patient as well as listen to what [the mentor] was saying about discharges to me which was a bit unfortunate that it all came at once really ... but I saw the speech therapist yesterday and we had a talk about what the patient was going to go home with ... and the dietician - I saw the dietician once prompted by [the mentor] and that was interesting talking to her and she had a couple of leaflets I looked at for people who have dysphagia.*
>
> *Nicola, year 3*

This participant managed her own learning by observing and questioning the therapists involved in patient care, gaining a holistic view of care delivery. She was able to recognise the conflict arising from learning opportunities being provided by both the therapist and her mentor simultaneously, and was able to follow up the former the next day in order to make the most of the situation.

Becoming a team member was important in enabling participants to learn from its members. A first year student commented on going into a new placement stating:

> *You think, oh you want them to like you but you also want to get in their sort of framework ... so you imagine it's a circle - you don't want to be on the outside, you want to be the one joining in so they don't look at you as the one on the outside they look on you as part of them.*
>
> *Angela, year 1*

This need to fit in was vital and influenced the behaviour of students. Once accepted by the team they felt that they could ask for learning experiences but not while they were still 'on the outside'.

A typical learning experience for all, especially third year students, was being asked to participate in the doctor's ward round. Branch students were often allowed to take the place of the registered nurse and deal directly with medical staff whereas CFP students were more likely to be kept in the background. Some medical staff accepted and respected student nurses, whereas others were unhappy if the registered nurse was not there to *'look after them'*. This was typical of occupational socialisation where traditionally nurses were the 'doctor's handmaiden' - a role that some medical staff were clearly reluctant to change.

Self-confidence was an influencing factor for students in their being accepted by medical staff. A third year student, discussing how she handled a doctor's round, identified that being in her final placement made her appreciate the need to control her own learning, stating:

> *I think it was slowly happening in my last ward but now all of a sudden - I think the job's loomed, I've just secured my job, and I'm thinking - you've got to do it now.*
>
> *Ruth, year 3*

She had high self-confidence as she had just been offered a post as a Staff Nurse. She was anticipating her future role as a registered nurse, knowing that she would have to manage the doctors herself [expectations]. Her ability to do this was helped by her colleagues trusting her and allowing her to 'get on and do it'. The doctors she was working with helped her to 'act out' the role of staff nurse by treating her with respect and also providing her with explanations. She identified:

> *... he didn't put me on the spot, he didn't ask me exactly what's that, he did it in a way which was very good ... I felt very comfortable with him.*
>
> *Ruth, year 3*

These factors helped her to manage her own learning and gain valuable anticipatory experience in preparation for her future role.

Expert Practice

The use of role models was a frequently observed learning strategy. Students particularly appreciated being able to observe or work with expert practitioners. They would often pass comments related to practitioners who they rated as 'good', sometimes related to the quality of their performance and occasionally expressing anxiety that they would not be able to do as well [expectations]. They learnt a variety of knowledge, skills and attitudes from the experts that they worked with. This was both through copying their

behaviour and also through reflecting on how such experts managed care [levels of learning].

A second year student, working in the accident and emergency department, was given the choice to observe or participate in resuscitating a patient by her mentor. She chose to observe and learnt much from this experience, not only the skills involved but also about her own reaction to an emergency situation and an increased awareness of the roles of others [building experience].

The experience was a disturbing one as during resuscitation the team were made aware that the patient's wife had arrived and that she and her husband had just had an argument that terminated when he walked out of the house; the resuscitation was an unsuccessful one. The student described part of the experience as follows:

> *I wanted to be an observer of it rather than participate ... it seemed like they were going on for quite, you know, about half an hour or even longer ...I mean to me it didn't look as if they were trying very hard, it may have been because I've never seen one before in real life, you know when you see them on TV they're like uhh .... but it seemed quite sort of like relaxed in a way ... I wish I had done the CPR I mean I'm glad I didn't because I think I wouldn't have seen so much ... there was a medical student there who they asked would she do the defib and she was (laughs) looked, you know, I mean it was quite nice because she actually looked at me as if to say oh god what am I doing ... and I sort of smiled back and it was really nice at that moment 'cos you actually knew someone else knew how you were feeling.*
>
> *Isobel, year 2*

Her identification with the junior doctor was an interesting one, in this experience she recognised their shared learning needs and emotional reactions, which were handled differently by the supervising mentor and senior doctor. She later commented:

> *I cried ... 'cos my mentor asked me if I was alright and she put her arm round me and I just started crying ... 'cos you know when my mentor went off [to speak to the patient's wife] I thought well I would really have liked her to be there [with me] all the time, which I know is selfish when I know the patient's*

> *wife was sitting in the relatives room ... I think it was different to what I'd expected, completely different, I didn't think I'd cry ... I think it was the situation that he had actually died and he and his wife had had an argument.*
>
> *Isobel, year 2*

The student's awareness of her own needs and the desire to put these in front of those of the relative was an honest admission of her personal priorities. She knew that it was inappropriate to want the mentor to give her attention but nevertheless recognised her own insecurity in this situation.

A first year student, working in the labour ward, was able to witness a midwife's intuitive knowledge when a patient began to experience difficulties. The midwife described her 'gut feeling' that 'things were going wrong' to her peers but was unable to support this by factual evidence. They questioned her about all possible aspects of the care, trying to help her to identify the cause of her concerns, but were unable to find a basis for these concerns. Ultimately there were signs of foetal distress, and an emergency caesarean operation was performed. The student commented:

> *To know that they do support each other ... sort of made me feel reassured for later on ... that was good.*
>
> *Angela, year 1*

The critical reflective discussion that went on between the midwife and her colleagues taught the student much about expert practice [levels of learning]. The fact that other, experienced midwives were unable to help the midwife identify the cause for concern helped the student to learn about the process of clinical decision making. She was able to witness the support the midwife received in making her judgement even when there was no tangible evidence.

However much of the conversation she listened too contained 'jargon' that made it difficult for her to follow, she discussed how this made her feel left out, saying:

> *I was thinking I've (laughs) got no idea what you're talking about ... they were sort of in their own world ... all sort of together in their language and I thought if you were a patient in that sort of instance it must be quite scary to have people .... I've been a patient once and I had two doctors talking over me and it's the worse feeling ever because it feels like it's you, and they're talking about you and they're not letting you know.*
>
> *Angela, year 1*

This issue of not understanding jargon was frequently observed with CFP students, but by the time students were in their third year I observed them using the jargon themselves, apparently unaware that they were 'shutting others out' of their conversation. They were 'together in their own language' as this student had so aptly observed. Whilst this may be accepted as occupational socialisation it raised the question of whether the students were applying their knowledge of communication.

Being Supported

One of the most significant factors in students being able to manage their own learning was the degree and type of support that they were given in practice. Positive support enabled students to be independent, whereas negative support was restrictive and reduced their ability to access learning opportunities.

Throughout the three years of the programme students learnt to become accountable and responsible for their own actions. A supportive mentor enabled them to assume responsibility at an earlier stage because they had the confidence of someone 'being there' to back them up and therefore felt able to take the risk of assuming responsibility. In turn this assisted them to begin to be accountable for their own actions, preparing them for future professional accountability. Three categories emerged from this sub-theme, 'risk taking', 'self-centred practice' and 'talking to the house'. A relationship

was identified with this sub-theme and the focus group categories of 'safety net', 'self-centred practice' and 'expectations'.

Risk Taking

Supportive mentors allowed students to take risks and thus to gain valuable experience [safety net]. They would say *'go on, I'm here if you need me'* or *'don't worry I'll take the blame if anything goes wrong'*. When working with such mentors students demonstrated increased confidence in their own ability and expressed enjoyment in learning. A common strategy used by supportive mentors was a problem-based approach to learning. They would encourage students to find out for themselves and to apply their knowledge in practice, holding reflective discussions with them after care had been delivered.

One example was when a mentor informed a first year student that a patient had hurt her leg by walking into a catheter stand. The student was asked to go and assess the wound and then report back to the mentor who said *'can you remember what to look for'* to which the student replied *'yes - chicken and chips'*. This comment left me perplexed until I interviewed the student and discovered that the day before the mentor had taught her signs and symptoms of inflammation, when assessing another patient who had a varicose ulcer, using an experiential approach to learning.

The mentor had done this by asking the student, before going to the patient, what her favourite meal was if she went to a restaurant to eat. When she replied chicken and chips the mentor had asked her how she would know it was a good meal, getting the student to talk about the size of the portion, the smell of the food, the colour, whether it was greasy to look at, the temperature of the food - all signs of inflammation (swelling, unpleasant odour, redness, oozing fluid and heat).

This approach had allowed the student to work out the answers for herself in a safe learning environment where she would not feel silly if she got things wrong. She was able to apply this knowledge to the new situation and make an accurate assessment of the leg injury. The mentor then encouraged her to decide upon and implement action to treat the injury, directly supervised by the mentor who was ready to help if there were difficulties. The student identified that this approach had given her confidence in her knowledge and skills.

Self-Centred Practice

Conversely some mentors were unhelpful to students. They would make statements such as *'we didn't have anyone to help us so get on and do it";* this made students anxious that they would do wrong and be told off. They would refuse to allow students to access learning opportunities, telling them to *'get on with the work'* instead of allowing them to observe and participate in the care they were delivering. Observation of such behaviour confirmed the nature of this theme, one that was initially identified in analysis of focus group data.

A third year student, working in a very traditional nurse-centred practice setting, identified conflict with her previous experience in a ward which had been very patient-centred in its approach to care. She found it hard to question the orders given to her to carry out task orientated care. Her coping mechanism was to subversively carry out patient-centred care. When asked to *'do the blood pressures'* at the beginning of the day she took time to sit on each patient's bed and carry out an individual assessment of their needs which she followed up throughout the day. At the end of the day she repeated her actions, this time carrying out a patient-centred evaluation of care, and then sat at the nurses station with the other staff to write up the reports. In doing

this she behaved in a way that enabled her to 'fit in' with the staff of the ward [expectations], but was able to implement her own patient centred philosophy of care. She recognised that this was not good practice but stated:

> *I think you can learn just as much from things you don't think are right than you do from the things you think are good, and although you can't change things it teaches you how not to do things and how you would change practice when you become qualified and do all the teaching yourself.*
>
> *Ruth, year 3*

This was a statement that I had heard from many previous students, but not all were able to carry out their intentions when they became registered nurses. Ruth recognised this saying:

> *Sometimes I get really worried because I think - will I suddenly not care, and that's the time I get worried, I'm thinking is nursing for me because I don't want to be like some of these nurses - it panics me sometimes, thinking is it a thing that all nurses say and suddenly they become a bit fatalist.*
>
> *Ruth, year 3*

Hopefully her awareness meant that her philosophical approach to nursing had been internalised and would enable her to practice patient-centred care in the future. The reality shock of entering practice has been recognised for many years (Kramer 1974), and may account for beliefs being compromised in order to be accepted into the new role of registered nurse.

Another third year student experienced a similar conflict; this time having worked in a traditional setting first and then going to the nursing development unit. She stated:

> *I've seen standard care plans where basically boxes are ticked and dated, and they're done at the nurse's station, and they're done through glass windows - they see the patient through a glass window I think, oh yes that occurs, they must have good eyesight or something.*
>
> *Nicola, year 3*

Her words 'done through glass windows' represented the way in which some nurses delegated care to untrained staff and only did the paperwork. They

wrote reports on patients that they hadn't actually been near, but only nursed from a distance by telling others what to do. This reflected a 'task orientated' approach to care, in which as nurse became more senior they were less involved in direct care.

Talking to the House

The most common coping strategy used by students was to share their experiences with their friends, particularly those they lived with. A second year student described this as 'talking to the house'. Not all of the students shared their accommodation with other nursing students; some lived with students from different schools and would describe the horror of their friends when they described some of their experiences to them. In particular they used the strategy of 'talking to the house' when dealing with death.

One first year student described being on duty when a lady had a massive gastric haemorrhage and died and how she had shared this experience with one of her peers, saying:

> *I think it was the shock ... to have her come up and grab me and she was going on about a patient dying but I didn't know if the patient had actually died and I was going to see a dead body ... but when I got there she was really struggling for breath ... and there were pools of blood everywhere and I think that was the worst thing ... I kept thinking that I didn't want her to die when I was there, it would have been alright if I'd seen her afterwards I just didn't want to be there ... and they said go and get a nurse so I went off and I didn't go back in because I just ... I think it was like special effects, you wouldn't think that it could happen to somebody having all this blood ooh ..... I mean it was good 'cos I went home and I just sat down, I sat there with a cup of tea and then [my friend] came in and I was like oh god I just talked it through with her and that helped - I mean she hasn't seen anything like that but she has seen a dead body ... so she said yeah I know what you're feeling.*
>
> *Carol, year 1*

This was a graphic example of peer support, but only one of a number of instances where students talked about helping each other to cope. In this

particular instance the student had first had the chance to sit down with a staff nurse who made sure she was feeling all right before allowing her to drive home.

Active Learning

Students utilised several strategies to increase their learning opportunities. They appeared to be aware that their priority was to learn, as had been identified by one of the participants in the focus group interviews. However they also realised that for the staff they worked with patient care was the main priority. Active learning strategies were appropriate to their learning styles, providing concrete experiences that they could later reflect on to gain the most from their experience.

The attitudes of some qualified staff led them to be manipulative in their approach to negotiating learning opportunities at times, resulting in the category called 'bargaining'. Two other categories that emerged from this sub-theme were 'assertiveness' and 'questioning'. The category of 'doing' underpinned all of the sub-themes in that participants used concrete experience as a basis for reflecting - fitting with their defined predominant learning styles. A relationship was identified with this sub-theme and the focus group categories of 'bringing theory to life', 'building experience', 'levels of learning', and 'bargaining'.

Bargaining

This category was identified from data analysis from the focus groups and continued to be observed throughout participant observation. Students learnt very quickly that if they started by participating in 'the work to be done' then they would be able to ask for learning opportunities that they specifically required.

The category was most strongly identified in CFP students who had short placements, perhaps because they had less time to become a member of the team. However branch students were observed to carry out similar behaviour but seemed not to be so aware of their action, perhaps having been socialised into manipulating trained staff in order to meet their learning needs.

A first year student discussed how her experience was different by having me with her, in that the Staff Nurse had allowed her a choice of patients to care for. She described her normal experience on the ward saying:

> *I wouldn't normally have an HCA with me ... usually there would be me and a trained nurse and I'd usually be there getting on with it ... so I'd talk to her, try and grab her (trained nurse) literally if I wasn't too sure about a patient and say ok I can do such and such - usually I would have it delegated to me by a Staff Nurse but ... I'd try to negotiate who we'd do, but I'd like to negotiate more.*
>
> *Esther, year 1*

This powerlessness was typical of CFP students who felt that they had to do what they were told. They lacked the experience and assertiveness skills to ask for useful learning experiences. Some like Esther would try and negotiate openly, others would subversively manipulate staff.

I observed another first year student asking to care for the patients she had looked after the day before, because she knew the workload was quite small, so that she would later have time to go and watch an x-ray investigation that she was interested in seeing. As we worked together that day she identified that this was a strategy that she often used to gain access to learning opportunities. She had learnt that staff were more likely to say yes to a request for a learning experience if they had seen her do some work.

An issue that arose here was the perception of the role of the student. Many staff commented to me, during work, that they perceived supernumerary

status as a problem. They thought it was 'better in the old days' when students were apprentices and 'did their share of the work'. Another factor observed was the effect of changing staffing ratios, in that there were a lower number of registered nurses compared to HCA's. Many of the clinical areas relied heavily on bank [registered] nurses to make up the numbers. This meant that the pool of regular nurses was small, providing few people on duty who actually knew all about the patients and ward organisation. They appeared stretched in trying to supervise students, HCA's and bank staff, as well as contribute to completing the workload. Thus their comments to me may have reflected their frustration at staffing levels.

Assertiveness

Throughout participant observation students who were observed to be more assertive were much more likely to gain access to relevant learning opportunities. Some of these students were naturally confident, their personality allowing them to be assertive. Others identified that they knew they needed to be assertive but could not always put this into practice. Although they learnt assertiveness as part of the interpersonal and communication skills unit at the university using their skills in practice was a different matter [bringing theory to life].

In each year group it was possible to identify at least one student who was lacking in assertiveness skills. These students were observed in practice to see what affect this had on their ability to control learning. One first year student noticeably held back and waited for staff to tell her what to do. This resulted in a staff nurse commenting that 'the student was not very good - slow to learn'. Interestingly at the end of her shift when interviewed the student's perception was quite different, she said:

> *It's been quite quiet today compared to other days, it's been quite nice really because I've actually seen the staff nurses and I haven't been with HCA's as much so I've actually felt like I'm getting more of an insight into the ward ... how I'm going to see it when I'm qualified.*
>
> *Carol, year 1*

The strategy of leaving students for HCA's to look after was a common one, and one that if the student was assertive and questioning was perhaps not too dangerous. However for students like Carol it was not a good learning strategy. HCA's are not necessarily good teachers, they may know what to do but do not always have the knowledge base to explain why [levels of learning]. Some have acquired inappropriate caring skills because they do not understand the reason for particular approaches. I was interested to find that Carol had found her day with a trained nurse useful and felt she had learnt much [building experience]. However she had not made this apparent to the staff nurse who therefore considered that she had not learnt much at all.

A week later when working with Carol again she appeared more confident. In discussion at the end of the day I said this to her and she identified:

> *I've got used to the patients and I've got used to the layout of the ward and where things are ... because I'm always on the yellow team, it's always certain staff that you're on with.*
>
> *Carol, year 1*

Continuity of experience appeared to be an important factor for less assertive students. Once they felt part of a team they were more confident to ask questions and talk about their concerns. On this occasion the Staff Nurse appeared satisfied with Carol's performance.

Knowledge gave less assertive participants the confidence to ask for experience. A first year student was asked to be involved in an admission interview where the staff nurse asked her to assess the patient's activities of living (ALs). When reflecting on this later she identified:

> *That was quite useful because we've done it in the College and it made me recall them... we had to do an exercise like having the AL's in front of us and ask - someone had a scenario of a patient and we had to ask using the AL's about them ... so that brought it all back.*
>
> *Carol, year 1*

The opportunity to practice in a less threatening environment gave Carol confidence when expected to use this skill in practice [building experience] demonstrating the value of experiential learning.

Assertive participants were observed to be more likely to be offered learning experiences without having to ask. This may have been because they appeared highly motivated and thus staff felt rewarded for teaching them because of the interest they showed. However at the same time there was a tendency to give them more responsibility than they were ready for indicating that the staff were not aware of their limitations [levels of learning].

One first year student was left in charge of two bays of patients on a surgical ward, including some patients who had recently undergone surgery and thus needed specialist care. At this stage of the programme she should have been working mainly under direct supervision, observing and participating as appropriate to her knowledge and skills. She commented:

> *Well ... the first thing when we got here, I knew 'cos I'd looked at the off duty yesterday, I knew that it was only me and [the Staff Nurse] on ... but this has happened once before since I've been here so I was prepared for it and I knew that [another Staff Nurse] was going to come on a bit later, however I also knew that there were a couple of patients who were going to come back from their operations and I knew Mr * was quite ill, well he has been over the last few days so I was worried about that because I wouldn't want to be left in that situation where I felt uncomfortable and worried about what I was doing or anybody there, and when I got here I could tell actually immediately we came on to the ward the tension you could feel it.*
>
> *Angela, year 1*

Angela was a confident assertive student who worried that she would not be able to cope. Her confidence led staff to treat her like a more experienced student instead of realising her limitations [levels of learning]. This situation was a potentially dangerous one for the student and for patients, and I was compelled to 'step out of my researcher role' and insist upon closer supervision. A Staff Nurse had to cancel her plans to take time owed to her and remain on duty, reluctantly providing supervision for the student, albeit that she chose to do so by sitting at the nurse's station rather than working with the student.

Questioning

Questioning was a strategy used in many ways, asking people questions to find out, being questioned by others and self questioning to help learning and planning. Branch students, on the whole, were very confident to ask questions to increase their knowledge base, and accepted being questioned by others as a useful learning strategy [building experience]. CFP students sometimes felt threatened when asked questions, they often said *'I don't know'* even when they did because they were frightened of giving a wrong answer and looking silly.

A second year student, in her first branch placement in the accident and emergency department had to assist a doctor in suturing a lacerated head wound. The experience started with a shock when the doctor caught hold of the patient's hair and a skin flap peeled right back as if the patient had been scalped. However the student remained composed until the doctor started asking her questions about the drugs he was using for local anaesthesia. The student in reflection said:

> *That awful shock when the doctor caught hold of his hair and the skin all came back ... I completely forgot what I was thinking then, ... and the doctor asked*

me and ... I mean I completely - I was just thinking, 'cos I read about adrenaline last week and I completely forgot.

Isobel, year 2

The doctor, in this instance, demonstrated patience and led her through what she could remember until she finally got the right answer. Isobel identified this as a useful learning strategy, knowing she would now remember because she had been made to work it out for herself [bringing theory to life].

Another second year student was asked to do a drug round on a trauma ward. She used active questioning throughout to find out what she wanted to know, identifying later that this technique was quicker than going to look it all up for herself. However she also realised how time consuming this strategy had been for the staff nurse and said:

I think it would have been perhaps better if she'd said - patients who you worked with on Wednesday, do you want to come and do theirs 'cos you know them better than you know everybody else and if I take you on a whole drug round ... I'm just going to bombard you.

Gill, year 2

The holistic approach to care, carrying out all care for a small group of patients, was frequently observed and appeared to be a useful learning strategy. Students appeared to find it easier to understand knowledge if they could relate it to patients they cared for, reflecting their predominantly concrete learning styles [bringing theory to life].

A third year student, who was very confident, identified the value of being questioned saying:

Before when I've done drugs with other nurses ... their approach is more like tell me what it is then look it up in BNF (British National Formulary) kind of thing ... I didn't have questions fired at me about what different things were and what different names and side effects and so you can almost be on automatic pilot and doing drugs and you just go along and dish the drugs up a bit amiably but today having [the Staff Nurse] say to me what's that and what's that, it was me thinking all the time - you really had to think about

everything, and it was really making you look and you know look and compare drugs.

Ruth, year 3

Questioning in this case stimulated her to learn. She was conscious that she would soon be a registered nurse and be expected to carry out a drug round without supervision; therefore the impetus to learn was strong. However for a less confident student this approach could have been quite daunting.

A third year student recognised the need for a CFP student to ask questions. She sat in for handover report in the morning and a staff nurse sent the CFP student, who arrived to join the team, away. The third year student later said:

I said to him at dinner time ... if you want to know anything ask me you know I'm quite willing to tell you and he just said oh yeah ... I just feel really sorry for him I was thinking oh god I know exactly what you're feeling, you know you feel really stupid when you're a first year and you're really afraid to ask absolutely anything you know, and you're treated - like you have to know the ward rounds, the culture of the ward as such and he doesn't know any of that ... just to be able to fit in ... and I don't know I was, I'm a bit ashamed, I think it's a shame for him that it's his first ward really - because he's going to find out really he's going to think this is normal on an adult ward when it's not really.

Ruth, year 3

This student recognised that the ward she was working in had quite a ritualistic approach [levels of learning]. They continued to consider that first year students were very junior and consequently restricted their learning opportunities. In this way they perpetuated a traditional 'task orientated' approach to learning to nurse. The pattern of placements was such that the CFP student would not have another adult placement until the branch programme, therefore having a long period before possibly a different type of experience would change their perceptions of adult nursing [building experience].

A first year student described asking herself questions to learn. She was in a mental health placement where some care was very ritualistic (such as routine catheterisation of incontinent patients) and other aspects very progressive (such as hand massage to decrease stress). When asked how she identified what was good or poor practice she replied:

I often question in the back of my mind but I don't say much.

Denise, year 1

She went on to identify that she would seek the answers to her questions from books, friends or sometimes asking a member of staff. This strategy was observed with other CFP students but less so with branch students who were more ready to ask direct questions. They seemed to appreciate that they had to demonstrate competence in practice and thus that it was important to get answers to their questions from their role models.

Conclusions

This chapter has described the categories and sub-themes arising from analysis of the data from participant observation, linking them to the previously identified categories from analysing focus group data (Table 5.2).

PARTICIPANT OBSERVATION SUB-THEMES	FOCUS GROUP CATEGORIES
Self-directed Learning	• Building experience • Bringing theory to life
Learning from people	• Building experience • Levels of learning • Expectations
Being Supported	• Safety net • Self-centred practice • Expectations
Action learning	• Bringing theory to life • Building experience • Levels of learning • Bargaining

Table 5.2. Relationship of Sub-themes and Categories

Perceptions gained from focus group data were found to be realistic and ongoing. They were described more clearly or became slightly altered by the main study data. The additional data gained from participant observation clarified the previous categories, or slightly changed their nature, allowing theory to emerge.

The most significant factor in students being able to manage their own learning in clinical practice appeared to relate to the provision of a safe learning environment. All of the sub-themes, and their related categories, were found to contribute to the core concept of 'Safety Net', discussed in greater depth in chapter 6. This core theme when used effectively and combined with action learning approaches enabled participants to 'manage their own learning' in clinical practice. Strategies developed to enhance support and action learning are discussed in chapter 7.

CHAPTER 6

SAFETY NET

The role of the mentor in facilitating control and reflective learning

This chapter provides a descriptive analysis of the core theme emerging from the data, set within the current framework of knowledge. The nature of support provided for participants in practice was found to be the most significant factor in enabling them to manage their own learning. Where this was facilitative, providing a safe learning environment, they were seen to take actions to manage their own learning. This is comparable to providing a safety net for a trapeze walker. Knowing that there was something (someone) there to catch them if they 'fell' provided the confidence to have a go at a dangerous skill. Where support was lacking, or of poor quality, participants held back from trying out new skills in case they did something wrong. Mentors who encouraged reflective approaches to learning enabled students to increase awareness of their developing knowledge and skills. In turn this facilitated them managing their own learning and developing self-confidence in their ability to 'practice' as a nurse.

The theme was initially identified in the preliminary focus group study (chapter 4) where participants gave many examples of the influence of their mentors (formal supervisors of student nurses in clinical practice), and others who provided support, on their ability to manage their own learning. This finding was strongly confirmed through participant observation in the main study. The quality of support appeared to affect the confidence of participants in testing their knowledge and skills in practice. Trying out nursing skills for the first time was a dangerous act because in many cases it could have resulted in harm to the people participants were caring for. A supportive mentor or supervising practitioner enabled risk-taking that appeared to result in increased learning.

A variety of terms are used to describe those who supervise learning in clinical practice, including mentor, preceptor, clinical supervisor, clinical teacher, practice teacher and lecturer practitioner. These terms and their roles will be explored and related to the findings of this study where appropriate.

Strategies for Supporting Practice Learning

Mentors

The term mentor has caused much controversy; academics and researchers have identified that there is a lack of agreed definitions for the terms used for those who provide support to learners (Phillips, Davies and Neary 1996; Gray 1998; Watson and Harris 1999; Morton-Cooper and Palmer 2000). Throughout this chapter the term mentor is taken to be:

> *A supportive, experienced practitioner involved in facilitating learning in clinical practice.*

In the study sometimes this person was formally assigned to such a role (appointed), and on other occasions took it on voluntarily (volunteered) by being interested in helping the participant to learn. Occasionally the role was adopted because the student asked them to teach or explain (selected), something that not all practitioners expressed a willingness to do. As the main issue for exploration was the effect of being supported no differentiation has been made between mentors who are 'appointed', 'volunteered' or 'selected' excepting where this in itself is a significant factor.

Development of Mentorship

It is generally acknowledged that mentoring has its origins in classical Greece (Morton-Cooper and Palmer 2000:36). The notion of an experienced person helping an inexperienced one to learn a new knowledge and skills has been taken up in many situations for example business management, teaching and

caring environments. The nature of these relationships varies according to the organisation and the environment. Some use structured coaching or training relationships, whilst others are less structured or focus more on facilitated learning. Some are informal and others are formal and recorded. Some involve assessment of the learner by the mentor and others do not.

A model of mentoring

Gray (1989:21) described a model of situational mentoring for use in organisational cultures. He identified a mentor-protégé relationship model (Figure 6.1) where the power base shifted from the Mentor (M) to the Protégé (P).

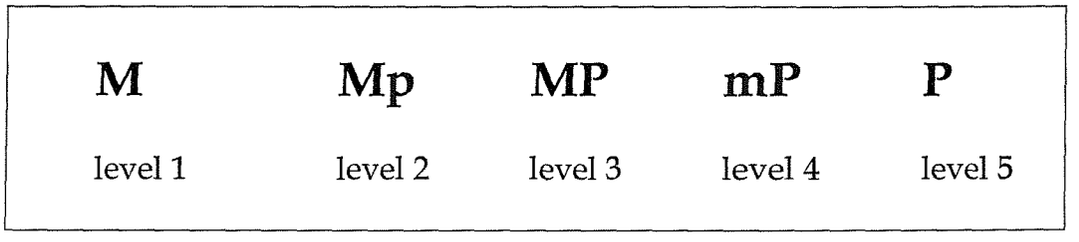


Figure 6.1. : Gray's Mentor-Protégé Relationship Model

At level 1 (M) the mentor dominates, giving a strong lead to the protégé The balance of the relationship changes throughout the model, with the mentor gradually giving over control of learning to the protégé and taking on a more supportive role, until by level 5 (P) the protégé dominates.

Whilst this model was designed for organisational cultures, such as business management, it has been adapted for many learning organisations. The relationship could start at any level according to the experience of the people involved, for example a student nurse may start at level 1 (M) needing strong guidance from their mentor when they have no experience. As they progress throughout pre-registration education the level of support would change, allowing them to become more independent, reaching at least level 3 (MP), equal partnership, by the end of their programme.

Evidence gained from this research suggests that provision of a 'safety net', using facilitated learning, could enable them to reach level four (mP) and exceptionally level five (P) within the pre-registration programme. The student would then dominate the relationship with the mentor being present in a supportive role [safety net] as required by the student. Experience as a registered nurse would further enable growth to level five (P), that of autonomous practice, working with peers to continue their professional development. The defined period of preceptorship, as recommended by the UKCC (1993a) should facilitate progress through level 4 (mP) to level 5 (P).

Individuals should be expected to move backwards and forwards along the continuum as circumstances change, for example students starting a new placement might regress to level one (M) but then rapidly move forward. Similarly newly qualified nurses might regress to level three (MP) during the beginning of the transition period from student to staff nurse and then rapidly progress through levels four (mP) and five (P). A registered nurse being promoted, or returning to work after a break in practice, might regress to a previous level and need more support when taking on a new role but subsequently regain level five (P).

Participants in this research demonstrated movement through the mentorship model. Year 1 students were predominantly at level 1 (M), probably due to the short length of their placements and their relative inexperience in clinical practice. One exceptional student, Angela, appeared to reach level 3 (MP) by the end of the year's observation. Her natural assertiveness enabled her to develop negotiating skills to access learning opportunities. Year 2 students varied between levels one (M), two (Mp) and three (MP). The latter was more evident in longer placement at the beginning of the branch programme, but not all reached this level. Year 3 students varied between level two (Mp), three (MP) and a

couple reached level four (mP). Confidence and assertiveness skills appeared to be influencing factors with regard to reaching the higher level. Although all of the third year students were about to become registered nurses by the end of the observation period one lacked self-confidence and continued to operate more at level two (Mp).

Traditional nurse training supervision

Traditional apprenticeship style nurse 'training' used role modelling as its prime learning strategy, commonly known as 'sitting by Nellie', but did not specifically identify a person with responsibility to take on the mentoring role. This tended to be a passive approach to learning relying on the student nurse identifying the salient points to develop their competence. Observing and doing were the main learning strategies, there was little formal teaching in clinical practice. Trial and error was perhaps a common, although undesirable, form of learning. The approach to nursing was task orientated within a hierarchical structure intended to ensure that inexperienced students were less likely to commit major errors. This restriction of complex tasks to the final year of training enabled students to observe such tasks many times before being 'allowed' to practice.

Traditionally trained nurses often recall a key practitioner who helped them to learn. Chapter 7 describes an approach to preparing mentors arising from the findings of this study. Personal experience of teaching novice mentors found that they were able, through reflective analysis, to identify practitioners from their own training who met criteria for a mentoring role but were not formally identified as such. Analysing their own experiences helped them to construct their role as a mentor.

Situated Learning

The use of a mentor enabled situated learning to occur. As the curriculum for the nursing degree specified that fifty percent of the programme should be practice-based this element was of equal importance to learning that took place in the university. The focus group theme of 'bringing theory to life' demonstrated how experience in practice enabled students to make sense of the knowledge they were gaining and to develop further knowledge from practice. Reflection in and on learning helped students to 'build experience' by enabling them to make links between current and previous learning, and also between knowledge gained in the university and that gained in clinical practice. The main study sub-themes of 'learning from people' and 'being supported' clearly identified the importance of facilitated learning. Support from experienced practitioners proved to be the significant factor in enabling self-directed learning to take place.

STAGE	ACTIVITY
• Modelling	Demonstrating and drawing attention
• Coaching	giving feedback on performance
• Scaffolding	supportive help in complex skills
• Fading	withdrawing as skill develops
• Articulation	learner is able to make understanding explicit
• Reflection	learner compares own performance to that of the expert
• Exploration	consider and try out alternative options

Figure 6.2 Stages of Situated Learning (after Cope et al 2000)

Cope et al (2000:852) in discussing situated learning identified the importance of expert practitioners focusing the learner's attention on salient cognitive features of an activity. This turned the passive role model into an active model by ensuring engagement with the learning experience between the mentor and learner. Through this strategy the mentor could use their expert knowledge and skill to teach and provide feedback. Several stages of the learning experience were identified (Figure 6.2) that combined to develop knowledge and skill in practice.

Participants in this research demonstrated progression through these stages, supported by their mentors. They used strategies such as observing, copying, asking questions, gaining explanations, taking risks supported by their mentors and gradually increasing independence, critically reflecting on actions, comparing themselves to other students and qualified practitioners and identifying alternative actions to take on another occasion. Students verbalised the value of support from their mentors saying how this gave them confidence to try new skills. Participant observations confirmed this perception.

Current models of mentoring

The formal use of mentors in nursing education has grown over the past two decades, particularly with the introduction of Project 2000 style programmes from the mid 1980s. The English National Board in their regulations for programmes leading to admission to parts 12-15 of the *Professional Register* (ENB 1993a 10.1) identified that:

> *Adequate and appropriate supervision must be provided for students during periods of practical experience to facilitate the development of the skills.*

However the mentor, as defined in this role, was not intended to be involved in assessing students in practice. Morton-Cooper and Palmer (2000:39-46) clarified that a mentoring role should be enabling and empowering. They described three

main approaches to mentoring each with similar but different functions that they classified as 'Classical' (primary) mentoring, 'Contract' (facilitated or secondary) mentoring and 'Pseudo' (quasi or partial) mentoring.

The first, 'Classical mentoring', was described as an informal process lacking in specific purpose and function, without defined structure, unpaid and potentially long lasting. They stated 'it is our considered opinion that formal assessment and documentation procedures have no place in this type of mentoring' (Morton-Cooper and Palmer 2000:46).

'Contract mentoring' is perhaps the closest to the planned mentoring experience defined by the regulatory bodies [UKCC & National Boards]. Morton-Cooper and Palmer (2000:46) summarised this approach as having clear purposes, functions and outcomes with possibly financial rewards and limited time duration. Currently no provision has been made for financial reward for mentors.

'Pseudo-mentoring' relationships were described as short lived and focusing on specific tasks (Morton-Cooper and Palmer 2000:46). The short placements, of four weeks, experienced by participants in this study may have resulted in such relationships. In both the focus group study and participant observation participants commented on not having enough time to get to know their mentors before it was time to move on again.

The issue of whether mentors should be involved in assessment was clarified in the approval of new standards for the preparation of teachers by the UKCC in December 1999, published in March 2000. These included advisory standards for mentors and mentorship (Appendix 12) that included a section on assessment, which stated that mentors should:

- demonstrate a good understanding of assessment and
- implement approved assessment procedures

(UKCC 2000c:10).

This standard clarified policy on the role of the mentor as an assessor. These advisory standards were subsequently adopted by the English National Board in their publication related to pre-registration programmes (ENB 2001a).

The reality of clinical practice was that there were insufficient staff resources to have separate mentors and assessors. Participants in this study frequently identified the difficulty in working with their appointed mentor on a consistent basis, commenting that they worked with many different staff each of whom had little opportunity to get to know them well. When they were able to work with their mentor they expected feedback on their performance, thus naturally identifying their mentor as an assessor. Neary (2000:463) also identified this assumption in her study related to supporting students learning and professional development in which students clarified their expectation that mentors should be prepared and trained as assessors.

Watson (1999) carried out a study to determine pre-registration students experiences and perceptions of mentoring. She found that both students and mentors shared the perceptions that the mentor role involved facilitating learning, assessing, acting as a role model and providing support in practice. However students also perceived that mentors had a role in planning learning. Watson concluded that each defined the role according to their individual understanding and not necessarily by the formal definitions of mentor role that were available from regulatory bodies or the university. Similar perceptions were found with participants in this study and contributed to the development of a new approach to mentor preparation described in chapter 7.

O'Connor et al (1999:334) identified that the 'process and progress of learning' in relation to individual students is a joint responsibility of education and service. They stress the importance of integrating theory and practice and assessing these jointly. Neary (2000:465) argued that traditionally heavy workloads for practitioners have resulted in distant supervision. Similar behaviour was observed in this study that made it difficult for mentors to assess performance effectively.

May and Veitch (1998:63) identified that Tutors had limited contact with students because of the multiple demands made of them and consequently made little contribution to assessment 'in' practice. During participant observation in this study university teachers were seen in the clinical environment on only two occasions. On both occasions the Teacher had come to 'visit' the area, as part of their link teacher role, rather than specifically to see the student. However one teacher did take the student away to discuss progress. This finding is consistent with the typical 'Link Teacher' role that is predominantly a liaison one, intended to support practitioners in their supervisory roles rather than students.

The role was one that was under consideration within the university where the students in this research were studying. The third phase of a research project by colleagues into the effectiveness of the link teacher role was in progress. They identified that:

> *Clinical link lecturers have an important role to play in integrating theory with nursing practice.*
>
> Skelton et al (1998:1)

The first phase of the project had shown that it was 'the lecturer, and not the speciality or location' that had the strongest effect on staff perceptions of 'the effectiveness of the link teacher role'. Phase two of the project had examined the perspectives and judgements made by clinical staff that had resulted in the scores in the first phase. Additionally they had identified the common elements

of the role that were most highly regarded by staff. Finally the third stage had changed the link teacher's role to implement the aspects that were highly regarded. This new role was then evaluated and they concluded that improvement was evident in;

- perceived valuation of the link teacher's role
- frequency and predictability of visits by the link teacher
- accessibility and contact with the link teacher
- perceived clinical credibility of the link teacher

(Skelton et al 1998:2).

In conclusion they suggested that the link role of teachers needed to be defined, and agreed with clinical staff in order to provide the desired quality of support.

Preceptors

Preceptors were introduced by the UKCC as part of implementing standards for Post Registration Education and Practice (PREP) (UKCC 1993a). The original intent was to provide formal support for newly qualified and returning nurses through the critical transition period as they moved into new roles.

The phenomenon of 'reality shock' (Kramer 1974) had long been recognised, as was the need to support role transition. The UKCC recommended a period of preceptorship of four months. A significant issue in supervising a newly qualified nurse was that both preceptor and preceptee were on the *Professional Register,* therefore both were responsible and accountable for their own actions. This changed the nature of the relationship to one of peer support rather than teacher and learner.

Morton-Cooper and Palmer (2000:107) identified a particular problem with traditionally prepared practitioners acting as preceptors to new [Project 2000 style] nurses stating:

> *Those newly qualified in the last ten years have been put in the unenviable position of having to defend their formal standards or pre-registration preparation (i.e. Project 2000) as well as their own performance in relation to earlier traditional methods of training.*

Participants in this study observed that often newly qualified nurses appeared to have no support as staffing levels did not allow this, and consequently expressed concern related to their own support once they qualified. They also frequently commented on negative views of their Project 2000 style programme expressed by the practitioners they worked with. Although still students they found themselves defending their programme, but at the same time questioning whether it was an adequate preparation for practice. Such queries were typical of those explored by the UKCC Commission for Education that reviewed pre-registration programmes and subsequently made recommendations for change (UKCC 1999).

Supportive mentors valued the student's style of programme and encouraged them to express their learning needs. Participants who had this experience were more confident about the support they would receive as qualified nurses, through preceptorship, in the future. Morton-Cooper and Palmer (2000:111) described the opposing approaches of practitioners, acting as preceptors, as enabling or disabling. They identified characteristics of effective supporters as being open, constructive, accessible, responsive to the needs of others, easy to trust, comfortable with themselves and their abilities and able to command mutual respect.

The original concept of preceptorship was developed for nursing, midwifery and health visiting as part of a review, by the UKCC between 1989-1994, of post registration education and practice known as the PREP Project. The philosophy of lifelong learning was recognised and other recommendations arising from the

project included standards for periodic re-registration (UKCC 1994a). These comprised of Continuing Professional Development (CPD) and Practice standards.

The CPD standard required practitioners to undertake at least 35 hours of learning activity over the three years preceding re-registration. These were to be recorded in a personal professional profile. The practice standard required practitioners to have worked at least 750 hours in practice in the five years prior to re-registration. Nursing, midwifery and health visiting are self-regulating professions. Practitioners are required to self-assess that they have met the CPD and practice standards, and must comply with requests from the UKCC to provide evidence for audit of how they have met the requirements.

Preceptorship is therefore the beginning of the process of being accountable and self-regulating. Once their name is on the Professional Register practitioners are subject to the Code of Professional Conduct and the Scope of Professional Practice, the two main standards for registered practice. These provide professional guidance and standards for behaviour as a registrant. Through meeting the CPD and Practice standards they maintain their registration.

During this research participants identified their personal needs for continuing support and professional development once they qualified. In particular third year students demonstrated anxiety about the realistic expectation of having a preceptor. Their experience with newly qualified colleagues had led them to believe that this was variable. When applying for jobs they expressed a preference for clinical areas where they had worked as students and knew that the quality of support was good. They also saw themselves supporting others, a

third year student when talking about how she would support students once she was qualified said:

> *I need to build up a good relationship with them and identify what their learning needs are and how they learn ... just tell them that I'll be there you know ... I think it's just knowing that security and that safety net's there for you.*
>
> *Ruth, year 3 student*

Although she was projecting forward to her own role as a qualified nurse there was perhaps an underlying need being expressed for the nature of support that she would want herself. She was identifying the characteristics of an effective mentor that could be transferred to a preceptor.

Lecturer Practitioners

The past decade has seen considerable growth in the use of lecturer practitioners. These are practitioners who take on an educational role but at the same time maintain a clinical workload. They would have undertaken preparation for their teaching role, normally a full teaching qualification, and would also be regarded as experts in their clinical speciality.

The nature of and preparation for such roles has developed to match changes in health care delivery and nursing education. Recognition of the need for lifelong learning, to meet the changing demands of health care, as described in chapter 2, predicated the need for an educator who could work in both academia and practice. Additionally nursing roles have changed to meet re-organisation of health care delivery.

