

**Title: A Qualitative Study Investigating the Similarities and Differences of Diploma
and Undergraduate Nursing (Adult) Students**

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Grounded Theory: development and formation