The NHS Plan (DoH 2000) identified the government's proposals for changing the roles of doctors and nurses, and also an agenda for developing interprofessional education further. Section 8 of the plan identified possible new structures for doctors, associated with the aim of 'providing better and broader

educational experience' (section 8.27). A new body was proposed called the Medical Education Standards Board (8.28) that would replace the existing separate bodies of the Joint Committee for Postgraduate Training in General Practice and the Specialist Training Authorities

Section 9 addressed changes for nursing roles, explicitly identifying the need to 'work flexibly across traditional boundaries' (9.2.). It stated:

> *NHS employers will be required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks (9.5).*

In particular the plan proposed that there should be 'joint training across professions (9.18). These changes may appear radical but in reality have been developing for a number of years. As nursing and medical education changes, and also the environments in which they take place, there is an increased need for teachers who can work in both academia and practice. The proposed changes provided an opportunity for developing interprofessional education in pre-registration programmes for all health care professions. Such education needed to be grounded in practice, with the intent of improving the quality of health care delivered by integrated teams of health professionals.

The precursor to Lecturer Practitioners may be identified as Clinical Teachers. These were teachers who, although based in clinical practice, were separate from practice in that they did not take a clinical workload. Personal experience as a Clinical Teacher led to the conclusion that the role was unsatisfactory in that such teachers did not 'belong' to practice and therefore had reduced power to effect change in practice. It was necessary to work 'through' clinical colleagues who had the legitimate power to make changes in practice. Equally Clinical Teachers were at the bottom of the teaching hierarchy and had little power to effect change in education. The typical career path of a Clinical Teacher was to

rapidly move into a full teaching role as a Nurse Tutor, which tended to lead to a reduction of input to practice.

McElroy (1997:147-148) suggests that a tension exists with regard to the credibility of nurse teachers in clinical practice, identifying a lack of clarity regarding the teacher's role in clinical practice. The development of Lecturer Practitioners (LP's) dealt with this issue. Teachers who were able to use 'real life' experience to inform their teaching, and had the necessary skills to facilitate learning, were more able to assist students to integrate theory and practice - bringing theory to life.

The local context in which this research was carried out was one in which a policy was being developed to move toward a greater ratio of Lecturer Practitioners. The Trust where students gained most of their experience had commenced a study to determine the effect of Lecturer Practitioners on the delivery of health care. Early [informal] results have indicated an unexpected finding in that the presence of a Lecturer Practitioner in the unit appears to have resolved issues of recruitment and retention. Qualified nurses appear to consider that they will receive better continuing professional development in such areas and have more support in their roles.

The UKCC have recognised the importance of such roles by developing a teacher preparation standard for Practice Educators (UKCC 2000c) that is of equal standing to that of Lecturers (Appendix 13) Both require post-graduate preparation programmes and lead to qualifications that are 'recordable' on the Professional Register. Lathlean (1997) in her research on the lecturer practitioner role concluded that such roles were beneficial in a number of ways, such as:

- enhancing the integration of theory and practice;

- rectifying the situation whereby practice has been consistently undervalued in nursing education and
- raising the status of clinical practice to equivalence with (or even superiority over) the theoretical contribution

The introduction of new approaches to pre-registration education of nurses (UKCC 1986; UKCC 1999) requires that appropriate support structures are present in clinical practice. Roles such as that of Lecturer Practitioners (or Practice Educators) provide a structure that can in turn support mentors in effectively carrying out their support role.

Clinical Supervision

Clinical supervision was devised as a strategy for supporting qualified nurses and health visitors in their practice and continuing professional development. Kohner (1994:1) stated that:

> *Clinical supervision is a formal arrangement that enables nurses, midwives and health visitors to discuss their work regularly with another experienced professional.*

The system also fitted the requirement made of NHS employers by the Secretary of State (DoH 1999a) for Clinical Governance - a framework to assist practitioners in developing, maintaining and improving standards of care delivery. Klein 2001:210-211) suggested that clinical governance was possibly a response to problems being experienced with regulating the medical profession, against a background of serious issues such as the Bristol enquiry into the deaths of 15 children while or after undergoing cardiac surgery. Professional self-regulation appeared to be failing. The subsequent investigation and conviction of a GP, Harold Shipman in January 2000, for murdering 15 of his patients added more pressure for reform of quality monitoring and self-regulation by the professions.

The regulatory body supported the strategy of clinical supervision in that the UKCC published a position statement (UKCC 1996:1) recommending that:

The incorporation of the UKCC's key statements into systems of clinical supervision will allow more effective professional development of nurses and health visitors.

Clinical supervision for nurses and midwives was not made a statutory requirement, as it was for midwives (UKCC 1993b, UKCC 1994b), although the regulatory body reserved the right to reconsider this position. Six key statements were identified (Table 6.3.)

UKCC Key Statements for Clinical Supervision
1. Clinical supervision supports practice, enabling practitioners to maintain and promote standards of care.
2. Clinical supervision is a practice-focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor.
3. The process of clinical supervision should be developed by practitioners and managers according to local circumstances. Ground rules should be agreed so that practitioners and supervisors approach clinical supervision openly, confidently and are aware of what is involved.
4. Every practitioner should have access to clinical supervision. Each supervisor should supervise a realistic number of practitioners.
5. Preparation for supervisors can be effected using 'in house' or external education programmes. The principles and relevance of clinical supervision should be included in pre- and post-registration education programmes.
6. Evaluation of clinical supervision is needed to assess how it influences care, practice standards and the service. Evaluation systems should be determined locally.

Table 6.3. Extract from the UKCC Position Statement on Clinical Supervision.

There were a variety of models proposed for implementing clinical supervision such as one-to-one, group and peer group approaches (Butterworth and Faugier 1992, Bishop 1998, Butterworth et al 1998). However uptake of the proposals was piecemeal. The fact that it was recommended rather than a required standard, by the regulatory body, may have influenced perceptions and priorities.

The majority of qualified staff taking the role of 'mentor' to participants in this study were not involved in Clinical Supervision. One Trust had decided to commit itself to developing such a system but only two participants in this study had experience in this particular Trust. Consequently the facilitators of learning were trying to use strategies with which they had little or no experience themselves. This issue was addressed by the curriculum planning group when developing the programme for preparation of mentors, as discussed in chapter 7.

The Theoretical Framework for Support

The theoretical framework within which the research was designed, implemented and analysed is an eclectic one. A variety of theorists have informed the work such as Schon (1983 and 1987); Knowles (1984); Jarvis (Jarvis, Holford and Griffon 1998); and Boud (Boud, Cohen and Walker 1993; Boud and Miller 1996; Boud and Feletti 1997). Their theories related to reflective learning, professional development, experiential learning, adult learning and problem-based learning underpin the student-centred approaches described in this research. There is a wealth of literature related to the concepts espoused by these theorists that readers may access. Therefore the following is a summarised account of the relevance of their concepts to this specific research.

Reflective learning

Schon's theory of reflective learning (1983) underpinned the use of reflective interviews for both focus groups and during participant observation. The course team in planning the programme for these students had introduced various learning strategies that made use of reflective learning, such as critical incident analysis, teacher led reflective discussions and reflective diaries. These mainly related to reflection-on-action, enabling students to 'look back on' experiences in order to make sense of them. The opportunity to discuss such experiences with their peers and teachers was intended to clarify issues and enable planning for

future experiences. It may be argued that for effective reflective learning to occur there is a need to develop skills for reflection-in-action to enable students to improve their clinical decision making skills in practice.

Practitioners are in research terms 'insiders', they have access to detailed knowledge at the time that an event is occurring. It is therefore argued that highly developed skills for reflection-in-action would result in increased ability to use this 'unique knowledge' for the better care of patients. Such a notion fits with the concept of patient-centred care, where the patients are empowered to make decisions regarding their own care experience. Given that each patient care experience is likely to be a 'one off' it is vital that nurses are equipped with appropriate decision making skills that enable them to make relevant decisions at that 'moment in time'. However such patient-centred care, although identified by Binnie and Titchen (1999:182) as challenging, enjoyable and satisfying, does have a cost. Smith (1992:136) identified that:

> *Nurses have to work emotionally on themselves in order to appear to care, irrespective of how they personally feel about themselves, individual patients, their conditions and circumstances.*

She labelled this the 'emotional labour of nursing' and suggested that nursing education needed to include preparation for such a cost to the individual.

Professional Development

Schon's theory for 'educating the reflective practitioner (1987) was used both for students and qualified nurses. Practice may be described as the 'art' of nursing in that nurses use personal [tacit] knowledge to make decisions in practice, often not being able to articulate what that knowledge is or why their decision is the best one. Reflective strategies enable an increased awareness of such knowledge. Throughout the research there were examples of qualified practitioners

reflecting-in-action, either independently or with their peers. Students learnt from these role models and copied their behaviour.

The impetus for this research related to the lack of 'control' that teachers had in clinical practice and therefore the need for learning in this environment to be 'self-managed'. Given that nursing as an 'art' is dynamic the argument is strengthened for nurses to be effective at reflecting-in-action in order to continuously develop their knowledge and skills. Peer reflection, as a normal activity of working life, could result in more effective care delivery. Such conclusions influenced the development of a new approach to preparing practitioners to take on the role of 'mentor' as described in chapter 7.

Experiential learning

Jarvis et al (1998:46)define experiential learning as:

> *The process of creating and transforming experience into knowledge, skills, attitudes, values, emotions, beliefs and senses.*

As identified in chapter 1 nurses are concrete learners, therefore strategies that enable students to gain the most from practice experiences fits their learning styles (Kolb and Fry 1975) and also facilitates development of professional abilities. The prescribed 50% practice component of nursing pre-registration education provides opportunities for experiential learning. Experiential strategies, both in practice and university learning experiences, could enhance the effectiveness of learning.

Various strategies were used to facilitate effective experiential learning in clinical practice for the participants in this study. These included a variety of different clinical placements to provide opportunities to learn a range of nursing knowledge and skills. Educational strategies such as role-play, case studies, scenario based learning in a skills laboratory, reflective discussion, critical

incident analysis, and log books were utilised. Most importantly support by mentors was provided but as student evaluation indicated this was of variable quality. Evidence arising from this research enabled such strategies to be reviewed in order to consider a more effective approach to learning. Subsequent developments to the curriculum are discussed in chapter 7.

Adult learning

Knowles andragogical theory (1984) was used as a foundation for designing the programme that the participants undertook (Table 6.4.).

Assumption	Strategy
The need to know	Defined outcomes for units of learning so that students 'knew' why they had to learn topics/subjects/skills - relating theory to practice
The learner's self-concept	Student centred learning approaches - enabling students to take responsibility for their own learning
The role of the learners' experience	Problem-based learning approaches that allow students to be 'creative' and use wide ranging sources of knowledge
Readiness to learn	Sequencing learning so that theory is related to practice experience; Building theory and practice knowledge incrementally to enhance readiness to progress
Orientation to learning	Scenario or case study approaches to increase realism in academic environments, combined with supported learning in practice
Motivation	Providing feedback on performance at frequent and regular intervals to increase motivation to learn; Reflective discussions with peers and teachers to increase understanding and contribute to confidence building

Table 6.4. Strategies for Adult Learning

The underlying assumptions made by Knowles (1984:55-61) provided a source for designing strategies for learning and teaching. The course team shared these assumptions and strategies were developed in order to maximise an adult approach to learning. However criticism may be made in that the curriculum development group could not possibly involve all academic and practice teachers with which the students would have contact. Therefore further strategies had to be devised to ensure that the philosophy developed by the curriculum development group could be shared with others. Such approaches are discussed in more detail in chapter 7.

Problem-based learning

Engel (in Boud and Feletti 1997) suggested that problem-based learning was 'not just a method but a way of working'. He considered that it was an eminently suitable approach for professional education and 'an essential means for higher education' to progress into the new century (Boud and Feletti 1997:25). Such an approach is also appropriate for interprofessional education strategies. Currently several regulatory bodies already require evidence of skills in collaborative working as part of their undergraduate programmes (UKCC & the National Boards, GMC, CPSM & CCETSW). It is reasonable to conclude that problem-based learning approaches reflect the reality of working together - with professionals sharing problems and reaching solutions together.

An attempt was made for participants in this study to use problem-based learning on their reflective study days and in the use of scenario based learning in the clinical skills laboratory. Case studies were used in some of the academic themes such as ethics, nursing theory and behavioural sciences. Once again the lack of input of university teachers into practice environments made it difficult to implement problem-based learning in clinical practice. Observation in practice identified that some initiatives were taking place but these relied upon the

interest and motivation of individual members of staff and their ability to motivate others to join in such initiatives. Evidence gained from this study influenced an action learning approach that is described in chapter 7.

Conclusion

The emergent theory from this research may be summarised as follows:

> *Students are best able to manage their own learning in clinical practice when they are actively involved and facilitated to learn by 'mentors' who allow them the freedom to take risks, and provide a 'safety net' to protect them in taking such an approach.*

Evidence gained from analysis of focus group data and participant observation reflective interviews, combined with observations and positioned within the field of knowledge has resulted in this conclusion. However it should be recognised that this theory relates to the effective use of support roles. Evidence from this study indicates that when such roles are ineffective they may impede the ability of students in managing their own learning. The category 'self-centred practice', identified from focus group analysis (Chapter 4:122-128), demonstrated the negative aspects of mentoring. This category was further substantiated in the sub-theme 'being supported' derived from participant observation (Chapter 5:154-156) in which many examples of inappropriate or inadequate support were identified.

Personal knowledge of preceptorship is that it is of variable value. Where clinical leaders support the concept it provides valuable support to practitioners who are in transition between roles. However often the demands of providing service, combined with the number and nature of those needing support i.e. newly qualified and returning nurses, agency and bank nurses, other professionals as well as students and HCAs, may prohibit effective support being provided. The fact that Clinical Supervision is only a recommendation from the regulatory body means that it is often ignored in practice.

Morton-Cooper and Palmer (2000:194 compared the relationships of mentoring, preceptorship and clinical supervision. They concluded that in response to the challenging and turbulent changing nature of health care delivery:

> *It is also vital to consider supportive relationships, whereby care workers and professional practitioners can feel free to develop at their own rate and in their own terms.*
>
> *(Morton-Cooper and Palmer 2000:203)*

They suggest that a range of support mechanisms will facilitate personal and professional development. Curriculum development arising from this study (Chapter 7) has addressed the issue of providing effective support for pre-registration students, whilst at the same time addressing the development of relevant knowledge and skills for mentors. This has laid the foundations for continuing professional development and provided a basis for self-directed learning leading to effective use of support mechanisms available.

Facilitated learning appears to be more effective than teacher led learning. Ideally practice teachers [mentors] should be 'selected' by students. However this is not a practical recommendation. The numbers of students passing through clinical areas for placements, related to the number of staff with the appropriate knowledge and skills to carry out the mentoring role, does not allow for choice. Mentors who 'volunteer' to take up the role are likely to be more motivated to support students. However this is only choice for one half of the partnership; a risk remains of personality clashes or work pressures interfering with effectiveness of the role. The reality of support is that the majority of mentors are 'appointed' to their role. Therefore the need for effective preparation programmes for this role is vital. Local developments in mentor preparation made as a result of this research are described in chapter 7.

Several other factors also affect the quality of mentoring. The length of the student's placement is important. The ENB (2001b:7) identified that:

> *High quality and longer practice placements, in a supportive environment, will help students gain better practical skills and ensure that they are able to provide the care needed by patients and clients.*

Changes to pre-registration programmes, following the UKCC's recommendations (1999) include longer placements to facilitate achievement of 'fitness for practice'. The use of learning strategies in clinical placements that support professional development is another significant factor. Critical reflection, whether it is verbal or written, can be seen to enhance knowledge acquisition.

Support relationships may be seen as a continuum or a cycle. Students commence with being 'supervised' by a mentor, gradually taking a more active role in the relationship and thus altering the balance of power from the mentor to themselves. Once newly qualified supervision transfers to a preceptor, an experienced nurse who assists them in transition of their role from student to registered nurse. Subsequent support is provided through Clinical Supervision, with qualified nurses providing peer support for continuing professional development. Finally the 'once student' and now 'experienced nurse' is able to take on the roles of mentor and preceptor themselves.

The effective use of support strategies appears to rely upon the use of 'action learning' approaches - strategies that reflect the dominating learning styles of nurses. The use of experiential and reflective learning strategies, combined with adult learning approaches appears to result in effective, high quality learning experiences. Such approaches are underpinned by a variety of educational theories, as previously discussed, and are relevant to learning in clinical practice.

It should be recognised that active approaches are not the only strategy for supporting learning in practice. Electronic based learning (e-learning) may be

used to complement other strategies. An example would be the use of computer conference packages. Personal experience gained with the Open University allowed access to such a package. OU students were able to access a topic conference, tutorials, expert and technical advice, peer 'chat rooms' and have on-line debates. This strategy made it possible to access learning materials and support from teachers who were 'at a distance'. There was an advantage in that communication was a-synchronous, therefore teacher and student could access information at any time of the day or night - a 24 hour teacher for 7 days a week. Disadvantages were the lack of face-to-face contact, the inability to pick up on non-verbal communication and delays in responding to each other due to pressures of other aspects of work or life. Therefore it is advocated that such learning strategies should support more active ones not replace them.

Having analysed the data and defined emergent theory the findings from this research were used to influence curriculum development, thus meeting the final aim of the study. Developments are described and discussed in the final chapter of the ethnography.

CHAPTER 7

REFLECTING BACK - LOOKING FORWARD

Conclusions, curriculum development and future action

The findings of this study reveal the need for quality support in practice (a safety net) with a supplementary need to actively involve students in their learning. Effective mentors who facilitated learning through active and reflective approaches enabled participants to control their learning. This appeared to enhance the quality of learning and develop participants' self-confidence

Throughout analysis of the data and writing up the ethnography the findings were used to develop nursing curricula and also to adapt the preparation of mentors to enable improved support of students. Specifically 'action learning' approaches were developed in both pre- and post registration nursing education in order to facilitate the control of learning by students.

This chapter describes actions taken, based on the findings of the research, provides a personal reflection on the study and identifies recommendations for the future.

Curriculum Development: Pre-registration Programmes

The programme that participants had followed was revalidated while the data was being analysed and written up. Curriculum development, re-validation, implementation and evaluation of the re-validated programme, including the changes introduced as a result of this research, provided an 'action context' in which the data was collected. This new version of the programme has recently been reviewed and revalidated again to introduce the recommendations for changes to nursing education as identified by the UKCC (1999).

Presentations of preliminary findings from the research were made to academics, practitioners, student groups and wider professional audiences. This contributed to curriculum development and enabled dissemination of findings to a wider audience. Debate with such groups enabled development of ideas that in turn further influenced curriculum development. Strategies for action learning that were introduced included action plans, action learning groups and portfolio construction. These were introduced and evaluated.

Action Plans

It had become clear, through the research, that when students were able to control their own learning they tended to gain more from the opportunities available to them. However, whilst confident students were able to ask for learning experiences the less confident found this difficult. A strategy was needed that would legitimise students being able to 'ask for experience'. The researcher convened a curriculum development sub-group that included service and education providers. This group examined the existing approach of using a student profile (see chapter 2) to assess learning in clinical practice to determine how to make this approach more active.

The group recognised that the resulting new profile must provide evidence that the competencies of nursing had been gained by the end of the programme, whilst at the same time using student evaluation of the existing profile to develop it into a more student-centred tool. The profile also had to be flexible to meet the needs of students regardless of the branch programme they were following. It was agreed that statements would therefore need to be written in broad terms that could be interpreted to meet the specific needs of the type of nursing.

A new profile has been designed (Appendix 14). which has five sections:

1. Care giving skills;
2. Interpersonal and communication skills;
3. Organisational skills;
4. Professional development skills and
5. Teaching and facilitation skills.

Each section has various sub-sections and is divided into three stages. It is intended that stage 1 should be carried out under close supervision; stage 2 under more distant supervision and that by the end of stage 3 students would be largely working independently.

Sub-sections contain a statement at each level allowing both students and practitioners to understand how knowledge and skills develop throughout the programme. The focus alters as the programme progresses, in recognition of the increasing amount of knowledge and skills that students gain i.e. stage 1 - caring for a single patient, stage 2 - caring for a small group of patients and stage 3 - caring for a community of patients. There are 22 sub-sections, each with a statement at each level. An example is included as Table 7.1.

Care Giving Skills			
	Stage 1	**Stage 2**	**Stage 3**
1.1. Assessment of Health and Health Care Needs	1.1.1. Able to make an accurate nursing assessment of an individual patient/client identifying total needs	1.1.2. Able to carry out accurate nursing assessments for a group of patients/clients	1.1.3. Able to be accountable for the nursing assessment of patients/clients within his/her care

Table 7.1: Example of Profile Statements

To complement the profile an action plan has been designed (Appendix 15), for students to use in collaboration with their mentor and personal tutor. Students select the profile statement that they want to develop and construct learning objectives that will demonstrate acquisition of knowledge and skills.

The onus is on the student to initiate this action and agree their defined objectives with both their mentor and personal tutor. In this way a tripartite relationship has been developed as a support strategy. The mentor is responsible for ensuring that the students' proposed action is achievable in practice and supporting the student in accessing appropriate learning opportunities. The personal tutor is responsible for ensuring that the proposed actions are at an appropriate level of learning, related to the stage of the programme, and supported by evidence gained from practice, reading or research. This results in both practice-based evidence and evidence-based practice.

Assessment criteria identify that students have to complete 8 action plans, on a formative basis, by the end of semester one, and complete the remaining stage 1 outcomes, on summative basis, by the end of semester two. Semesters continue to be six months in length. Thereafter completion of 50% of the outcomes for each stage has to be completed for each of semesters three and four (stage 2), and five and six (stage 3), all on a summative basis. Students are able to control their own learning by selecting the order that they will achieve the statements and designing their own learning objectives to meet these. They continue to discuss the action plans and their evidence on a formative basis during action learning groups prior to submitting them for formal assessment.

Validity and reliability of assessment was achieved through the need to have both the mentor and the personal tutor agree the objectives. Preparation of mentors to implement this strategy combined with students having one personal tutor throughout the programme (unless that person left employment) ensured that a consistent approach was taken to all students. Quality assurance processes ensured regular meetings of mentors and personal tutors to debate clinical profiles and action plans. Mentors were able to contact personal tutors to discuss action plans or any problems experienced at any time. Discussion could take

place either by telephone, e-mail or face-to-face meetings. Similarly students had regular contact with personal tutors either on an individual basis, through one-to-one meetings, e-mail, by telephone or as a group in action learning group meetings.

The use of action plans provided a strategy for students to control their learning, within parameters that reflected the defined outcomes of the programme and therefore ensured that they also met the requirements of the regulatory body. Initially students required explanation, support and feedback in constructing learning objectives. As they progressed through the programme they gained expertise in writing appropriate objectives and their plans became much more student centred. Discussion of action plans within action learning groups enabled peer learning and support.

Action Learning Groups

The concepts of action learning groups as described by Graham (1995) and confluent education (Francke and Erkens 1994) were used to develop an action learning approach for undergraduate students. The intended outcome was to facilitate self-development throughout the programme. Students were divided into small groups, not exceeding 15 and assigned to a personal tutor. Together they formed an 'action learning group' (ALG) that met once every two weeks during each semester. The defined aim of the ALG was:

> *To enable undergraduates to raise awareness of their self-development and to critically review this through dialogue with their peers using evidence of learning collected through reflection on their progress in both theory and clinical practice.*

The defined objectives, adapted from Graham (1995) were as follows:

- *To provide a forum for sharing learning experiences which are meaningful to the undergraduate*

- *To enable undergraduates to raise their awareness of the self-development process which is taking place*
- *To provide a safe environment for undergraduates to express and disclose in a personal and dynamic way their self-development*
- *To foster creative interaction in a trusting environment:*
  - *between the undergraduate and the self-development process*
  - *between the undergraduate and peers who are also in the self-development process*
  - *between the undergraduates and the facilitator whose role is to foster such development*
- *To provide a means of reflecting on ones own commitment and involvement in the discipline of nursing.*

At the beginning of the re-validated programme initial ALGs were used to introduce students to the concepts of action learning and reflective learning. The first two ALGs tended to be teacher led to allow students to gain an understanding of the approach. However teachers were briefed to encourage strong student participation and use experiential teaching strategies as much as possible. The locus of control rapidly moved from teacher to student with the teacher facilitating learning rather than taking a traditional teaching lead. This reflected Gray's (1989) Mentor-Protégé model and also the seven stages of situated learning described by Cope et al (2000), both described in chapter 6.

One aspect that enhanced this was that they were asked to devise their own ground rules. This activity enabled them to take ownership of the ALG at an early stage. This was usually accomplished by breaking them into three smaller groups, to facilitate discussion, each producing possible ground rules. These were then share as a whole group and consensus reached on the final ground rules to guide the ALGs. A typical example is included as Table 7.2.

Group X: Action Learning Group Ground Rules

- Confidentiality will be respected within the bounds of the Code of Professional Conduct (UKCC 1992)
- Group members will be non-judgemental towards each other
- Group members will respect each others opinions and not laugh at each other
- Group members will listen to each other even if the topic is not of interest to them as an individual
- Respect will be shown for unwillingness to share thoughts either within learning sets of the whole group
- The identity of people will be protected when talking about them
- Discussion of incidents will not continue outside of the ALG
- Group members will be prepared to compromise
- Time will be allocated as 1 hour in learning sets, 15 mins break for coffee and 45 mins whole group discussion to share relevant issues
- Membership of learning sets will be reviewed at the beginning of each semester
- Every member is expected to contribute an issue for discussion at least once per semester
- Time will be allocated at the beginning of each ALG according to the number of members who wish to raise issues
- Breakout time will be taken if discussion becomes heated or distressing on condition that all members return after 5 mins
- Once action has been agreed with individuals the group will decide if there is to be any further feedback

Table 7.2: Example of Action Learning Group Ground Rules

As with this particular group sometimes they would choose to break into smaller groups of 4/5 students for part of the session so that they could have a more intimate discussion. These were called learning sets. On such occasions the ALG would re-convene as a whole group to share key issues arising from the learning set discussions. This strategy appeared to help the less confident to participate as the smaller size of the group made it less threatening to make a contribution.

Guidelines were given to students to assist them in learning the process of action learning, adapted from Francke and Erkens (1994). These identified the need to

prepare for the ALG by considering their learning experiences and identifying those that they wished to explore further with their peers. They were asked to write brief reflective observations on their practice days to assist them in sharing experiences in the group. During the ALG students who presented an issue would lead discussion, trying to identify both the cognitive (mind) and affective (feeling) factors present in the experience they were sharing.

Group members were asked to help their colleague to become aware of what had been achieved, what could be done differently and what decision-making processes had been used. They achieved this through questioning, commenting and suggesting alternative actions. There was an expectation that students would take personal responsibility for summarising the discussion and stating their intentions for future action as a result of the debate. Where appropriate their peers would ask for feedback on such action at the next ALG. A typical discussion that occurred during an ALG with third year students[1] started as follows:

> *Student A: I went with the District Nurse to see this lady who had just been discharged from hospital. The lady said isn't it good I haven't got cancer - well we had gone to give her some chemotherapy. The lady said the doctor had told her it was just a tumour. The District Nurse didn't correct her and went on to give the drugs. When we were back in the car I asked her why she hadn't explained properly to the lady and she said the doctor doesn't like patients to know they have cancer.*
>
> *Student B: That's dreadful*
>
> *Student C; That happened to me as well, I don't see how it can be informed consent if they don't know that they've got cancer, how can they understand the chemotherapy.*
>
> *Student A: I said that to her and she said that's what the doctor instructs them to do.*

The discussion that followed, involving the whole group, identified several similar examples. The students discussed the issues of informed consent, the

[1] Notes written post ALG with permission from the students concerned

ethics of not giving correct information, nursing roles related to how in this example the District Nurse was taking the traditional role of 'Doctors handmaiden' and professional responsibility and accountability.

They questioned the student involved about her action at the time and discussed possible alternatives. One was able to share her action in a similar situation. They also considered the implications of being a student and their feelings of powerlessness. Prompted by the personal tutor they considered how they would handle a similar situation once they were qualified. Ultimately the student concerned agreed her future action and additionally that she would report back to the group related to the outcome of this.

Personal Tutors involved in ALGs formed their own 'action learning group'. With permission from the students we shared experiences, protecting identities, so that we could reflect on our own management of the situation. As the approach was new to teaching staff we were learning at the same time as the students we were teaching. It was interesting to discover the similarities of student experiences and to identify how our responses varied according to our professional backgrounds. We discovered that our emphasis was different depending on whether out main focus was ethics, education or practice. Our self-development matched that of our students.

Learning Portfolios

Throughout each year of the programme students were required to construct a learning portfolio, each year building on the one before. This was designed to provide an overarching assessment tool throughout the programme, demonstrating their personal and professional development. It enabled students to meet the regulatory body requirements for a portfolio that provided cumulative information about the students' achievement and progress,

demonstrating the inter-relationship of theory and practice (ENB 1995c). It also prepared them to meet the UKCC requirement that all qualified practitioners keep evidence of their professional development in a personal professional profile (UKCC 1990, 2001).

Finally it provided evidence that students' preparation had enabled them to be 'Fit for Practice' (the regulatory body's requirement), 'Fit for Purpose' (the employer's requirement) and 'Fit for Academic Award' (the HE requirement).

Learning portfolios contained biographical information, summaries of academic and clinical work, examples of academic assignments relevant to practice, completed action plans with supporting evidence for each semester, examples of critical incident analysis reports of significant experiences and finally a forward looking plan for development in the future. Evidence included in support of action plans was required to demonstrate their knowledge and research base for practice. Additionally they were encouraged to seek evidence from those they worked with, such as witness statements related to their actions and abilities, to demonstrate how they were applying their knowledge and skills in practice. These strategies enabled them to 'build knowledge' from practice, challenging what they had seen and done and demonstrating consideration of alternative actions for the future.

During the year students discussed evidence that they would put in their learning portfolio with their personal tutor to gain formative feedback. At the end of each year they would submit the completed portfolio as a summative assessment. A typical assessment question for this assignment was:

> *Write a reflective report on the progress you have made in your first year with regard to developing your knowledge and skills to take on the role of a nurse.*

When writing this reflective report they were expected to reference evidence in

the learning portfolio as well as relate to theory that they had learnt. As they progressed through academic levels of study the demands made upon them in reflective reports increased from description, application and analysis to become more critically reflective, synthesising data from a variety of sources and developing their judgemental abilities. Their portfolios also became a useful learning resource that they were able to refer to as they progressed through the programme.

Evaluation

The learning strategies of action plans, action learning groups and portfolio construction were combined into a unit for the undergraduate programme called the 'Portfolio Unit'. It was awarded 30 credits each year at academic levels 1, 2 and 3 respectively. (A whole years study was worth 120 credits, therefore this unit represented a significant proportion of learning). As a formal programme unit it was subjected to quality assurance mechanisms. These included evaluation from students, teachers, mentors, external examiners and other service providers.

Informal evidence was obtained from verbal comment in ALGs, mentor comments in clinical practice, teacher ALG discussion and comments from colleagues. Significantly the high number of colleagues who asked to become an ALG tutor indicated the value given to the approach. As further intakes were made to the programme gradually all teaching staff took on this role. Those who had already gained experience as an ALG tutor were asked to 'mentor' their peers in order to provide consistency of approach and support for those less experienced in action learning approaches.

Students evaluated the unit well, making comments such as:

- enabled me to discuss issues from practice
- sharing others experiences has contributed +++ to my learning

- my course seems to have been centred around the ALG and this has been good
- good to let off steam and talk about problems

Data, collected from student evaluation questionnaires (Appendix 16), indicated that they considered the unit to have clear outcomes, felt encouraged to participate, were encouraged to think independently, found the unit relevant to professional requirements, found the assessment useful, took responsibility for their own learning and made good use of learning support facilities during the unit.

Curriculum Development: Post-Registration Programmes

Having developed an action learning approach for undergraduate pre-registration students it was considered vital to prepare their mentors to be able to facilitate such approaches to learning. Previous mentor preparation had utilised traditional approaches to teaching and learning such as lectures, discussions and seminars with some opportunity for teaching practice. The curriculum development sub-group for the Portfolio Unit felt that mentors should be able to experience the same approaches to learning as pre-registration students. Consequently the mentor preparation programme, known as the ENB 998, was re-designed to make use of action learning approaches.

An extended curriculum sub-group was set up, led by the researcher, involving previous curriculum developers for the existing ENB 998 as well as members of the portfolio sub-group. This group considered that experiencing similar educational strategies would reflect the activist and reflector styles of nurses as described in chapter 1. An action learning approach would enable student mentors to experience active learning and enhance their understanding of the strategies for teaching and learning in practice. In order to achieve the desired outcome the group designed and validated a programme, delivered over a ten

week period, that included the strategies of action learning groups, facilitated learning materials and utilised learning portfolios.

Action Learning Groups (Post-registration)

The ALG approach used was as described for pre-registration students, with groups of 15 students divided into three learning sets. The process of meetings was virtually the same except that student mentors met for three hours (including a break for coffee/tea). The ALG time was divided into an initial period for reflective learning (normally a minimum of one hour), incorporating the ALG process as described previously. This was followed by a whole group discussion, facilitated by the personal tutor, to explore issues raised. In this part of the meeting the tutor acted as an expert resource to answer questions and clarify theory-practice relationships. Finally the group would have time to determine future action, how they would go about the required learning for the next week and how they would act themselves and support each other.

The structure of the programme was designed as half a day for an ALG and half a day for facilitated learning. Additional expectations were for self-directed learning equivalent to at least one day per week and further time for portfolio construction and teaching practice. These expectations had been clarified with service providers who sponsored student mentors. However in reality student mentors found that the demands of providing service often interfered with self-directed learning time. Many worked extra shifts to cover staff shortages, which increased the demands on their personal time during the length of the programme.

Student mentors received a handbook prior to commencing the programme that identified the expectations and contained the facilitated learning materials for the programme. The demands made of these student mentors to manage their own

learning were high, and for many it was their first experience of student centred learning. On the whole commitment to the programme was very high and achievement tended to be of a good standard.

Facilitated Learning Materials

The emphasis of the programme was on student managed learning. This was achieved by writing worksheets for each day of the programme with activities for the student mentor to carry out prior to attending the ALG. The Personal Tutor for the group took the role of facilitator of learning. Each ALG had a specific focus (summary included as Appendix 17) that the teacher would facilitate. These developed the activities from each worksheet, allowing student mentors to reflect on their own learning and increase their understanding by exploring concepts with each other and the tutor. Small group work and experiential learning strategies were dominant in these sessions.

In particular two weeks were devoted to teaching practice, one for classroom teaching and one for teaching in clinical practice. The main group was divided into half to allow for a smaller audience, reducing the threat of peer teaching in the classroom. Student mentors would write comments on a formative evaluation form for each other (Appendix 18) and the teacher would video the teaching practice for each student mentor. Only the person concerned saw these videos as an additional means of enabling self-evaluation. They were encouraged to comment on the video evidence when evaluating their own teaching.

Teaching in clinical practice was assessed by a peer [in practice]; this person was required to already possess a teaching qualification such as the ENB 998. The assessment form used was strongly similar to the one used in classroom assessment so that student mentors were familiar with the assessment criteria (Appendix 19).

Facilitated worksheets (example as Appendix 20) guided student mentors to relevant articles to read, activities to do and reflective activities. This put the onus of learning on to them. When they commenced their ALG it was quickly apparent which student mentors had carried out the activities fully and which had given them less attention. Peers within the group quickly developed group norms of behaviour where they would either put pressure on another to do the work or condone lack of preparation. The latter usually related to peers where they considered there was a justifiable reason for failing to 'pull their weight'. Teachers encouraged students to contribute learning materials they had discovered themselves and in this way an annual review of the materials led to inclusion of articles found to be particularly valuable by student mentors.

Teachers who took on the role of facilitator to these groups met together on a regular basis to evaluate delivery of the programme and review materials and learning strategies. The researcher developed tutorial guides for each ALG (example as Appendix 21) to ensure that a consistent approach was taken by teachers. These served as broad guidelines that teachers could adapt to enable flexibility to respond to individual or group differences that might emerge. Tutorial guides were reviewed at the ALG teacher meetings and changes made in accordance with evaluation of this group.

Learning Portfolios (Post-registration)

Learning portfolios were used throughout the programme. These provided a resource for teaching and learning as well as a means of formative and summative assessment. Baume (1998:4) provided a simple definition of learning portfolios as 'an organised and annotated collection of documents'. In respect of this programme they were designed to provide evidence of self-development through reflection and the inclusion of evidence of reading and activities related to teaching and learning in clinical practice. Worksheets guided learning, which

was enhanced by formative feedback from peers and the Personal Tutor during ALGs in order to assist student mentors to select appropriate evidence for inclusion in the portfolio. At the end of the programme student mentors were asked to write a reflective essay on their self-development, drawing on evidence in the portfolio, to submit as a summative assignment. They were given a period of time after completion of the final ALG and facilitated learning to enable reflection-on-action.

Evaluation (Post-registration)

Student mentors were encouraged to write a reflective diary throughout the programme. Extracts from this were included, if appropriate, when writing their reflective essay for the portfolio assignment. The diary remained personal and private to them, although some chose to submit the whole with their portfolio at the end of the programme as evidence of their self-development. One student[2] took the approach of writing a pre-ALG statement and then a post-ALG statement to demonstrate how her thoughts changed. She stated in relation to the second ALG:

> *Pre-ALG: This still feels rather over my head and I don't feel prepared to do what I am being asked to do. It is all rather stressful.*
>
> *Post-ALG: Last week I advised myself to take each week as it comes, now I am going to advise myself to take each question on the worksheet as it comes. You aren't prepared to do what you are being asked to do. You are being expected to prepare yourself! Student centred learning! Get used to it, it must be effective or they wouldn't encourage it on this module. I have spoken to a colleague in my ALG who is expressing similar concerns and offered the same advice.*

These thoughts were typical of student mentors at the beginning of the programme, whilst they were adapting to unfamiliar learning approaches.

[2] Permission given by the student to reproduce statements

The same student in her final week reflective comments wrote:

> *Although I feel a little troubled about the reflective assignment, I am actually feeling both intrigued and a little excited by my development in this course. I have completed the self-assessment for worksheet 10 and have realised the effectiveness of the training.... I have been nothing if not honest in my reflections and did not honestly expect to have grown so much in this course. I was not motivated at the onset and was sceptical of the degree of humanistic approach adopted. I have felt over-worked and expected my learning to suffer as a result. I have, in fact, proved myself wrong in the most positive way.*

This student mentor took the unusual approach of keeping a visual chart of her growth over the programme, rating herself out a 10 in the following areas:

1. Psychological state
2. Self-esteem
3. Subject knowledge level
4. Confidence level
5. I understand what I'm supposed to be doing and I can do it
6. External pressures outside of the course

In areas one to five she demonstrated considerable growth throughout the course, giving scores from 0.75-2 in the first week and scores of 9 in the final week. External Pressures were fairly constant throughout, being both personal and professional in nature.

There was a high spot in week 6 when work problems were high due to staff shortages and her husband providing little support at home. There was also some conflict within her ALG. She stated:

> *It seems that I am feeling put upon at home, at work and within my ALG at the moment. I must be careful not to over-react in any one situation as a result of the influences from other situations.*

This period of the programme was also where student mentors carried out teaching practice, in the classroom and in clinical practice. Many commented that their stress levels were raised prior to this activity but also that once completed it was the most useful part of the programme for developing confidence in themselves as teachers.

The programme was formally evaluated by a questionnaire for each group. Such evaluations were strongly favourable in statistical terms with students identifying that the programme was well organised, they were encouraged to participate, to think independently, received prompt feedback and made good use of the resources available to them. Qualitative comments included statements such as:

- *Initially I found the style of this unit quite difficult i.e. I felt alone and unsupported. I now realise that it is beneficial to take responsibility for my own learning.*
- *This unit was well structured. Logically following a learning sequence and building skills weekly e.g. analysis, evaluation. The study skills learnt will be useful for the rest of the Diploma course. The explanation of theories for a learning environment and having to relate them as we were learning was an excellent strategy. The peer review of teaching experience was valuable both in terms of reading other comments and in analysing the experience myself. An excellent unit.*
- *This has been a new experience, enjoyable but taxing. Would have liked longer study days - in many ways to have more discussion with peers.*

Some student mentors undertook this programme as a stand-alone unit, whereas others took it as part of a Diploma in Nursing programme, at the end of the first of two part time years. The latter frequently commented that it would have been helpful to have had this unit first as it helped so much with their study skills.

Perhaps the most significant evaluation came from current pre-registration students who had mentors who had been prepared from the new programme. They consistently commented on how well their mentors understood them and how good they were at facilitating learning.

Action Learning

The theory underpinning all of the action learning approaches was reflective learning as defined by Schon (1983; 1987) as described in chapter 6. McGill and Beaty (1992:17) define action learning as:

> *... a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done.*

This definition builds on the relationship between action and reflection as identified in reflective learning models and strategies as described by Carr and Kemmis (1986); Kolb (1975); Carr (1995) Johns (1994) and Jarvis et al (1998). Action learning, incorporating reflective learning, resulted in strategies for teaching and learning that enhanced students managing their own learning.

Development of Nursing Education

During the course of the research study there were further developments in nursing education. These arose as a result of changing policies from the regulatory body as well as a change in government stimulating a profusion of policy papers.

The UKCC Education Commission reported its conclusions (UKCC 1999) and made recommendations for changes in nursing education. These responded to the evaluative studies carried out on the Project 2000 style programmes and related issues that were reviewed by the Commission; for example Bartlett et al (1998); Carson and Hamer (1997); Collingwood (1996); Day et al (1997); Elkan and Robinson (1994); Gerrish (1999);Jowett et al (1992); Luker et al (1996); Neary (1996); Phillips et al (1996) and White et al (1994).

A total of 33 recommendations were made (Appendix 22) related to the areas of increasing flexibility, achieving fitness for practice and working in partnership. Changes included were the increased use of accreditation of prior learning and access routes to enable entry to nursing education and the reduction in the length of the common foundation programme from eighteen to twelve months with a corresponding lengthening of the branch programme to twenty-four months.

The Commission recommended that programmes should be specified in terms of outcomes for theory and practice. These were subsequently developed as outcomes of the CFP and competencies for the end of the branch programmes. The balance of programmes remained at 50% theory and 50% practice but it was recommended that placements should be longer. Supervision in practice was identified as a key component, as were the continued use of portfolios and strategies that encouraged problem solving and experiential learning.

The importance of partnership between education and service providers was stressed and the first 16 programmes of the new style commenced in Partnership sites in England in September 2000. The UKCC commissioned research to determine a baseline for the nursing competencies. In turn this will facilitate evaluation of the outcomes and competencies of the new programmes. At the time of writing this ethnography further exploration is being made of the place of interprofessional education in pre-registration programmes and the nature of the branch programmes, two recommendations of the Commission that required further consideration.

A change in government resulted in a significant number of policy papers related to health and social care and the education of practitioners. 'The New NHS: Modern, Dependable' (DoH 1997) set the scene for future developments. This was quickly followed by 'A First Class Service: Quality in the New NHS' (DoH 1998) and 'Making a Difference' (DoH 1999a). Regional NHS Executives adopted the latter as a guiding format for developing health and social care services establishing project teams throughout England to implement the policies.

There is a similarity between the key points from 'Making a Difference' and the recommendations from the Commissions report 'Fitness for Practice' (UKCC 1999). The former was concerned with strengthening the nursing, midwifery and

health visiting contribution to health care. In particular the government recommended that education be strengthened to ensure that nurses and midwives are properly prepared to contribute fully to a modern NHS. New roles and new ways of working were recommended to release the untapped potential of nursing, midwifery and health visiting. Subsequently Nurse Consultant posts have been created, strengthening the nursing leadership capacity in health care. There is a concerted thrust toward increased inter-professional education to enable more effective teamworking in practice and changing role boundaries of health and social care professionals.

A Personal Reflection on the Study

Throughout this ethnography personal reflective comments have been included. This final section contains reflective comments from the perspectives of being a researcher, a teacher and a nurse.

Researcher Perspective

My initial expectations changed as findings began to emerge from the data. One of the main observations arising from transcribing the reflective interviews, attributed to personal inexperience in participant observation and conducting reflective interviews, was that the theory emerging from the data related more to how students learnt in clinical practice rather than how they managed their learning.

This focus changed as I became more skilled in my role as a researcher and as my personal relationships with the participants developed. In general interviews carried out in the first four months of the study were more 'researcher centred' whereas those carried out in the remaining eight months were much more 'participant centred'. Personal skills in facilitating reflective learning were developed.

As findings from participant observation began to take shape the relationship of emerging themes to those from the focus group analysis became clear. I was able to confirm the 'perceptions' of learning that focus group participants had shared and identify their reality in practice. It was these findings that enabled the curriculum development described in this chapter. In turn these developments helped to clarify analysis of data, returning the focus to how participants managed their own learning.

It is typical of qualitative research that its' nature changes as the study develops. The initial intent to gather data with a view of influencing curriculum development changed the nature of the research and it became a more applied study. This made it consistent with Boyle's view (1994:167) of ethnography offering cultural explanations and having pragmatic outcomes (see chapter 3). In this way I became a 'tool' of the research rather than just the researcher, as I influenced actions from the early findings of the study.

My initial choice of grounded theory as an approach now appeared appropriate. Concerns that the limitations of time and constraints of gaining access would not allow theory to be developed diminished. In reality a modified form of grounded theory was achieved with early analysis shaping subsequent data collection and in turn leading to action to implement findings that further clarified theory.

One difficulty experienced was in managing the quantity of data generated from the study. Enthusiasm to collect sufficient data had resulted in more than I knew what to do with. Kvale (1996:179) when discussing how to deal with an overload of data suggests that the important question is:

> *How do I go about finding the meaning of the many interesting and complex stories my interviewees told me?*

The change in analytical strategy to use 'mind-mapping' was helpful, it enabled

me to cope with my 'overload' of data and to answer the questions posed. The use of cross checking with data analysed through more conventional approaches served to confirm the reliability of the new approach to analysis.

A key issue was the 'ethics of presence'. I was aware that my presence as a participant observer had effects on the participants, the clinical staff and the nature of data collected. Participants would verbally comment on the difference of their experience 'because I was there' as identified previously. Clinical staff would appear to be conscious of my presence and act 'out of character' according to comments made by the participants. As identified in chapter 3 they would sometimes make remarks about doing things the right way because I was there, or be reluctant to allow me to observe them working with participants. I was aware that this resulted in the participants having a different experience than they would if I were not there.

In turn this affected the nature of data collected. If I had been able to be a complete observer then I could have covertly collected data. However the outcome is unlikely to have been different. The accounts of learning in practice gathered from the two focus groups were strongly similar to data collected through participant observation, suggesting that the theory developed would have been the same. Thus the findings are deemed to be credible, transferable, dependable and confirmable (see chapter 3).

Teacher Perspective

Perhaps one of the most difficult aspects of the research was to not 'act as a teacher'. There were frequent occasions when this resulted in conflict as I became concerned about participants lack of knowledge or inappropriate interpretation of it. At other times I could identify teaching opportunities that were not perceived by either the participant or the clinical staff. These conflicts were

usually resolved by reverting to the role of teacher after I had completed the reflective interview, becoming a Clinical Teacher again - explaining and discussing issues relevant to the day with the participants, guiding them in their learning and suggesting strategies that would help them. In this way I learnt helpful strategies for mentors to use and thus this experience helped in redesigning the mentor preparation programme.

A further experience that helped in developing the mentor preparation programme was using reflective interviews. These proved to be enabling to the participants who were able to clarify and explore their experiences. They were able to draw their own conclusions and use critical reflection for developing their knowledge and skills.

As a teacher I was interested in gaining feedback on the influence of my presence, as a researcher, on the nature of learning that participants experienced. Information was gained through the critical reflective analysis that I had asked them to write related to one day, of their choice, when I had been with them. These provided me with feedback on my own role as a researcher when situations had arisen that led me into behaving as a teacher.

A first year participant described a particular learning situation:

> *Mid-morning I was asked to give a male gentleman a wash at his bedside. I was relieved to know that you were there. It was the one thing I have not looked forward to doing. I feel embarrassed and stupid thinking the way I do. I have never washed a man before and was worried about how to keep his dignity and privacy. I was not sure exactly how to cover him so he did not feel embarrassed. I always think that they must look at me and imagine I am as young as perhaps their daughter or granddaughter. As you were there it was good to watch how you attacked the situation. I will now feel at ease and confident in keeping their privacy.*

In this situation a qualified nurse had asked the participant to do the wash without checking if she knew what she was doing. Her competence had been

assumed. I realised when reading this account that I had unconsciously adopted a 'teacher role' through acting as a role model although I had not consciously set out to teach her how to handle the situation.

A similar experience occurred with a second year participant working in the A & E department. She was asked to stay with a young woman who was thought to have psychiatric problems until the duty psychiatrist could come to assess her. The patient was having a pseudo-labour, believing that she was pregnant. The student stated in her reflection:

> *The good thing about having Janice follow me round was when I was in a situation, such as the one with [the psychiatric patient] I was able to watch how she dealt with the situation and learn from it. The bad thing was that when I got stuck I tended to turn to Janice sooner for advice than if there was no one there with me.*

This was an issue that I was aware of and usually would divert the participant to find out from their mentor or another member of staff.

A third year participant described an incident that arose out of different policies in the hospitals where she had gained experience. In her current placement she wanted to learn how to take blood for a glucose test (BM) on a diabetic patient. The hospital policy did not allow students to do this whereas other hospitals do allow this under supervision. In the dialogue that ensued the participant asked me to clarify the position.

The Staff Nurse decided that if I supervised the participant then she could do the procedure - I quickly clarified that this was not my role as a researcher and we discussed the issues of accountability and responsibility when teaching students. Eventually the Staff Nurse agreed that the participant could learn how to do the procedure as she would soon be a Staff Nurse herself and be expected to do this. On reflection the participant concluded:

> *Looking back I could have asserted myself more initially, and not relied on the nurse researcher as much when giving [Staff Nurse] rationale for the completion of the BM. I now realise the importance of the student's responsibility to recognise the best learning strategy for them and make their mentors aware of these.*

This participant, being almost at the end of the programme, was much more aware of her learning needs. She put these before the research that I was doing and was prepared to try and use me as a teacher to achieve her own outcomes.

Finally I was used as a teacher in an unexpected way. Many clinical staff, of all grades and different professions, made opportunistic use of my presence for career guidance related to their professional development.
Other professionals particularly wanted me to explain changes in nursing education and the impact this would have on their own professions.

Nurse Perspective

Perhaps the major conflict for me as a Participant Observer was to not use my nursing knowledge and skills. As identified in chapter 3 I had considered the ethics of this and devised my own ground rules for when I would step out of my researcher role and become a nurse, based on the UKCC Code of Professional Conduct (UKCC 1992). However thoughts and actions are not the same thing. There were times when I witnessed ineffective care. It was very hard not to comment or interfere with care delivery. Although my baseline was that patients should come to no harm there is a 'grey area' where although harm is not being done the patient is also not receiving good care. In these incidents I used my own colleagues as a reflective sounding board and spoke to colleagues who were acting as Link Tutors to areas where I had witnessed 'poor quality' so that they might use their influence to effect change.

Concluding Reflections

Throughout this study I have personally developed in many ways. My knowledge and skills as a qualitative researcher have grown. I have learnt, sometimes through making mistakes, how to design and develop a research study using ethnography. Personal skills in conducting reflective interviews have developed and influenced my approach to teaching and learning. My belief in student centred approaches to learning as being the most effective for learning in clinical practice remains and has become stronger.

If I were to carry out a similar study I would not collect so much data. I now appreciate that it is quality rather than quantity of data that is important. Clarifying the focus and method of data collection would result in a more manageable amount of data. Analysis would be more efficient if interviews were carefully focused on the research question, cutting down the volume of extraneous data.

Using the findings of the research to develop pre- and post-registration curricula was rewarding. The units developed continue to be used, with some further refinement as a result of evaluation but essentially the concepts remain. This strengthens the confirmability of results.

Conclusion and Further Recommendations

This study was designed firstly to find out what strategies undergraduate students used to manage their own learning in clinical practice and secondly how effective these strategies were. The methodologies of focus groups and participant observation demonstrated that there were many influencing factors that enabled or interfered with students managing their own learning. The most significant factor identified was the quality of support in clinical practice, especially from the mentor. Support also came from other sources such as their

peers, their friends and their personal tutor. Additionally it became clear that active involvement in learning increased the likelihood of students managing their own learning in clinical practice.

The third purpose of the study was to find out how curriculum development could be influenced to enhance self-directed learning. Through observation it was discovered that when students were actively involved they tended to learn more effectively from the learning opportunities available to them. Consequently findings were disseminated to colleagues involved in re-developing the nursing degree and the mentor preparation programmes. Sub-groups, led by the researcher, developed units for these programmes that were based on action learning. These were implemented and evaluation indicated that they were more effective in facilitating self-directed learning for undergraduate students and their mentors.

This study has been concerned with students based at one university. The theoretical context of the study (Chapter 6:185-190) indicates that the findings and strategies developed in this study would be appropriate to other populations of nursing students, and also that action learning is an effective approach for health professionals. There is a need to carry out further research, on a wider population, to confirm the transferability of findings from this study and further develop the strategies arising from them.

Changes in nursing education, stimulated by policy makers and other research evidence, are in line with the findings of this study. Effective supervision for students in practice is clearly an important issue, and one that is being addressed at several levels of education delivery. Practice-based and practice-focused learning are central to current nursing education. This study contributes to the development of such approaches.

INSTITUTE OF HEALTH AND COMMUNITY STUDIES
C.F.P. : Nursing Practice Profile

Name of Student _____ Course/Intake _____

Placement _____ Semester _____

Dates : From _____ To _____

The learning opportunities overleaf are designed to prepare the student to apply knowledge, skills and attitudes to meet the nursing needs of individuals, and assume the responsibilities and accountability that nursing registration confers. (ENB Pre-Registration Learning Outcomes 1989)

Levels of Skill and Performance Requirements

Level 1: The Student has **observed** the skill being performed by a competent practitioner.

Level 2: The student has **assisted** a competent practitioner in the performance of the skill.
(This level to be achieved by the end of Semester III in all skills except Professional Development skills where level 1 is acceptable)

Level 3: The student has **performed** the skill under the supervision of a registered nurse.
(This level to be achieved by the end of Semester IV)

Level 4: The student has **sustained** a skilled performance in a variety of settings under the supervision of a registered nurse.
(This level to be achieved by the end of Semester V)

Level 5: The student has **maintained professional competence** and has enabled others to learn.
(This level is to be achieved by the end of Semester VI)

Each Level is to be signed and dated by a competent practitioner / registered nurse.

Initial Interview Summary

Orientation to Area	Fire regulations explained	Emergency procedures explained	Lifting techniques appropriate to the area explained
Signature	Signature	Signature	Signature

Mid Placement Interview Summary **Date**

Mentor Signature **Student Signature**

LEARNING OPPORTUNITIES

COMMUNICATION SKILLS	Talking and listening, using appropriate insight to • patients / clients..... • their relatives friends..... • clinical staff.....
	Reading and writing skills related to relevant clinical nursing documents and data
	Developing relevant computer literacy skills (where appropriate)
CARE GIVING SKILLS	Assessing patients/clients using observation and interview skills.
	Identifying physical and psycho-social needs of patients/clients.
	Identifying patient/client problems accurately and in priority order.
	Formulating realistic patient/client centred goals.
	Planning care and negotiating care plans with patients/clients and their relatives.
	Implementing care in accordance with agreed standards and protocols.
	Evaluating the effectiveness of care.
HEALTH PROMOTION	Identifying the individual health needs of patients/clients.
	Advising patients/clients and their relatives and friends on health promotion.
PROFESSIONAL DEVELOPMENT	Displaying professional attitudes and behaviour.
	Functioning as an effective team member.
	Utilising relevant research and other literature as a basis for practice.
	Managing available resources effectively.
	Demonstrating awareness of the ethical and legal requirements for practice.

Level 1 (observed)	Level 2 (assisted)	COMMENTS - especially those related to progression towards higher levels

Summary of Short Non-Institutional Placement (where applicable)

Signature of Competent Practitioner

Record of Observational Visits

Sickness/Absence dates ....

End of Placement Interview Summary (Date) _____

Signature (Mentor) Student

Please return the completed form to Bournemouth House by _____

Evaluation of Placement by Student

Signature *Date*

Discussion with Personal Tutor

Achieved the required Level for Semester YES ☐ NO ☐

Tutor Signature Date

INSTITUTE OF HEALTH AND COMMUNITY STUDIES
ADULT BRANCH : Nursing Practice Profile

Name of Student _____ Course/Intake _____

Placement _____ Semester _____

Dates : From _____ To _____

The learning opportunities overleaf are designed to prepare the student to apply knowledge, skills and attitudes to meet the nursing needs of individuals, and assume the responsibilities and accountability that nursing registration confers. (ENB Pre-Registration Learning Outcomes 1989)

Levels of Skill and Performance Requirements

Level 1: The Student has **observed** the skill being performed by a competent practitioner.

Level 2: The student has **assisted** a competent practitioner in the performance of the skill.
(This level to be achieved by the end of Semester III in all skills except Professional Development skills where level 1 is acceptable)

Level 3: The student has **performed** the skill under the supervision of a registered nurse.
(This level to be achieved by the end of Semester IV)

Level 4: The student has **sustained** a skilled performance in a variety of settings under the supervision of a registered nurse.
(This level to be achieved by the end of Semester V)

Level 5: The student has **maintained professional competence** and has enabled others to learn.
(This level is to be achieved by the end of Semester VI)

Each Level is to be signed and dated by a competent practitioner / registered nurse.

Initial Interview Summary

Orientation to Area	**Fire regulations explained**	**Emergency procedures explained**	**Lifting techniques appropriate to the area explained**
Signature	Signature	Signature	Signature

Mid Placement Interview Summary **Date**

Mentor Signature **Student Signature**

LEARNING OPPORTUNITIES

COMMUNICATION SKILLS	Talking and listening, using appropriate insight to : • patients /clients..... • their relatives friends..... • clinical staff.....
	Reading and writing skills related to relevant clinical nursing documents and data
	Developing relevant computer literacy skills (where appropriate)
CARE GIVING SKILLS	Assessing patients/clients using observation and interview skills.
	Identifying physical and psycho-social needs of patients/clients.
	Identifying patient/client problems accurately and in priority order.
	Formulating realistic patient/client centred goals.
	Planning care and negotiating care plans with patients/clients and their relatives.
	Implementing care in accordance with agreed standards and protocols.
	Evaluating the effectiveness of care.
HEALTH PROMOTION	Identifying the individual health needs of patients/clients.
	Advising patients/clients and their relatives and friends on health promotion.
PROFESSIONAL DEVELOPMENT	Displaying professional attitudes and behaviour.
	Functioning as an effective team member.
	Utilising relevant research and other literature as a basis for practice.
	Managing available resources effectively.
	Demonstrating awareness of the ethical and legal requirements for practice.

Level 3 (performed)	Level 4 (sustained)	Level 5 (competent)	COMMENTS - especially those related to progression towards higher levels

Summary of Short Non-Institutional Placement (where applicable)

Signature of Competent Practitioner

Record of Observational Visits

Sickness/Absence dates ....

End of Placement Interview Summary **(Date)** _____

Signature (Mentor) ***Student***

Please return the completed form to Bournemouth House by _____

Evaluation of Placement by Student

Signature **Date**

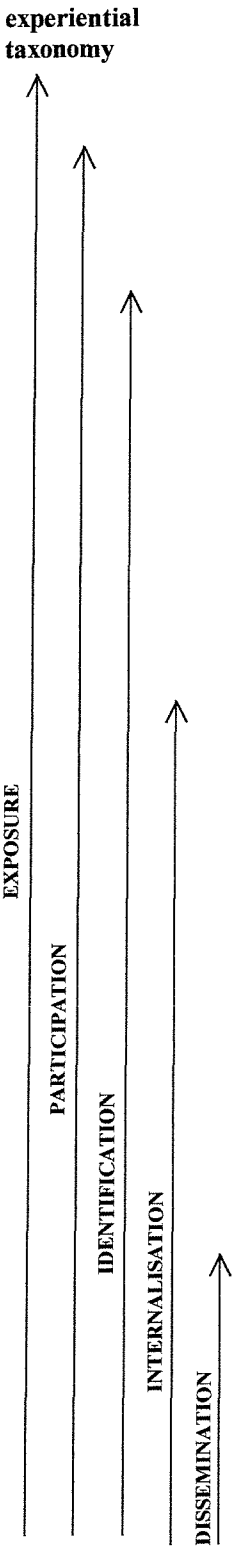
Discussion with Personal Tutor

Achieved the required Level for Semester **YES** ☐ **NO** ☐

Tutor Signature **Date**

INDICATIVE CONTENT PROBLEM BASED LEARNING DAYS

Theory/Practice		topic area	
Observation	OVERVIEW	1. Observation of practice area.	
Data	OVERVIEW	2. Measurement data.	1st Placement
Int.Per.Skills	OVERVIEW	3. Non-verbal communication.	
Safety	OVERVIEW	4. Hygiene and safety needs.	**1st SEMESTER**
Observation	ASSESSMENT	5. Assessment data.	
Int.Per.Skills	ASSESSMENT	6. Conversation analysis.	2nd Placement
Physical care	ASSESSMENT	7. Coping with aggression.	
	ASSESSMENT	8. Breaches in physical defence.	
Safety	ASSESSMENT	9. Community profile.	
Planning	ASSESSMENT	10. Learning needs.	3rd Placement
	ASSESSMENT	11. Breaches in psychological defence.	
Teaching	ASSESSMENT	12. Planning care	**2nd SEMESTER**
Physical care	INTERVENTION	13. Negotiated care-control	
Stress	INTERVENTION	14. Body image	4th Placement
Client centred care	INTERVENTION	15. Planning care	
	INTERVENTION	16. Evaluation of a skill procedure	
	INTERVENTION	17. Relieving anxiety in clients.	
Int.Per.Skills	INTERVENTION	18. Dealing with pain.	5th Placement
	INTERVENTION	19. NHS Complaints	
Q.A.	EVALUATION	20. Evaluating care. – Q.A.	**3rd SEMESTER**



Groups in the community will discuss the care in the home, clinic, or other setting. Topics from the above list that are appropriate to non-institutional care will be utilised, but different subjects such as, health education, or care of the carers, may be agreed between the tutor and mentor in the community.

APPENDIX 4

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB
1		January					February				March				April				May					June				July					August				September				October					November				December				
2	1994	2	9	#	23	30	6	#	20	27	6	#	20	27	3	#	#	24	1	8	#	22	29	5	#	#	26	3	#	#	24	#	7	#	#	28	4	#	#	25	2	9	#	23	30	6	#	20	27	4	#	#	25	
3																																																						
4	BSc '91	S	5	5	PLACEME			.	.	.	.	.	.	.	.	.	H	H	S	6	PLACEME			.	.	.	.	.	6	PLACEME			.	.	.	.	.	H	H															
5	BSc '92	S	3	3	PLACEME			.	3	H	H	Semester 4				PLACEMENT												Semester 4				S	S	S	S	H	H	5	5	PLACEME			.	.	.	.	.	.	.	.	.	S	H	
6	BSc '93	S	Semester 1							PLACEMENT				H	H	S	Semester 2											PLACEMENT				S	S	S	S	H	H	PLACEMENT				Semester 3										S	H	
7	BSc '94																																							Semester 1								PLACEMENT				S	H	
8																																																						
9	Res Meth Course																																								TERM 1													
10	Res Activity																																								Initial Literature Search													
11																																																						
12		January					February				March				April					May				June				July					August				September				October					November				December				
13	1995	1	8	#	22	29	5	#	#	26	5	#	#	26	2	9	#	23	30	7	#	#	28	4	#	#	25	2	9	#	23	30	6	#	20	27	3	#	#	24	1	8	#	22	29	5	#	#	26	3	#	#	24	#
14																																																						
15	BSc '92	H	5	5	PLACEME			.	.	.	.	.	.	.	.	.	H	H	S	6	PLACEME			.	.	.	.	.	6	PLACEME			.	.	.	.	.	H	H															
16	BSc '93	H	S	3	PLACEMENT				3	H	H	Semester 4				PLACEME			.	.	.	.	.	.	.	.	.	Semester 4				S	S	S	S	H	H	5	5	PLACEME			.	.	.	.	.	.	.	.	.	S	H	H
17	BSc '94	H	Semester 1							PLACEMENT				S	H	H	Semester 2											PLACEMENT				S	S	S	S	H	H	PLACEMENT				Semester 3									S	S	H	H
18	BSc '95																																							Semester 1								PLACEMENT				S	H	H
19																																																						
20	Res Meth Course		TERM 2															TERM 3																																				
21	Res Activity		Research Design															Prep for Focus Groups											**BR Focus Group**																									
22			Continuing Literature search																								**CFP Foc. Group**											**Year 2 obs**					**Year 3 obs**					**Year 1 obs**						
23																											Interim Analysis											Interim analysis + continuing literature search																
24																																																						
25		January				February				March					April				May				June					July				August				September					October				November				December					
26	1996	7	#	#	28	4	#	#	25	3	#	#	24	#	7	#	#	28	5	#	#	26	2	9	#	23	30	7	#	#	28	4	#	#	25	1	8	#	22	29	6	#	20	27	3	#	#	24	1	8	#	22	29	
27																																																						
28	BSc '93	5	5	PLACEME			.	.	.	.	.	.	.	.	.	H	H	S	6	PLACEME			.	.	.	.	.	6	PLACEME			.	.	.	.	.	H	H																
29	BSc '94	3	3	PLACEMENT				3	H	H	Semester 4				PLACEME			.	.	.	.	.	.	.	.	.	Semester 4				S	S	S	S	H	H	5	5	PLACEME			.	.	.	.	.	.	.	.	.	S	H		
30	BSc '95	Semester 1							PLACEMENT				S	H	H	Semester 2											PLACEMENT				S	S	S	S	H	H	PLACEMENT				Semester 3									S	S	H		
31	BSc '96																																							Semester 1								PLACEMENT						
32																																																						
33	Res Activity			**Year 2 obs**					**Year 1 obs**							**Year 2 obs**				**Year 3 obs**							**Year 1 obs**						**Year 3 obs**																						
34				Interim analysis + continuing literature search																																																		
35																																																						
36		January				February				March					April				May				June					July				August					September				October				November				December					
37	1997	5	#	#	26	2	9	#	23	2	9	#	23	30	6	#	20	27	4	#	#	25	1	8	#	22	29	6	#	20	27	3	#	#	24	#	7	#	#	28	5	#	#	26	9	#	23	30	7	#	#	28		
38																																																						
39	Bsc '94	5	5	PLACEMENT												H	H	S	6	PLACEMENT								6	PLACEMENT								H	H																		
40	BSc '95	3	3	PLACEMENT				3	Semester 4				H	H	PLACEMENT												Semester 4				S	S	S	S	H	H	5	5	PLACEMENT											S	H	H		
41	BSc '96																																																					
42	BSc '97																																																						
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44	Res Activity	Commence final analysis																																																				
45	CODE		BSc = BSc (Hons) Clinical Nursing + intake year																	Res Meth = Research Methodology course															Placement = clinical practice weeks																			
46			S = Self-directed study week																	Res Activity = Research Activity															Numbers 1, 2, 3, 4, 5 and 6 correspond to Semester number																			
47			H = Holiday																	Prep = preparation															Semester = theory weeks in University																			

May 23rd 1995

All Students
BSc (Hons) .....
1992 Intake - Adult Branch
1993 Intake - Adult Branch
1994 Intake - CFP/Adult Branch
1995 Intake - CFP

Dear Student,

RE: Research 'How do undergraduate student nurses take responsibility for their own learning in clinical practice?'

I am writing to ask if you would like to volunteer to participate in the above research project. I am registered as a post-graduate student at Southampton University and as you can see particularly interested in student learning strategies in clinical practice.

I am planning to commence fieldwork for this study in June 1995, there are two phases in which I need assistance from students. The first involves 4/5 students each from the CFP and Adult Branch meeting as focus groups to discuss learning in clinical practice. The second phase involves 4 students each from years 1, 2 and 3 allowing me to work with them in practice on 6-12 occasions for each student, as a participant observer, over the period of September 1995 to August 1996. Full explanation of each phase is attached.

If you would be interested in volunteering to participate in the research please give your name to me, you can send me a note in the internal mail. I will also make arrangements with your year tutors to come and talk to the whole group about my research and to make definite arrangements with volunteers at an appropriate time i.e. weeks commencing June 25th for 1994 Intake, July 9th for 1992 Intake, September 10th for the 1993 Intake and October 29th for the 1995 Intake. (If I receive more volunteers than I need I will agree with them how the actual sample is selected).

Thank you for taking the time to read this information, I look forward to hearing from you.

Yours sincerely,

Janice R Gosby (Mrs)
Head of Pre Qualifying Programmes.

'How do undergraduate student nurses take responsibility for their own learning in clinical practice?'

PHASE 1: FOCUS GROUPS

I intend to start data collection by forming two focus groups, one for CFP and one for the Adult Branch. I need 4/5 students to participate in each group, the CFP group to be from the **1994 Intake** (placement July 2nd - 29th) and the Adult Branch group to be from the **1992 Intake** (placement July 16th- August 12th). Each group will meet for 1/2 to 3/4 hour per week for 4 weeks of placement; meetings will be scheduled in agreement with participants on your weekly study day in the university.

What will you have to do?

We will meet in my office (B409, I will provide tea/coffee and biscuits) and discuss your learning experiences in practice. These sessions will be recorded so that I can transcribe them carefully after the meeting. You will have your identity protected at all times and will be free to withdraw at any time from the group.

Why?

This is to help me to gain a students' perspective of learning in clinical practice and will help me to identify issues that are important to you.

PHASE TWO: PARTICIPANT OBSERVATION

I wish to follow 4 first year students (**1995 Intake**), 4 second year students (**1994 Intake, this does not have to be the same students as participated in the focus group**) and 4 third year students (**1993 Intake**) through a year of practice from September 1995 to August 1996. During this period currently I plan to work with each student on 6-12 occasions. As I am carrying out an ethnographic study the method may change during the year as themes emerge from data collection.

What will you have to do?

I will agree shifts to come and work with you in the role of participant observer, i.e. I will help you carry out your work and at times stand back and watch you working with others e.g. your mentor. You may use me as your assistant where appropriate or ask me to withdraw if you feel it necessary. You may withdraw yourself at any time during the study. I expect to do whatever shift times you normally work and also to do some weekend work. At the end of the shift I need about half an hour of your time to reflect back over the day with me. Once again I will record these discussions so that I can give you my full attention and transcribe afterwards. I will also ask you to keep a diary of critical learning experiences in between the time we work together.

Why?

I need to understand the student experience of learning in the clinical environment and this is best done by working with and observing you at work. I also need to know what you think is possible and important regarding being responsible for your own learning in the clinical environment.

What about the research report?

I will keep you informed of how the work is progressing and what themes are emerging by writing brief summaries at appropriate points during the study. I would also value your thoughts as to what you think is coming out of the experience. If possible I will do presentations to the whole Intake group so that your colleagues know what is happening. When the report is finished I will give you an executive summary and you will be able to borrow a full copy to read, once it has been examined, if you want to. I will also give you the opportunity to come to a presentation.

What will be the consequences?

I hope that once I have findings from the research I will be able to influence course design to help future students to learn effectively in the clinical environment. Also to help mentors to carry out their role effectively.

UNITED KINGDOM CENTRAL COUNCIL

Code of Professional Conduct for the Nurse, Midwife and Health Visitor

Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to:

- safeguard and promote the interests of individual patients and clients;
- serve the interests of society;
- justify public trust and confidence and
- uphold and enhance the good standing and reputation of the professions.

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;

2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;

3 maintain and improve your professional knowledge and competence;

4 acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;

5 work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care;

6 work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team;

7 recognise and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor;

8 report to an appropriate person or authority, at the earliest possible time, any conscientious objection which may be relevant to your professional practice;

9 avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their person, property, residence or workplace;

10 protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest;

11 report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;

12 report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;

13 report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care

14 assist professional colleagues, in the context of your own knowledge, experience and sphere of responsibility, to develop their professional competence, and assist others in the care team, including informal carers, to contribute safely and to a degree appropriate to their roles;

15 refuse any gift, favour or hospitality from patients or clients currently in your care which might be interpreted as seeking to exert influence to obtain preferential consideration and

16 ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations.

Reference

United Kingdom Central Council for Nurses, Midwives and Health Visitors (1992) [third edition]; **Code of Professional Conduct**; London, UKCC.

PhD Fieldwork Interview

CFP FOCUS GROUP

Transcription July 4th 1995

Meeting in my office 12.30pm

Present: Janice Gosby (JG), Olivia (O), Lesley (L) & Frances (F) from BSc 1994 Intake (Susan did not arrive)

JG. OK. Let me just remind you before we start that the aims of these meetings are for me to find out your perceptions about learning in clinical practice, so after I've done this introductory bit I want to largely sit back and listen to you. (Um) so although it's is an office, we're sat in an office, the intention of having coffee and everything is just for you to feel like you're having a coffee break with your colleagues and to talk like you normally would do to each other, and forget if you can that I'm here.

I might, now and again, give a little prompt, you know if there's something that I'm wanting to explore a little bit, but largely I'll try and stay quiet and let you just talk to each other. So (pause) for this first session really all I want you to do is talk to each other about learning in clinical practice, you've all had two clinical placements now so you've got some thoughts about how you learn in clinical practice, and I'd like you to just talk to each other about how you go about learning and what helps and what hinders, that sort of thing.

If you find that the group runs out of things to talk about remember that that what I'm interested in is your experiences, so you might just focus on that and think of an experience, an example, something that actually happened and just tell the others about it, or you might want to question one of the others about something they've said. So, usually when that happens, if it goes quiet, somebody will say, think of something and ask each other, and again I'll try and hold back myself and let you start each other off again and hopefully that'll get it going, and what I'm looking for is as many views as possible. So, if somebody says something and you think 'Oh I was going to say that', don't hold back because you might have had a slightly different experience. So, again, treat it like your coffee time conversation and say what you'd normally say to each other (laughter) and the tape recorder and I will listen in (laughter) and obviously what's going to happen afterwards, I'm planning that we'll talk for about half an hour, probably, is I'll be transcribing the tape, and then when I've got a collection of tapes I'm going to be analysing them and looking for things that come out. So, when we meet over the next few weeks I've got some things that I'm interested in, but what I don't know at the moment is whether those are teacher perceptions. So, I want to listen to you first and then if I find that there's some things cropping up I might say to you next week

will you focus your discussion around this, because something's cropped up. Does that make sense to you? (nods, yes from all).

So, perhaps to start off and just to get you used to sort of talking to each other, and it'll also help me, it'll be a little voice test on there (pointing to dictaphone), if you'd just say what your name is, (um) a sentence about yourself, anything, just to open up a little bit, but when I listen then it'll help me to match the voice to the name which is going to be one of my problems that I'm going to have to sort out. So, at this point use your real names 'cos you don't know what each others pseudonyms are anyway, and when I transcribe the tapes I'll change your real name to the pseudonym OK, right, so I'll sit back and leave it to you.

L. Well, as the oldest one I might as well start (laughter). I'm Lesley, (um) mature student, mother of four, first year here.

O. I'm Olivia, I'm twenty .....

F. I'm Frances, ... two children, (um) first year course student, first time in education, (er) so (pause) how do we learn when we're on placements?

L. Well, we've had these discussions before when we meet up on a Tuesday and we discuss (um) and sometimes whinge about what's happened or not happened, good and bad experiences that we've had. I think, as far as learning goes (um) from my point of view it's nice to be shown the ropes of the ward, go along with your mentor or another experienced nurse, who will explain what she's doing and not just do it, and then watch what you're doing and let (telephone rings) you have a go as well, rather than just observe all the time.

F. Yeah (pause) then be left to get on ...

L. Yeah

F. ... left to (pause) like develop ...

L. (Mmm)

F. ... without being (um) considered a minion, you know ...

L. Yeah

F. ... being given credit for your ability but at the same time being ...

L. Allowed some initiative

F. ... initiative, yeah, and being watched over but you know sort of, did you find that everything, I certainly did (um) found that everything, most of the things I learnt you had to learn or to be asked to learn for yourself.

O. That's right

F. For instance in the first placement on maternity if I hadn't have said can I can I can I, for instance giving pethidine injections or things like, if I hadn't have asked I wouldn't have been allowed, you know and half the time if I hadn't have been (um, pause, er) quite forward and just walked in and said right I'm a student may I stay, into the actual labour rooms then I would have been

stood in the corridor for days at a time, you know I had to take it upon myself to do it and I found that in, so far, in the first two placements, don't know

L. That it's up to you

F. Yeah, it's entirely up to me to teach myself and to be asked to be taught..... (ah) mental health I tend to count as something totally different and never to be visited again, but speak about that later.

L. Well I was more or less left to my own devices on my first placement (um) some of the staff just referred to me as the student (um) and I wasn't really involved unless I was with my mentor I wasn't really involved, nothing was explained to me. I was just left to fetch and carry, and if I did ask something like one time I couldn't get this gentleman's blood pressure and (um) when I asked for help I was given the reply 'oh there's a machine in the linen room use that'

F. (Mmm)

L. But not shown how to use this particular machine so I didn't learn anything at all

O. I find that the younger nurses that are sort of maybe out of (um) nursing, nurses who've been here say two or three years ago then they sort of tend to help more and they know what it's like to be a student nurse. Ones that trained about sort of 50 years ago (laughter) or more well you know they just sort of you know they just expect you to learn yourselves, on the ward yourself.

L. (Mmm)

F. I'm finding them a little more theory based

O. Yeah

F. I mean and that's not a bad thing and then the ...

L. There is some hostility towards degree nurses

F. (Mmm) oh definitely

O. Yeah

L. That we know it all but can't do anything (laughter)

F. Yeah, I found that. I found mental health was (um) really, I had been dropped in at the deep end, it was just sort of 'Oh you're here just sit on the door' and it was so mind bogglingly boring mainly because, I felt, because the staff weren't interested in their own job let alone taking on board the students.

O. There was a lot of like 'go and talk to the other patients' and they didn't give you any guidelines of what...

F. Yeah

O. ... sort of things to say to them. They didn't tell you what the patient was like, they might be suicidal or something and I might have said the wrong thing

F. Absolutely, no mental health training whatsoever

O. (Mmm mmm)

F. Just go and talk to a patient

O. It's dangerous really in some respects

L. All the more reason then why you should have (um) stuck with a mentor ...

F. (Mmm)

L. ... for those first few days there

F. I've been unlucky with mentors so far, even on this third placement. I've not yet (um) had a mentor, you know a designated mentor. They've been designated but I always find they're on nights or on holidays (laughter) so, it worked to my advantage on maternity because I could find out who was doing the most interesting things every day and then sort of tag along with a certain person and basically chat them up and get to stay with them and learn that way. But on mental health it was just park yourself in a corridor and you'd have an 8 hour shift in the corridor most days, guarding the door, you know.

L. I think it has to do with the morale of the staff that you're working with as well ...

F. Definitely

L. ... (um) where I was in care of the elderly the staff were not interested, they weren't happy people and that's reflected in how they treat others. But on my paediatric placement we were all working to the common good and I really felt quite accepted and part of the team up there. So if I wasn't with my mentor then I would go and watch and participate with another trained member of staff, and (pause) very good for the parents I think and the children.

F. (Mmm) positive. I'm finding that I've only done (um) one 12 hour shift on ward ... at ..... where I am at and staff are younger and much more enthusiastic and it's different. Like you say they're generally happy people, (um) they're generally all right in their own private lives (um) so they're not bringing their own problems to work and they're very (ah) education orientated in that they know, they're all doing education, we're together, they're all qualified but they're all taking study days so that's reflected in how they view you, and (pause) they even apologised when they asked me to go round with an HCA, apologised that she wasn't trained, and I said 'well that's fine, the first day you get to know the ward and everything and that's fine'. You get to know the routine, it can be a bit nerving, can't it.

L. When you try and apply something that you've learnt and that you know to be right and you get people laughing at you

F. (Mmm)

L. Well that happened when I offered a patient that had been on the commode the hand washing facilities and they just scoffed at it.

F. (Mmm)

L. They thought that was hilarious, you know, this is the real world love get on with it (laughter)

F. Shocking

L. Yeah

JG. How did the patient feel?

L. The patient was surprised, she'd never been offered hand washing facilities before and she probably never was again.

A. No

L. It's like on another occasion (um) the difficult patient, well I didn't find her difficult, I thought she was wonderful actually. She was a very, could be, cantankerous old lady but full of spirit (um) but when a nurse comes along

and says 'I'm just going to stick you on the bedpan' you can understand why the patient takes umbrage at that.

F. (Mmm)

L. But you approach it in a different way 'would you like to spend a penny before lunch' much more approachable and she was fine.

F. (Mmm mmm)

L. I must admit on occasions like that (um) I had to use my own feelings as a person. Having, I've been a patient myself and as a mother and as a mature student and knowing how people want to be spoken to and respected.

F. It's funny being ..... on a ward and trying to learn because the interpersonal skills thing comes out, and most of the ..... nurses I've come across so far fall into the trap of calling everyone love and dear, and whereas it's quite strange because that's not in my language, and so my way of communicating is different and still popular and fine, but in that way it's quite different because I feel a little bit you know separate ..... but you know I just don't like using love (sounds embarrassed, clears throat) and stuff like that, and not, I don't think any of us as students use those terms outwardly but I'm wondering if it's something you fall into as time goes on, easy expressions to use.

L. I think you're probably right

O. Yeah

F. Lots of loves and dears

O. You know it's putting patients down

L. But sometimes it can be meant in a very (um) very kindly (um)...

O. It depends who you say it to

L. ... yeah a very kindly way

F. (Mmm)

L. ... (um) almost as mother to child

O. (Mmm)

L. ... but at other times it can be condescending and patronising

O. Patronising, that's right

F. (Mmm)

L. So...

O. Especially to the older people

L. Yeah, (pause) sometimes I think it can work, I mean I have used it with children, and (um) especially when they need comfort, I think it does go down well

F. (Mmm, pause) Do you find that (um), I feel if I was a quiet person then I wouldn't have done very well on my placements. Because I'll look after my own interests, and others of course, that I'll look at what I want and try and gain that from it then I find that I get taught and shown those things because, because I'm a bit strong willed, but I'll bully my way into it whereas someone like poor ..... on maternity, which is definitely a woman's domain I feel, and he's a male nurses (laughs) but (um) I feel that...

L. Left out

O. Yeah

F. ...someone like ..... who spent sort of 4 weeks in the corridor again, because he you know because he...
L. Not assertive enough
F. ...wasn't assertive enough to stay in, you know
O. He can be too assertive
F. (Mmm) oh yes
O. It just how thinks he wants to speak to you, you might not have been there
F. That's true, yeah
L. It definitely helps if the person you're with knows why they're doing something, sometimes they don't, I mean I asked a question (um) 'why (um) is the backrest not allowed to be out if somebody has had a stroke'...
F. (Mmm)
L. ... and 'oh I don't know we just do it like this' so I still to this day don't know, you can prop them up on pillows but you can't put the backrest out, so they're doing something that they've never bothered to find out why, so I'm just as ignorant as they are. I suppose I could read it up, check it out but I haven't done
F. Yeah, actually the same thing happened on Sunday, there was a patient with a viral infection in a side room being barrier nursed and as I was to do the obs I asked " have you got a special sphyg and stethoscope to go in with this particular patient that's being barrier nursed 'no no no just use the same one' I went 'you sure' they said 'that's the way it is' you know that was the reply
L. We had a chap with (um) clostridium who was in a side room, and all his family and grandchildren were going in there, sitting on the bed and everything and I thought what sort of barrier nursing is this
F. (Mmm)
O. I think you have to use your initiative a lot more in the placements, it's down to you really...
F. That's what I meant earlier...
O. ... to look for information
F. ... (Mmm) that's what I meant, using your initiative and trying to gain it, and knowing when to be quiet and humble (laughs)
O. I mean well they're trying to carry out their work aren't they, and you've got to try and fit in around them and sort of find things out for yourself because they haven't really got the time, well...
F. No even going on a different ward with different people on your first day, and washing somebody for instance. That can be quite traumatic for a student, I found so because they do it different, you know each ward, and you might be considered this is what I tend to worry about is how people consider me, you know how they consider my actions as a student on the ward. I want to do it their way so that I fit in firstly and then learn from that way because I mean I was washing this chap actually and I thought 'gosh I'm sure I'm not doing it to there way' you know, I mean did they take his shirt right off or just lift it up you know, did I look awkward and clumsy you know, and things like, I'm very aware of things like that all the time so it's nice really to go round with

an HCA or something or do something and do some of the basic tasks first and just learn their way and fit in their little system because it's all ...

L. Provided that their ways are good ways otherwise...
F. (Mmm)
L. ... you could be learning some really bad behaviours
F. Oh, yeah I appreciate that
L. So unless they've had continuing education
F. (Mmm)
L. You could be stuck with some sort of procedure from the dark ages that's no longer relevant
F. I didn't mean that the whole procedure I just meant the little..
L. But it is the little things though, some people are interested in them
F. (Mmm)
L. Sort of keeping up with (um) modern practice and client centred practice and other people are sort of stuck in the same sort of practice they had when they first qualified and nothings going to shift them from that practice
O. Self centred practice
F. (Mmm)
L. Yeah, so that's definitely the difference between the sort of mentor or team that you might work with
F. Yeah that's right, I mean I wouldn't want to go on the first day and try and change the world, you know because... I don't think that's a good idea... but yeah
O. I found that in mental health that my mentor hadn't even heard of a practice profile and he hadn't got a clue how to fill it in either, but I mean on the placement I'm in now I mean she actually asked me to bring my practice profile in on Wednesday when I mentioned it to her she was saying 'and we'll get you meeting your objectives before the end of the month, we'll get you to do everything you know', really sort of positive about teaching.
F. Helps a lot doesn't it
O. Really nice, yeah
L. On my first placement the green mentor handbook was taken and then filed away and it was never seen again, never referred to at any time and (um) never sort of had time to sit and look at the log book either so they see it as something that we have to do out of their time.
F. (Mmm)
L. Now this time I've started at *** House and it hasn't seemed relevant up to now to give them the mentor handbook or the profile, but just to get straight in and meet the people and get to know them, which is what I did yesterday. One of the residents came up and met me, introduced himself and then we were sitting in the garden chatting for more than half an hour. I think that's also very good practice (pause) as we're not there to nurse.
F. That's right
L. It's their home so (pause) that's some useful learning as well.
O. It's a bit in their routine

L. Well some people find talking to others (um) easier than others, but I do talk a lot anyway (laughs). I've had many years of experience (laughs) so I didn't find that too difficult. Although one particular chap is quite heavy going in terms of his philosophy and his outlook on religion and dying and so forth. You could end up being quite bogged down with (um) emotional problems and such language and sort of hold back. I don't think (um) any teaching can really totally prepare you for that, not until you're actually in that position.

O. I found in mental health though that listening is more important than talking. Whatever you say is not actually going to change their mind and if they think they're a ... you know, failure, to actually talk about it helped a lot (pause)

L. We're going dry now.

F. (Mmm) Talk to the machine. I don't know what, I'm trying to think of moving experiences that are relevant to how you learn ...

JG. One of the things you touched on when we met last week, I don't know if you remember, at the end you started to talk about supernumerary status?

F. Oh yeah, well ...

JG. Do you want to think about that a little bit and how it relates to how you learn?

F. Yeah, (um) on the first placement on maternity you're a great pair of hands for the midwife I felt, a gopher - fetching and carrying which wasn't a bad thing because you're learning where things are and you still feel involved. I think it's important for a student to feel involved, but in the mental health situation well someone has to sit at the end of the ward by the door to (um) in a way you're guarding the patient that's under observation, you know, you're not allowing them off the ward basically, and to sit there for hours and hours at a time really not even knowing why you're there or any other reason, it's mind bogglingly boring and (um). From adult, like in an adult placement where you can be busy, physically busy to actually be on mental health where there's no physical tasks, people aren't physically ill, you know they're mentally ill, that was the thing for me, you aren't actually nursing in the physical sense.

O. Yeah we weren't supernumerary on mental health so they didn't have any time to take out for teaching you, they were always too busy doing their own jobs. When you're supernumerary, not supernumerary sorry they usually sort of like to teach you the ways because then they can go off on a coffee break while you do their work.

F. Yeah, on mental health you're certainly used for the tasks, serving dinner and things like that in the canteen, certainly well used for that but because people weren't physically ill you didn't, I personally didn't really feel that I was nursing. I felt I was just a (um) paid help almost, but not being paid, I really did. I had to go through the desk on my own to find any literature about mental health, about depression and I had to really teach myself in general because they just felt (pause), I don't know it's a totally different situation towards health. I mean, all of the staff smoked on that ward, all of the staff

smoked all day long on the ward I was on you know. I should say 50% of them had extreme emotional problems of their own ...

O. You weren't sure which were the patients and which were the staff (laughter)

F. Yeah, and (um) so (um) yes definitely mental health's not for me but that's only a small part of my training and I don't feel that I'm going to branch that way, but good experience.

O. You're not fully trained, so you just ...

L. On the other hand you could end up on a ward, an extremely busy ward, as I was on where they're so short of staff that you're just there ...

F. (Mmm)

L. ... to answer the buzzers ...

F. Yeah you ...

L. ... and you don't get beyond that, just bed pans and ...

O. You have to go and find someone and ask what you should do

L. Yeah, you never actually get any time to stop and think of why you're doing something, or to go and look up anything about that particular patients condition or why they're nursing in (pause) in that way or A.D.L.'s or anything, there wasn't time for any of that.

F. No, that's hard then because you're not learning anything. That's my objective on this placement, is to really get to grips with the paperwork side and then the care planning side and then look at it all. But, I mean, did you feel that the ward could almost not have run without you there running around.

L. Yeah, yeah. On one particular morning there was one HCA, a newly qualified staff nurse and myself to look after 28 patients ...

F. Rubbish

L. ... I mean yes supposedly you're supernumerary so what can you do?

F. (Mmm) There's no way you could sit down and say 'sorry I've got to fill in this, this is more important'.

L. It's very easy for the trained staff to let you just go on and become an HCA, it would help them 'cos the big onus is on getting everything done by lunch time, 'haven't you finished your patients yet', well, what's the big deal, you know, you spend an extra five minutes talking to them and they're happy, all right they're not dressed till half past eleven - does it matter?

F. No

L. You know while the trained staff go and do the real nursing (sarcastic tone), the drugs round and the dressings and so on ...

F. Yeah, I'm a bit, I'll be able to talk about it more later, but the difference between I mean the one I'm on now they're very aware of theory and skills and they really do say you're supernumerary. So any tasks you're going in to they're almost apologising for it if it's mundane you know. So that's quite interesting really 'cos I think it's going to be good for learning you know, 'we will show you, we will teach you', which is quite nice you know (um) but, ... interesting because this is primary, supposedly primary team nursing (um) and (um) it's quite, I'm interested to that and standard, you know they've got standard shift work, and on the ward it's 12 hour shifts and it's quite

interesting but really it's no different to any other ward except that the members of staff argue about 'that's your patient and that's mine'. On the other wards you're designated patients, it all sort of mingles in together quite nicely, it doesn't seem to be a clear definition.

L. Do you think also because we're university based that a lot of staff see us being under the jurisdiction of the university in terms of what we're taught so they don't go out of their way (um) for the teaching process. 'Oh it's not really our job, they belong to ... wherever'. Whereas previously I went to work on an orthopaedic ward as an auxiliary years ago and I was taught everything I know by the staff on that ward who took responsibility for me, ...

F. Yeah

L. ... from the sister down to the staff nurses and other auxiliaries. They were active teachers all the way through. They didn't seem to think 'oh well, you know, she should be learning it from somebody else.

F. I'm quite lucky in that respect on this placement because two of the nurses are from the first degree course that they ran at this university, so you know they're sort of heads up about it all, so they understand you know the system but generally I would say, again, going back to mental health, they certainly felt totally detached you know, or felt that we were totally detached from them, that we belonged to the university and we were just there ...

O. Not part of it

L. Yes

F. ... because we had to be and they would tolerate us

O. Yeah, and when you told them you were doing adult nursing and you were a degree student that was it you know, they didn't want to know you particularly, it felt awful, you felt guilty almost ...

F. I was a bit naughty ...

O. being adult adult ...

F. Yeah, I was a bit naughty actually, I felt I couldn't say that I was actually an adult nurse, I just said I haven't decided yet until I branch ..

L. What ...

F. ... because ... (laughs)

L. Veracity and all that ...

F. ... you know I must be honest I felt I had to, I really just felt I had to you know.

O. I found that a lot more theory we do, like we're doing Roper's model and that's not related to practice at all, because yesterday for a bit of a laugh I was reading through their care plans and for things like expressing sexuality they put (um) wife and widow and stuff like that and (pause) I was thinking ...

L. Or I've read one that said 'a well preserved lady' (laughter)

O. ... and I thought it was more to do with their illness not with their health state, you know - if you're a widow you don't have sex

F. Yeah, I saw one on Sunday and they just put their ages in sexuality you know ...

O. Yeah

F. ... so if they were over 60's so it doesn't count

(pause)

O. ... or else they just put in no problems or normal ...

F. (Mmm)

O. ... which doesn't really mean anything

F. No

O. They're not applying theory to practice, theory like we do here does help a lot you know.

F. That's right, there is a balance somewhere between theory and practice that's got to be a working balance. I suppose as more and more, you know theory comes into nurse training it will rise wont it?

O Yes

L. I'd like to see the theory actually come on to the ward a lot more with us (um) with active teaching, that's what I'd really like. So that we could be tested on whether we actually understand what we're doing and why we're doing it. So, somebody like yourself (to JG) could suddenly turn up (um) where there is a student nurse(um) to see how they're putting that into practice (pause). That would be a bit nerve racking but I think it would be quite useful.

F. (Mmm) What about the practical skills (um) for instance you know we have the clinical skills lab downstairs don't we ...

L &O Yeah

F. ... for the first few weeks bit it's very, very (um) ...

O. But you just don't remember anything

F. ... no, you don't remember a lot and it's not very (ah) you know, I don't know, it's not very practical almost ...

L. Yeah, the other thing is ...

F. ... don't practice anything practical.

L. ... the other thing I did think of is there's so many care homes and nursing homes in this area, wouldn't it be a good idea when we're doing our clinical skills to actually go and do some basic nursing care ...

F. (Mmm)

L. ... in some of these places ...

F. (Mmm)

L. ... instead of in the skills lab

F. Washing ...

L. Yeah

F. ... (um) like bed panning, feeding

L. Yeah, talking to people ...

F. (Mmm)

L. ... understanding the sort of problems we're likely to see outside ...

O. You learn most of your basic nursing skills in a nursing home

L. ... instead of doing it to each other

F. Yeah

O. Even rightly or wrongly, I don't know but you do

F. I feel that whether you're supernumerary or not in a case, in a setting like that a lot of nursing homes would have you, that's a good idea really.

L. Yeah, they could see us as an extra pair of hands for the morning ...

F. (Mmm)
L. ... and we'd be learning. Look when we did our blanket baths and we turned up wearing shorts ...
F. (Umph)
L. ... I mean is that real or not? How many people do you see wearing shorts? Now all of a sudden, you know, some people may never have seen a naked body let alone an old or infirm or ill one.
F. ... and aseptic techniques and dressings, just very very (whistles) there it is, goodbye, wasn't it, stuff like that.
O. I just think it's the more and more you do things and see things the more you learn basically, just see stuff over and over again.
F. I feel that Friday afternoons could be well spent on something like that or whatever or a day a week ...
O. Just practising
F. ... for a while
L. There's no way I could do an aseptic dressing or you know to say how to the technique if I was asked to do that in practice now
O. The woman I saw yesterday, ... I'd forgotten how to do blood pressures, things like that. Thinking back, in mental health on my last placement we didn't do anything, so "I'll get you to do all the ward obs' so she made me go around and do 20 patients and by the end of the shift you know (laughs) I was doing them really easily
L. Yeah
F. But I found, for instance on maternity, they'd come to suture a client and I hadn't been taught any aseptic technique or I didn't have a clue and the midwife was going 'get your hands off the trolley' I thought 'oh help' there was this trolley there, she was unwrapping it for suturing and you know I'm there and she said 'can you put some of this in there' and I'm just doing it and she says 'oh don't touch it'...
O. Because it's green
F. ... and it wasn't until, you know, later I realised that, oh gosh of course, having not done any form of (pause) I don't think that was appropriate. I mean it wasn't really up to the midwife to explain it to me as a student,
L. It was the same problem with the obstetricians that, I mean he was shouting at me for not touching but I didn't really have a clue what I was doing and I didn't need a lecture from him, even more humiliating, felt really useless.
F. (Mmm)
L. They probably better tell them that it's your first placement or your first year and you don't know anything, to tell them how ignorant you are and then make allowances for you.
F. That's right.
L. Otherwise if you act as if you're confident they expect you to know more than you actually do.
F. That's right, that can happen, but realistically I mean you could pick them up all the time as well. They tell you not to touch the green and then they wear no gloves or anything all the time, just wading right in where just a second ago,

well you know (pause). did you ever get any 'well you're only a student', no well anyway no, I got messy, I had to go and change my white top because I got messy on maternity and I put a green surgical top on and I had a doctor sitting in the coffee room happily talking to me for half an hour and then somebody came, a midwife came in and asked me to go out with her, and he looked at me, he said 'oh what are you then', and I said 'oh just a student nurse', I didn't say just, I said a student nurse. That was it, he never spoke to me again (laughter). I think he thought I was a student, medical student, you know and ...

O. Did he tell you any interesting things, what was he talking about?

F. Oh yeah, yeah I was thinking this is very good here, we're having a good conversation ... even doctors wages, so ...

L. Privileged information, well I went into theatre and actually watched an operation going on (um) there was a consultant didn't speak to anybody at all, he just got on with it. It just sort of, everyone knew what was going on, he'd got his theatre nurses there and I felt that I couldn't ask him anything, just (pause, sigh) there wasn't the opportunity, he just went in, done his thing and that was it, we were out again. So although it was quite interesting to watch I really wish I could have sort of said 'oh what are you doing and why are you doing that'

F. It comes down to personalities again though doesn't it. You can't cater for all of the people all of the time. Well I mean even the students' own personality and the relevant teachers and (pause) everybody has their own personalities and you've got to try to get in the middle somewhere I suppose. That's where we come into our own self teaching again, but it ...

L. They were quite good in recovery though, they were explaining how they, what they were looking for and respiration and morphine pumps and all that. Well it's actually quite boring sitting there waiting for people to recover. They did explain why and what was going on so that bit I thought was useful.

F. (Mmm) you know on the current round of placements I feel a little bit behind having not done an adult placement you know, going from maternity to mental health and then it's my third placement and there's people like yourselves in the room when we're doing a lesson and you can all talk about this, that and the other and I feel 'God I'm getting so far behind', especially the abbreviations, you lose it on the abbreviations. On the ward now B.M.I.'s they were going on about on Sunday and I'm going 'B.M.I.'s oh oh' body mass index I learnt later but if I remember something there's a B.M. it's an abbreviation they were shouting out on maternity. B.M. something about blood for babies, baby blood test I think it is, I can't remember exactly but it's - they use B.M., they say 'check the B.M.'s' and it's for a certain test on babies. I'm finding abbreviations on my first shift I was going, at first I was a bit shy to ask and then I must admit that I've got to know or else you're going to make mistakes, you don't know what it is and you can't guess can you, so ...

L&O No

F. ... I'm asking and then sometimes it's tempting to guess. I did speak to another student and they were guessing the (um) Blood Pressures ...
O. Oh God
F. ... because, because they were saying it was 'too noisy in the ward and I just can't hear it so I just guess it', naughty ...
L. Bad practice
F. ... I think you should get it right from the start and if you don't hear it you should just, gotta say 'I just don't hear this one'
JG. You've been going half an hour now, this has gone really quickly for me. There's some wonderful things coming out from what you're saying and you're beginning to dry up a little bit now, in search of words, so lets call it to a halt for today.

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Post interview issues of stroke positioning and barrier nursing picked up by JG and discussed with students.
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PhD Fieldwork Interview

BRANCH FOCUS GROUP

Transcription July 25th 1995

Meeting in my office 11.00am

Present : Janice Gosby (JG), Teresa (T), Ursula (U), Veronica (V) and Wendy (W)

JG Thank you for coming back again and this week I want to develop the conversation just a little bit further. Listening to the sort of issues you were raising last week when we talked - there's two particular things that I'd like to explore which were coming out to an extent and relate to some of the other things that you said. One of them is about being a degree student and I'd like you to think about what your expectations are of you - being a degree student, and what you think other peoples expectations are - of the fact that you've got a label 'degree, that you're a degree student', and the thing that's related to that is theory either being integrated into practice, using theory in practice, or theory coming out of practice. Where you've done something and you feel the experience of doing something has actually increased your knowledge. OK so if you can just hold on to those two things and just think of the experiences that you've had, particularly in this placement you're in now but also going back to other placements and think of examples where maybe being a degree student or the relationship between theory and practice has come through. So like last week I'm just going to sit back, when you're ready to start talking just talk and I'll listen to you.

T Well I think sometimes there's too much emphasis. When you go to a ward and you're labelled degree student and ... I'm not sure why that is and I sort of tend to say to people 'ignore the degree bit, it's no different so far as you're concerned', and I don't know if anybody else feels like that but I feel that we should be treated no differently.

W I definitely emphasise that as well that clinically we should be no different, we'll come out as a 'D' grade the same as the diploma students and should be able to do the same clinical skills as diploma students

T And we've got the same learning needs haven't we in the practical environment

U Yes, I think a lot of staff nurses at the moment think that we students don't get the same amount of time clinically as diploma students ...

T Yes, that happened to me yesterday ...

U ... and I think ...

T ... but I tell them because *** (tutor) apparently worked it out and he said that he'd worked it out and there was 6 weeks difference, that's all which is minimal. Yesterday on the ward ... sorry am I going on a bit here (others shake heads) ... yesterday on the ward there was an HCA on my ward and he's

just going to be doing nurse training and he had all the bumph there, and I said to him 'what are you going to do then, which course are you going for'? Well he said 'I need to earn some money, I can't do the degree course 'cos I wont earn any money'. Well I said 'how old are you' and it turned out he's 29 and he's been working, he'll be an independent student, so I told him just what I get from *** County as a grant and I can just ..... you know the recent diploma qualified people are sort of 'oh well I shall never do the degree' and I said ' no, well you might not ever want to but I said he's younger than you, he might and if he does it now well you know he might have to pay for himself and everything' and I just think it's bad that there's all these nurses and prejudices floating around and putting off a young guy like that who could do the degree and benefit from it.

U Well I think that's the way that nursing's going isn't it. I think it's going to be degree orientated eventually, the same as teaching

T I notice that some of the diploma students who have qualified now, not students - were diploma students, are already thinking about doing the degree, 'cos I know somebody, I can't remember which hospital it was at, their nurse manager was very much into higher education and after 6 months after qualifying she was put on the degree course already ... you know, she'd only just got her diploma so I think ...

U Practical ...

W The hierarchy are, I think they are more into it, 'cos many of the sisters and that now are doing the part time degree aren't they

T I was talking to another nurse the other day who actually started ... she said 'oh, I started off as an EN and I thought I'd be fine for life' and then she said 'I did my conversion course and I thought that's it now I'm and RGN, that'll be fine' I think she's thinking about doing her diploma or degree now and she said to me 'Even your BSc won't be enough, you'll have to do MSc' ... I was thinking I've had enough for a while but yeah I can see her point, especially with nurse practitioners and extended role ... you have to have, you sort of ... you have to have it down on paper as it were to ... sometimes to prove that you're up to it

W Yeah

U I find the research, you know relating to practice really useful, you know the research input that we've had here. The research lessons and you know doing the dissertation. I found that really useful you know when looking at (er) my own practice and getting articles and research to back up my own practice, and I found it a really useful, valuable tool ...

T Yes

U ... whereas you know I don't think the diploma really get that so perhaps they can't evaluate other peoples' research perhaps as well as we are able to because they haven't had that input ...

W and they don't think about putting it into practice, so it's ...

U yeah

W ... I think a lot of nurses in practice sort of tend to dismiss it, dismiss research as sort of being 'oh well that's all right in uni but it doesn't work in real life'

and you need to find a way to sort of learn from the research and see if it does work, you can't just swallow what's in a journal - see if that's right, if that's the way to go. You need to sort of investigate it I think

U It's the only way to change practice for the better as well I think

T I think the managers, the managers say that, I mean at my interview in A & E - I mean he said that himself you know ...

U Yeah

V Where I am at the moment it's quite um specialised at the *** unit and (er) in my dissertation that was orientated towards (um) terminal cases and disclosure and it's quite useful to be able to talk to nurses who've had a lot of experience in that area and from the research it has helped you to be able to talk a little bit more on their level and to understand ... to put a bit of the theory into practice and talk with them about it and I was discussing (um) articles to do with hydration and terminally ill patients and she was asking which articles I'd read and .. you know she was saying 'there's only one disadvantage' no what did she say 'there's only one advantage and that's because hydration prevents thirst' and ... then I was saying 'no there's others as well and according to this article...' and she said 'depends what you read' and so it was really good we ... you know ...

W yeah you were able to talk to her ...

V ... you're using their experience and ...

W your knowledge, yeah

T I found that out that my dissertation helped me to sort of take a helicopter view, that's what they call it (laughter) of (um) what was going on in the community with pain which is what mine was about. Whereas I think if, like when I was working in the community, you become obsessed with single patients and how it is on the ground level, whereas if you sort of step back out of it and you look at the theory and then talk to nurses about how it is in practice as you were just describing, and you sort of think about how it, how you could improve it, how you could improve your own practice. Perhaps how good practice is at the moment

U It's like research gives you so many different perspectives, as you say it gives you an overview of the situation and it's up to you to delve out the important bits and see how you know those important parts of the research could you know improve your practice. It makes you more objective as well you know, you do take a step back you know from caring for people as such you know, the nitty gritty of working on the wards. you take a step back and you're able to look at an overview of you know all sorts of different situations and see how well you can adapt those if you ... like when people say ' oh such and such wont work' if you're on the ward you could perhaps accept that it wont work 'cos it looks really busy and people are coming along demanding your attention, but if you step back and you think about how you're organised you can see perhaps a different way could be implemented

T Well it's funny how when we were doing these dissertations we just thought they were a nightmare and ... oh why have we got to do it but I think probably in retrospect I should think perhaps that all of us now can just see the benefit

of it ... and you wouldn't want it changed for future intakes really would you, because although it's a nightmare at the time once it's over it's ... you feel quite proud of it don't you

W I think you have learnt from it, I think you do need the time to concentrate don't you, whereas learning how to be a nurse in practice is difficult enough anyway, and having the dissertation on top of it at the time, but having another assignment to do - you've got to put your concentration on another subject - it's quite difficult really isn't it

T That was difficult, but now we're on this last placement with no written work to do I just feel so relaxed there and I know it's ... it's a really nice area and ward and they're very switched on but I just feel so relaxed and just ... it's nice to just sort of go home and look up things to do with the clinical ...

W Yeah you can really learn from practice can't you ...

T You can,

W What you learn is really related to what you see every day and it's really nice, whereas before I was trying to learn one thing on the ward, going home trying to write some of my dissertation about another subject and then having to try and do another assignment on another subject and you can't learn any of them properly ...

T No, you're playing about with all the different bits ...

W ... but I think it was good that most of our dissertations were definitely practice based weren't they, which I think ...

V Yeah

W ... is the only use of degrees actually. I think you ought to know all about the theories but I don't think they necessarily helped me very much in everyday life, some of the theories that we learnt but ...

U I get quite excited actually when like you've got a situation on the ward (um) a bit sort of something on mouth care or terminally ill and (um) chemotherapy, and (um) the nurses - the sisters very into you know research for mouth care and (er) she was you know trying to find the best mouth wash and stuff to use and (er) I got quite excited about it because it was like a little project for me to do and I said 'well I'd like to get involved with that' and so I went off and I'm currently looking at ...

W Doing your own research

U ... yeah, yeah. it's nice because I'm actually working with her as well because she's interested in the subject as well so it's going to benefit the ward ... and it's interesting for me to find out ...

W That's how I see us as using our research skills, I don't think ... a lot of people that us degree nurses are going to go on and we're going to want to do big research projects, not actually be in practice and you know, but I don't - think about like that, I'm just thinking as you say like mini little projects ...

U (Mmm)

W ... just to help in practice

U yeah

W and educate the other people on the ward

V Yeah like a friend of mine who qualified last year she did her dissertation on pain and she's thinking of doing a pain booklet for her ward ...

W That's really the place isn't it

V yeah

T and they've been there a year now so she's not gone in in the first week to say 'oh I'm a degree ...'

V no, not straight away

U She's got the experience from the ward ... I think that's what a lot of staff nurses feel that we're going to do, we're going to come back onto the ward, they think we'll start quoting research off the top of our heads and I think that's that's why we get such a bad ...

W The management sessions that we have I understand that the diploma students don't have them and I know that ...

T oh didn't they

W ... no, very little management input. Some of the nurses that I've been talking to have said 'oh you're doing the degree course are you, well you're just training to be managers aren't you, you don't want to be a proper nurse' whereas they've been using the same management skills as we're being taught for years but because they have a specific name now - like the interpersonal skills that we have and the research that we have, because we give it a specific names and we're taught it in a classroom they think we want to take it away from practice sometimes

T It's funny how ... I had ages ago now I think I don't know whether she meant it as a compliment or an insult but she said 'I'm glad to see they're getting less academic people in now' (laughter) and then on my surgical placement my mentor said to another nurse 'oh Teresa's like we used to be' and I thought is that a compliment or not? I don't know quite, they've got this perception that with degree nurses being academic and no common sense, but I don't know where they get it from, that's what I don't understand, it's like a myth that's been built up

W I felt when we first started that a lot of us, especially the ones that didn't come straight in from 'A' levels ... those of us who came in straight from 'A' levels we still seemed to be in school mode a bit as it were or in college mode, and (um) sort of you thought of yourself more as a student, especially when we were in university for lectures all day long before we'd been on the first placement. I could understand perhaps where that comes from a bit in the beginning, you're a bit nervous, a bit shy because you don't know how to adapt to the ward culture do you?

T You don't know what they want of you

W But now we're definitely nurses first, definitely but with the theory to back it up, I like to think ...

T I hate when you go on a ward and they say 'what are you?' you know ... and 'yes but what course are you on?' does it matter, you know and one person said to me 'so what are you doing, this project 1810?' (laughter) very sarcastic ...

V No, it's quite a new course here I suppose they felt a bit insecure at first ...

T They do some of them

V ... fear of the unknown isn't it

W I think it's a shame that as qualified nurses with all their experience they have so much to teach us and I think if they concentrate enough on teaching us what they know then we could perhaps pick out the ones that we want to be our role models and pick out the bits of knowledge from different people that we meet and we feel is useful, and anything that they tell us that we think 'well that sounds good, bit traditional bit sort of ritualistic' we could go away and think about another time, but they seem very reluctant sometimes don't they, to tell us anything 'cos they think it wont fit in with our course or something

T And this sort of extends to outside nursing as well, when I first started the course I bumped into an old school friend, I said 'guess what I had a mid-life crisis, I changed ... I'm going to be a nurse', "oh' she said 'are you? What the new type nursing?', "yes" I said 'I'm going to do a degree', "oh my god' she said 'an academic nurse, you wont know what to do' you know, she's never worked in nursing at all yet she got this message from somewhere, ... it's so odd ...

W Whereas in the end when we're a staff nurse or midwife will anybody know the difference?

V No, no

U What I worry about is having the confidence to be able to ... to use research in practice when I'm qualified, how am I going to be able to change ... because as I said earlier it's like you can't go onto a ward you know as a student nurse and quote research at people and expect them to change their practice, and I just wonder how, how I'm going to be able to do that ..

T I don't know, I think you'll get support from the DipHE 'cos that's academic as well, you know they're not ...

U ... yes and they're qualified staff, that have been qualified a while and ...

W ... it seems that you have earn your respect first doesn't it, as a staff nurse or as a student, whatever set you are, earn your respect first and sort of get into the ward culture and then, then you're able to start looking at ideas and giving suggestions ...

V Point out advantages ...

W Yes

T And most wards have staff meetings don't they and things, where people are allowed to ... encouraged to, I think on *** they do, you know encouraged to ...

W ... to challenge the tradition or the ritual

T ... I think the thing is we'll all go, you know, we'll hope to find an area where we feel comfortable, where they ... you know, I can't see any of us going into a traditional ward where ... you know, not for long anyway

V No

W I was talking to somebody the other day who works for the hospital, she's not nursing or medical based, and she was saying to me 'so how are you going to be different then, to the diploma nurses, 'cos I've talked to some of them and

it would scare me' she said 'to have some of those diploma nurses nursing me', 'oh dear why' and she said to me 'now your course is for academics so do you have more academic knowledge than them, is it more like a medical training?' and she was saying to me, and I was trying to convince her that no clinically we were supposed to be the same and she asked me as a degree nurse if I would feel more confident or be more able to challenge the doctors, she said 'well if you saw some drugs that you thought didn't suit a patient as a degree nurse you could go and challenge the doctor couldn't you?' and I said 'well no, when I qualify I don't think I will be able to' with a degree or not I need the experience, it's not my course it will be the experience that gives me the authority and the competence and confidence to ...

U Be assertive, to do that, yeah

T And the DipHE's are going to have that as well, I mean, eventually they're the same ... but that's down to personalities isn't it more than the course

W It's up to us to use our knowledge from whichever course we've been on, whichever opportunities are around, to ... isn't it, we're not automatically going to learn to be nurse practitioners just because we've done a degree at the moment

T Not even going to want to be ...

U I think doing the degree course has enabled me probably to ... to be more self-directed in my learning ...

T It's more of a personal thing isn't it ...

U Yeah, I think I'll be more able to learn once I'm a staff nurse now because I've got the skills to be able to learn, to be able to look at research ...

W And to step back and see what ...

U ... yeah, and I think that's what this course offers ...

W ... it encourages us to criticise things, or to particularly analyse anyway, what ever's going on theory or practice

U yeah, yeah

W ... whereas perhaps traditionally they were more encouraged to 'this is how you do this and this is how you're going to do it' whereas now we're sort of told about asepsis and about infection and things and it's up to us to use our knowledge to put it into practice

U ... yeah, and so increase our learning

W 'Cos it wont stop at the end of the course

U No

(pause)

W I think (um) one of the benefits about the degree course, I think probably the only difference they see now ... nurses on wards, is that we're supernumerary and diploma students aren't which causes a bit of conflict sometimes doesn't it

T Yeah

W They think that we're not there to work just to ... but we've said that we're quite willing to ...

U muck in

W ... yeah

U I think you have to state that right from the start ...
T Well you have to prove that you're ready to work ...
U Yeah
T ... you have to prove yourself

JG You're drying up, you've been going for 25 minutes, that's actually a long long time so just come to a stop and that's great. Thank you very much, let's put you at rest and finish for this week. That's really good.

PhD Fieldwork Interview

Year 1 : July 9th 1996

Angela : Early Duty (07.15-15.15 + reflective interview) - acute surgery, 2nd week of 3rd CFP placement, semester 2.

Staffing : Team 1: S/N, HCA and BSc student, Team 2: S/N, HCA and DipHE student

JG I'm going to do just what I did last time, I'm going to say to you first of all start off by just thinking back over today and what for you have been the learning opportunities ...

A Right

JG ... and just talk about them and I'll pop in and ask questions

A Right (um) well I think today I don't think I've really done anything different today which is a bit of a shame I think 'cos I sort of want to do something different each day, however I have done part of (um) an admission again which is good practice and I think probably the more practice I get the more confident I'll feel so that would that was that was a good part of the day (um) and I've sort of spent a lot of time doing obs and things like that and maybe standing around a bit, well I just sort of did basic things I'd call not basic but the sort of things that you do every day (um) ...

JG Yes but they're becoming familiar now?

A ... oh yeah yes (um) which is good I'm glad I do those because otherwise there'd be I'd feel perhaps as if I wasn't doing what I part of my job whatever (um) I also helped you wash that man which I've never washed a man before so that was (um) a new experience and I have to say I was nervous about that more so than a woman 'cos I've never I've not bothered about females at all ...

JG Yes

A ... but I've never washed a male sometimes I think ohh maybe I they might feel (um) worried because I'm quite young and do you know what I don't know if that's right in saying do you know what I mean ...

JG Yes

A ... (um) but you don't want them to feel embarrassed ...

JG Yes

A ... (um) and it would be awkward but it I think it went ok ...

JG Yes

A ... so (um) I think you helped that being with you doing it would have been better than me on my own for my first time ...

JG Right

A ... because then I could see you how you sort of helped him keep his privacy and ...
JG Yes
A ... his dignity so now next time I'm not going to be bothered at all ...
JG Right
A ... so that's good that was actually a good part of the day (um) (um) we also put some drugs away which helped because I got to see around the treatment room ...
JG Yes
A ... and have a look round there which is important 'cos sometimes you just don't know where things are and now at least I know where bits are going and (um)
JG Yes and the problem of matching the names up because ...
A (Mmm)
JG ... it had one name on the order form ...
A Yeah
JG ... and a different name on the box (laughs)
A It's always yes glucose and dextrose well that's the simplest ones but you know it is difficult sometimes you think what are they talking about it says here one drug and they're talking about another ...
JG Yes
A ... they all have different extra names I know when they come off patent they ...
JG Yes
A ... they other company's can produce it (um) I know that from working past working ...
JG Yes
A ... but it's still very difficult
JG Yes and the Frumil that didn't have a name that matched the order form at all ...
A No no
JG ... until we asked somebody else to ...
A Yes who knew luckily
JG ... because we couldn't find a BNF (laughs)
A (Um) what else have I done (um) I can't think made some beds (laughs)
JG (Mmm)
A Which is quite important ...
JG (Mhm)
A ... it's quite therapeutic making beds actually
JG It gives you a chance to have a rest sometimes ...
A Yes
JG ... too doesn't it?

A Yes I find it's nice too and I sort of think maybe I sit on peoples patients beds a lot because people some nurses don't think you should sit on beds ...
JG Yeah
A ... because you can cross infect and catch germs however I think that you're more relaxed with a patient they feel more relaxed, when you're standing over them I can't ...
JG Yes
A ... talk to them properly and you're staring down at them and they can't you can tell they're not comfortable ...
JG Yes
A ... and I'm not comfortable ...
JG Yes
A ... so I think if you sit there and chat you feel much more comfortable and then conversation flows (um) so and that's a good chance to sort of relax as well rest your feet 'cos my feet do ache sometimes (um) ...
JG Yes
A ... so that's good and then you get to chat to people and they tell you their worries a lot of people when I've been doing obs have asked me little things ...
JG Yes
A ... and you think you've been worrying about that (um)
JG Yes
A ... like Mr L (um) who he (um) wasn't well yesterday he was you could tell at the time he was very worried about it and he was scared by the fact that he couldn't stop his shaking ...
JG Yes
A ... and today you could still see it was playing on his mind by saying though I did bring the subject up you could see that he was watching his temperature is it has it gone up you know and he thought he was on the mend and that was upsetting him too so that can play an effect on his general ...
JG And he was interested when I was talking to you about the pattern of the temperature and the pulse and ...
A Yes he was
JG ... he was listening to what was going on ...
A Going on yes
JG ... and he seemed quite interested ...
A Yes it helps I think ...
JG ... to know
A ... when they have that information 'cos then it sometimes it can make it clearer to them ...
JG Yes

A ... (um) however I don't know whether there's time to explain every little thing like that but it does help when you occasionally have that ...
JG Yes
A ... and it helped me because I wouldn't I could see there was a connection but couldn't quite work out what the connection was ...
JG Yes
A ... whereas now if I see that I'll be able to think right Angela check the pulse as well ...
JG Yes
A ... just to see if there is a change ...
JG Yes
A ... (um) which is good
JG Yeah
A So I have learnt quite a bit actually today (laughs) as it happens
JG One of the other things I jotted down was we started off with Mr H who was in pain ...
A Yes
JG ... and you and I were later on talking about pain control or lack of it ...
A (Mmm)
JG ... and you were saying that you've seen some different things on this ward ...
A (Um)
JG ... and sometimes they get it regularly and sometimes they're not
A Yeah (um) a lot of the patients don't like to ask for pain killers ...
JG Yes
A ... unless they're in severe pain and I think Mr H (pauses) this is a judgement from my point of view shows his pain more than other patients ...
JG Yes
A ... he tends to roll round in bed moaning and groaning which sounds horrible, I'm not being horrible to him, whereas a lot of patients will sit there and then when they move and they're in absolute agony you realise but unless you ask it shows that you won't know and a lot of them sit there and go oh you know I'm all right it's not got too bad that I can't bear it and I've said you don't have it like that, that isn't what you're in here for (um) ...
JG So you've learnt to pick up on the non-verbals ...
A Yes
JG ... and to recognise when they're in pain even when they're not saying?
A Yes yes like (um) one of the ladies in bay 4 she moans or groans when you move her ...
JG (Mmm)

A ... other than that she's fine however you also know that perhaps this is another judgement but she does like a bit of attention ...
JG Yes
A ... from other people so she does as soon as she walks into the bay she'll start walking with a bit of a groan and you know that it isn't that bad maybe that's awful to say but you know because she's doing it for the other patients to feel sorry for her but then in a way ...
JG From your point of view it's deciding what sort of pain relief they want ...
A Yeah
JG ... and with Mr H this morning ...
A He needed that pain relief
JG ... he needed pain relief I don't know that he needed pethidine I don't personally I would have given him something slightly milder because I think like you I was picking up that he was making a bit ...
A More of it
JG ... more of it than he ...
A He is that type of man
JG ... when you looked at what he looked like later he looked so different and I reckon he would have got away with something milder
A He was in exactly the same state then as when he came back the night of the operation and he rolled round like that then ...
JG (Mmm)
A ... now you could say he probably was in a lot of pain then ...
JG (Mmm)
A ... but now (pauses)
JG I think he's in discomfort now ...
A (Mmm)
JG ... as opposed to acute pain
A And he's just thinking well I don't have to be like this which I suppose he's got a point but perhaps if he just mentioned it rather than roll round ...
JG Yes
A ... because you they do seem to say oh it's Mr H
JG Whereas the other gentleman we looked after Mr R who's got the patient controlled analgesia ...
A (Mmm) yes
JG ... was very sensibly like he used it before we got him out of bed ...
A Out of bed yes
JG ... so that it would work but ...
A He was ...
JG ... he was much more ...
A He was more independent ...

JG Yes
A ... with his pain control whereas Mr H sort of wanted mothering in a way but I suppose you have those type of people you have to cope with both types ...
JG Yes
A ... (um) 'cos you wouldn't... you would probably never make Mr H independent ...
JG Yes
A ... in his pain control he's always want that
JG But so you're learning quite a lot about assessing patients pain but I think I wonder whether you're learning about the management because I felt that the pain was mismanaged in that ...
A (Mmm)
JG ... he'd gone a whole day without any pain relief ...
A (Mmm)
JG ... so yes he's making a big fuss now whereas if they routinely offered pain relief when they did the drug rounds then ...
A (Mmm)
JG ... there does seem to be this fear of giving patients analgesia instead of saying lets give it and keep them pain free and you can get them doing so much more ...
A (Mmm)
JG ... you know
A Yes because one of the ladies here (um) she has had her pain control reduced and they say as soon as you start feeling pain tell us ...
JG Yes
A ... whereas perhaps if they kept it up at least until she gets quite bad then they start giving out more well if they kept it off then she wouldn't be such a difficult patient ...
JG Yes
... well she's not difficult but you know (um)
JG So it will be interesting for you to compare when you go to other ...
A Other wards
JG ... placements and you look at different ways of managing pain
A (Mmm) yeah
JG Yes
A Yes 'cos the lady who came in earlier (tutor)?
JG Yes
A She was the one I always remember her lecture very clearly on pain control ...
JG Yes
AJ ... (um) it's yeah I think back to that lecture quite a lot when I'm on here ...

JG (Mmm)
A ... and so it's good that something clicks in with theory (laughs)
JG Yeah so it begins to make a bit of sense of it
A Yes yes yeah
JG OK
A (Um) let me think what else have I done (um)
JG I was just thinking when back to the bed bath and also when we were helping Mr L in the bathroom but (um) just learning how to deal with all the tubes ...
A (Mmm)
JG ... when you're trying to do things ...
A I know
JG ... it's not so much what you're doing but what do you do with the IVI and ...
A (Mmm)
JG ... CVP line and everything else
A It takes me a lot longer than everybody else as well which I feel guilty about 'cos you think ohh where does this go and you don't want to hurt them ...
JG Yes
A ... and (um) you don't want to pull anything out (um) but yes
JG But that's just lack of practice isn't it
A Yes
JG When you've done it a lot more you'll be as quick as anybody else
A Yes yeah but that is difficult really because Mr R's got a central line and all that ...
JG Yes
A ... he's got loads and I end up thinking where do they all go I'm going to get twisted up which makes a lot ...
JG Right
A ... a lot more work (mmm) so yeah that can be difficult ...
JG Yes
A ... very difficult
JG And there was there was one point when G took you off to explain what the gentleman in bay 1 had had done ...
A (Mmm)
JG ... he'd been for an angiogram and I stood away, what was happening there?
A Yes (um) let me think back (um) she was just explaining oh crikey my memory's gone ...
JG He'd had an angiogram

A ... yes he'd gone down (pauses) oh they'd put they'd put a dye (um) in to see (um) whether there was any obstructions in his arteries in his leg ...

JG (Mhm)

A ... (um) and also the dye was going to go up further to see if anything was ...

JG (Mmm)

A ... just to check really it wasn't any it was just to see that everything else was fine, that the arteries were working properly (um) and she said it was a fairly simple oper... well you know operation and she took me to see him and he was quite pink actually ...

JG (Mmm)

A ... and she said that I think that was the dye?

JG (Mhm)

A Yeah (um) and oh she showed me where it was oh and she was telling me that they have to be very careful because with the artery it can ex... (um) it can pop out I can't think what she said exactly ...

JG (Mhm)

A ... but anyway you get a the blood can shoot and you have to press down fairly but that was quite interesting ...

JG (Mmm)

A ... (laughs) (mmm) but yes so it was quite a difficult though it was I think quite a common procedure ...

JG (Mhm)

A ... (um) it still shows how dangerous ...

JG That's right

A ... each operation can be

JG That's right so did she tell you what to observe on him now, now that he's come back?

A (Um) he to observe that there was no (um) no cracks ...

JG (Mmm)

A ... or any sores (um) they tell you always to look for pressure sores where all over the body but especially around the area that there's been the wound area (um) and if any if there was any bleeding or anything like that 'cos she said sometimes it can occur ...

JG (Mmm)

A ... and that's when you know it can be very dangerous ...

JG (Mmm)

A ... so just to watch that and basically observe his observations checking his obs

JG Right (mmm)

A And that was it really oh and he started to have sips of water now ...

JG (Mmm)

A ... and I think he can eat this evening I think
JG Yes yes because once the immediate recovery is over he can ...
A Yeah
JG ... he's straight back to being independent again
A Yes that was good
JG OK and we had the debate about lifting ...
A (Mmm)
JG ... when we went to help out at the female end
A Yes (um) I had noticed that they don't really (um) they don't do Australian lift here however then I did think when I was on the ladies especially at one point we had an awful lot of very frail ladies like Mrs S and I did wonder whether the Australian lift would be suitable because she's so tiny (um) and I could just imagine breaking something (laughs) you know popping your shoulders under her arms you know ...
JG Yes
A ... I thought it could be a bit dangerous ...
JG Yes
A ... and also the other student nurse he he just lifts her but I said to him I don't want to do that lift even though it was on Mrs S and she's so tiny ...
JG (Mmm)
A ... I said that's not what I've been taught to do, it's a drag and I said I don't want to do that 'cos I don't want to hurt my back basically ...
JG (Mmm)
A ... and he said oh we've been taught to do this and I said sort of well although we're doing different courses, he's doing Diploma, we couldn't have been taught two different lifting procedures ...
JG (Mmm)
A ... and so I said well I'm not doing it this way so we sort of changed the lift a bit but (um) and a lot of people they don't I've only seen one Australian lift being used ...
JG Yes
AJ ... I know an awful lot of heavy patients as well
JG At the end of the day it's making sure that you're using a safe procedure which is going to protect your back and protect the patient isn't it ...
A (Mmm) Mrs S ...
JG ... but I thought it was useful really that we had the debate because it raised the awareness for all of us ...
A (Mmm)
JG ... as to how we were going to move that lady because she was quite big, she was going to need three of us ...

A And she's very she hasn't got much strength either so she relies on you a lot ...
JG Yes
A ... because I everybody says oh it's all right to her we've got our feet in front of you, you can't slip but every time we say that I think but if she does slip our backs are just going to go ...
JG Right what I thought was interesting was that the slings were there and I'd seen them there but it was only when I said I wasn't prepared to just do an arm lift that the staff nurse said oh well we'll use the slings then so I thought it's a shame really when they somebody's actually thought she needs slings to lift her and yet they weren't going to use them ...
A (Mmm) they were just sitting there yeah
JG ... so whereas the lift she was going to do an arm lift I think is much more unsafe than an Australian ...
A (Mmm) yeah
JG ... so (um) yeah it's a problem
A But she is a big lady well not big but she's because she is ...
JG It's her ...
A ... she is overweight and she puts all her weight on you ...
JG Yes
A ... she can't be independent she can't help much ...
JG Yes
A ... she does help very a lot for her ...
JG (Mmm)
A ... but that isn't very much but I do try to get the patients to do as much as they can ...
JG (Mmm)
A ... 'cos an awful lot of them can wiggle do you know what ...
JG (Mmm)
A ... you know move themselves a tiny bit and I think that sometimes they can control their own pain by doing that ...
JG (Mmm)
AJ ... because if they do it they can do it in their own time and as long as you're there they feel quite confident (um) and I think what they can do helps them with movement anyway, they get to move about a bit they don't some do but (ah) ...
JG (Mmm)
A ... yeah it is difficult 'cos I do go home sometimes and my back aches but I don't think that's from well I just think it's from general wear and tear of the day but it does show you that you are up and down an awful lot ...
JG (Mmm)

A ... like emptying catheter bags and ...
JG Yes
A ... kneeling down to pick the thing off the end of the bed ...
JG (Mhm)
A ... and it is worrying really (said quietly)
JG I was thinking also that in report today two of the admissions one was the gentleman Mr P ...
A (Mmm)
JG ... who's (um) been found to have a pancreatic tumour ...
A (Mmm)
JG ... which sounds like it's bad news and the other one was Mrs W ...
A (Mmm)
JG ... who was an open and close that's two patients on the ward whose prognosis is very poor has anyone sort of talked you through that and how to cope if the patient asks questions or anything?
A (Um) no (um) we've had since I've been on here quite a sort of spate of ...
JG (Mmm)
A ... terminally ill I came on to find two gentlemen which and Mrs W came in that day ...
JG (Mmm)
A ... (um) and I actually found that quite difficult ...
JG Yes
... because I sort of spent quite a lot of time with one gentleman who went to the MacMillan unit the next day anyway but Mrs W I sort of went down with her ...
JG Yes
A ... and the she was when in the anaesthetic room so I talked to her before she went down I went down with her and I came back and I was on with her the whole time and she got the news and her husband sort of came to me when he came in the first day ...
JG Right
A ... and they told him over the phone (sounds amazed) and I thought that was absolutely horrendous ...
JG That's pretty unusual 'cos they don't ...
A ... that was the doctor they said they phoned I don't know whether he phoned in the morning and he demanded to know ...
JG Oh right
A ... (um) or whether they told him on the phone but (um) I did find that very difficult ...
JG Yes

A ... (um) not really (um) not really what to say in a way I don't know more for me to cope with it 'cos I've never been around so many patients sort of dying ...

JG (Mmm)

A ... but they've all been so cheerful it's (um) I don't know if Mr B's been told yet (whispered) I think he ...

JG No I don't know the doctors were certainly trying to speak to him today but certainly ...

A Going to yeah

JG ... but I don't know if they have ...

A (Mmm) yeah

JG ... and yes (um) very often when people first know ...

A They go into denial ...

JG ... it's almost disbelief yes so ...

A ... 'cos I couldn't believe ...

JG ... you sometimes get an inappropriate euphoria ...

A (Mmm) yeah 'cos when Mrs W had been told in the morning and she sat there the whole day which I found the hardest thing ...

JG (Mmm)

A ... she sat there all the day just sat there chatting to people and then she'd just keep staring but she wasn't upset at all and you imagine ...

JG Has she talked about it since?

A Not really her husbands talked about it a lot ...

JG (Mmm)

A ... I don't know whether she's talked about it to anybody else but to be honest I'm not saying me particularly but I think I've got closest to her out of anybody on the ward ...

JG (Mmm)

A ... (um) and she hasn't really talked to me about it it's just the sort of thing I'll say I'll sort of say to her how are you which is a silly question ...

JG (Mmm)

A ... but it's the only one you can think of sometimes and how do you feel and things like that and she's sort of said fine dear and but she's not actually showing her feelings and I don't think she's showing to her husband either because he came in that first day and spoke to me and went up to her and they kissed each other and that was it they sat down and chatted but so I think it was both of them trying to be strong for each other ...

JG (Mmm)

A ... (um)

JG And she's probably not come to terms with it yet

A But they don't think she's got long

JG No
A One of the nurses was saying yesterday her eyes have got a yellowy tinge (said very quietly) ...
JG (Mmm) (mmm)
A ... but I don't know you see I thought she I thought she looked quite healthy ...
JG And (um) ...
A ... when she came back (coughs)
JG The other one in report was Mr G who's got the thrombosis ...
A (Mmm)
JG ... which I haven't looked at it but I gather it's quite a ...
A It's a ...
JG ... large swelling ...
A (Mmm)
JG ... and (um) what they were saying in report was (ah) to tell the doctors immediately if he gets any chest pain so has anybody explained that to you?
A No I didn't even know
JG No because you came a little late then (her tyres had been slashed on her car) so you missed that bit but do you know what the danger is of having a thrombosis there?
A It can explode can't it?
JG it can break up ...
A Break up yeah
JG ... and travel round the system so what they're looking for is potentially he could end up having a pulmonary thrombosis because a little bit could travel to the lungs ...
A Oh yeah
JG ... and that's why they want to know immediately if he starts saying he's got chest pain ...
A Right
JG ... because (um) from what they were saying and we haven't looked at the leg he's got quite a large swelling ...
A He has I saw his leg yesterday
JG ... and they're anticipating that it will start to break up but then there's a very great danger that he'll have a pulmonary embolus, blood clot ...
A (Mmm)
JG ... and that would be a major problem to him ...
A (Mmm)
JG ... so again it's sort of dealing with somebody without - knowing things about them without necessarily ...
A Yeah yeah
JG ... making an issue of it ...

A It is yeah
JG ... out of it isn't it?
A 'Cos some people have sort of said oh once some of the HCA's have said they don't know what to say to patients when they go when they know they're going to die (said quietly) ...
JG (Mmm)
A ... and they say they don't want to be in a position where a patient says can I talk and be asked some questions and then not be informed ...
JG (Mmm)
A ... 'cos some of them are actually closer than the nurses ...
JG (Mmm) (mmm)
A ... to patients so they're more likely to talk to them ...
JG (Mmm)
A ... and and I think that's really awkward for them (um) but oh I don't know really I - I suppose it is I think it would be very very useful to have a sort of a time on bereavement and how to help ...
JG Yes
A ... not just bereavement you know the time before the patient dies ...
JG Yes
A ... how to cope with that for you ...
JG Yes
A ... as a nurse or whatever however I think you learn to cope with it because a lot of people on here I think cope very well ...
JG Yes
A ... I think they sort of they don't look upon it I think I've been looking on (pauses) upon it differently to them I think they've come to terms with coping with that type of patient whereas (pauses) I don't know I don't know I suppose you do get used to it ...
JG (Mmm)
A ... which just sounds awful but (pauses)

[knock on door - somebody cleaning comes in and leaves again]

JG OK so what do you think you're learning from from that sort of experience then?
A (Um) oh well how to oh sort of deal with other situations that arise and to oh and to cope for me probably ...
JG Yes
A ... as well (um) it's made me more oh I can't think (um) what's the word (pauses) it's made it's made me more aware of things around me ...
JG (Mmm)

A ... (um) but it's oh but it's also made it so real 'cos I've never really looked upon it though I've had grandparents which have died ...
JG (Mmm)
A ... you look it is different looking at it from ...
JG (Mmm)
A ... that point of view to looking at families from the outside in ...
JG (Mmm)
A ... (um) and I'd never really seen that before ...
JG (Mmm)
A ... (um) so that shows a lot and it I found that quite difficult to cope with at first (um)
JG What helps you to cope Angela?
A Chatting probably to my friends ...
JG (Mmm)
A ... I'm very lucky 'cos I'm moving in with there's three of us who are nurses ...
JG (Mmm)
A ... (um) and we were only saying last night actually we don't know how the ones who aren't moving in with nurses are going to cope ...
JG Yes
A ... because we found it so useful not just for that sort of situation ...
JG Yes
A ... but we go back we don't talk about patients but we like discuss what's happened in the day and it's so good to talk about it and ...
JG Yes
A ... also if you're upset like one of my friends a patient died on her on her first placement ...
JG Yes
A ... and she cried for literally two days running ...
JG Yeah
A ... but and unluckily we were all not there but she phoned us all ...
JG Yeah
A ... and like it was good to talk because though you can talk to those around you who aren't nurses and they're really good they don't know how it feels ...
JG it's not the same
A ... it isn't the same until you're in that situation ...
JG Yeah
A ... (um) so it is lucky like that ...
JG Yeah
A ... and also my mum's a nurse so ...
JG Yeah
A ... I've got I've got her (um) so I'm very lucky actually and I ...

JG Yeah
A ... people who know me for not stop talking so (laughs) ...
JG (laughs)
A ... I'm lucky that I'm not one of those that would probably hide
JG So you can verbalise your feelings ...
A Yeah yeah
JG ... quite well
A And I think I'm fairly good at listening because people do tend to I do tend to listen to a lot of people (laughs) ...
JG Yes
A ...with (um) who are upset which is nice for me because it makes me feel that I'm good at the other at listening so I don't feel so guilty when it comes to you being upset you think I'm not I've been there for them which I think is just as important on the ward you've got to be able to listen as well as talk so
JG The only other thing I can remember from today is probably at lunch time when you were talking about one of the other students and the difference in that person's approach to yours ...
A (Mmm)
JG ... how probably how does that experience effect you being a student on the ward, you were saying ...
A (Um)
JG ... he's very confident and ...
A Yeah he makes (um) ...
JG ... he makes you feel inadequate
A ... yeah as my first adult placement I probably found he was very difficult to cope with ...
JG Right
A ... and I actually went home one day thinking oh am I doing the right course (um) and (pauses)
JG He made you feel insecure?
A Yeah and I felt completely useless and he ruined my day ...
JG Yes (laughs)
A ... and by the end of it I just thought ohh I don't want to be with people like this...
JG Yes
A ... but the others weren't like that and as soon as I found out that I'm not the only one who feels like that it made a completely different ...
JG Right
A ... (um) feeling you know
JG So now you cope with him
A Yeah he annoys me (laughs) but I cope with him and I find it better if I don't talk to him that much ...

JG Yeah
A ... if I just do things it's not that he's horrible I'm sure that he's a really nice bloke but it's just he I think he is too confident for the stage he is at ...
JG (Mmm)
A ... and I think that's dangerous ...
JG (Mmm)
A ... I don't know maybe it's not dangerous I think it can be dangerous (um)
JG So what comes out of that is you judge your own performance by comparing yourself with other students ...
A (Mmm) well I ...
JG ... which isn't always right
A No I sort of said yesterday to one of the staff nurses I was on with, we were chatting and I said I don't feel confident that confident compared to him and she said well looking at you when you walk round the ward you are confident ...
JG Yes
A ... she said you look confident which is the main thing ...
JG (Mmm)
A ... she said none of us have said oh Angela's not competent of confident ...
JG (Mmm)
A ... (um) which boosted my confidence and she said we'd rather you that way than his way ...
JG Yes
A ... (um) and she said also you've also got to work as a team and he is not in that team ...
JG Yes
A ... (um) and she said whereas you respect us she said and we don't want respect - we do we've all got respect for each other and I think that's quite important ...
JG Yes
A ... I've always been brought up to respect authority figures anywhere at home but I do class them as they know more and they have more experience than me so ...
JG Right
A ... I sort of respect that's why I always like to thank them if they've helped me ...
JG Yes
A ... because then I know that they'll come back and do it again ...
JG Yes
A ... (um) and I don't think he does that ...

JG (Mmm)
A ... (um) and I just think he's going to lose out in the end so if I look upon it as that I'm fine (laughs)
JG You're fine yeah you are you're fine I think that's sort of covered everything I had down on my list, is there anything else you want to talk about before we finish?
A (Um) no not really (um) I'm looking forward to carrying on with this ...
JG (Mmm)
A ... and that's it really
JG You look considering it's only your second week you're looking very settled and you're thinking for yourself and you're sorting things out ...
A Oh that's good
JG ... so you're looking confident
A Yeah yeah I think with just the more experience I get (um) and the more things I keep making myself do that's what I've got to do for me 'cos I am ...
JG Yes
A ... I can I do get very nervous like when I gave my first injection on maternity ...
JG Yes
A ... I was as nervous as anybody could be whereas now I look at thinking of doing an injection and I'm nervous but I've also got the determination ...
JG Yes
A ... (um) and like with the suppository yesterday I thought oh no I can't do that maybe I'll do it wrong but then something took over and I thought no you've got to do it Angela ...
JG Yes
A ... or else you're never going to do it and that's what I've got to make myself do keep doing and with that I think I'm pleased I've got that now
JG (Mmm) and so before we get together again you're going to ..... to the staff nurse about trying to follow a patient through and ...
A Yes yeah I shall do that (um)
JG Feel ok about asking for your learning experiences
A Yeah yeah I'll do that when I come on on Saturday so when you come on I should have done it maybe
JG Yeah
A Been through it so good
JG OK great thanks, bye.

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PhD Fieldwork Interview

Year 2: May 1st 1996

Isobel : Day Duty (09,00-17.00 + reflective interview) - Accident & Emergency department, 4th week of 1st Branch placement, semester 4.

Staffing : S/N and BSc Student for A & E Clinic am, joined EBS staff in the afternoon

JG Ok right thanks we're going to do just what we did last time today's been quite different really from when we worked together a little bit earlier on ...
I (laughs) yeah
JG ... so you talk to me about your day and how it's gone and what you've learnt
I (Um) the clinic was interesting ...
JG Yes
I ... that was good learning sort of the way the nurse interacts with the (um) doctor supposedly (refers to doctor not interaction) (um) and the way that the clinics run I didn't really expect it to be it's more like a off the circulation line when a product comes in and you just work ...
JG (Mmm)
I ... through it like that it's more like that rather than anything else it's nice that the nurse knew some of the patients ...
JG Yes
I ... or the doctor knew some of the patients as well ...
JG Yes
I ... shows a bit more of the continuity of care which you don't normally get in A & E ...
JG Yes
I ... sort of assessing peoples dressings stuff like that (um) that was interesting (um) the EBS was a waste of time (laughs) ...
JG (Mmm) (laughs) right
I ... completely too many staff too many patients came in at once the staff the nurses all did their bit and then they were just waiting for the doctor to come along because there were so many medical patients (um) usually you learn more but you couldn't really learn much ...
JG Yeah
I ... and we did one admission and that was it and that was (um) I mean apart from that you just felt like a spare piece ...
JG (Mhm)
I ... standing around

JG So you didn't really belong to anyone in there did you?
I No you felt lost
JG Yeah
I Normally it's all right I did a good shift on Monday night ...
JG Yes
I ... but then today was just a waste of space
JG Yes ok so you didn't go much on that
I Well I don't think I'd have got much going into A & E either ...
JG (Mmm)
I ... because they had they've only had one patient
JG (Mmm) it's very quiet today yes
I (Mmm)
JG It must be the effect I'm having
I You should have been here Monday (laughs)
JG Yeah tell me about Monday what happened there?
I Oh (um) it was a good shift I had a good shift in EBS but there was more doctors referrals 'cos they wait until Monday to go and see their GP so you get more referrals I think ...
JG Right
I ... at least that's what I understand by it (um) it was a lot more organised because there was only three of us ...
JG Yes
I ... two two staff nurses and me it was nice because we could all do bits and that and they actually made me feel part of the team ...
JG Right
I ... which I didn't at all today I just felt like somebody lost
JG Right you were talking earlier about the organisation of care in there and today it seemed very haphazard ...
I Yeah
JG ... there didn't seem to be any organisation
I I really think they should have two nurses to each cubicle ...
JG Right
I ... I mean one nurse to two cubicles ...
JG Yeah allocate
I ... that way yeah
JG So then you'd know they were your patients ...
I Well I mean you know on a ward when you come on shift you'll stay you'll stay down one end of the ward or the other end ...
JG Yes
I ... it could be like that ...
JG Yes
I ... I could make a suggestion to my mentor ...
JG Right

I ... see what she says on Friday
JG Right yeah that might be something valuable ...
I (Mmm)
JG ... to comment on really ...
I Yeah
JG ... from your experience there
I Also make me feel not quite so lost
JG Ok but just thinking to the man that you did do the admission on you did that very confidently ...
I (Mmm)
JG ... yeah
I Although whatever H just completely you know sort of took everything I'd the work away that I'd done that made me feel a bit like a fool
JG Why do you think that?
I Well I mean I didn't really know what dysphagia was I knew it was a problem with some sort of speech working ...
JG Right
I ... and I mean (huh) his problem wouldn't I mean I thought he'd have more problems with his leg I didn't really know what dysphagia meant and I mean I'll go away and look it up ...
JG Do you know what it means now ...
I Well no
JG ... have you looked it up from having seen what's wrong with him?
I I know that dys is something wrong ...
JG Right
I ... phagia is the sort of movement and ...
JG With him it's the swallow ...
I Yeah
JG ... so he can't swallow so dysphagia which is very close to dysphasia ...
I Yeah
JG ... which is the speech problem ...
I (Mmm) I knew it (um) dysphasia
JG ... so dysphagia (emphasises the second syllable) is difficulty in swallowing
I Right
JG Right which is obviously what he's got so the fact that he's had those diverticulum on his oesophagus means he's he's had a problem there before ...
I (Mmm)
JG ... and I think the standard investigation now would be to try and put an endoscope down ...
I (Mmm)

JG ... and find out whether his oesophagus is just narrowing down ...
I (Mmm)
JG ... and whether there's scar tissue or whether there's a tumour or something there
I I didn't find her very helpful ...
JG Right
I ... at all she was a bit abrupt
JG And remember that this is a muscular organ ...
I (Mmm) there's peristalsis there
JG ... so this could even be muscle spasm yeah ok
I It's quite interesting because I mean that's why I went and asked the doctor about the x-ray and he was a bit abrupt as well (laughs) ...
JG Right
I ... must have been the wrong day (laughs)
JG I was interested I was looking over your shoulder at that point and I thought that if you look at the left lung (said hesitantly trying to work out on self whether it was left or right) she says - I thought it was displaced slightly and he said absolutely nothing about that but to me there seemed to be a bulge there ...
I (Mmm)
JG ... which I wouldn't expect to be there but he said nothing about it ...
I (Mmm)
JG ... so I'd actually be interested to see the report on that x-ray
I Yeah the only problem with A & E is you can't really you can follow up but then you know (pauses)
JG When you've got junior doctors there who don't necessarily know anyway ...
I (Mmm)
JG ... so they're learning as much as you
I It was I mean I thought I might be able to see something but it was a bit sort of blunt as if oh you stupid girl you know ...
JG (Mmm)
I ... he didn't I mean you only find these things out by asking but one doctor yesterday was very on Monday very good he was telling me that (um) the difference between venous and arterial blood gases ...
JG (Mhm)
I ... and the fact that (um) the O_2 should always be higher than the CO_2 ...
JG (Mhm)
I ... and that's when if it's higher if it's too low you know you've usually got venous and arterial ...
JG yeah
I ... and so I thought that was really interesting ...

JG right
I ... and also the SA.O_2 levels should be really high ...
JG Yes
I ... but one of the ones he took it was low ...
JG (Mmm)
I ... so he said I'm going to try it out on one of the others on one of the other doctors so he did and she said oh yeah (laughs) told him sort of teased him a bit because she'd been listening but it was really good ...
JG Yeah
I ... I thought that was really useful not as I need to know but it could be useful looking at them
JG So is that something that you covered in theory did you look at oxygen exchange when you did the respiratory system?
I No (said doubtfully)
JG You can't remember?
I Not really well we did a bit probably but not very much it's really it was interesting because he said you know a lot of junior people don't realise ...
JG Right
I ... so something that you can pick up and practice
JG so might you go back to your physiology books now and look at oxygen exchange again?
I (laughs)
JG No (laughs)
I Yeah probably I think I'd probably find out more about the (um) the thing that girl had the fibrosis thingy
JG Yeah I'm just thinking that that (um) the oxygen level and the carbon dioxide level are something you're going to come across again ...
I (Mmm)
JG ... in your medical ward ...
I Yeah but then I will look it up
JG ... so it now that you've realised the relationship to practice it might be something to follow up
I I do know that you breathe oxygen in and breathe carbon dioxide out ...
JG Right right but if you have a look in a physiology book it will tell you how the oxygen level and CO_2 level changes from arteries to veins ...
I I'd have to learn it all
JG ... right but is it going to be boring now you relate it to if you think about patient ...
I They could be all just boring values ...
JG Right
I ... and not really sort of there's no easy way of remembering it

JG Yes back to your partial pressures
I (laughs)
JG OK (um) what else about admitting that chap (pauses) taking his history, getting all the information?
I (Um) it was confusing in a way because he wasn't actually volitating vomiting (ohh) he was more regurgitating ...
JG Yes
I ... (ah) that and the difference is if you vomit it's all slushed up whereas regurgitation's usually as it went in ...
JG That's right
I ... slightly changed
JG Right so it was important to collect the information correctly wasn't it?
I (Mmm) because when he said he was vomiting it was it was clear fluid and I thought was it clear fluid with fluids and food ...
JG Right
I ... or what so that's why I asked him ...
JG Right
I ... it's like I used the analogy of a sandwich ...
JG Yes
I ... whether it's if he ate a sandwich whether the sandwich came back as it had gone down or whether it was vomit
JG So how did you learn the right questions to ask?
I I'll ask (um) probably they're the two I put it to him in an analogy like a sandwich
JG Yeah but how did you know to ask that, have you seen other people?
I (laughs)
JG It just seemed common sense to you?
I Yeah
JG Right yeah
I 'Cos when he said he wasn't vomiting ...
JG That's fine so you worked it out for yourself?
I Yeah
JG Yes
I He said it was more regurgitation so I thought well ...
JG Yeah (pauses) yes
I It made more sense
JG Yes I thought ...
I Anyway when you see one it's usually got carrots in anyway (laughs)
JG ... what I was noticing was that you weren't just asking a question and getting an answer and writing it down, when you got the answer you were obviously thinking about the answer and then clarifying which is ...
I Yeah

JG ... perhaps something I wouldn't have seen you do a year ago
I No I mean when I wrote something down I thought well hang on a minute better get some more sort of background on to it ...
JG Yes
I ... (mmm)
JG Yes so does that come out at all of the sort of questions people ask you when you've collected information and you go away they say what about this and you realise you need to know more/
I Yeah I mean I've learnt more questions like the thing that have you ever been a patient here before ...
JG Yes
I ... and some other questions which are useful ...
JG Right
I ... which I've included but I mean most of them I mean what I asked him was basically stuff I just went through in my mind ...
JG Right
I ... in no particular order ...
JG Right
I ... I didn't just think oh I'd better ask that I just thought oh well what about that ...
JG Right
I ... I didn't think about it's just how I asked
JG Right so it's so in fact you've absorbed some of the information ...
I (Mmm)
JG ... and it's just ...
I Yeah
JG ... what seemed sensible at the time
I When he said he's been having it for quite a while but he did say he hadn't had anything to eat last night and then he said he had something this morning ...
JG Yes
I ... but usually if you eat something you usually vomit it but if you don't eat something you usually regurgitate it
JG Right so what I saw was you demonstrating not just admitting the patient but you were doing an assessment ...
I (Mmm)
JG Yes you (emphasised) were doing the assessment you weren't collecting the information and leaving somebody else to assess ...
I (laughs)
JG ... you were actually doing that yourself ...
I Yeah

JG ... you know from the sort of questions you were asking, the observations you were making so that suggests you've made quite a bit of progress ...
I (Mmm) I mean when ...
JG ... over the year
I ... we've had people in with (um) sort of MI's and then you sort of oh no (mmm) don't know if I've admitted any lately I don't think I've admitted anybody (laughs) ...
JG (Mmm)
I ... 'cos there's just been the nurses doing it (um) (pauses) you know sort of things like has it happened in the past (pauses) whatever history looking at the doctors letter ...
JG Right
I ... (um) that's why I said to him well when did you have the operation ...
JG Yes
I ... I can't remember which the latest one and he knew which one I was talking about ...
JG Yes
I ... I can't remember the name but (um) I think it's easier to find out what's leading up to it
JG Right and I noticed that was one of the comments I was going to make that you actually read that letter before ...
I (Mmm)
JG ... you went and admitted him so that ...
I It was interesting as well
JG ... you already had some background information
I Yeah
JG Yes
I You also know more about the patient ...
JG Yes
I ... 'cos when I didn't really know what dysphagia was I thought I'd better look it up ...
JG (Mmm)
I ... better look at the letter to see what it was ...
JG Right
I ... also the letters it's interesting to see whether you can actually read them or not ...
JG Yes (laughs)
I ... (laughs) that one I couldn't
JG Yes some of the writing was (um) very difficult to read (laughs)
I I had a really good doctors letter one day it was so nice neat and tidy ...
JG Yes

I ... amazing
JG Must have been a woman doctor
I I think it was actually
JG Yeah (laughs)
I (laughs)
JG Yeah they tend to write more neatly ok right (um) just before we leave the EBS bit although we weren't working in the observation ward but you sort of a bit on the edge about that girl who was just discharging herself
I Yeah because it had abdo pain I thought well perhaps it's appendicitis it might perforate ...
JG (Mmm)
I ... 'cos she'd got S for surgery ...
JG (Mmm)
I ... I presume it was her because ...
JG Yes
I ... I looked at all the other aches and pains and I thought well it doesn't look like any of them ...
JG Yeah
I ... and (um) 'cos that's why I said to her oh do you know is it (um) appendicitis 'cos I thought well if it's appendicitis and it might burst ...
JG Yes
I ... infection and God knows what else
JG Do you think she looked very ill?
I No she looked quite well
JG She looked quite well did you hear what the doctor said about the x-ray or were you in the other room?
I No I didn't
JG As the doctor came back after she'd looked at the x-ray and said well the only thing it shows is constipation
I Well (exclaimed)
JG So (uh) that may well be the cause ...
I Yeah
JG ... of her abdo pain
I I mean she'd been there for four hours that's not bad going ...
JG It's not
I ... I did feel like saying well I'm sorry but four hours is nothing really compared to some people
JG And in fact the staff nurse did say that to her ...
I Yeah
JG ... just after you'd gone to see to that other patient
I What did she say just sort of four hours is enough?
JG She just she'd just had enough she wanted to go

I Well yeah I mean fair enough the doctor didn't know very much about fibro-myealgia but then again a lot of the doctors wouldn't ...
JG (Mmm) that's right
I ... like when we were on paeds and we had that little boy with Angelmans ...
JG Yes
I ... were you there?
JG Yes I was
I Yeah and hardly anybody knew anything about it and well you need these sort of people to be able to tell you what it is
JG That's right that's right what about the mother's attitude to that girl?
I I think she thought that she was a bit daft ...
JG Yeah
I ... going ...
JG Yeah
I ... 'cos she said oh well I am her mother and then the nurse did point out well she's over 18 ...
JG Yes
I ... but I think it's quite hard because I think the mother wanted to get it all sorted out I mean the girl did but she didn't couldn't be bothered to stay around
JG Yeah ok yes I think I just picked up that she wasn't really feeling that bad ...
I No
JG ... and I wondered how much of it was a bit of attention seeking to start with but she just got bored ...
I Yeah I think ...
JG ... sitting around
I ... I mean for five hours four hours is not bad waiting ...
JG it's not
I ... especially in there and it's not bad in there I mean it's not as if it's hectic and all that sort of stuff ...
JG (Mmm) ok let's let's go back to the clinic because that was a very much more interesting ...
I (Mmm)
JG ... morning than I expected it to be ...
I Yeah it was for me
JG ... really yeah
I Especially the girl with the burns
JG OK what do you think you really learnt out of this morning?
I (Um) (laughs)
JG What have you gained personally?
I (ha ha) try and organise your doctors

JG Yes that's a good point because she did organise him in the end didn't she?
I (Mmm)
JG I mean she was tolerant but she did organise him
I I thought I made quite a good suggestion put him in a chair and just wheel him up and down (laughs)
JG Yes (laughs)
I 'Cos I mean that's really what he wanted
JG Yes
I I mean a lot of them could have actually just been seen for 5 seconds to say well we need the plaster off ...
JG Yes
I ... and then go and do something else I thought he was a bit (pauses) I don't know (um) sarcastic about when that boy with the head injury ...
JG Yes
I ... with the (um) stitches ...
JG Yes
I ... I mean she was trying to get them out and he was being quite sarcastic about it ...
JG Yeah
I ... rude I thought well excuse me but there are small
JG Yes and they'd been put in much too tight ...
Yes
JG ... and they'd certainly cut through ...
I (Mmm)
JG ... and they hadn't served as stitches at all the wound was still open
I I felt like saying well you do it then because I mean he should have appreciated the fact that it was a lot of blood on the top that had all scabbed on as well
JG Yes I mean unfortunately he's going to have quite a scar there ...
I Yeah
JG ... because of that having happened when you get the scab formation you're more likely to get the scar ...
I (Mmm)
JG ... so which is a shame but it looks like he perhaps wasn't advised properly in the beginning ...
I No
JG ... to keep washing the blood away and I was just concerned when his mother said to start with that it keeps bleeding and I thought well that doesn't sound right
I Yeah when she said that I thought ooh it's not supposed to do that ...
JG Yeah

I ... I think he was actually quite worried he was very worried about it I think the doctor made it worse ...
JG Yes
I ... and I know he's (um) she said she'd got he'd got good bedside manners with patients but in that case I don't think he had
JG Right what about the way the staff nurse handled it?
I I think she handled it very well diplomatically ...
JG Yes
I ... saying that you know the stitches hadn't worked they'd been put in too tightly and with giving the reasoning behind it and saying he would have to have more stitches in
JG (Mmm) yes and again we had a mother there that that mother wasn't quite as anxious as the one this afternoon ...
I No
JG ... and she was sitting back and letting the nurse and doctor ...
I I think she was laughing at she was a bit she was worried ...
JG Yes
I ... but she I sort of smiled at her when I walked past ...
JG Yeah
I ... reassure her that ...
JG Yeah
I ... well even just smiling even if you don't say anything
JG What else did you learn this morning?
I (Um) (pauses) the different oh I mean I saw the different types of bandaging again ...
Yes
I ... also the thing with that future thingy
JG Yes futura splints
I Yeah
JG And making the thumb extension
I 'Cos a lot of I've worked with a couple of children with rheumatoid arthritis that had them ...
JG Yes
I ... (um) a Downs girl she had it on her fingers and she wouldn't wear it and unless I told unless made her put it on ...
JG Right
I ... she'd wear it for me but no-one else ...
JG (Mmm)
I ... I mean they don' look that painful ...
JG No no they don't they support
I ... yeah I mean when she said they don't put them on children ...
JG Yeah
I ... I thought in some ways there a lot nicer ...

JG Yeah
I ... than having tubigrips...
JG Yeah
I ... but then again a lot of people wear them because they make them rely on them too much
JG Yes the OT was quite good when ...
I (Mmm)
JG ... she was teaching you what she was doing wasn't she?
I I was really put off and then that's really amazing when it goes back to white again that was really interesting ...
JG Yes
I ... not the sort of thing you get to see often 'cos I wondered what the hairdryer was doing there ...
JG Yes yes
I ... and the pan of water
JG Ok yes and she made it possible for you to ask questions didn't she ...
I (Mmm)
JG ... I mean she invited ...
I Yeah
JG ... questions from you which was helpful and the patient seemed to enjoy it ...
I Oh yeah
JG ... because he was learning as well
I Oh yeah I mean it's like my mentor said it depends who the patient is she was telling me something over a patient and she said (um) 'cos he'd been in quite a few times and well she said oh he doesn't mind me saying this because he's been in before and knows what the score is ...
JG That's right
I ... which I mean she was assuming but then again she knew him ...
JG That's right
I ... to a certain extent
JG But again even just going back to that admission you did I said a few things over the patient because I could see that you he'd been asking questions while you were out ...
I (Mmm)
JG ... and he wanted to have some idea as to what was going on ...
I (Mmm)
JG ... so I thought I wasn't going to say anything nasty or ...
I He did look he did look worried but then again it was all stuff that was useful wouldn't scare him
JG That's right and you know at least it's not such a shock then ...
I (Mmm)

JG ... when the doctor comes in and says I need to do so and so ...
I Yes
JG ... I think just explaining why they're doing the investigation ...
I (Mmm)
JG ... is really important to the patients
I Yeah I found that boy that came in with his I presume it was his mother the one who'd broken her arm ...
JG Yes
I ... on the ice ...
JG Yes
I ... I thought God what an arrogant sod ...
JG Yes
I ... 'cos he kept going God to you have to keep moaning shut up woman get out of here (mimics his tone of voice) ...
JG Yes
I ... and I thought well you know she's in pain she may be in pain you know
JG Yes (pauses) yes she obviously needed him because she was one handed but (um) ...
I (Mmm)
JG ... he struck me that he was going through typical adolescent ...
I (Mmm)
JG ... puberty (laughs)
I Get lost yes (mmm)
JG When he grows up he'll be fine (laughs)
I (Mmm)
JG Yeah ok one of the other things I noticed you did today (um) firstly M took off a backslab and then she let you do one ...
I Yeah
JG ... yeah so how about that?
I Oh I've cut plasters before ...
JG Right
I ... when they let me loose at *** hospital cutting plasters not with patients in them ...
JG Yeah
I ... and I felt confident in doing it because I'd already had a go at cutting one but it was completely different because I couldn't get the scissors through (laughs) it was really embarrassing ...
JG And I had the concern that she said to you use the scissors this way and I thought no that's not the right way up but I didn't want to say anything in front of the patient ...
I (Mmm)
JG ... that's why I quietly said it to you afterwards

I Yeah because I've seen them using them the other way round
JG Yeah because I would understand the flat bit to be ...
I (Mmm)
JG ... to go along the skin so that you don't ...
I It struck me because where she cut that wound
JG ... yes that's right so you don't injure the patient
I (Mmm)
JG Yeah
I But I mean I held it up anyway with my finger
JG Yeah yeah
I But then the patient kept ripping the tubi-grip and made it harder to cut it
JG Right do you is it helpful to actually take it off yourself and just feel what it's like to unbend that?
I (Mmm) I felt a thicker plaster you know ...
JG Yes
I ... a full cast not quite light it was quite easy to cut as well with the drill but I thought ooh it's going to go down on it so
JG Yeah ok so that was a helpful experience and (um) the little girl who screamed her head off
I (Mmm) don't
JG (laughs) still hear the screams
I I felt so sorry for her ...
JG Yeah
I ... I felt surely that when they said oh a pot of water I felt surely it couldn't have been that it must have been more to get that amount of burns (pauses)
JG Yes because she had both legs burnt ...
I (Mmm)
JG ... and the father had quite a big burn ...
I Well she had a little burn on the one side and the other one was well when they burst the blister I thought oh God I mean like you said you thought it was going to go everywhere
JG Yes I thought it was going to squirt ...
I (Mmm)
JG ... and it just didn't yeah
I I don't know whether it means that it's healed better or whether it's not
JG Well there's obviously the the tissue fluid has being produced in there has ...
I (Mmm)
JG ... gone like jelly ...
I (Mmm)

JG ... that's all I mean that fluid is keeping the skin underneath ...
I Moist
JG ... moist etc but obviously the blister bit on the top that was dead skin ...
I (Mmm)
JG ... which is what M was saying therefore it didn't hurt when she stuck her needle in ...
I (Mhm)
JG ... because it was dead skin but it was more of the child being frightened of ...
I And also the fact that it was a needle and also I think she didn't like the sight of it ...
JG ah
I ... because she kept saying take it away
JG Do you think that looking at the wound actually brings back it happening to her and is it that that's making her scream?
I Yeah probably
JG Do you think she remembers the pain of that happening?
I But I think it's the sight as well ...
JG (Mmm)
I ... because she put her mum when we saw her ..... as well she grabbed her mum's hand and put it over her eyes ...
JG Yes
I ... but (um) I think she liked I think she liked my expression of it was like lemon jelly ...
JG Yes
I ... she laughed ...
JG She laughed
I ... but then she promptly started crying again
JG So did you find that that time that you experienced in paediatrics was actually helping a little bit because you didn't get too phased by her screaming her head off whatever?
I (Um) I think I was more interested in looking at the burn itself ...
JG (Mmm)
I ... also trying to keep her occupied because I know that's when it's hard ...
JG Yeah
I ... when I said to her think of the thermometer ...
JG Yeah
I ... you know as a lollipop and suck it ...
JG Yeah
I ... I mean it's hard actually when the parents are there like that ...
JG Yeah

I ... and the parents they speak two languages ...
JG Yes
I ... 'cos you don't know how much the child understands
JG That's right it struck me that you your communication skills you were actually using the language you'd used back in paediatrics ...
I (Mmm)
JG ... you automatically fell into that
I Yeah
JG Yes you didn't feel conscious of it?
I I used it with K as well (laughs)
JG Yes right (laughs)
I That was quite I mean it was you did sort of feel yourself thinking well what's appropriate
JG (Mmm)
I I don't think the mother understood the (um) when I said to her well how come you escaped ...
JG Yes yes she didn't ...
I No
JG ... give you an appropriate answer did she?
I No I don't think she understood
JG Ok and then you went in the plaster room ...
I (Mmm)
JG ... with the little boy having a plaster
I Oh God it was all shush shush shush ...
JG (laughs)
I ... get your hands off that plaster before it gets stuck everywhere
JG (laughs)
I It's like what I said to the mother it's like cats and dogs ...
JG Yes
I ... whenever you get a bit of paper or a bit that's just been cemented they always have to walk in it ...
JG Yes
I ... have to have their fingerprints
JG He was copying the plaster technician ...
I (Mmm)
JG ... 'cos he watched him moulding it and he just wanted to push and see if it it moved
I I don't blame him though ...
JG Yeah
I ... 'cos it's quite interesting to feel it I mean have you ever had wet plaster on ...
JG Yes
I ... it feels really quite nice

JG Yeah
I Sort of goes everywhere (um) the other thing was that other girl with the burn ...
JG Yes
I ... I mean she was completely different ...
JG Yes
I ... but it was I mean there was a girl screaming last week and she wasn't anything like her you know ...
JG Yes
I ... it had healed really well 'cos I expected there to be blisters on that little girl and I think the shame is that they'll both have scars there ...
JG Yes
I ... different colour skin especially with the coloured girl because she was slightly coloured anyway ...
JG Yes
I ... I mean that the other girl surprised me how she was embarrassed about it
JG Yes she was embarrassed in fact by the pinkness ...
I Yeah and also her flaky skin ...
JG ... against her brown skin
I ... and I don't blame her for the flaky bit
JG Yes it was so horrid
I (Mmm)
JG And I think the quicker it's off the better for her
I She's (um) I don't I would agree with her I would want to pick them all off ...
JG Yeah
I ... get rid of them the quickest
JG Yes so although she was young her self-image was already quite important to her wasn't it?
I (Mmm) that's why I was quite surprised 'cos I said to her you know you like people to go round sort of saying oh you are brave and it was oh no it's horrible ...
JG Yeah
I ... and it surprised me in a way there was quite I mean she was quite precocious (laughs) ...
J She was she was
I ... she ..... of them didn't she?
JG Yes and the way she behaved you'd think she was older
I (Mmm)
JG Yes
I I suppose that does make people grow up in some ways
JG Yes and she'll have to adapt to having scars there because ...

I (Mmm)
JG ... she will have some scars on her...
I Oh yeah
JG So really it's been a day of real contrasts hasn't it?
I In a way it has been it has been interesting but the last few hours has just dragged (laughs)
JG Yes
I The last two hours was like you know it felt like (yawns) walking in a swamp or something
JG Just to just to finish off then Isobel you started this morning talking to me about how you felt about the cardiac arrest ...
I Yeah
JG ... the other day do you want to talk about that a bit?
I It was interesting and then the one of the staff nurses asked me if I wanted to do the (um) cardiac massage but I said no because I haven't seen one ...
JG Right
I ... and I wanted to be an observer of it rather than participate ...
JG (Mmm)
I ... I didn't really want to participate (laughs nervously) anyway ...
JG Right
I ... you know it just felt a bit funny ...
JG (Mmm)
I ... (um) it seemed like they were going on for quite you know about half an hour even longer ...
JG (Mmm)
I ... but (um) they had one doctor in charge and he said I think we'll just go for another five minutes ...
JG (Mmm)
I ... well she was with me for most of it but she was actually finished working but she went to see the patient's wife
JG Right and at the time you were resuscitating him were people aware then what his past history was or was it just ...
I Yeah they knew they knew
JG ... that he came in they did yeah
I That's why they didn't carry on for long
JG But did they know right at the beginning or was it that ...
I Oh yeah oh yeah they knew right at the beginning
JG They did yeah
I (Mmm) I mean they I don't know if they knew very at the beginning or whether the ambulance came in I think that when the ambulance men came in with him they said oh he's had three previous MI's before
JG Right

I I mean to me it didn't look as if they were trying very hard ...
JG Yeah
I ... it may have just been because I have never seen one before in real life you know when you see them on TV they're like uhh uhh uhh ...
JG Yes
I ... but it was quite sort of like relaxed ...
JG Yes
I ... in a way
JG Yes right but they're used to doing it ...
I (Mmm)
JG ... so they look relaxed
I They know the patient's already been in ...
JG Yes
I ... dying not dying in some ways I wish I had done the CPR I mean I'm glad I didn't because I think I wouldn't have seen so much
JG Right so what did you do did you just stand and watch?
I I just stood and watched tried to ...
JG (Mmm)
I ... there was another medical there was a medical student there who they asked her if she would do the (um) defib and she was (laughs) looked you know I mean it was quite nice because she actually looked at me as if to say oh God what am I doing ...
JG Yeah
I ... and I sort of smiled back and it was nice it was really nice that just that moment ...
JG Yes
I ... 'cos you actually felt as if someone knew someone else knew how you were feeling ...
JG Yes
I ... yeah but I know I've hardly used CPR I knew that when she'd done the defib I'd probably still be standing nearby and got shocked (laughs nervously) ...
JG Yeah
I ... but (um) it was it was interesting
JG Yeah how did you feel when it was over?
I (Um) oh I nearly cried ...
JG (Mmm)
I ... but I mean I've got I thought you know you get to the point when you I thought there's someone's going to say something to me I'm going to start crying ...
JG (Mmm)
I ... so I just like my mentor said are you all right I went (mmm) (mmm) then she goes oh do you want to come in with me and tell the relatives

and I went oh God no way no way (raises tone of voice, sounds frightened) ...

JG Yes

I ... I thought that would be the worse thing 'cos I would just start crying and ...

JG Right

I ... to me that would seem really insensitive 'cos it was this woman's husband ...

JG Yeah

I ... nothing to do with me ...

JG yeah

I ... I would have felt quite bad actually crying when I didn't even know him

JG Right so it was an emotional experience for you?

I (Mmm) I mean one of the staff nurses had said to me have you ever laid someone out before and I said well yeah hope that I didn't say only one person ...

JG (Mmm)

I ... and it was really different then from someone who'd just died that moment ...

JG Yes

I ... (um) sort of you know took his clothes helped take his clothes off and actually washed his hands so that they were nice and clean if I went in to see like a relative ...

JG Yes

I ... I'd like to see them nice and clean so that's I did it how I'd like to ...

JG Yes

I ... and his tongue was sticking out slightly so I managed to put my finger in ...

JG Yes

I ... pull it down and then close it so he actually looked a lot better ...

JG Yes

I ... looked quite peaceful (um) and then I went back probably about an hour or two hours later ...

JG Right

I ... just to see him and he actually looked very a hell of a lot more peaceful 'cos his face had gone back to a normal colour ...

JG Right

I ... not a normal colour you know ...

JG Yes yes

I ... but a better colour than it was 'cos you know ...

JG Yes

I ... it was bright like the colour of your jacket (deep pink) ...

JG Yes
I ... and it looked sort of natural
JG Right so that made you feel better?
I (Mmm)
JG How else did you deal with your feelings?
I I cried ...
JG Yes
I ... 'cos my mentor asked me if I was all right and she put her arm around me and I just started crying ...
JG Yeah
I ... which was nice you know that's why I thought of doing something on how student's are supported during death (for research project) ...
JG Yes
I ... 'cos I did feel I felt you know really alone ...
JG Yes
I ... during it ...
JG Yeah
I ... so you know my mentor went off and I thought well I would have really liked her to be there ...
JG Right
I ... all the time which I know is selfish when I know the mo.... you know the patient's wife was sitting in the relative's room ...
JG Right
I ... (um) I think it was actually it was different to what I expected completely different I didn't think I would cry
JG Right right it's not a bad thing to cry
I Oh no I mean I said to her I was crying for him but then I think it was the situation that he had actually died and he and his wife had had an argument ...
JG Yes
I ... when I was cycling home I thought you know whenever I see someone that's died or heard someone's just died I think God I'm glad I'm not married or I don't want to get married because ...
JG (laughs)
I ... you've got to put up with someone dying really close ...
JG Yeah
I ... I mean they'd be married say what about forty years ...
JG Yes
I ... at least
JG Right so he was a real person to you although you'd never met him before?
I Yeah it was sad
JG (Mmm)

I I mean he looked like a drunk at first because he'd been gardening ...
JG (Mmm)
I ... possibly got called a drunk never mind but I mean found out he'd actually crashed his car while having the MI ...
JG Yeah
I ... he'd spewed the ambulance men had done CPR and he'd spewed ohhh ...
JG Yeah
I ... which I thought was ohh
JG Yeah so how about next time Isobel now that you've had that experience?
I I'll probably do the cardiac massage
JG Yeah you feel you've you could go along and do it now?
I I feel I could do it now yeah
JG Yeah
I I've ..... now
JG Yeah and so if you have another one while you're still here and it's not successful how will you talk it through with somebody afterwards?
I I shall go and look I mean I talked to one of my friends by phone ...
JG (Mmm)
I ... when I got in I told her what had happened ...
JG (Mmm)
I ... and I actually felt much better talking about it then ...
JG Right
I .... because it was after ...
JG Right
I ... at the time I felt really sick shake and you know ...
JG Yes
I ... just felt awful kept going through oh you're all right and that ...
JG Yeah
I ... it's just seeing your first cardiac arrest I mean it is a shock ...
JG Yes
I ... and I think people appreciated that
JG Do you think sharing that experience with your friends has helped them as well?
I Yeah I mean one of my friends her sister works in is a secretary and she works in an Accident Department in *** ...
JG Yeah
I ... she sees a lot as well ...
JG Yeah
I ... and she said oh yeah my sister said they were a bit like that ...
JG Yeah
I ... (um) I think it I mean it helped talking to other people about it ...

JG Yes
I ... I think if it happened again I'd rather I'd like to lay them out again ...
JG Yes
I ... 'cos it made me feel as if I was doing something for them
JG Yes and certainly it sounds like going back to see him again afterwards helped you ...
I Yeah
JG ... because you were able to reassure yourself that it was very peaceful ...
I It was the worse ...
JG ... after seeing ...
I ... the worse thing was when I was like cleaning his hands I kept thinking he was going to jump off and ohh ...
JG Yeah
I ... I kept thinking he was alive and it was a horrible feeling ...
JG Yeah
I ... I mean ...
JG Were you by yourself?
I Some of the time yeah ...
JG Yeah
I ... 'cos the (um) staff nurse had to fill in the coroner's report and stuff like that ...
JG (Mmm)
I ... (um) but the first person I'd actually found dead I couldn't cope and it was the matron had had a go at me about it ohh and (um) I went back to see her later to see how she looked ...
JG (Mmm)
I ... she looked horrendous ...
JG (Mmm)
I ... but at least I went back ...
JG (Mmm)
I ... 'cos this guy actually looked a lot better ...
JG Yes
I ... he looked younger ...
JG Yes
I ... 'cos they say the wrinkles all go and that
JG Yes ok so at the end of it it was a useful experience ...
I (Mmm)
JG ... I'm not going to say a good one (laughs sympathetically)
I I felt glad afterwards I'd actually helped lay him out ...
JG Yes
I ... it made me feel more better about it 'cos you know I was worried for his relatives and that

JG Yes right and the staff nurse had a difficult choice she had the relative and she had you ...
I (Mmm)
JG ... but I mean she ...
I And she was off duty
JG ... effectively she had to go and look after the relative ...
I And she was off duty as well
G ... and she was off duty yeah
I It was a call beyond the line of duty (laughs)
JG Yeah (laughs) ok but somebody picked you up fortunately
I Oh yeah she did come back and talk to me about it ...
JG Yeah
I ... in the morning (laughs)
JG Ok I think that's covered everything I've got written on my list but is there anything you want to talk about?
I (Um) I mean just the incident with the sharps ...
JG Oh yes
I ... I thought that was quite important ...
JG Yes
I ... I mean she was walking along with a needle (laughs) ...
JG Yes
I ... and I could have quite easily have walked into it ...
JG That's right
I ... anybody could have done ...
JG Putting you at risk
I ... I mean ...
JG Are you going to do anything about that?
I No because I mean I didn't really could just be a one off with her ...
JG (Mmm)
I ... I really did feel like I was sort of doing something distracting at the time I thought I should have actually said to her excuse me would you could you cover it up ...
JG (Mmm)
I ... I mean afterwards it's taking the staff if I'd told one of the staff nurses off for taking for going along with ...
JG Right
I ... with (um) not getting rid of his needles ...
JG Yes
I ... I felt embarrassed I felt really bad about that but ...
JG Except you're using your knowledge ...
I (Mmm)
JG ... and you know that you're right
I And we're told to sheath to cover our sharps up ...

JG That's right
I ... or keep them in the little blue tray
JG Perhaps you could just you know nicely not nastily sort of say to * I don't know if you realised this but you threw away a needle that was not covered ...
I (Mmm)
G ... earlier
I Could do yes
JG Just nicely point it out and make her aware
I But I mean she wasn't even carrying it the tray I mean I wouldn't mind so much ...
JG Yes
I ... if she was like carrying the blue tray ...
JG Yes
I ... because when I finish with them if I'm doing tetanus I usually put them back in the pot they came out of
JG Which suggests she's a bit blasé about it
I (Mmm) thinks she's a gladiator (laughs)
JG But the other thing is if you don't want to confront her is just to say can I come with you while you're doing that one can you tell me about the health and safety side of it ...
I (laughs)
JG ... you can make her tell you
I It would be assertive
JG Yes
I ... cover up your needles
JG Yes you can be assertive or manipulative ...
I Yes
JG ... one or the other make your choice
I Only it's hard 'cos you think oh I should know her a bit better before saying anything
JG But it also shows the depth of your knowledge ...
I (Mmm)
JG ... and your awareness and you won't do that ...
I Yeah hopefully well there's I'm sure there's an occasion when I will
JG Yeah well ok yeah anything else
I No bedtime
JG Bedtime ok that's fine thank you very much it's been a good day

PhD Fieldwork Interview

Year 3 : September 2nd 1996

Ruth : Early Duty (07.30-15.30 + reflective interview) - elderly/medicine, 8th week of final branch placement, semester 6.

Staffing : S/N, BSc student and 2 X HCA for Red Team (12 patients + admission)

JG *Fine talk to me about today and what's been happening*
R Today has felt really disjointed to be honest it's been a not a nice shift in a way it's been it just seems to be so bitty today and it's been hard, although I'm meant to be team leader it's been very hard to co-ordinate what on earth's happening, for a start getting everyone together today has been a nightmare (laughs) and to try and do anything with ...
JG (Mmm)
R ... I mean there has been some things I've had the advantage of being I went to the first social round ...
JG Yes
R ... which I thought was a waste of time when I was there as I said to you because it wasn't a social round and I was actually thinking oh good we can you know get to know what happens and I was quite enthusiastic but once I got here I thought it's not worth actually writing anything down 'cos this is just like the doctors round you know like ward rounds again so what's the point in this really I just thought it was a waste of time (laughs) and then I suppose going on the doctors round this morning was good 'cos that was like reminding yourself again about your person it was like getting to know the patient again ...
JG Yes
R ... from why they'd come in 'cos sometimes it easy to forget with all the investigations why originally the patient's sitting there in front of you what exactly they're presenting with so that was good and I didn't feel too scared although I felt a bit worried about it
JG Fine was that the first time you've done a Consultants round?
R For a long time I've done a Consultants round with someone else next to me but not alone ...
JG Right
R ... so I was a bit worried that I was going to get questions fired at me that I wouldn't know the answer to I could see me going oh my god you know ...

JG Yeah
R ... don't ask me a question but as it was it was fine it wasn't too bad ...
JG Yes
R ... at all really
JG Yes and when you did get a question you didn't know you just went away and found out
R Yeah
JG Yes
R That's good I suppose (laughs)
JG Right yes it was all right yes
R (Mmm)
JG OK
R What else happened today thinking back to instances I did that admission on that patient ...
JG (Mmm)
R ... which was quite nice because it makes a change that you can take someone away from the business of the ward and it was quite relaxing for that admission ...
JG Yes
R ... and I had time just to sit and talk and talk for a little while again I it's just been almost like a rush today I haven't there's been able to give what I wanted to there's been a lot I would like to do ...
JG Yes
R ... and I feel like I've compromised on things today like for example someone's pain one of the ladies pain who's not one of mine up in bay 5 ...
JG Yes
R ... you know I would have liked to normally it's like oh what sort of pain is it how long have you had it for and I'd love to say all this but today I've just found with the extra pressures of trying to get ...
JG Right
R ... knowing there's an admission down the ward and I mean I suppose this is real life really ...
JG Right
R ... and you have to put a bit of prioritising ...
JG Right
R ... so I suppose today it was a bit about what is important ...
JG Yes
R ... you know sitting there and stopping I had to stop a couple of times just think hold on here you're going too fast slow down what's important so ...
JG Right
R ... they made me think about that a bit

JG Right so you were managing yourself?
R Yeah basically (laughs)
JG Thinking on your feet
R Yeah trying to
JG Reflecting in action
R Well yes I suppose so (laughs)
JG (laughs)
R And also like it's funny like even when I was doing the doctors round I was really concerned that people got breaks you know ...
JG Yes
R ... it was like J have you had your break you know and all this ...
JG Yes
R ... and it just seems like so much to do at once and I was thinking goodness in a few weeks time this is going to be for real you know this is like play acting at the moment you're role playing and ...
JG Right
R ... now this is going to be the real thing but yeah I mean I sat down and I felt that I was trying to prioritise and organise things
JG Yeah
R ... which was quite a nice feeling ...
JG Yes
R ... knowing that it actually worked out I suppose in the end it wasn't too bad and nothing untoward happened
JG Right so looking back on the day now is there anything you would change?
R (pauses) I'd like well I would change in the fact that I would like to have spent more time with certain individuals ...
JG Right
R ... today (um) take Mr G I would like to have spent more time with him today ...
JG (Mhm)
R ... because I think he needs a lot of input and perhaps a lot more stimulation than he's getting now 'cos it's all right us saying he's like he's confused or whatever and he's just sitting there but really we haven't really given him anything to stimulate him ...
JG (Mmm)
R ... we've left him as such ...
JG (Mmm)
R ... and I suppose yes I would have liked to have sat with him ...
JG Right
R ... probably have talked more, communicated to him ...
JG Right

R ... (um) trying to think if there's anything different (pauses) I mean some of the social round I wish sometimes I was a bit more knowing a bit more knowledgeable about certain things with the patients you think you know everything ...

JG (Mmm)

R ... or a lot of things ...

JG (Mmm)

R ... and you always there's always someone picks up on something you don't know and it makes you feel really inadequate like oh no I don't know that but then you have to remind yourself that you do know a lot more than they're asking you about this one certain thing

JG Right so thinking back to the beginning of the day would you have delegated the patients any differently, thinking of the staff you had in the red team?

R Perhaps because I don't know though 'cos we had heavies the trouble is we had heavy people at our end ...

JG Right

R ... (um) bay 5 and heavy people in bay 1 ...

JG Right

R ... perhaps if in bay 1 there wasn't a heavy person in there I perhaps would have gone down there myself and got the auxiliaries to have gone up in bay 5 ...

JG Right

R ... which would have left me ready to do ward rounds an easier thing to leave as such ...

JG Right

R ... I think I would have done that more than likely like if there wasn't a gentleman down there who needed them because then I suppose it's hard to get away from someone who's dependent like if we were in the middle of Mrs P and the doctors came ...

JG Yes

R ... that's quite difficult to get out of really you know you can't really just leave Mrs P (laughs)

JG Yes I was wondering about the 2 auxiliaries working together whether in retrospect you might have said 1 auxiliary with the staff nurse and 1 with you and whether that would have allowed you to get away when the doctors came ...

R Perhaps yeah

JG ... a bit more

R Yeah perhaps it would have done

JG (Mmm)

R Yeah

JG Really 'cos with both of you (um) because the staff nurse looked after the other Consultant ...
R (Mmm)
JG ... you were both in a position that you needed to be able to get away ...
R We need someone to back us up really
JG ... so maybe although the auxiliaries like working together it might have been better to have split ...
R Yeah
JG ... them up
R Yeah I think sometimes I'm a bit of a diplomatically does it and then I think well they were working together already you can carry on if that's what makes you happy ...
JG Yeah
R ... it's almost like if someone says lead a team I think my always first question is well what would you like to start off with I haven't got used to like being able to delegate straight I suppose it's quite good it's diplomatic I suppose
JG It is but then are you giving nurse centred care or patient centred care?
R Yeah that's the problem isn't it you should be thinking what's going to be best for your patients
JG (Mmm)
R Yeah 'cos you try it's hard because you're trying to sort out your team ...
JG right
R ... and you're trying to co-ordinate your team as in your nursing so everyone works well together 'cos you need to well integrate your team that's one thing ...
JG Yes
R ... I've definitely learnt ...
JG yes
R ... but also you need to have the best for your patients ...
JG That's right
R ... so you've got to have like a jigsaw and match them up and try and make them equals you know good patient care
JG Yes that's right because with the two auxiliaries working together you inevitably divided the patient care into tasks a bit ...
R (Mmm)
JG ... because there were some things they couldn't do for patients ...
R That's very true
JG ... so then ...
R Yeah that's true actually
JG ... you went to a bit of task orientation didn't you?
R Yeah which is what I'm against so I shouldn't do it

JG That's right either you or the staff nurse were going in and doing their drugs and whatever else instead of doing holistic care
R That's true
JG Yeah
R Yeah 'cos like Mrs P we could do everything for really ...
JG Yes
R ... couldn't we?
JG Yes yeah ok ok yes just going back to the very beginning of the morning I was interested that S who's the new student just attached himself to us because we were sat having report from the night staff ...
R (Mmm)
JG ... so he's not been here long enough to know the way that this ward works ...
R No
JG ... and then he got sent away ...
R I know he's rebelling ...
JG ... how were you feeling at that point when he got sent away?
R I almost felt like I don't know I thought at first we were all sitting there and I was thinking I was quite happy that I was included in on it and I wasn't sent away myself so at first it was oh good I'm not going to be sent away and I'm actually appreciated here ...
JG (Mmm)
R ... so it was that at first and then when S got sent away I thought he's going to have to learn I suppose (laughs) I suppose I felt I feel frustrated for him because I look at him as a first year student and I think you know he's following again like a sheep almost ...
JG Yes
R ... and I'm feeling like I said to him at dinner time he came in with me at dinner time and I just said to him if you want I know I'm not in your team but if you want anything ask me you know I'm quite willing to tell you and he just said oh yeah I just feel like at the moment I don't really know what's happening today and I just felt really sorry for him I was thinking god I know exactly what you're feeling you know you feel really stupid when you're a first year and you're really afraid to ask absolutely anything you know and you're treated he hasn't like you have to know the ward rounds the culture of the ward as such and he doesn't know any of that even ...
JG (Mmm)
R ... just to even be able to fit in ...
JG (Mmm)
R ... and I was I don't know I'm a bit I was ashamed I think it's a shame for him that this is his first ward really because he's going to find out

really he's going to think this is normal on an adult ward when it's not really this is a bit ...

JG Although he's quite assertive because a little while ago I was with him when we'd just put Mr G on a commode and one of the auxiliaries came and told him to do something else and he said I'll come in a minute we're doing something else now ...

R (Mmm)

JG ... and so he said no you know ...

R Which I'm glad yeah if he carries on like that he'll be all right

JG If he hadn't had me stood next to him he might not have been able to say no but because I was stood there ...

R (Mmm)

JG ... he obviously felt he could say no you know

R It's funny though ...

JG Yeah

R ... I've never it's funny having a first year on the ward because you do make comparisons all the time ...

JG Yes

R ... I'm looking at him thinking did I used to be like that?

JG Yes

R Is that what I used to do did I feel that way and you can almost feel you feel like unnerved for them as well ...

JG Yeah

R ... because ...

JG So it makes you realise how much you've learnt?

R Yeah I think so it's nice in a way 'cos you think cor I know that and it makes it highlights your own strengths sort of thing ...

JG Right

R ... but also I don't know you learn I suppose it's about empathising for your fellow students you really do and hopefully that will make you when you start teaching as a mentor myself it will make me appreciate things more 'cos I still feel very much for him and feel you know know how he's going through I think ...

JG Yeah yes that's good my impression of today was very much that you were acting as staff nurse it was quite a different experience really from where we started last week because today you were just the team leader right from the start and nobody as you say nobody questioned nobody suggested you shouldn't sit in on the night report ...

R (Mmm)

JG ... so you very much took that role on and acted it out which was good experience ...

R (Mmm)

JG ... so for me your learning opportunities today have been management ones and I think it's ...
R I think so
JG ... reflecting back on that and thinking what have I learnt about management today ...
R I think that's more it
JG ... as opposed to what you learnt about care
R Yeah because the care's just been the care I've been giving all the time ...
JG Yeah
R ... whereas the management thing yes I realise I've sat in report ...
JG Yeah
R ... you know holding myself back from doing things and I really had to stop myself sometimes I feel like I run like a bull at a gate wanting to do everything 'cos I'm so enthusiastic sometimes I just want to get everything done and ...
JG Yeah
R ... and you know finished and fitted into the everything should be done in the morning ...
JG Right
R ... I'm always programmed into that really I just want all the patients to be happy and wonderful (laughs) but you know I stop I do have to stop myself I realise now I'm going to have to stop and say delegate a few things if I'm going to be a staff nurse 'cos I'm going to ..... myself out (laughs)
JG Right so it's been a good experience really you've learnt quite a lot today
R Yeah I suppose so yeah in retrospect 'cos I was thinking when I was thinking oh Janice is going to do this interview I was thinking well what exactly have I learnt ...
JG (Mmm)
R ... and I was thinking I don't really know you know I couldn't actually pick up anything ...
JG (Mmm)
R ... in itself but you say that yeah
JG Yes I mean just thinking of where you initially started that you didn't feel it had been such a good day but it's because you've had the typical staff nurse's day where you can't just go in and do what you think you're going to do because so many things happen that change it ...
R (Mmm) that's it ...
JG ... which is what happened to you
R ... it's so frustrating isn't it ...
JG Yes

R ... you're trying to do one thing and it's like someone asks you midway again can you do this and you think oh no I've got this to do and it's like you know I'm thinking oh you panic I think it's a case of just taking a step back and saying now what is important ...
JG Right
R ... and I think I learnt that today if it's one thing I think it's that ...
JG Yes right
R ... you know then I say stop ...
JG Yes
R ... think and then go again
JG And you did that quite well when we'd had a break and then you said right I've got to get everyone back together again communicate the changes ...
R Yes (laughs)
JG ... because you were aware that you knew things had changed and you needed everyone else to do it even although you weren't able to just do that because people got called away
R No and also because Like J had been working on her own ...
JG Yes
R ... and I was thinking well she's done all the washes and that perhaps she'd like to see something as well and I felt that she's very much been on her own ...
JG (Mmm)
R ... and I thought perhaps it was a bit unfair this morning ...
JG Right
R ... I felt she'd been dumped on a bit to be honest ...
JG (Mmm)
R ... so I thought well let's get time to if there's anything worrying anyone ...
JG Right
R ... perhaps then would be the time
JG Right so do you feel that that actually worked?
R It would have done if you didn't get interrupted yeah
JG Yeah
R I think so because then I felt confident I needed to know myself that everything was together
JG Yes
R I don't like it when if you're in a team I feel you have to work as a team and when we didn't really know what each other were doing it was like 3 people working separate going on separate lines you know one of us was going one direction the other was going another and I just felt like we needed to be pulled back ...
JG Yes

R ... and say hey what's going on here ...
JG Yes
R ... and then start again
JG Yeah
R Yeah
JG Yeah and when you came to give handover report to the late staff did you suddenly become conscious that you'd been totally wound up with the *** (Consultant) patients all the time ...
R Yeah I did
JG ... and you had to give handover for the others as well
R And that was really hard ...
JG Right
R ... because yeah exactly you concentrate on them so much and that's why I nearly skipped them out because I hadn't actually really looked after them which was awful really (laughs) and I was thinking yeah you do you get almost like focused ...
JG Right
R ... and like any other patient on the ward then you know you can't actually remember anything it's like brain dead syndrome
JG So what will you do next time you're on duty to not experience that again?
R Well definitely I would like what I was going to say if when again we needed handover from K back from the other round ...
JG (Mhm)
R ... to then go back in there and know everything ...
JG (Mmm)
R ... but we didn't have the handover back from her ...
JG Right
R ... it's all about communication that's what I've learnt
JG So you did it one way but you didn't get it the other way
R Yeah I could have done with it the other way back again
JG So next time you'll ask?
R Yeah
JG Right right so you've actually learnt a lot ...
R Yeah
JG ... today I think really
R Yeah I think so (laughs)
JG Yeah it's been good ok that's everything I had on my list but is there anything else you can think of?
R No not really I don't think there's anything to add no
JG No that's fine can I just ask you finally ...
R Yeah

JG ... looking back on the last year then perhaps how you think that you've learnt to control your own learning - what works for you individually?

R I think if we're talking about skills then nursing skills in itself what helps me is is like steps step one is like I've learnt like this step process ...

JG Yeah

R ... step one is to almost watch someone no step one is to identify you need to learn something then step two is to actually say hey can I watch you do it please then it's like step three's someone watch me while I do it then step four is like I'll do it on my own and if I've got any problems I'll come to you as in my mentor ...

JG (Mmm)

R ... it's like a step by step process ...

JG Right

R ... but I feel for me it's a watch it once and get on get on with it really get in there I think you can't learn anything as a bystander you really need to be I don't know you've got to overcome like your fears ...

JG Yes

R ... 'cos there's a lot of things I'm really scared about doing but I think I just push myself and I have to do it it's almost like you have to do it

JG Right and what helps you then in that?

R What in being able to push myself?

JG What helps you to achieve learning the way you want to learn?

R Having someone it's about again it's having someone who's willing to sit there and say hey yeah you can I'll watch you it's feeling safe enough to know that it's ok to make mistakes I think it's ok it's like that other day when I did that CVP reading with L ...

JG (Mmm)

R ... and it was a case of I know it's ok to do this in front of you I feel safe ...

JG Right

R ... you're a fellow student and it doesn't matter if I make mistakes it's having that feeling ...

JG Yeah

R ... that it's all going to be ok ...

JG Yes

R ... so a lot of it's I think It's trust in the other person you're with ...

JG Yes

R ... it's like a trusting relationship ...

JG (Mmm)

R ... and just that feeling of being secure

JG Right and is it helpful to talk over things with other people after you've done them?
R Definitely yeah I mean reflecting back on it yeah ...
JG (Mmm)
R ... you can do also not just incidents but like skills in itself but talking about things that I've not been happy with like the amount of the lady who came up I talked about before who was consented when she was confused ...
JG Yes
R ... I felt really bad about that in myself and ...
JG (Mmm)
R ... was quite assertive with the Consultant but I wanted to know what other people thought ...
JG Right
R ... and you know you need reassurance that you're not the only one who feels these things ...
JG That's right
R ... sometimes you feel like it's you against the world and the doctors it's nice just to sit with someone who will sit and talk about and instantly reflect on it and say you know is there anything we could have done
JG That's right
R Definitely
JG So it must have been reassuring today when doing the doctors round when the Consultant went to great pains from S ...
R Yeah
JG ... to listen to his chest ...
R Exactly
JG ... because he's very confused but she waited and waited until ...
R (Mmm)
JG ... he did understand what she was saying ...
R (Mmm)
JG ... and he said yes before she did it didn't she?
R (Mmm) but even then I was learning from her 'cos I was watching her interpersonal skills I didn't think they were very good ...
JG yeah
R ... 'cos she was standing over him ...
JG That's right
R ... I was thinking all the time I was thinking get down on his level bend you know touch him ...
JG Yeah
R ... and I was it was almost like I had to hold my hands I wanted to touch S all the way through that you probably saw me edging ...

JG Yes
R ... and I was thinking I just want to help him
JG Yes and I was interested in the beginning when he stood up that she was very concerned that she wanted him to sit down ...
R Yeah
JG ... (um) but I wasn't sure at the time whether that was just a power relation whether she was concerned about him physically ...
R Yeah
JG ... but I was surprised that she didn't sit down with him ...
R I noticed that she didn't ...
JG ... when she sat him down yeah
R ... she didn't really touch anyone or sit with anyone her manner wasn't ...
JG (Mmm) and yet verbally she was actually quite good ...
R Very yeah
JG ... because she dealt with his confusion in a good way like when he said something really silly she just said I don't understand what you're saying she didn't you know (um) ...
R She didn't like waffle ...
JG ... waffle at him yeah ...
R ... or say something patronising
JG No no she wasn't so in that way verbally she was quite good it was her non-verbal communication ...
R (Mmm) I think they ...
JG ... that I wanted to change
R Yeah that's like me I really wanted to touch him it was like I had to hold myself back like if those doctors - other ones weren't round her I would have got there ...
JG (Mmm)
R ... and sat with him myself ...
JG Yeah
R ... but I mean it's even that knowing thinking it ...
JG Yes
R ... in your own mind but actually probably you being here and asking me why I did certain things is always making me now when some things happened I'm always thinking ...
JG Yes
R ... mostly consciously you know why did I do that and would I have done it differently or you know how would I change that and I'm always thinking that now ...
JG Right
R ... continually
JG Good

R I suppose that's quite good in that way I'm more aware definitely
JG Right so in a couple of weeks time when you start the new job ...
R Yes (sounds excited)
JG ... how are you going to help your students?
R I think really just hopefully like I said I need just build hopefully build up a good relationship with them and identify what they need ...
JG Right
R ... what their learning needs are and how they learn and just know tell them that I'll be there you know whatever and make sure that they know that you will be there ...
JG Right
R ... I think it's just knowing that security and that safety net's there for you
JG (Mmm) yeah ok that's fine thank you very much
R No problem

UKCC Advisory Standards for Mentorship and Preceptorship

Advisory Standards for Mentors and Mentorship

Communication and working relationships enabling:

- development of effective relationships based on mutual trust and respect
- an understanding of how students integrate into practice settings and assisting with this process
- provision of ongoing and constructive support for students.

Facilitation of learning in order to:

- demonstrate sufficient knowledge of the student's programme to identify current learning needs
- demonstrate strategies that will assist with the integration of learning from practice and educational settings
- create and develop opportunities for students to identify and undertake experiences to meet their learning needs.

Assessment in order to:

- demonstrate a good understanding of assessment and ability to assess
- Implement approved assessment procedures.

Role modelling in order to:

- demonstrate effective relationships with patients and clients
- contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated
- assess and manage clinical events to ensure safe and effective care.

Creating an environment for learning in order to:

- ensure effective learning experiences and opportunity to achieve learning outcomes for students by contributing to the development and maintenance of a learning environment
- implement strategies for quality assurance and quality audit.

Improving practice in order to:

- contribute to the creation of an environment in which change can be initiated and supported.

A knowledge base in order to:

- identify, apply, and disseminate research findings within the area of practice.

Course development which:

- contributes to the development and/or review of courses.

Nurses, Midwives and Health Visitors who take on the role of mentor must have current registration with the UKCC. They will have completed at least twelve months full-time experience (or equivalent part time).Mentors will require preparation for, and support in, their role. This should include access to a lecturer and/or practice educator as well as support from their line manager.

Recommendation 28 of *Fitness for practice* states that: "Service providers and HEIs should formalise the preparation, support and feedback to mentors of pre-registration students. This should be continued by service providers, in line with best practice, for preceptors of newly qualified nurses and midwives".

Advisory Standards for Preceptors and Preceptorship

Communication and working relationships enabling:

- an understanding of how practitioners integrate into a new practice setting and assisting with this process
- understanding and assisting with the problems of transition from pre-registration student to registered and accountable practitioner.

Facilitation of learning in order to:

- demonstrate sufficient knowledge of the practitioner's programme leading to registration to identify current learning needs
- help the practitioner to apply knowledge to practice.

Creating an environment for learning in order to:

- act as a resource to facilitate professional development.

Practitioners who take on the role of preceptor will be first level nurses, midwives or health visitors who have normally had at least twelve months (or equivalent) experience within the same or associated clinical fields as the practitioner requiring support.

Recommendation 21 of *Fitness for practice* states that: "All newly-qualified nurses and midwives should receive a properly supported period of induction and preceptorship when they begin their employment".

UKCC Programme Outcomes - Practice Educators and Practice Education

Communication and working relationships enabling:

- development of effective relationships based on mutual trust and respect;
- an understanding of how students/registered practitioners integrate into a new practice setting and assisting with this process and
- provision of ongoing and constructive support for students and registered practitioners.

Facilitation of Learning in order to:

- demonstrate the ability to facilitate effective learning within an area of practice;
- demonstrate the ability to be the prime educator in practice;
- demonstrate the ability to facilitate learning for those intending to become Specialist Practitioners;
- identify individual potential in students and practitioners through appropriate systems. As an expert in practice, advise on educational opportunities that will facilitate the development and support of specialist knowledge and skills and
- demonstrate strategies that will assist with the integration of learning from practice and educational settings.

Assessment in order to:

- have a good understanding of assessment and ability to assess and
- implement approved assessment procedures.

Role Modelling in order to:

- demonstrate effective relationships with clients/patients and
- create an environment in which practice development is fostered, evaluated and disseminated.

Creating an Environment for Learning in order to:

- ensure effective learning experiences and opportunities to achieve learning outcomes for students through mentorship, and for registered practitioners through preceptorship, clinical supervision and provision of a learning environment and

- explore and implement strategies for quality assurance and quality audit.

Improving Practice in order to:

- contribute to the creation of an environment in which change can be initiated and supported and

- identify ways in which multi-professional working would benefit patients/clients and contribute to the development of strategies to deliver quality care within a multi-disciplinary/multi-agency context in partnership with patients/clients.

A Knowledge Base in order to:

- identify, apply and disseminate research findings within their area of practice and

- identify areas of practice that require evaluating and set up strategies for effecting this.

Course Development that:

- contributes to the development and/or review of courses.

Content

The content of the programme of education should be that which will enable the outcomes to be achieved.

BOURNEMOUTH UNIVERSITY
Institute of Health & Community Studies

Advanced Diploma & BSc (Hons) Clinical Nursing with Professional Registration in Nursing

CLINICAL PRACTICE ASSESSMENT

Contents
Clinical assessment is accomplished via a tripartite agreement between the student, the clinical assessor and the student's personal tutor. The Clinical Link Tutor is involved if there are any specific situations related to the clinical area.

There are five main sections of core skills for clinical assessment:

1 Care Giving Skills

2 Interpersonal and Communication Skills

3 Organisational Skills

4 Professional Development Skills

5 Teaching and Facilitation Skills

Each section is further divided into sub-sections. Three stages of achievement are identified, with an individual statement of ability for each sub-section at each stage. The statements are written in broad terms which allows translation into specific objectives according to the clinical speciality. It is these objectives which form the action plan for the student to achieve.

During clinical placement the student, clinical assessor and personal tutor select and agree statements appropriate to the student's experience and learning needs. These are then formulated into an action plan and discussion occurs related to how the student will evidence each statement. The Action Plan is signed again at the time when each statement of learning outcome has been achieved and witnessed. Each student may attempt to evidence a statement of skill for as many occasions as is necessary, but **all** attempts must be recorded.

Additionally the student and clinical assessor may identify specific skills related to the clinical area and negotiate objectives to be achieved at the appropriate stage.

Progression
In general terms students are expected to progress from achieving stage one under close supervision, stage 2 under minimal supervision to achieving competence to practice independently by the end of stage 3. All students will be required to reach certain stages by the end of each Semester as follows:

Semester 1	8 outcomes (formative)
Semester 2	All stage 1 outcomes
Semester 3	50% of stage 2 outcomes
Semester 4	All stage 2 outcomes
Semester 5	50% of stage 3 outcomes
Semester 6	All stage 3 outcomes

SUMMARY OF CLINICAL PROGRESS

1. CARE GIVING SKILLS

	Stage 1	Stage 2	Stage 3
1.1 Assessment of Health and Health Care Needs	1.1.1 Able to make an accurate nursing assessment of an individual patient/client identifying total needs	1.1.2 Able to carry out accurate nursing assessments for a group of patients/clients	1.1.3 Able to be accountable for the nursing assessment of patients/clients within his/her care
1.2 Health Promotion	1.2.1 Able to identify an individual patient/client's health promotion needs	1.2.2 Able to advise patients/clients regarding their health promotion needs	1.2.3 Able to advise patients/clients and significant others regarding health promotion needs
1.3 Identification of Problems related to Health Status	1.3.1 Able to identify the problems of an individual patient/client	1.3.2 Able to identify the problems for a group of patients/clients	1.3.3 Able to identify and prioritise patients/ clientsÌ problems
1.4 Formulating Goals	1.4.1 Able to negotiate goals for an individual patient/client	1.4.2 Able to negotiate goals for a group of patients/clients	1.4.3 Able to utilise a variety of agencies in order to negotiate goals for patients/ clients within his/her care
1.5 Planning Care	1.5.1 Able to negotiate and devise a plan of care for an individual patient/client	1.5.2 Able to negotiate and devise a plan of care for a group of patients/clients	1.5.3 Able to access a range of information in negotiating care plans for the patients/clients within his/her care
1.6 Implementing Care	1.6.1 Able to implement the planned care for an individual patient/client	1.6.2 Able to implement the planned care for a group of patients/clients	1.6.3 Able to be accountable for the decisions made when implementing the planned care for patients/ clients within his/her care
1.7 Technical Care	1.7.1 Able to recognise and describe the use of technology within the clinical area	1.7.2 With guidance. is able to use a range of equipment as part of individualised care	1.7.3 Able to select and use appropriate equipment for patients/clients within his/her care
1.8 Evaluation of Care	1.8.1 Able to evaluate the effect of nursing care for an individual patient/client	1.8.2 Able to evaluate the effect of nursing care for a group of patients/clients	1.8.3 Able to evaluate the significance of nursing care and its impact upon the clinical team

2. INTERPERSONAL AND COMMUNICATION SKILLS

	Stage 1	Stage 2	Stage 3
2.1 In relation to patients/ clients	2.1.1 Able to establish effective communication with an individual patient/client	2.1.2 Able to establish effective communication with a group of patients/clients	2.1.3 Able to be accountable for all interpersonal interaction with patients/clients
2.2 In relation to significant others (i.e. partners, family, friends)	2.2.1 Able to establish effective communication with significant others with respect to an individual patient/client	2.2.2 Able to establish effective communication between significant others with respect to a group of patients/ clients	2.2.3 Able to effectively negotiate between significant others and patients/clients in a wide range of situations
2.3 In relation to the multi disciplinary team	2.3.1 Able to communicate relevant information to nursing colleagues	2.3.2 Able to communicate relevant information to other members of the multi-disciplinary team	2.3.3 Able to take a key role in establishing lines of communication within a health care team
2.4 In relation to nursing documentation	2.4.1 Able to correctly complete all nursing documentation for an individual patient/client	2.4.2 Able to correctly complete all nursing documentation for a group of patients/clients	2.4.3 Able to correctly complete all relevant documentation for patients/ clients within his/her care

3. ORGANISATIONAL SKILLS

	Stage 1	Stage 2	Stage 3
3.1 Managing Care	3.1.1 Able to organise care for an individual patient/client to meet assessed needs	3.1.2 Able to organise care for a group of patients/clients to meet assessed needs	3.1.3 Able to be accountable for managing care for a group of patients/clients
3.2 Managing people	3.2.1 Able to demonstrate own role within nursing team	3.2.2 Able to function within the multi-disciplinary team	3.2.3 Able to take the role of team leader, co-ordinating care delivery and delegating to others
3.3 Managing Other Resources	3.3.1 Able to identify resources for delivering care and use these appropriately	3.3.2 Able to select and adapt resources to changing situations	3.3.3 Able to justify the use of resources and identify the need for change

4. PROFESSIONAL DEVELOPMENT SKILLS

	Stage 1	Stage 2	Stage 3
4.1 Accountability and responsibilities for Nursing Practice	4.1.1 Able to demonstrate an awareness of own responsibilities within a nursing team.	4.1.2 Able to be responsible for delegated patient/client care	4.1.3 Able to be accountable for patient/client care and delegate to others
4.2 Ethical issues for Nursing Practice	4.2.1 Able to identify ethical issues relating to the care for an individual patient/ client	4.2.2 Able to demonstrate an ethical awareness within practice	4.2.3 Able to discuss ethical issues with patients/ clients, and/or their representatives and act in the light of these discussions
4.3 Legal Requirements for Nursing Practice	4.3.1 Able to relate legal requirements to own practice	4.3.2 Able to relate legal requirements of nursing care for a group of patients/clients	4.3.3 Able to deliver care in accordance with the legal requirements of clinical practice
4.4 Professional attitudes and behaviour	4.4.1 Able to act in a professional manner within a nursing team.	4.4.2 Able to recognise the impact of own actions on members of the nursing team	4.4.3 Able to demonstrate professional attitudes and behaviour commensurate with the role of the registered nurse

5. TEACHING AND FACILITATION SKILLS

	Stage 1	Stage 2	Stage 3
5.1 Motivation to Learn	5.1.1 Demonstrates an interest in clinical practice	5.1.2 Able to link theory to practice	5.1.3 Able to motivate others to learn
5.2 Teaching Skills (Colleagues)	5.2.1 Able to identify areas of learning opportunity in the clinical area	5.2.2 Able to participate in a teaching programme	5.2.3 Able to teach colleagues
5.3 Health Education	5.3.1 Able to participate in a health education programme for an individual patient/client	5.3.2 Able to participate in a health education programme for a group of patients/clients	5.3.3 Able to educate patients/clients and significant others with regard to health needs

Student Name: _____

Allocation: _____

Date: _____

Course: _____ **Intake:** _____

•Orientation to Area

• **Signature:** _____
•
•Summary of Initial Interview
•
•
•
•
•
•

•
•
•
• **Signature:** _____
•
•Fire Regulations explained

• **Signature:** _____
•
•Emergency Procedures explained

• **Signature:** _____
•
•Manual Handling techniques appropriate to the area

Signature: _____

On completion of the Semester/Allocation

Clinical staff evaluation of student progress

Signature(s) _____ **Date** _____

Student evaluation of learning experience

Signature _____ **Date** _____

Clinical Practice Assessment Action Plan

Student Name: _____

Course: _____ **Intake:** _____

Clinical Assessor Name: _____

Skill Statement Code: _____

Planned Objectives to Evidence Statement

Objectives Agreed: **Date:** _____

Student Signature: _____

Clinical Assessor Signature: _____

Personal Tutor Signature: _____

Evidence of Achievement of Objectives:

Summary by student:

Key Learning Points:

Objectives Achieved: **Date:** _____

Student Signature: _____

Clinical Assessor Signature: _____

Personal Tutor Signature: _____

Comments by Clinical Assessor in the event of non-achievement of Objectives.

Summary Evaluation of the Portfolio Unit

Teaching, Learning and Assessment Questionnaire 1998/1999

Course: Adv Dip CN/RN **Intake:** Oct 96
Unit Leader: (Anon) **Semester:** 5 **Date:** 3/99

Your contribution to evaluation of the course is valuable for course monitoring and development. Please indicate your response to the statements below by placing a tick in the appropriate box.

UNIT: Portfolio unit/ALG

61 Respondents

		Strongly Agree	Agree	Disagree	Strongly Disagree
1	The learning outcomes of this unit were clear to me	25%	67%	8%	
2	I feel encouraged to participate within this unit	36%	59%	5%	
3	The unit is well structured	11%	77%	10%	1%
4	Relationship between the unit and course is made clear	28%	69%	3%	
Seminar/Practical Classes					
5	Topics relate to learning outcomes of the unit	16%	74%	7%	
6	Relationship with lecture sessions is clear	17%	77%	6%	
Lectures					
7	Lectures address the key issues of the unit	26%	70%	4%	
8	Lectures are delivered at a pace which suits me	19%	74%	7%	
Intellectual and Professional Objectives					
9	I have been encouraged to think independently	50%	50%		
10	The content is relevant to professional requirements	41%	56%	3%	
Assessment					
11	Assessments are useful learning experiences	20%	77%	2%	
12	Feedback is received promptly	38%	69%	2%	2%
Support					
13	I am encouraged to take responsibility for my learning	50%	50%		
14	I make use of learning support facilities (e.g. libraries, open learning centre)	38%	57%	1%	

Thank you for your co-operation in taking part in this survey.

Please take this opportunity to provide your own comments about this unit.

Summary of comments

* *Enabled me to discuss issues from practice*

* *Sharing others' experience has contributed +++ to my learning*

* *Not taken seriously by some of the group*

* *My course seems to have taken place centred around the ALG and this has been good*

* *Useful point of contact*

* *Good to let off steam and talk about any problems*

* *Pity there are no reflective sessions post-qualifying*

SUMMARY OF ENB 998 WORKSHOPS

PROPOSED TUTORIALS	INDICATIVE FOCUS
1 **Action Learning**	Participants will be introduced to the programme and discuss the content and learning approach. In particular they will explore the concept of action learning and its' relevance to self and peer development. They will be encouraged to devise ground rules related to how they will function as an action learning group. Discussion of compiling evidence related to their development for the portfolio will take place, and they will consider how to implement the focused worksheet on assessing needs for week one.
2 **Assessing Learning Needs**	Data collected on their worksheets will be used to consider individual learning needs and how to accommodate these. Participants will work from a basis of self-assessment and through reflective discussion consider how to assess the needs of others. The focused worksheet for week 2 will relate to profiling an individual with learning needs.
3 **Profiling an Individual**	Participants will use their profiles to identify learning opportunities in practice that could meet the needs of their learner. Working in groups they will consider how a plan could be constructed to meet identified needs and maximise the use of learning opportunities, considering the ethical issues arising from this. The focused worksheet for week 3 will relate to acting in a supervising capacity for their identified learner.
4 **Supervisory Roles**	Participants will be asked to reflect upon their experiences of acting as Clinical Assessor, Preceptor and Clinical Supervisor, sharing these with their peers. They will identify the knowledge, skills and attitudes necessary to carry out these roles. The focused worksheet for week 4 will relate to determining how learning takes place, especially in clinical practice.
5 **Assessment in Clinical Practice**	Working in action groups participants will compare and contrast old/new practitioners. They will consider the strengths and weaknesses of the tripartite relationship utilised for undergraduates. They will practice setting learning objectives and writing action plans, considering how they would use these to assess competence. The focused worksheet for week 5 will relate to selecting teaching approaches in practice supported by relevant learning theories.
6 **Selecting Teaching Theories and Strategies-approaches for clinical practices supported by learning**	Working in small groups participants will determine the appropriateness of adult learning theory, reflective learning theory and experiential learning approaches related to teaching in practice. They will discuss various teaching and learning strategies which could be used to implement these. The focused worksheet for week 6 will require them to plan a teaching/learning experience to practice with their peers.
7 & 8 **Teaching Practice**	Participants will practice their teaching skills using a variety of strategies with peers as students and evaluators. Worksheets for these weeks will consist of (a) a structured reflection of their teaching experience and (b) a plan to teach a learner in their own clinical environment which they will implement prior to week 9.
9 **Reflecting on teaching in clinical practice**	Participants will share reflections on their teaching experiences, both in the classroom and in practice, using peers to determine their strengths and weaknesses. In particular they will consider giving and receiving feedback, and strategies for enhancing the effectiveness of this. The focused worksheet for week 9 will concern evaluating the clinical learning environment.
10 **Critical Reflection and Action Planning**	Participants will reflect with their peers to evaluate their own performance as a teacher and assessor in practice. They will share the evidence they have collected and discuss this in relation to the knowledge base for their practice as a teacher and assessor. Individually they will construct an action plan for their future development in this role. The focused worksheet for week 10 will relate to a review of their initial self-assessment of learning needs to determine what progress has been made.

FORMATIVE TEACHING ASSESSMENT - For use in the classroom

Course Member **Date**

Assessor **Time**

Learners **Topic**

Very Good	Good	Needs further develop-ment		COMMENTS
			LESSON PLAN * Clear aims and objectives are stated * Topic is related to the learner's identified needs Relevant teaching and learning strategies are selected * The session follows a logical sequence * Appropriate selection of teaching aids * Consideration has been given to the nature of the learning environment	
			INTRODUCTION * Assessment of the learner's previous knowledge and skill is evident * Clear introduction to the session is given * The teacher gains the interest of the learner	
			DEVELOPMENT * The learner is involved in the teaching/learning experience * Explanation of principles and concepts is given where appropriate * Questioning is used – teacher to learner – to check understanding, and encouraged – learner to teacher – for the learner to clarify information * Links are made between theory and practice * Verbal and non-verbal communications are appropriate * Aids are used where relevant	

Very Good	Good	Needs further develop-ment		
			PRACTICAL SKILL **(where applicable)** * Role model demonstrates the skill at normal pace * The skill is broken into relevant stages and demonstrated again if appropriate * Complex aspects of the skill are discussed in detail * The learner is allowed to practice under supervision, and feedback on performance is given	
			CONCLUSION * Summary of main points is given * Learner is encouraged to reflect on what has taken place	
			FOLLOW UP * The learner is given follow up references/handout * The teacher evaluates the effectiveness of the teaching/learning session	

OVERALL ASSESSOR COMMENTS

STUDENT TEACHER EVALUATION

SIGNATURES:

Student: ..... Peer assessor:.....

FORMATIVE TEACHING ASSESSMENT - For use in practice

Course Member **Date**

Assessor **Time**

Learners **Topic**

Very Good	Good	Needs further develop-ment		COMMENTS
			LESSON PLAN * Clear aims and objectives are stated * Topic is related to the learner's identified needs Relevant teaching and learning strategies are selected * The session follows a logical sequence * Appropriate selection of teaching aids * Consideration has been given to the nature of the learning environment	
			INTRODUCTION * Assessment of the learner's previous knowledge and skill is evident * Clear introduction to the session is given * The teacher gains the interest of the learner	
			DEVELOPMENT * The learner is involved in the teaching/learning experience * Explanation of principles and concepts is given where appropriate * Questioning is used – teacher to learner – to check understanding, and encouraged – learner to teacher – for the learner to clarify information * Links are made between theory and practice * Verbal and non-verbal communications are appropriate * Aids are used where relevant	

Very Good	Good	Needs further develop-ment		
			PRACTICAL SKILL **(where applicable)** * Role model demonstrates the skill at normal pace * The skill is broken into relevant stages and demonstrated again if appropriate * Complex aspects of the skill are discussed in detail * The learner is allowed to practice under supervision, and feedback on performance is given	
			CONCLUSION * Summary of main points is given * Learner is encouraged to reflect on what has taken place	
			FOLLOW UP * The learner is given follow up references/handout * The teacher evaluates the effectiveness of the teaching/learning session	

OVERALL ASSESSOR COMMENTS

STUDENT TEACHER EVALUATION

SIGNATURES:

Student Teacher:..... Assessor:.....

ENB 998: WORKSHEET 3

SUPERVISORY ROLES
(Mentor/Clinical Assessor, Preceptor, Clinical Supervisor)

You are asked to complete the following individual activity in preparation for Tutorial 4

Suggested time needed: 3 hours guided study (University day)
6 hours student managed (own time)

The Aim of the Worksheet is to identify your own knowledge regarding Mentorship and Preceptorship (NB For the new pre-registration courses the term clinical assessor is used instead of mentor)

1 Read Chapters 3 and 4 in Morton-Cooper and Palmer (1993) for an overview of mentoring and preceptor support for systems

2 Read the articles by Armitage and Burnard (1991) Earnshaw (1995) and Campbell et al (1994).

3 Reflect on your own experience of mentorship and preceptorship identifying whether this experience was as: mentor or student (mentee), preceptor or new RN (preceptee), write brief notes on this

4 Identify positive and negative aspects implicit in the roles described in (3) above

5 'You can only be an effective mentor or preceptor if you have previously had the experience of mentor/preceptor support'. Write your thoughts regarding this statement in preparation for discussion in the next workshop

6 Describe how mentor/preceptor support systems link theory to practice

7 In preparation for the next study day, define and briefly describe the concept 'clinical supervision'

READING

Armitage P and Burnard P, (1991) Mentors or Preceptors? Narrowing the Theory Practice Gap, *Nurse Education Today 11, 225-229*

Campbell, I; Larrivee, L; Field, P; Day, R and Reutter, L; 'Learning to nurse in the clinical setting'; *Journal of Advanced Nursing;* (1994) 20, 1125-1131.

Earnshaw, G; 'Mentorship: the student's views'; *Nurse Education Today,* (1995) 15, 274-279.

NB: Remember to put the completed worksheet, annotations of your reading and any supporting evidence into your learning portfolio on a weekly basis.

Tutorial Guide for Action Learning Group Activity
(Tutorial 4)

SUPERVISORY ROLES

Stage 1: Action Learning Group: suggested time 45 mins.

1. In learning groups of 3/5 critically reflect on the work you have done in preparation for this workshop i.e. compare experiences of mentorship, preceptorship or being a clinical supervisor. Consider how these roles help to integrate theory with practice.

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Stage 2: Teacher facilitated discussion: suggested time 60 mins.

2. As a whole group discuss statement 5 from the worksheet.

3. Discuss the concept of clinical supervision, using experience of group members who have had experience in this and available documentation (UKCC and NHSE) to help you to clarify the process and outcomes.

4. Consider how this process could be implemented in your area, how could it help you and your peers to manage personal and professional development.

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Stage 3: Using experience for learning: suggested time 30 mins

5. Discuss with your group how you could use experience as a basis for learning as part of your role as a practitioner and a teacher.

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Stage 4: Action plan for next week: suggested time 30 mins.

6. Give out next worksheet, discuss the activities and agree group action to prepare for action learning next time.

NB Timing allows for 15 min coffee/tea break to be taken either between stage 1 & 2 or between stage 2 & 3.
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UKCC Fitness for Practice (1999) – Summary of the Recommendations

Increasing flexibility

1. Careers services should offer a breadth of advice which encourages access for all, both those with no formal qualifications as well as graduates.
2. Recruitment and selection should be a joint responsibility between service providers and HEIs.
3. The good practice of service providers, HEIs and FEIs co-operating to provide entry to pre-registration nursing and midwifery programmes through a year 0 (Access) programme should be continued.
4. The use of AP (E) L should be introduced to allow for more flexible entry to pre-registration nursing programmes.
5. The year 1/CFP should:
    - enable students to achieve a common level of competence at the point of entry to the branch programme
    - be reduced to one year
    - be taught in the context of all four branches
    - enable integration with the branch programmes
    - ensure that practice skills and placements are introduced at an early stage in the programme.
6. Students who choose to leave the pre-registration nursing or midwifery programmes having successfully completed at least year 1/CFP should be able to benefit from their academic and practice credit by having it mapped against other credit frameworks regulated by the statutory regulatory bodies in each of the four countries.
7. Recognising the constraints, more flexibility should be introduced for pre-registration nursing programmes concerning the point at which branch selection is made, with options being available at both the point of recruitment and during year 1/CFP. Where possible, students should be asked to nominate a first and second choice of branch programme.
8. The Commission urges an expansion of graduate preparation for nursing and midwifery because of:
    - the nature of clinical decision making required
    - the current demands of service providers, particularly for workforce flexibility and role diversity
    - the close approximation of the current diploma preparation to graduate level
    - government targets for participation in higher education
    - the increasing demand for graduate nursing places but limited supply of places
    - the increasingly competitive labour market
    - career expectations of young people

9. A common definition of attrition and a required minimum data set for pre-registration programmes should be agreed and put in place for use across all four countries of the United Kingdom.

Achieving fitness for practice

10. The standards required for registration as a nurse on parts 12, 13, 14 and 15 of the UKCC register should:
    - be constructed in terms of outcomes for theory and practice
    - make the 50 per cent practice component of the course hours transparent
    - specify that consistent clinical supervision in a supportive learning environment during all practice placements is necessary.
11. The subject benchmarking to be undertaken by the QAA should be jointly developed with the UKCC and the National Boards and should address outcomes which are:
    - core and specific to nursing
    - core and specific to midwifery
    - transferable
    - consistent with the QAA threshold for degrees and diplomas.
12. Consideration should be given as to whether pre-registration midwifery education should move to an outcome based competency approach.
13. Students, assessors and mentors should know what is expected of them through specified practice outcomes which:
    - form part of a formal learning contract
    - give direction to practice placements
    - are jointly negotiated between the service providers and HEIs.
14. The use of a portfolio of practice experience should be extended to demonstrate a student's fitness for practice and provide evidence of rational decision making and clinical judgement.
15. The portfolio should be assessed through rigorous practice assessment tools which identify the skills which students have acquired and highlight any deficits which need to be addressed.
16. The sequence and balance of university and practice-based study should be planned to promote an integration of knowledge, attitudes and skills.
17. The current programme model of four branches of nursing should be reviewed in the light of changing health care needs. The review should consider a range of options including a redefinition of branch structures and generalist nurse preparation.
18. Practice placements should be designed to achieve agreed outcomes which benefit student learning and provide experience of the full 24 hour per day and seven day per week nature of health care.

19. To make the best use of practice placements, interpersonal and practice skills should be fostered by the use of experiential and problem-based learning, increased use of skills laboratories and access to information technology, particularly in clinical practice.
20. To enable nursing and midwifery students to consolidate their education and their competence in practice, there should be a period of supervised clinical practice of at least three months towards the end of the pre-registration programme. This practice period is intended to be a transitional period with clearly specified outcomes and should be managed by specifically prepared nurses and midwives.
21. All newly qualified nurses and midwives should receive a properly supported period of induction and preceptorship when they begin employment.
22. Programme changes resulting from the Commission's recommendations should be systematically evaluated in respect of achieving fitness for practice.

Working in partnership

23. Service providers and HEIs should continue to develop effective, genuine partnerships to support:
    - their respective commitments to students
    - curriculum development, implementation and evaluation
    - joint awareness and development of service and education issues
    - delivery of learning in practice
    - defining responsibilities for underpinning learning in practice
    - monitoring the quality of practice placements.
24. An accountable individual should be appointed by purchasers of education to liaise with the service providers and HEIs to support:
    - the provision of sufficient suitable practice placements
    - staff and students during placements
    - the development of standards and specified outcomes for placements
    - the delivery and effective monitoring of the contract to ensure that the contractual requirements are met.
25. Recognising that no one individual can provide the full range of expertise required by students, service providers and HEIs should work together to develop diverse teams of practice and academic staff who will offer students expertise in practice, management, assessment and mentoring and research.
26. Service providers and HEIs should support dedicated time in education for practice staff and dedicated time in practice for lecturers to ensure that practice staff are competent and confident in teaching and mentoring roles and lecturers are confident and competent in the practice environment.
27. The good practice of formalised arrangements for access to practice for lecturers and to education for practice staff should be adopted by service providers and HEIs.

28. Service providers and HEIs should formalise the preparation, support and feedback to mentors of pre-registration students. This should be continued by service providers, in line with best practice, for preceptors of newly qualified nurses and midwives.
29. Funding to support learning in practice should be reviewed to take account of the cost of mentoring and assessment by practice staff and the cost of lecturers having regular contact with practice.
30. To improve workforce planning for nursing, NHS requirements should increasingly be informed by comprehensive information from the private and independent sector.
31. Taking into account changes in health and social care delivery, the government departments of health, social care and social services, education and employment, in each of the four countries, should work together to ensure that the preparation of health care assistants and social care assistants is based on common standards.
32. The health care professions should be actively encouraged to learn with and from each other by:
    - purchasers of education including inter-professional teaching and learning – as appropriate – as a criterion for evaluating the quality of education
    - explicit encouragement for inter-professional learning in planning of all pre-registration curricula
    - the development of shared use of learning resources and technology in practice placements
    - the UKCC leading joint initiatives with relevant regulatory bodies.
33. We recommend that consideration should be given to the most appropriate method of funding students of nursing and midwifery in the future. The forthcoming government review of nursing, midwifery and professions allied to medicine (PAMs) student funding in England should consider the professed willingness of the private and independent sector to participate in funding students.

GLOSSARY

Activities of Living:	those daily activities that a person would normally undertake for themselves when fit to do so (derived from the model of nursing described by Virginia Henderson 1961 and developed by Roper et al 1985)
Branch programme:	the second component of a Project 2000 style programme where nursing students study one of the following specialities – adult, mental health, learning disabilities or children's nursing
Clearing:	a limited time period, following publication of 'A' level results, which is part of the application process for programmes in higher education where applicants who have not attained a place at university can identify potential vacancies and apply to be considered
Clinical Grading:	a system for paying qualified and unqualified nurses with differentials according to the responsibilities of their roles
Common Foundation Programme:	the first component of a Project 2000 style programme where learning is shared between nursing students who will enter different specialist branches of nursing
Continuing Professional Development:	(CPD) formal or informal development of staff in their role

Degree/RN:	a bachelor's degree at ordinary or honours level with qualification as a registered nurse, offered by many higher education institutions in collaboration with health care NHS Trusts
Diploma in Higher Education:	(DipHE) the minimum academic level for qualifying as a registered nurse (RN) set by the regulatory body (UKCC)
English National Board:	(ENB) the nursing, midwifery and health visiting regulatory body for England
Health Care Assistant:	(HCA) a support worker for qualified nurses who carries out delegated nursing work or undertakes social care duties in clinical practice
Holistic Care:	a system where one nurse takes responsibility for delivering all of the care required by a patient (where possible) to ensure continuity of care for the patient and the avoidance of fragmented care delivered by several different nurses.
Internal Markets:	a system of purchasers and providers for health care and education, set up by the Conservative government as part of health service reforms
Joint Validation:	programme approval jointly by higher education institutions and relevant statutory bodies

Link Tutor:	a university teacher who 'links' with specific clinical areas to provide support to staff in supervising students, to support students in placements and to contribute to the development of both staff and care in that particular environment
Mentor:	a qualified nurse, midwife or health visitor who takes responsibility for supervising and guiding the learning of a pre-registration student in clinical practice
Paramedic:	a person who has specific training and education to undertake defined medical duties e.g. an ambulance worker
Personal Tutor:	a teacher in higher education who takes responsibility for monitoring the progress of, and providing pastoral support to, a student throughout the length of their programme
Placement:	a work area providing experience in clinical practice as part of a pre- or post-registration programme to facilitate the development of applied knowledge and skills to undertake a new or enhanced role
Preceptor:	a qualified nurse, midwife or health visitor who takes responsibility for supervising and guiding the learning of a newly qualified or returning practitioner in clinical practice

Primary Nursing:	a system of nursing care delivery where a nurse takes on the 'prime role' of assessing, planning, implementing and evaluating care for a patient, taking responsibility for the direction of others involved in that patient's care
Project 2000:	the colloquial name given to the style of nursing education programmes that commenced in 1983 as a result of the review of nursing and midwifery education carried out by the UKCC on their inception
Rostered service:	a period of time in the final year of a Project 2000 style Diploma programme where students could be 'counted in' staffing numbers for clinical areas, providing that their experience was 'educationally led'
Skill mix:	the ratio of qualified to unqualified nursing staff involved in delivering patient/client care
Statutory body:	a regulatory body created through primary legislation
United Kingdom Central Council:	(UKCC) the regulatory body for the whole UK for nursing, midwifery and health visiting; responsible for setting policy and standards for education, maintaining the professional register, investigating allegations of misconduct and providing professional advice

REFERENCES

BARTLETT, H. HIND, P. TAYLOR, H. & WESCOTT, L. 1998. *An Evaluation of Pre-Registration Nursing Education: a literature review & comparative study of graduate outcomes.* Oxford: Oxford Centre for Health Care Research and Development.

BASZANGER, I. & DODIER, N. 1997. Ethnography: Relating the part to the whole. *In:* Silverman, D. ed. *Qualitative Research: Theory, method and practice.* London: Sage Publications.

BAUME, D.1998. *Portfolio Guide for the Open University Course H851 Teaching in Higher Education.* Milton Keynes: Open University.

BEAUCHAMP, T. & CHILDRESS, J. 1994. *Principles of Biomedical Ethics.* 4th Ed. New York: Oxford University Press.

BENNER, P. 1984. *From Novice to Expert: Excellence and power in clinical nursing practice.* California: Addison-Wesley.

BERG, B. 1989. *Qualitative Research Methods for the Social Sciences.* Massachusetts: Allyn and Bacon.

BINNIE, A. & TITCHEN, A. 1999. *Freedom to Practise: the development of the patient-centred nursing.* Oxford: Butterworth Heinemann.

BISHOP, V. 1998. *Clinical Supervision in Practise: some questions, answers and guidelines.* London: Macmillan Press.

BOUD, D. COHEN, R. & WALKER, D. eds. 1993. *Using Experience for Learning.* Buckingham: SRHE and Open University Press.

BOUD, D. & MILLER, N. 1996. *Working with Experience: Animated learning.* London: Routledge.

BOUD, D. & FELETTI, G. 1997. *The Challenge of Problem Based Learning.* 2nd ed. London: Kogan Page.

BOURNEMOUTH UNIVERSITY. 1990. *BSc (Hons) Clinical Nursing with Professional Registration: Student Handbook.* Department of Nursing Health and Community Studies: Bournemouth University.

BOYLE, J. 1994. Styles of Ethnography *In:* Morse, J. ed. *Critical Issues in Qualitative Research Methods.* Thousand Oaks: Sage Publications.

BRADSHAW, P. 1989. ed. *Teaching and Assessing in Clinical Nursing Practice.* London: Prentice Hall.

BRADSHAW, P. 1995. The Recent Health Reforms in the United Kingdom: some tentative observations on their impact on nurses and nursing in hospitals. *Journal of Advanced Nursing.* 21,pp 975-979.

BRIGGS, A. 1972. Chairman. *Report of the Committee on Nursing.* London: HMSO.

BURAWOY, M. BURTON, A. FERGUSON, A. FOX, K. GAMSON, J. GARTRELL, N. HURST, L. KURZMAN, C. SALZINGER, L. SCHIFFMAN, J. & UI, S., 1991. *Ethnography Unbound: power and resistance in the modern metropolis.* Berkeley: University of California Press.

BUTTERWORTH, T. & FAUGIER, J. 1992. *Clinical Supervision and Mentorship in Nursing.* London: Chapman & Hall.

BUTTERWORTH, T. FAUGIER, J. & BURNARD, P. eds. 1998. *Clinical Supervision and Mentorship in Nursing.* London: Stanley Thornes Publishers

BUZAN, T. & BUZAN, B. 1995. *The Mindmap Book: radiant thinking, the major evolution in human thought.* 2nd ed. London: BBC Books.

CAMPBELL, I. LARRIVEE, L. FIELD, P. DAY, R. & REUTTER, L.1994. Learning to Nurse in the Clinical Setting; *Journal of Advanced Nursing.* 20, pp 1125-1132.

CAREY, M. 1994. The Group Effect in Focus Groups: planning, implementing and interpreting focus group research. *In:* Morse, J. ed. *Critical Issues in Qualitative Research Methods.* Thousand Oaks: Sage Publications.

CARPER, B. 1978. Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science.* 1, (1), pp 13-23.

CARR, W. 1995. *For Education: towards critical educational inquiry.* Buckingham: Open University Press.

CARR, W. & KEMMIS, S. 1986. *Becoming Critical: education, knowledge and action research.* London: The Falmer Press.

CARSON, S. & HAMER, S. 1997. Evaluating the Impact of Education and Training in the Health Service. *NHS Executive.*

CASEY, G. 1996 The Curriculum Revolution and Project 2000: a critical examination. *Nurse Education Today.* 16, pp 115-120.

CLARE, J. 1993. Change the Curriculum - or Transform the Conditions of Practice? *Nurse Education Today.* 15; pp 282-286.

COHEN, L. & MANION, L. 1994. *Research Methods in Education.* 4th ed. London: Routledge.

COLLINGWOOD, M. 1996. *The Goals of Nurse Education 1948-1992.* Unpublished PhD Thesis, Herriot Watt University.

COPE, P. CUTHBERTSON, P. & STODDART, B. 2000. Situated Learning in the Practice Placement. *Journal of Advanced Learning.* 31 (4), pp 850-856.

D'A SLEVIN, O. 1993. Facing the Future: credibility in a changing world. *Nurse Education Today.* 13, pp 241-249.

D'A SLEVIN, O. & LAVERY, M. 1991. Self-Directed Learning and Student Supervision. *Nurse Education Today.* 11, pp 368-377.

DAY, M. EDWARDS, C. & WATKINS, S. 1997. *Using Occupational Standards as a Complement to the Continuing Development of Healthcare Professionals and the Factors Which May Enhance or Inhibit This Approach.* The Norfolk and Norwich NHS Trust and the University of Sheffield.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES. 1979. *The Nurses, Midwives and Health Visitors Act.* London: HMSO.

DEPARTMENT OF HEALTH. 1989a. *Caring for People.* London: HMSO.

DEPARTMENT OF HEALTH. 1989b. *Working for Patients.* London: HMSO.

DEPARTMENT OF HEALTH. 1990 *The Community Care Act.* London: HMSO.

DEPARTMENT OF HEALTH. 1992. *The Health of the Nation: a strategy for health in England.* London: HMSO.

DEPARTMENT OF HEALTH. 1997. *New NHS: Modern, Dependable.* London: The Stationery Office.

DEPARTMENT OF HEALTH. 1998. *A First Class Service: quality in the new NHS.* Leeds: Department of Health.

DEPARTMENT OF HEALTH. 1999a. *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare.* Leeds: Department of Health.

DEPARTMENT OF HEALTH. 2000. *The NHS Plan: an action guide for nurses, midwives and health visitors.* Leeds: Department of Health.

DREHER, M. 1994. Dialogue: on Emic and Etic. *In:* Morse, J. ed. *Critical Issues in Qualitative Research Methods.* CA: Sage Publications Publications.

EARNSHAW, G. 1995. Mentorship: the Students' Views. *Nurse Education Today.* 15, pp 274-279.

ELKAN, R. & ROBINSON, J. 1993. Project 2000: the Gap Between Theory and Practice. *Nurse Education Today.* 13, pp 295-298.

ELKAN, R. & ROBINSON, J. 1994. *Project 2000: A review of published research.* University of Nottingham: Department of Nursing Studies.

ENGEL, C. 1997. Not just a method but a way of learning. *In* BOUD, D & FELETTI, G. eds. *The Challenge of Problem Based Learning.* 2nd ed. London: Kogan Page.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1985. *Professional Education/Training Courses.* Consultation Paper, London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1992. *3 Year Undergraduate Nursing and Midwifery Courses Leading to Admission to the Professional Register.* E.N.B. 11 5; 124th Meeting - 14.7.92.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1993a. *Regulations and Guidelines for the Approval of Institutions and Courses.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994a. *Creating Lifelong Learners.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994b. *DCL/25/RLV/November 1994.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1995a. *A Comparative Study of Outcomes of Pre-Registration Nurse Education Programmes: Interim report.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1995b. *Regulations and Guidelines for the Approval of Institutions and Courses.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 2000. *Education in Focus: Strengthening pre-registration nursing and midwifery education - curriculum guidance & requirements.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 2001a. *Preparation of mentors & teachers: a new framework for guidance.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 2001b. *Placements in Focus: guidance for education in practice for health care professions.* London: E.N.B.

ERAUT, M. ALDERTON, J. BOYLAN, A. WRAIGHT, A. 1995. *Learning to Use Scientific Knowledge in Education and practice Settings: an evaluation of the contribution of the biological behavioural and social sciences to pre-registration nursing and midwifery programmes.* London: E.N.B.

FETTERMAN, D., 1989. *Ethnography: step by step.* Newbury Park Thousand Oaks: Sage Publications.

FIELD, P. & MORSE, J. 1985. *Nursing Research: The application of qualitative approaches.* London: Chapman and Hall.

FRANCKE, A. & ERKENS, T. 1994. Confluent Education: an integrative method for nursing (continuing) education. *Journal of Advanced Nursing.* 19, pp 354-361.

FRETWELL, J. 1982. *Ward Teaching and Learning: Sister and the learning environment.* RCN Research Series: London, Royal College of Nursing.

GERRISH, K. 1999. *A Comparative Study of the Newly Qualified Staff Nurse's Perception of the Transition From Student to Qualified Nurse: Summary Report.* Sheffield Hallam University.

GIBBS, G. 1988. *Learning by Doing: a guide to teaching and learning methods.* Oxford: Further Education Unit.

GILBERT, N. 1993. *Researching Social Life.* London: Sage Publications.

GLASER, B. & STRAUSS, A. 1967. *The Discovery of Grounded Theory: strategies for qualitative research.* New York: Aldine de Gruyter.

GLEN, S. 1995. Towards a New Model of Nursing Education. *Nurse Education Today.* 15, pp 90-95.

GOSBY, J. 1987. *Individual Learning Styles as a Factor Affecting Nursing Curricula.* Unpublished MA (Ed). Dissertation, Southampton University

GOTT, M. 1984. *Learning Nursing: A study of effectiveness and relevance of teaching provided during student nurse introductory course.* London, Royal College of Nursing.

GRAHAM, I. 1995. Reflective Practice: using the action learning group mechanism. *Nurse Education Today.* 15, pp 28-32.

GRAY, W. 1989. Situational Mentoring: custom designing planned mentoring programs. *Mentoring International.* Vol 3, No.1 - Winter 1989.

GRAY, M. 1998. *A Longitudinal Investigation into the First Year Experiences of Being a Staff Nurse: the transition from diplomate to staff nurse.* Edinburgh: Napier University.

GREENWOOD, J.1993. Reflective Practice: a critique of the work of Argyris and Schon. *Journal of Advanced Nursing.* 18, pp 183-1187.

GREENHALGH & COMPANY LIMITED. 1994. *The Interface Between Junior Doctors and Nurses.* Macclesfield: Greenhalgh & Co.

GUBA, E. & LINCOLN, Y. 1985. *Effective Evaluation: improving the usefulness of evaluation on results through responses and naturalistic approaches.* San Francisco: Jossey Bass.

HAMMERSLEY, M. 1992. *What's Wrong With Ethnography?* London: Routledge.

HAMMERSLEY, M. & ATKINSON, P. 1983. *Ethnography: principles in practice.* London: Tavistock Publications.

HAMMERSLEY, M. & ATKINSON, P. 1995. *Ethnography: principles in practice.* 2nd ed. London: Routledge.

HENDERSON, V. 1969. *The Basic Principles of Nursing Care.* Geneva: International Council of Nurses.

HISLOP, S. INGLIS, B. COPE, P. STODDART, B. & McINTOSH, C. 1996. Situating Theory in Practice: Student views of theory-practice in Project 2000 nursing programmes. *Journal of Advanced Nursing,* 23, pp 171-177.

HOLLOWAY, I. 1997. *Basic Concepts for Qualitative Research.* Oxford: Blackwell Science Ltd.

HOLLOWAY, I. & WHEELER, S. 1996. *Qualitative Research for Nurses.* Oxford: Blackwell Science Ltd.

HONEY, P. & MUMFORD, A. 1986. *Manual of Learning Styles.* Berkshire: Honey & Mumford.

HORDER, J. Chairman. 1943. *Nursing Reconstruction Committee, Report.* London: Royal College of Nursing.

HYLAND, T. 1994. Experiential Learning, Competence and Critical Practice in Higher Education. *Studies in Higher Education.* 19 (3) pp 327-339.

IWASIW, C. & SLEIGHTHOLM-CAIRNS, B. 1990. Clinical Conferences: the key to successful experiential learning - Pre and Post Conferencing. *Nurse Education Today.* 10, pp 260-265.

JARVIS, P. HOLFORD, J. & GRIFFIN, C. 1998. *The Theory and Practice of Learning.* London: Kogan Page.

JOHNS, C. 1994. Guided Reflection. *In*: PALMER, A. BURNS S. & BULMAN, C. eds. *Reflective Practice in Nursing: the growth of the professional practitioner.* Oxford: Blackwell Scientific Publications.

JOHNS, C. 1995. Framing Learning Through Reflection Within Carper's Fundamental Ways of Knowing in Nursing. *Journal of Advanced Nursing.* 22, pp 226-234.

JOHNSON, M. 1995. Coping With Data in Ethnographic Study. *Nurse Researcher.* Vol 3, No.2 December.

JOWETT S. WALTON, I. & PAYNE, S. 1992. *Implementing Project 2000: an interim report.* Berkshire: National Foundation for Education Research.

JOWETT, S. WALTON, I. & PAYNE, S. 1994. *Challenges and Change in Nurse Education - a study of the implementation of Project 2000.* Berkshire: National Foundation for Education Research.

KITZINGER, J. 1994. The Methodology of Focus Groups: The importance of interaction between research participants. *Sociology of Health and Illness.* Vol. 16, (1), pp 103-121.

KLEIN, R. 2001. *The New Politics of the NHS.* 4th ed. Prentice Hall.

KNOWLES, M. 1975. *Self-directed Learning: a guide for learners and teachers.* New York: Association Press.

KNOWLES, M. 1984. *The Adult Learner: a neglected species.* 3rd ed. Houston: Gulf Publishing.

KOCH, T. 1994. Establishing Rigour in Qualitative Research: The decision trail. *Journal of Advanced Nursing.* 19, pp 976-986.

KOHNER, N. 1994. *Clinical Supervision in Practice.* London: Kings Fund Centre.

KOLB, D. and FRY, R. 1975. Towards an Applied Theory of Experiential Learning I*n*: Cooper, G. ed. *Theories of Group Processes.* Chichester: Wiley and Sons.

KRAMER, M. 1974. *Reality Shock: why nurses leave nursing.* St Louis: Mosby.

KVALE, S. 1996. *Interviews: an introduction to qualitative research interviewing.* Thousand Oaks: Sage Publications.

LASCHINGER, H.1986. Learning Styles of Nursing Students and Environmental Press: perceptions of two clinical nursing settings. *Journal of Advanced Nursing,* 11, pp 289-294.

LASCHINGER, H. & BOSS, M. 1984. Learning Styles of Nursing Students and Career Choices. *Journal of Advanced Nursing.* 9, pp 375-380.

LATHLEAN, J. 1997. *Lecturer Practitioners in Action.* Oxford: Butterworth Heinemann.

LAWLER, J. 1991. *Behind the Screens: nursing, somology, and the problem of the body.* Melbourne: Churchill Livingstone.

LE VAR, R. 1997a. Project 2000: A new preparation for practice - has the policy been realized? Part 1. *Nurse Education Today.* 17, pp 171-177.

LE VAR, R. 1997b. Project 2000 : A new preparation for practice - has the policy been realized? Part 2. *Nurse Education Today.* 17, pp 263-273.

LIPSON, J. 1989. The Use of Self in Ethnographic Research. *In:* MORSE, J. ed. *Qualitative Nursing Research: a contemporary dialogue.* Thousand Oaks: Sage Publications.

LUKER, K. CARLISLE, C. DAVIS, C. RILEY, E. STILWELL, J. & WILSON, R.1996 *Project 2000 Fitness for Practice.* Joint Report of the Universities of Liverpool and Warwick to the Department of Health.

MACLEOD-CLARK, J. MABEN, J. & JONES, K.1997. Project 2000: Perceptions of the philosophy and practice of nursing: shifting perceptions - a new practitioner. *Journal of Advanced Nursing.* 26, pp 161-168.

MAEVE, K.1994. The Carrier Bag Theory of Nursing Practice. *Advanced Nursing Science.* 16 (4) pp 9-22.

MASON, J. 1996. *Qualitative Researching.* London: Sage Publications.

MAY, N. & VEITCH, L. 1998. Working to Learn and Learning to Work: placement experience of Project 2000 students in Scotland. *Nurse Education Today.* 18, pp 630-636.

McELROY, A. 1997. Developing the Nurse Teacher's Role: the use of multiple focus groups to ensure grassroots involvement. *Nurse Education Today.* 17, pp 145-149.

McGILL, I. & BEATY, L. 1992. *Action Learning: a practitioner's guide.* London: Kogan Page Ltd.

MELIA, K. 1987. *Learning and Working: the occupational socialization of nurses.* London: Tavistock Publications.

MILES, M. & HUBERMAN, A. 1994. *Qualitative Data Analysis.* 2nd ed. Thousand Oaks: Sage Publications.

MILLER, C. TOMLINSON, A. & JONES, M. 1994. *Learning Styles and Facilitating Reflection*. London: E.N.B.

MORGAN, D.L. 1988. *Focus Groups as Qualitative Research*. Sage Publications University Paper Series on Qualitative Research Methods Vol 16; Beverly Hills CA: Sage Publications.

MORSE, J. ed. 1994. *Critical Issues in Qualitative Research Methods*. Thousand Oaks: Sage Publications.

MORTON-COOPER, A. & PALMER, A. 1993. *Mentoring and Preceptorship: a guide to support roles in clinical practice*. Oxford: Blackwell Scientific Publications

MORTON-COOPER, A. & PALMER, A. 2000. *Mentoring, Preceptorship and Clinical Supervision: a guide to professional roles in clinical practice*. 2nd ed. Oxford: Blackwell Science Ltd

NEARY, M. 1996. *An Investigation of the assessment of student clinical competencies during the common foundation programme (CFP) of Project 2000*. Unpublished PhD Thesis: University of Wales, Cardiff.

NEARY, M.1997. Project 2000 Students' Survival Kit: a return to the practical room (nursing skills laboratory). *Nurse Education Today*. 17, pp 46-52.

NEARY, M. 2000. Supporting Students' Learning and Professional Development Through the Process of Continuous Assessment and Mentorship. *Nurse Education Today*. 20 (6), pp 463-474.

NIGHTINGALE, F. 1859. *Notes on Nursing: what it is and what it is not.* Philadelphia: J B Lippincott; (1946); [facsimile of 1st edition, London, Harrison & Son].

NOLAN, J. & NOLAN, M. 1997a. Self-Directed and Student-Centred Learning in Nurse Education: 1. *British Journal of Nursing*. 6, 1, pp 51-55.

NOLAN, J. & NOLAN, M. 1997b. Self-Directed and Student-Centred Learning in Nurse Education: 2. *British Journal of Nursing*. 6, 2, pp 103-107.

O'CONNER, S. PEARCE, J. SMITH R. VOGELI, D. & WALTON, P. 1999. Monitoring the Quality of Pre-Registration Education: Development, validation and piloting of competency based performance indicators for newly qualified nurses. *Nurse Education Today*. 19, pp 334-341.

OGIER, M. 1982. *An Ideal Sister? a study of leadership style and verbal interaction of ward sisters with nurse learners in general hospitals.* London, Royal College of Nursing.

OLIVER, R. & ENDERSBY, C. 1994. *Teaching and Assessing Nurses: a handbook for preceptors.* London: Balliere Tindall.

ORTON, H. 1981. *Ward Learning Climate: a study of the role of the ward sister in relation to student nurse learning on the ward.* London: Royal College of Nursing.

OSTMOE, P. VAN-HOOZER, H. SCHEFFEL, A. & CROWELL, C.1984. Learning Style Preferences and Selection of learning Strategies: Consideration and implications for nurse education. *Journal of Nursing Education.* 23, 1, pp 27-30.

PALMER, A. BURNS, S. & BULMAN, C. eds. 1994. *Reflective Practice in Nursing: the growth of the professional practitioner.* Oxford: Blackwell Scientific Publications.

PARAHOO, K. 1997. *Nursing Research: Principles, process and issues.* Basingstoke: Macmillan Press.

PARKER, D. 1997. Nursing Art and Science: literature and debate. *In:* MARKS-MARAN, D & ROSE, P. eds. *Reconstructing Nursing: Beyond art and science.* London: Balliere Tindall.

PARKER, T. & CARLISLE, C. 1996. Project 2000 Students' Perceptions of Their Training *Journal of Advanced Nursing.* 24, pp 771-778.

PARKER, D. WEBB, J. & D'SOUZA, B. 1995. The Value of Critical Incident Analysis as an Educational Tool and its Relationship to Experiential Learning. *Nurse Education Today.* 15, pp 111-116.

PEDLEY, G. & ARBER, A.1997. Nursing Students' Response to Self-Directed Learning: an evaluation of a learning process applying Jarvis' framework. *Journal of Advanced Nursing.* 25, pp 405-411.

PEMBREY, S. 1980. *The Ward Sister - Key to Nursing: a study of the organisation of individualised nursing.* London: Royal College of Nursing.

PHILLIPS, T. BEDFORD, H. ROBINSON, J. & SCHOSTAK, J. 1994. *Education, Dialogue and Assessment: creating partnership for improving practice.* London: E.N.B.

PHILLIPS, R. DAVIES, W. & NEARY, M. 1996. The Practitioner-Teacher: a study in the introduction of mentors in the pre-registration nurse education programme in Wales, Part 1. *Journal of Advanced Nursing*. 23 (5), pp 1037-1044

PLATT, H. Chairman. 1964. *A Reform of Nurse Education, Report*. London: Royal College of Nursing.

POWELL, J. 1989. The Reflective Practitioner in Nursing. *Journal of Advanced Nursing*. 14, pp 824-832.

PRYJMACHUK, S. 1996. A Nursing Perspective on the Interrelationships Between Theory, Research and Practice. *Journal of Advanced Nursing*. 23, pp 679-684.

RANADE, W. 1994. *A Future for the NHS? Health Care in the 1990's*. London: Longman.

RANADE, W. 1997. *A Future for the NHS? Health care for the millennium*. 2nd ed. London: Longman.

ROBSON, C. 1993. *Real World Research: a resource for social scientists and practitioner-researchers*. Oxford: Blackwell.

ROLFE, G.1993. Closing the Theory-Practice Gap: a model of nursing praxis'. *Journal of Clinical Nursing*. pp 173-177.

ROLFE, G. 1996. *Closing the Theory Practice Gap: a new paradigm for nursing*. Oxford: Butterworth-Heinemann.

ROPER, N. LOGAN, W. & TIERNAY, A. 1989. *The Elements of Nursing: a model for nursing based on a model of living*. Edinburgh: Churchill Livingstone.

ROSE, P. 1997. Science and Technology: Tools in the creation of Nursing. *In:* MARKS-MARAN, D. & ROSE, P. eds. *Reconstructing Nursing: Beyond art and science*. London: Balliere Tindall.

ROYAL COLLEGE OF NURSING. 1985. *The Education of Nurses: A New Dispensation*. Commission on Nursing Education (The Judge Report); London: RCN.

RUBIN, H. & RUBIN, I. 1995. *Qualitative Interviewing: the art of learning data*. Thousand Oaks: Sage Publications.

RYAN, G. 1993. Student Perceptions About Self-Directed Learning in a Professional Course Implementing Problem-based Learning. *Studies in Higher Education*. 18, 1, pp 53-63.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT. 1999., *Our National Health, a plan for Action, a plan for Change*. Edinburgh, S.E.H.D.

SCHOFIELD, M. 1996. *The Future Healthcare Workforce : the steering group report.* Manchester: Health Services Management Unit.

SCHON, D. 1983. *The Reflective Practitioner: how professionals think in action.* Aldershot: Arena.

SCHON, D. 1987. *Educating the Reflective Practitioner: towards a new design for teaching and learning in the professions.* San Francisco: Jossey-Bass.

SCOTT-WRIGHT, M. 1961. *A Study of the Performance of Student Nurses in Relation to a New Method of Training With Special Reference to the Evaluation of an Experimental Course of Basic Nurse Education Being Conducted in Scotland.* Unpublished PhD thesis, University of Edinburgh.

SILVERMAN, D. 1997. *Qualitative Research: theory, method and practice.* London: Sage Publications.

SKELTON, G. PARTLOW, C. ANDREWES, C. GALVIN, K. & JONES, J. 1998. *The Effective Performance of the Clinical Link Lecturer Role: Phase 3.* Bournemouth University: Institute of Health and Community Studies.

SMITH, P. 1992. *The Emotional Labour of Nursing.* London; MacMillan Press.

SPRADLEY, J. 1980. *Participant Observation.* Fort Worth: Harcourt Brace Jovanovich College Publishers.

STEINAKER, N. & BELL, M. 1979. *The Experiential Taxonomy : a new approach to teaching and learning.* New York: Academic Press.

STRAUSS, A. & CORBIN, J. 1990. *Basics of Qualitative Research : grounded theory procedures and techniques.* Thousand Oaks: Sage Publications.

STRAUSS, A. & CORBIN,.J. 1998. *Basics of Qualitative Research: techniques and procedures for developing grounded theory.* 2nd ed. Sage Publications.

STREUBERT, H. & CARPENTER, D. 1995. *Qualitative Research in Nursing: advancing the humanistic imperative.* Philadelphia: Lippincott Williams and Watkins.

STREUBERT, H. & CARPENTER, D. 1999. *Qualitative Research in Nursing: advancing the humanistic imperative.* 2nd ed. Philadelphia: Lippincott Williams and Watkins.

THOMAS, J. 1993. *Doing Critical Ethnography: qualitative research methods series 26.* Thousand Oaks: Sage Publications.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1986. *Project 2000: A New Preparation for Practice.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1987. *Project 2000: the final proposals.* Project paper 9, February 1987, London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1990. *The Report of the Post-Registration Education and Practice Project (PREPP).* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1992. *Code of Professional Conduct.* 3rd ed London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1993a. *The Council's Position Concerning a Period of Support and Preceptorship for Nurses, Midwives and Health Visitors Entering or Re-entering Registered Practice, Annex One to Registrar's Letter 1/1993.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1993b. *Midwives Rules.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1994a. *The Future of Professional Practice - The Councils Standards for Education and Practice following Registration; March 1994.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1994b. *Midwives Code of Practice.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1996. *Position Statement on Clinical Supervision for Nursing and Health Visiting*. London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1999. *Fitness for Practice: The UKCC Commission for Nursing and Midwifery Education*. London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2000a. *Requirements for pre-registration nursing programmes.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2000b. *Registrar's Letter 15/2000 Directives 77/453/EEC Training programme for nurses responsible for general care.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2000c. *Standards for the preparation of teachers of nursing, midwifery and health visiting.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2001. *The PREP Handbook.* London: U.K.C.C.

USHER, R., & BRYANT, I. 1989; *Adult Education as Theory, Practice and Research : the captive triangle;* London: Routledge.

WATSON, H. & HARRIS, B. 1999. *Supporting Students in Practice Placements in Scotland.* Glasgow: Glasgow Caledonian University.

WEBB, C.1992. The Use of the First Person in Academic Writing: objectivity, language and gatekeeping. *Journal of Advanced Nursing*. 17, pp 747-752.

WILCOX, S. 1996. Self-Directed Learning in the University Setting. *Studies in Higher Education*. 21, 2, pp 165-176.

WOOD, R. Chairman. 1945. *Working Party on the Recruitment and Training of Nurses*. Report of the Interdepartmental Working Party, London: Ministry of Health.

WHITE, A. FITZPATRICK, J. & ROBERTS, J. 1994. An Exploratory Study of Similarities and Differences Between Senior Students from Different Pre-Registration Nurse Education Courses. *Nurse Education Today*. 18, pp 190-198.

BIBLIOGRAPHY

ABBOTT, P. & SAPSFORD, R. 1992. *Research Into Practice: a reader for nurses and the caring professions.* Buckingham: Open University Press.

ANDREWS, M. & CHILTAN, F. 2000. Student and Mentor Perceptions of Mentoring Effectiveness. *Nurse Education Today,* 20, pp.555-562.

ASHWORTH, P. GERRISH, K. HARGREAVES, J. & McMANUS, M. 1999.'Levels' of Attainment in Nursing Practice: reality or illusion? *Journal of Advanced Nursing,* 30 (1), pp.159-168.

ATKINSON, P. 1990. *Ethnographic Imagination: textual constructions of reality.* London: Routledge.

ATKINSON, P. 1992. *Understanding Ethnographic Texts: qualitative research methods series 25.* Newbury Park: Sage Publications.

BARTLETT, H. HIND, P. TAYLOR, H. & WESCOTT, L. 1998. *An Evaluation of Pre-Registration Nursing Education: a literature review & comparative study of graduate outcomes.* Oxford: Oxford Centre for Health Care Research and Development.

BASZANGER, I. & DODIER, N. 1997. Ethnography: Relating the part to the whole. *In:* Silverman, D. ed. *Qualitative Research: theory, method and practice.* London: Sage Publications.

BAUME, D.1998. *Portfolio Guide for the Open University Course H851 Teaching in Higher Education.* Milton Keynes: Open University.

BEAUCHAMP, T. & CHILDRESS, J. 1994. *Principles of Biomedical Ethics.* 4th Ed. New York: Oxford University Press.

BENNER, P. 1984. *From Novice to Expert: excellence and power in clinical nursing practice.* California: Addison-Wesley.

BERG, B. 1989. *Qualitative Research Methods for the Social Sciences.* Massachusetts: Allyn and Bacon.

BINNIE, A. & TITCHEN, A. 1999. *Freedom to Practise: the development of the patient-centred nursing.* Oxford: Butterworth Heinemann.

BISHOP, V. 1998. *Clinical Supervision in Practise: some questions, answers and guidelines.* London: Macmillan Press.

BLAXTER, L. HUGHES, C. & TIGHT, M. 1996. *How to Research.* Buckingham: Open University Press.

BOUD, D. COHEN, R. & WALKER, D. eds. 1993. *Using Experience for Learning.* Buckingham: SRHE and Open University Press.

BOUD, D. 1995. *Enhancing Learning through Self Assessment.* London: Kogan Page.

BOUD, D. & MILLER, N. 1996. *Working with Experience: animated learning.* London: Routledge.

BOUD, D. & FELETTI, G. 1997. *The Challenge of Problem Based Learning.* 2nd ed. London: Kogan Page.

BOURNEMOUTH UNIVERSITY. 1990. *BSc (Hons) Clinical Nursing with Professional Registration: Student Handbook.* Department of Nursing Health and Community Studies: Bournemouth University.

BOYLE, J. 1994. Styles of Ethnography *In:* Morse, J. ed. *Critical Issues in Qualitative Research Methods.* Thousand Oaks: Sage Publications.

BRADSHAW, P. 1989. ed. *Teaching and Assessing in Clinical Nursing Practice.* London: Prentice Hall.

BRADSHAW, P. 1995. The Recent Health Reforms in the United Kingdom: Some tentative observations on their impact on nurses and nursing in hospitals. *Journal of Advanced Nursing.* 21,pp 975-979.

BRANDES, D. & GINNIS, P. 1986. *A Guide to Student-Centred Learning.* Oxford: Basil Blackwell Ltd.

BRIGGS, A. 1972. Chairman. *Report of the Committee on Nursing.* London: HMSO.

BUCHAN, J. & O'May, F. 1998. Nursing Supply and Demand: reviewing the evidence. *Nursing Times.* Vol 94, No 26, pp 60-63.

BURAWOY, M. BURTON, A. FERGUSON, A. FOX, K. GAMSON, J. GARTRELL, N. HURST, L. KURZMAN, C. SALZINGER, L. SCHIFFMAN, J. & UI, S., 1991. *Ethnography Unbound: power and resistance in the modern metropolis.* Berkeley: University of California Press.

BUTTERWORTH, T. & FAUGIER, J. 1992. *Clinical Supervision and Mentorship in Nursing.* London: Chapman & Hall.

BUTTERWORTH, T. FAUGIER, J. & BURNARD, P. eds. 1998. *Clinical Supervision and Mentorship in Nursing.* London: Stanley Thornes Publishers

BUZAN, T. & BUZAN, B. 1995. *The Mindmap Book: Radiant thinking, the major evolution in human thought.* 2nd ed. London: BBC Books.

CALLAGHAN, I. & McLAFFERTY, I. 1997. An Audit Tool for Assessing the Learning Environment for Project 2000. *Nurse Education Today.* 17, pp 338-342.

CAMERON-JONES, M. O'HARA, P. & LINTON, A. 2000. *Evaluation of the Role of Nurse and Midwife Teachers in Support, and in the Quality Assurance of the Work, of Practice Placement Supervisors.* Edinburgh: The University of Edinburgh.

CAMPBELL, I. LARRIVEE, L. FIELD, P. DAY, R. & REUTTER, L.1994. Learning to Nurse in the Clinical Setting; *Journal of Advanced Nursing.* 20, pp 1125-1132.

CAREY, M. 1994. The Group Effect in Focus Groups: Planning, implementing and interpreting focus group research. *In:* Morse, J. ed. *Critical Issues in Qualitative Research Methods.* Thousand Oaks: Sage Publications.

CARPER, B. 1978. Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science.* 1, (1), pp 13-23.

CARR, W. 1995. *For Education: towards critical educational inquiry.* Buckingham: Open University Press.

CARR, W. & KEMMIS, S. 1986. *Becoming Critical: education, knowledge and action research.* London: The Falmer Press.

CARSON, S. & HAMER, S. 1997. Evaluating the Impact of Education and Training in the Health Service. *NHS Executive.*

CARSPECKEN, P. 1996. *Critical Ethnography in Educational Research: a theoretical and practical guide.* New York: Routledge.

CASEY, G. 1996 The Curriculum Revolution and Project 2000: a critical examination. *Nurse Education Today.* 16, pp 115-120.

CAVANAGH, S. HOGAN, K. & RAMGOPAL, T. 1995. The Assessment of Student Nurse Learning Styles Using the Kolb Learning Styles Inventory. *Nurse Education Today.* 15, pp 177-183.

CHEEK, J. 2000. *Postmodern and Poststructural Approaches to Nursing Research.* Thousand Oaks: Sage Publications.

CLARE, J. 1993. Change the Curriculum - or Transform the Conditions of Practice? *Nurse Education Today.* 15; pp 282-286.

CLARK, J. DEAN, D. KITSON, A. McFARLANE, J. PEMBREY, S. PICKERSGILL, F. TAIT, J. TIFFANY, R. WILSON-BARNETT, J. & WINDER, E. 1987. *In Pursuit of Excellence: a position statement on nursing.* London: The Royal College of Nursing.

COHEN, L. & MANION, L. 1994. *Research Methods in Education.* 4th ed. London: Routledge.

COLLINGWOOD, M. 1996. *The Goals of Nurse Education 1948-1992.* Unpublished PhD Thesis, Herriot Watt University.

COPE, P. CUTHBERTSON, P. & STODDART, B. 2000. Situated Learning in the Practice Placement. *Journal of Advanced Learning.* 31 (4), pp 850-856.

COUNCIL of DEANS and HEADS of UK UNIVERSITY FACULTIES for NURSING, MIDWIFERY & HEALTH VISITING. 1998. *Breaking the Boundaries: Educating Nurses, Midwives and Health Visitors for the Next Millennium: A position paper.*

D'A SLEVIN, O. 1993. Facing the Future: Credibility in a changing world. *Nurse Education Today.* 13, pp 241-249.

D'A SLEVIN, O. & LAVERY, M. 1991. Self-Directed Learning and Student Supervision. *Nurse Education Today.* 11, pp 368-377.

DAVIES, S. TWINN, S. & RILEY, E. 1993. *A Detailed Study of the Relationships between Teaching, Support, Supervision and Role Modelling for Students in Clinical Areas, Within the Context of Project 2000 Courses.* London: E.N.B.

DAY, M. EDWARDS, C. & WATKINS, S. 1997. *Using Occupational Standards as a Complement to the Continuing Development of Healthcare Professionals and the Factors Which May Enhance or Inhabit This Approach.* The Norfolk and Norwich NHS Trust and the University of Sheffield.

DENZIN, N. & LINCOLN, Y. 1998. *The Landscape of Qualitative Research: theories and issues.* Volume 1. Thousand Oaks: Sage Publications.

DENZIN, N. & LINCOLN, Y. 1998. *Strategies of Qualitative Inquiry.* Volume 2. Thousand Oaks: Sage Publications.

DENZIN, N. & LINCOLN, Y. 1998. *Collecting and Interpreting Qualitative Materials.* Volume 3. Thousand Oaks: Sage Publications.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES. 1979. *The Nurses, Midwives and Health Visitors Act.* London: HMSO.

DEPARTMENT OF HEALTH. 1989a. *Caring for People.* London: HMSO.

DEPARTMENT OF HEALTH. 1989b. *Working for Patients.* London: HMSO.

DEPARTMENT OF HEALTH. 1989c. *A Strategy for Nursing.* London: HMSO.

DEPARTMENT OF HEALTH. 1990 *The Community Care Act.* London: HMSO.

DEPARTMENT OF HEALTH. 1992. *The Health of the Nation: A strategy for health in England.* London: HMSO.

DEPARTMENT OF HEALTH. 1994. *The Heathrow Debate: the challenges for nursing and midwifery in the 21st Century.* London: HMSO

DEPARTMENT OF HEALTH. 1997. *New NHS: Modern, Dependable.* London: The Stationery Office.

DEPARTMENT OF HEALTH. 1998. *A First Class Service: quality in the new NHS.* Leeds: Department of Health.

DEPARTMENT OF HEALTH. 1999a. *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare.* Leeds: Department of Health.

DEPARTMENT OF HEALTH. 1999b. *Modernising Health and Social Services: developing the workforce.* Leeds: Department of Health.

DEPARTMENT OF HEALTH. 1999c. *Review of the Nurses, Midwives and Health Visitors Act: Government response to the recommendations.* Leeds: Department of Health.

DEPARTMENT OF HEALTH. 2000. *The NHS Plan: an action guide for nurses, midwives and health visitors.* Leeds: Department of Health.

DREHER, M. 1994. Dialogue: on Emic and Etic. *In:* Morse, J. ed. *Critical Issues in Qualitative Research Methods.* CA: Sage Publications Publications.

DRISCOLL, J. 2000. *Clinical Supervision: a reflective approach.* Bailliere Tindall.

EARNSHAW, G. 1995. Mentorship: the Students' Views. *Nurse Education Today.* 15, pp 274-279.

ELKAN, R. & ROBINSON, J. 1993. Project 2000: the Gap Between Theory and Practice. *Nurse Education Today.* 13, pp 295-298.

ELKAN, R. & ROBINSON, J. 1994. *Project 2000: A review of published research.* University of Nottingham: Department of Nursing Studies.

ELY, M. ANZUL, M. FRIEDMAN, T. GARNER, D & McCORMACK STEINMETZ, A. 1991. *Doing Qualitative Research: circles within circles.* London: The Falmer Press.

ENGEL, C. 1997. Not just a method but a way of learning. *In* BOUD, D & FELETTI, G. eds. *The Challenge of Problem Based Learning.* 2nd ed. London: Kogan Page.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1985. *Professional Education/Training Courses.* Consultation Paper, London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1992. *3 Year Undergraduate Nursing and Midwifery Courses Leading to Admission to the Professional Register.* E.N.B. 11 5; 124th Meeting - 14.7.92.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1993a. *Regulations and Guidelines for the Approval of Institutions and Courses.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1993b. *A Detailed Study of the Relationships Between Teaching, Support, Supervision and Role Modelling in Clinical Areas Within the Context of the Project 2000 Courses.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994a. *Creating Lifelong Learners.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994b. *DCL/25/RLV/November 1994.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994c. *Researching Professional Education: learning styles and facilitating reflection.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994d. *Researching Professional Education: education, dialogue and assessment: creating partnership for improving practice.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1994e. *The Current Teaching Provision for Individual Learning Styles of Students on Pre-Registration Diploma Programmes in Adult Nursing.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1995a. *A Comparative Study of Outcomes of Pre-Registration Nurse Education Programmes: Interim report.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 1995b. *The Evolving Role of the Nurse Teacher in the Light of the Educational Reform.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING., 1995c. *Regulations and Guidelines for the Approval of Institutions and Courses.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 2000. *Education in Focus: strengthening pre-registration nursing and midwifery education - curriculum guidance & requirements.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 2001a. *Preparation of mentors & teachers: A new framework for guidance.* London: E.N.B.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING. 2001b. *Placements in Focus: guidance for education in practice for health care professions.* London: E.N.B.

ENTWISTLE, N. 1981. *Styles of Learning and Teaching: an integrated outline of educational psychology for students, teachers and lecturers.* John Wiley & Sons.

ERAUT, M. ALDERTON, J. BOYLAN, A. WRAIGHT, A. 1995. *Learning to Use Scientific Knowledge in Education and practice Settings: an evaluation of the contribution of the biological behavioural and social sciences to pre-registration nursing and midwifery programmes.* London: E.N.B.

FATCHETT, A. 1998. *Nursing in the New Modern, Dependable?* London: Bailliere Tindall.

FETTERMAN, D., 1989. *Ethnography: step by step.* Newbury Park Thousand Oaks: Sage Publications.

FIELD, P. & MORSE, J. 1985. *Nursing Research: the application of qualitative approaches.* London: Chapman and Hall.

FISH, D. & TWINN, S. 1997. *Quality Clinical Supervision in the Health Care Professions: principled approaches to practice.* Oxford: Butterworth Heinemann.

FISH, D. 1998. *Appreciating Practice in the Caring Professions: refocusing professional development & practitioner research.* Oxford: Butterworth Heinemann.

FISH, D. & COLES, C. 1998. *Developing Professional Judgement in Health Care: learning through the critical appreciation of practice.* Oxford: Butterworth Heinemann.

FRANCKE, A. & ERKENS, T. 1994. Confluent Education: an integrative method for nursing (continuing) education. *Journal of Advanced Nursing.* 19, pp 354-361.

FRETWELL, J. 1982. *Ward Teaching and Learning: Sister and the learning environment.* RCN Research Series: London, Royal College of Nursing.

GERRISH, K. 1999. *A Comparative Study of the Newly Qualified Staff Nurse's Perception of the Transition From Student to Qualified Nurse: summary report.* Sheffield Hallam University.

GIBBS, G. 1988. *Learning by Doing: A guide to teaching and learning methods.* Oxford: Further Education Unit.

GIBBS, G. 1996. *Improving Student Learning: Using research to improve student learning.* Oxford: The Oxford Centre for Staff Development.

GILBERT, N. 1993. *Researching Social Life.* London: Sage Publications.

GLASER, B. & STRAUSS, A. 1967. *The Discovery of Grounded Theory: strategies for qualitative research.* New York: Aldine de Gruyter.

GLEN, S. 1995. Towards a New Model of Nursing Education. *Nurse Education Today.* 15, pp 90-95.

GLEN, S. & WILKIE, K. 2000. *Problem-Based Learning in Nursing: a new model for a new context?* London: Macmillan Press Ltd.

GOSBY, J. 1987. *Individual Learning Styles as a Factor Affecting Nursing Curricula.* Unpublished MA (Ed). Dissertation, Southampton University

GOTT, M. 1984. *Learning Nursing: A study of effectiveness and relevance of teaching provided during student nurse introductory course.* London, Royal College of Nursing.

GOTT, M. 2000. *Nursing Practice Policy and Change.* Oxford: Radcliffe Medical Press.

GRAHAM, I. 1995. Reflective Practice: Using the action learning group mechanism. *Nurse Education Today.* 15, pp 28-32.

GRAY, W. 1989. Situational Mentoring: Custom designing planned mentoring programs. *Mentoring International.* Vol 3, No.1 - Winter 1989.

GRAY, M. 1998. *A Longitudinal Investigation into the First Year Experiences of Being a Staff Nurse: the transition from diplomate to staff nurse.* Edinburgh: Napier University.

GREENWOOD, J.1993. Reflective Practice : A critique of the work of Argyris and Schon. *Journal of Advanced Nursing.* 18, pp 183-1187.

GREENHALGH & COMPANY LIMITED. 1994. *The Interface Between Junior Doctors and Nurses.* Macclesfield: Greenhalgh & Co.

GREENWOOD, J. & WINFREYDA, A. 1995. Two Strategies for Promoting Clinical Competence in Pre-Registration Nursing Students. *Nurse Education Today;* (1995), 15, pp 184 -189.

GRILLS, S. ed. 1998. *Doing Ethnographic Research: fieldwork settings.* Thousand Oaks: Sage Publications.

GUBA, E. & LINCOLN, Y. 1985. *Effective Evaluation: improving the usefulness of evaluation on results through responses and naturalistic approaches.* San Francisco: Jossey Bass.

HAMMERSLEY, M. 1992. *What's Wrong With Ethnography?* London: Routledge.

HAMMERSLEY, M. & ATKINSON, P. 1983. *Ethnography: principles in practice.* London: Tavistock Publications.

HAMMERSLEY, M. & ATKINSON, P. 1995. *Ethnography: principles in practice.* 2nd ed. London: Routledge.

HENDERSON, V. 1969. *The Basic Principles of Nursing Care.* Geneva: International Council of Nurses.

HENNESSY, D. & SPURGEON, P. 2000. *Health Policy and Nursing: influence, development and impact.* London: Macmillan Press Ltd.

HISLOP, S. INGLIS, B. COPE, P. STODDART, B. & McINTOSH, C. 1996. Situating Theory in Practice: Student views of theory-practice in Project 2000 nursing programmes. *Journal of Advanced Nursing,* 23, pp 171-177.

HOGSTON, R. 1993. From Competent Novice to Competent Expert: a discussion of competence in the light of the post registration and practice project (PREPP). *Nurse Education Today.* 13, pp 167-171.

HOLLOWAY, I. 1997. *Basic Concepts for Qualitative Research.* Oxford: Blackwell Science Ltd.

HOLLOWAY, I. & WHEELER, S. 1996. *Qualitative Research for Nurses.* Oxford: Blackwell Science Ltd.

HONEY, P. & MUMFORD, A. 1986. *Manual of Learning Styles.* Berkshire: Honey & Mumford.

HORDER, J. Chairman. 1943. *Nursing Reconstruction Committee, Report.* London: Royal College of Nursing.

HULL, C. & REDFERN, L. 1996. *Profiles and Portfolios: a guide for nurses and midwives.* Hampshire: Macmillan Press Ltd.

HYLAND, T. 1994. Experiential Learning, Competence and Critical Practice in Higher Education. *Studies in Higher Education.* 19 (3) pp 327-339.

ILLICH, I. & VERNE, E. 1976. *Imprisoned in the Global Classroom.* London: Writers and Readers.

IWASIW, C. & SLEIGHTHOLM-CAIRNS, B. 1990. Clinical Conferences: the key to successful experiential learning - Pre and Post Conferencing. *Nurse Education Today.* 10, pp 260-265.

JARVIS, P. 1992. Quality in Practice: the role of education. *Nurse Education Today.* 12, pp 3-10.

JARVIS, P. & GIBSON, S. 1997. *The Teacher Practitioner and Mentor in Nursing, Midwifery, Health Visiting and the Social Services.* Cheltenham: Stanley Thornes Publishers Ltd.

JARVIS, P. HOLFORD, J. & GRIFFIN, C. 1998. *The Theory and Practice of Learning.* London: Kogan Page.

J. M. CONSULTING. 1996. *The Regulation of Health Professions: report of a review of the professions supplementary to medicine Act (1960) with recommendations for new legislation.* London: J. M. Consulting.

J. M. CONSULTING. 1996. *The Regulation of Nurses, Midwives and Health Visitors.* London: J. M. Consulting.

JOHNS, C. 1994. Guided Reflection. *In*: PALMER, A. BURNS S. & BULMAN, C. eds. *Reflective Practice in Nursing: the growth of the professional practitioner.* Oxford: Blackwell Scientific Publications.

JOHNS, C. 1995. Framing Learning Through Reflection Within Carper's Fundamental Ways of Knowing in Nursing. *Journal of Advanced Nursing.* 22, pp 226-234.

JOHNSON, M. 1995. Coping With Data in Ethnographic Study. *Nurse Researcher.* Vol 3, No.2 December.

JOWETT S. WALTON, I. & PAYNE, S. 1992. *Implementing Project 2000: an interim report.* Berkshire: National Foundation for Education Research.

JOWETT, S. WALTON, I. & PAYNE, S. 1994. *Challenges and Change in Nurse Education - a study of the implementation of Project 2000.* Berkshire: National Foundation for Education Research.

JOWETT, S. 1995. *Project 2000 in practice - a follow-study of people from some of the first intakes of the diploma in nursing course.* Berkshire: National Foundation for Educational Research.

KITSON, A. 1996. Does Nursing Have a Future? *British Medical Journal.* Vol. 313, pp 21-28.

KITZINGER, J. 1994. The Methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health and Illness.* Vol. 16, (1), pp 103-121.

KLEIN, R. 2001. *The New Politics of the NHS.* 4th ed. Prentice Hall.

KNOWLES, M. 1975. *Self-directed Learning: a guide for learners and teachers.* New York: Association Press.

KNOWLES, M. 1984. *The Adult Learner: a neglected species.* 3rd ed. Houston: Gulf Publishing.

KOCH, T. 1994. Establishing Rigour in Qualitative Research: the decision trail. *Journal of Advanced Nursing.* 19, pp 976-986.

KOHNER, N. 1994. *Clinical Supervision in Practice.* London: Kings Fund Centre.

KOLB, D. and FRY, R. 1975. Towards an Applied Theory of Experiential Learning I*n*: Cooper, G. ed. *Theories of Group Processes.* Chichester: Wiley and Sons.

KRAMER, M. 1974. *Reality Shock: why nurses leave nursing.* St Louis: Mosby.

KVALE, S. 1996. *Interviews: an introduction to qualitative research interviewing.* Thousand Oaks: Sage Publications.

LASCHINGER, H. 1986. Learning Styles of Nursing Students and Environmental Press: perceptions of two clinical nursing settings. *Journal of Advanced Nursing,* 11, pp 289-294.

LASCHINGER, H. & BOSS, M. 1984. Learning Styles of Nursing Students and Career Choices. *Journal of Advanced Nursing.* 9, pp 375-380.

LATHLEAN, J. 1993. *The Implementation and Development of Lecturer Practitioner Roles in Nursing*

LATHLEAN, J. 1996. The Challenges of Longitudinal Ethnographic Research in Nursing. *Nursing Times*. Vol 1, No 1.

LATHLEAN, J. 1997. *Lecturer Practitioners in Action*. Oxford: Butterworth Heinemann.

LAWLER, J. 1991. *Behind the Screens: nursing, somology, and the problem of the body*. Melbourne: Churchill Livingstone.

LE VAR, R. 1997a Project 2000: a new preparation for practice - has the policy been realized? Part 1. *Nurse Education Today*. 17, pp 171-177.

LE VAR, R. 1997b. Project 2000: a new preparation for practice - has the policy been realized? Part 2. *Nurse Education Today*. 17, pp 263-273.

LEWIS, A. 1998. An Examination of the Role of Learning Environments in the Construction of Nursing Identity. *Nurse Education Today*. 18, pp 221-225.

LIPSON, J. 1989. The Use of Self in Ethnographic Research. *In:* MORSE, J. ed. *Qualitative Nursing Research: a contemporary dialogue*. Thousand Oaks: Sage Publications.

LONG, T. & JOHNSON, M. 2000. Rigour, Reliability and Validity in Qualitative Research. *Clinical Effectiveness in Nursing*. 4, pp 30-37.

LUKER, K. CARLISLE, C. DAVIS, C. RILEY, E. STILWELL, J. & WILSON, R.1996 *Project 2000 Fitness for Practice*. Joint Report of the Universities of Liverpool and Warwick to the Department of Health.

MACLEOD-CLARK, J. MABEN, J. & JONES, K.1997. Project 2000: Perceptions of the philosophy and practice of nursing: shifting perceptions - a new practitioner. *Journal of Advanced Nursing*. 26, pp 161-168.

MAEVE, K.1994. The Carrier Bag Theory of Nursing Practice. *Advanced Nursing Science*. 16 (4) pp 9-22.

MANDER, R. 1992. See How They Learn: experience as the basis of practice. *Nurse Education Today*. 12, pp 11-18.

MARKS-MARAN, D. & ROSE, P. 1997. *Reconstructing Nursing: beyond art and science*. London: Bailliere Tindall.

MARTON, F. HOUNSTALL, D. & ENTWHISTLE, N. 1984. *The Experience of Learning*. Edinburgh: Scottish Academic Press.

MASON, J. 1996. *Qualitative Researching*. London: Sage Publications.

MAY, T. 1997. *Social Research: issues, methods and process*. 2nd ed. Buckingham: Open University Press.

MAY, N. & VEITCH, L. 1998. Working to Learn and Learning to Work: placement experience of Project 2000 students in Scotland. *Nurse Education Today*. 18, pp 630-636.

McELROY, A. 1997. Developing the Nurse Teacher's Role: the use of multiple focus groups to ensure grassroots involvement. *Nurse Education Today*. 17, pp 145-149.

McGILL, I. & BEATY, L. 1992. *Action Learning: a practitioner's guide*. London: Kogan Page Ltd.

MELIA, K. 1987. *Learning and Working: The occupational socialization of nurses*. London: Tavistock Publications.

MILES, M. & HUBERMAN, A. 1994. *Qualitative Data Analysis*. 2nd ed. Thousand Oaks: Sage Publications.

MILLER, C. TOMLINSON, A. & JONES, M. 1994. *Learning Styles and Facilitating Reflection*. London: E.N.B.

MILLER, G. & DINGWALL, R. 1997. *Context & Method in Qualitative Research*. London: Sage Publications.

MORGAN, D.L. 1988. *Focus Groups as Qualitative Research*. Sage Publications University Paper Series on Qualitative Research Methods Vol 16; Beverly Hills CA: Sage Publications.

MORSE, J. ed. 1991. *Qualitative Nursing Research: a contemporary dialogue*. revised ed. Thousand Oaks: Sage Publications.

MORSE, J. ed. 1994. *Critical Issues in Qualitative Research Methods*. Thousand Oaks: Sage Publications.

MORTON-COOPER, A. & PALMER, A. 1993. *Mentoring and Preceptorship: a guide to support roles in clinical practice*. Oxford: Blackwell Scientific Publications

MORTON-COOPER, A. & PALMER, A. 2000. *Mentoring, Preceptorship and Clinical Supervision: a guide to professional roles in clinical practice.* 2nd ed. Oxford: Blackwell Science Ltd

NEARY, M. 1996. *An Investigation of the assessment of student clinical competencies during the common foundation programme (CFP) of Project 2000.* Unpublished PhD Thesis: University of Wales, Cardiff.

NEARY, M.1997. Project 2000 Students' Survival Kit: a return to the practical room (nursing skills laboratory). *Nurse Education Today.* 17, pp 46-52.

NEARY, M. 2000. Supporting Students' Learning and Professional Development Through the Process of Continuous Assessment and Mentorship. *Nurse Education Today.* 20 (6), pp 463-474.

NICKLIN, P. & KENWORTHY, N. 1996. *Teaching and Assessing in Nursing Practice: an experimental approach.* London: Bailliere Tindall.

NIGHTINGALE, F. 1859. *Notes on Nursing: what it is and what it is not.* Philadelphia: J B Lippincott; (1946); [facsimile of 1st edition, London, Harrison & Son].

NOLAN, J. & NOLAN, M. 1997a. Self-Directed and Student-Centred Learning in Nurse Education: 1. *British Journal of Nursing.* 6, 1, pp 51-55.

NOLAN, J. & NOLAN, M. 1997b. Self-Directed and Student-Centred Learning in Nurse Education: 2. *British Journal of Nursing.* 6, 2, pp 103-107.

O'CONNER, S. PEARCE, J. SMITH R. VOGELI, D. & WALTON, P. 1999. Monitoring the Quality of Pre-Registration Education: Development, validation and piloting of competency based performance indicators for newly qualified nurses. *Nurse Education Today.* 19, pp 334-341.

OGIER, M. 1982. *An Ideal Sister? a study of leadership style and verbal interaction of ward sisters with nurse learners in general hospitals.* London, Royal College of Nursing.

OGIER, M. 1989. *Working and Learning: the learning environment in clinical nursing.* London: Scutari Press.

OHRLING, K. & HALLBERG, I. 2000. Student Nurses Lived in Experience of Preceptorship. Part 1 - In relation to learning. *International Journal of Nursing Studies*. 37, pp 13-23.

OLIVER, R. & ENDERSBY, C. 1994. *Teaching and Assessing Nurses: a handbook for preceptors*. London: Balliere Tindall.

ORTON, H. 1981. *Ward Learning Climate: a study of the role of the ward sister in relation to student nurse learning on the ward*. London: Royal College of Nursing.

OSTMOE, P. VAN-HOOZER, H. SCHEFFEL, A. & CROWELL, C.1984. Learning Style Preferences and Selection of learning Strategies: Consideration and implications for nurse education. *Journal of Nursing Education*. 23, 1, pp 27-30.

PALMER, A. BURNS, S. & BULMAN, C. eds. 1994. *Reflective Practice in Nursing: the growth of the professional practitioner*. Oxford: Blackwell Scientific Publications.

PARFITT, B. 1996. *Nursing: new profession or dying art?* Glasgow: Glasgow Caledonian University.

PARAHOO, K. 1997. *Nursing Research: principles, process and issues*. Basingstoke: Macmillan Press.

PARKER, D. 1997. Nursing Art and Science: Literature and debate. *In:* MARKS-MARAN, D & ROSE, P. eds. *Reconstructing Nursing: beyond art and science*. London: Balliere Tindall.

PARKER, T. & CARLISLE, C. 1996. Project 2000 Students' Perceptions of Their Training *Journal of Advanced Nursing*. 24, pp 771-778.

PARKER, D. WEBB, J. & D'SOUZA, B. 1995. The Value of Critical Incident Analysis as an Educational Tool and its Relationship to Experiential Learning. *Nurse Education Today*. 15, pp 111-116.

PEDLEY, G. & ARBER, A.1997. Nursing Students' Response to Self-Directed Learning: an evaluation of a learning process applying Jarvis' framework. *Journal of Advanced Nursing*. 25, pp 405-411.

PEMBREY, S. 1980. *The Ward Sister - Key to Nursing: a study of the organisation of individualised nursing*. London: Royal College of Nursing.

PHILLIPS, T. SCHOSTAK, J. BEDFORD, H. & ROBINSON, J. 1993. *Assessment of Competencies in Nursing and Midwifery Education and Training (the ace project).* London: E.N.B.

PHILLIPS, T. BEDFORD, H. ROBINSON, J. & SCHOSTAK, J. 1994. *Education, Dialogue and Assessment: creating partnership for improving practice.* London: E.N.B.

PHILLIPS, R. DAVIES, W. & NEARY, M. 1996. The Practitioner-Teacher: a study in the introduction of mentors in the pre-registration nurse education programme in Wales, Part 1. *Journal of Advanced Nursing.* 23 (5), pp 1037-1044

PLATT, H. Chairman. 1964. *A Reform of Nurse Education, Report.* London: Royal College of Nursing.

POWELL, J. 1989. The Reflective Practitioner in Nursing. *Journal of Advanced Nursing.* 14, pp 824-832.

PRYJMACHUK, S. 1996. A Nursing Perspective on the Interrelationships Between Theory, Research and Practice. *Journal of Advanced Nursing.* 23, pp 679-684.

RAFFERTY, A. ALLCOCK, N. & LATHLEAN, J. 1996. The Theory/Practice 'Gap': taking issue with the issue. *Journal of Advanced Nursing.* 23, pp 685-691.

RANADE, W. 1994. *A Future for the NHS? Health Care in the 1990's.* London: Longman.

RANADE, W. 1997. *A Future for the NHS? Health care for the millennium.* 2nd ed. London: Longman.

REED, J. & PROCTER, S. 1993. *Nurse Education: a reflective approach.* Edward Arnold.

REID, B. 1993. But We're Doing it Already! - exploring a response to the concept of reflective practice in order to improve its facilitation. *Nurse Education Today.* 13, pp 305-309.

ROBSON, C. 1993. *Real World Research: a resource for social scientists and practitioner-researchers.* Oxford: Blackwell.

ROGERS, C. & FREIBERG, H. 1994. *Freedom to Learn.* 3rd ed. New York: Macmillan College Publishing Company.

ROLFE, G.1993. Closing the Theory-Practice Gap: a model of nursing praxis'. *Journal of Clinical Nursing.* pp 173-177.

ROLFE, G. 1996. *Closing the Theory Practice Gap: a new paradigm for nursing.* Oxford: Butterworth-Heinemann.

ROPER, N. LOGAN, W. & TIERNAY, A. 1989. *The Elements of Nursing: a model for nursing based on a model of living.* Edinburgh: Churchill Livingstone.

ROSE, P. 1997. Science and Technology: tools in the creation of Nursing. *In:* MARKS-MARAN, D. & ROSE, P. eds. *Reconstructing Nursing: Beyond art and science.* London: Balliere Tindall.

ROYAL COLLEGE OF NURSING. 1985. *The Education of Nurses: a New Dispensation.* Commission on Nursing Education (The Judge Report); London: RCN.

RUBIN, H. & RUBIN, I. 1995. *Qualitative Interviewing: the art of learning data.* Thousand Oaks: Sage Publications.

RYAN, G. 1993. Student Perceptions About Self-Directed Learning in a Professional Course Implementing Problem-based Learning. *Studies in Higher Education.* 18, 1, pp 53-63.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT. 1999., *Our National Health, a plan for Action, a plan for Change.* Edinburgh, S.E.H.D.

SCHOFIELD, M. 1996. *The Future Healthcare Workforce: the steering group report.* Manchester: Health Services Management Unit.

SCHON, D. 1983. *The Reflective Practitioner: how professionals think in action.* Aldershot: Arena.

SCHON, D. 1987. *Educating the Reflective Practitioner: towards a new design for teaching and learning in the professions.* San Francisco: Jossey-Bass.

SCOTT-WRIGHT, M. 1961. *A Study of the Performance of Student Nurses in Relation to a New Method of Training With Special Reference to the Evaluation of an Experimental Course of Basic Nurse Education Being Conducted in Scotland.* Unpublished PhD thesis, University of Edinburgh.

SHAKESPEARE, P. ATKINSON, D. & FRENCH, S. 1993. *Reflecting on Research Practice: issues in health and social welfare.* Buckingham: Open University Press.

SILVERMAN, D. 1997. *Qualitative Research: theory, method and practice.* London: Sage Publications.

SKELTON, G. PARTLOW, C. ANDREWES, C. GALVIN, K. & JONES, J. 1998. *The Effective Performance of the Clinical Link Lecturer Role: Phase 3.* Bournemouth University: Institute of Health and Community Studies.

SLEVIN, O. & BUCKENHAM, M. 1992. *Project 2000 The Teachers Speak: innovations in the nursing curriculum.* Edinburgh: Campion Press Ltd.

SLIFE, B. & WILLIAMS, R. 1995. *What's Behind the Research?: discovering hidden assumptions in the behavioral sciences.* Thousand Oaks: Sage Publications.

SMITH, P. 1992. *The Emotional Labour of Nursing.* London; MacMillan Press.

SPOUSE, J. & REDFERN, L. 2000. *Successful Supervision in Health Care Practice: promoting professional development.* Oxford: Blackwell Science Ltd.

SPRADLEY, J. 1979. *The Ethnographic Interview.* Fort Worth: Harcourt Brace Jovanovich College Publishers.

SPRADLEY, J. 1980. *Participant Observation.* Fort Worth: Harcourt Brace Jovanovich College Publishers.

STEINAKER, N. & BELL, M. 1979. *The Experiential Taxonomy : A new approach to teaching and learning.* New York: Academic Press.

STRAUSS, A. & CORBIN, J. 1990. *Basics of Qualitative Research : grounded theory procedures and techniques.* Thousand Oaks: Sage Publications.

STRAUSS, A. & CORBIN,.J. 1998. *Basics of Qualitative Research: techniques and procedures for developing grounded theory.* 2nd ed. Sage Publications.

STREUBERT, H. & CARPENTER, D. 1995. *Qualitative Research in Nursing: advancing the humanistic imperative.* Philadelphia: Lippincott Williams and Watkins.

STREUBERT, H. & CARPENTER, D. 1999. *Qualitative Research in Nursing: advancing the humanistic imperative.* 2nd ed. Philadelphia: Lippincott Williams and Watkins.

THOMAS, J. 1993. *Doing Critical Ethnography: qualitative research methods series 26.* Thousand Oaks: Sage Publications.

TRIPP, D. 1993. *Critical Incidents in Teaching: developing professional judgement.* London: Routledge.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1986. *Project 2000: A New Preparation for Practice.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1987. *Project 2000: the final proposals.* Project paper 9, February 1987, London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1990. *The Report of the Post-Registration Education and Practice Project (PREPP).* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1992. *Code of Professional Conduct.* 3rd ed London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1993a. *The Council's Position Concerning a Period of Support and Preceptorship for Nurses, Midwives and Health Visitors Entering or Re-entering Registered Practice, Annex One to Registrar's Letter 1/1993.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1993b. *Midwives Rules.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1994a. *The Future of Professional Practice - The Councils Standards for Education and Practice following Registration; March 1994.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1994b. *Midwives Code of Practice.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1996. *Position Statement on Clinical Supervision for Nursing and Health Visiting.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 1999. *Fitness for Practice: The UKCC Commission for Nursing and Midwifery Education.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2000a. *Requirements for pre-registration nursing programmes.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2000b. *Registrar's Letter 15/2000 Directives 77/453/EEC Training programme for nurses responsible for general care.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2000c. *Standards for the preparation of teachers of nursing, midwifery and health visiting.* London: U.K.C.C.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSES, MIDWIVES AND HEALTH VISITORS. 2001. *The PREP Handbook.* London: U.K.C.C.

USHER, R., & BRYANT, I. 1989; *Adult Education as Theory, Practice and Research : the captive triangle;* London: Routledge.

USHER, R. BRYANT, I. & JOHNSTON, R. 1997. *Adult Education and the Postmodern Challenge: learning beyond the limits.* London: Routledge.

VANHANEN, L. & JANHONEN, S. 2000. Changes in Students' Orientations to Nursing During Nursing Education. *Nurse Education Today.* 20 (8), pp 654-661.

WALLACE, M. 1999. *Lifelong Learning: prep in action.* Edinburgh: Churchill Livingstone.

WALSH, M. 2000. *Nursing Frontiers; accountability and the boundaries of care.* Oxford: Butterworth Heinemann.

WATSON, N. 1999. Mentoring Today - The Students' Views: an investigative case study of pre-registration nursing students' experiences and perceptions of mentoring in one theory/practice module of the Common Foundation Programme on a Project 2000 course. *Journal of Advanced Nursing.* 29 (1), pp 254-262.

WATSON, H. & HARRIS, B. 1999. *Supporting Students in Practice Placements in Scotland.* Glasgow: Glasgow Caledonian University.

WATSON, S. 2000. The Support That Mentors Receive in the Clinical Setting. *Nurse Education Today.* 20, pp 585-592.

WEBB, C.1992. The Use of the First Person in Academic Writing: Objectivity, language and gatekeeping. *Journal of Advanced Nursing*. 17, pp 747-752.
WICKS, D. 1998. *Nurses and Doctors at Work*. Buckingham: Open University Press.

WILCOX, S. 1996. Self-Directed Learning in the University Setting. *Studies in Higher Education*. 21, 2, pp 165-176.

WILSON, H. 1989. *Research in Nursing*. 2nd ed. CA: Addison-Wesley.

WOOD, R. Chairman. 1945. *Working Party on the Recruitment and Training of Nurses*. Report of the Interdepartmental Working Party, London: Ministry of Health.

WHITE, A. FITZPATRICK, J. & ROBERTS, J. 1994. An Exploratory Study of Similarities and Differences Between Senior Students from Different Pre-Registration Nurse Education Courses. *Nurse Education Today*. 18, pp 190-198.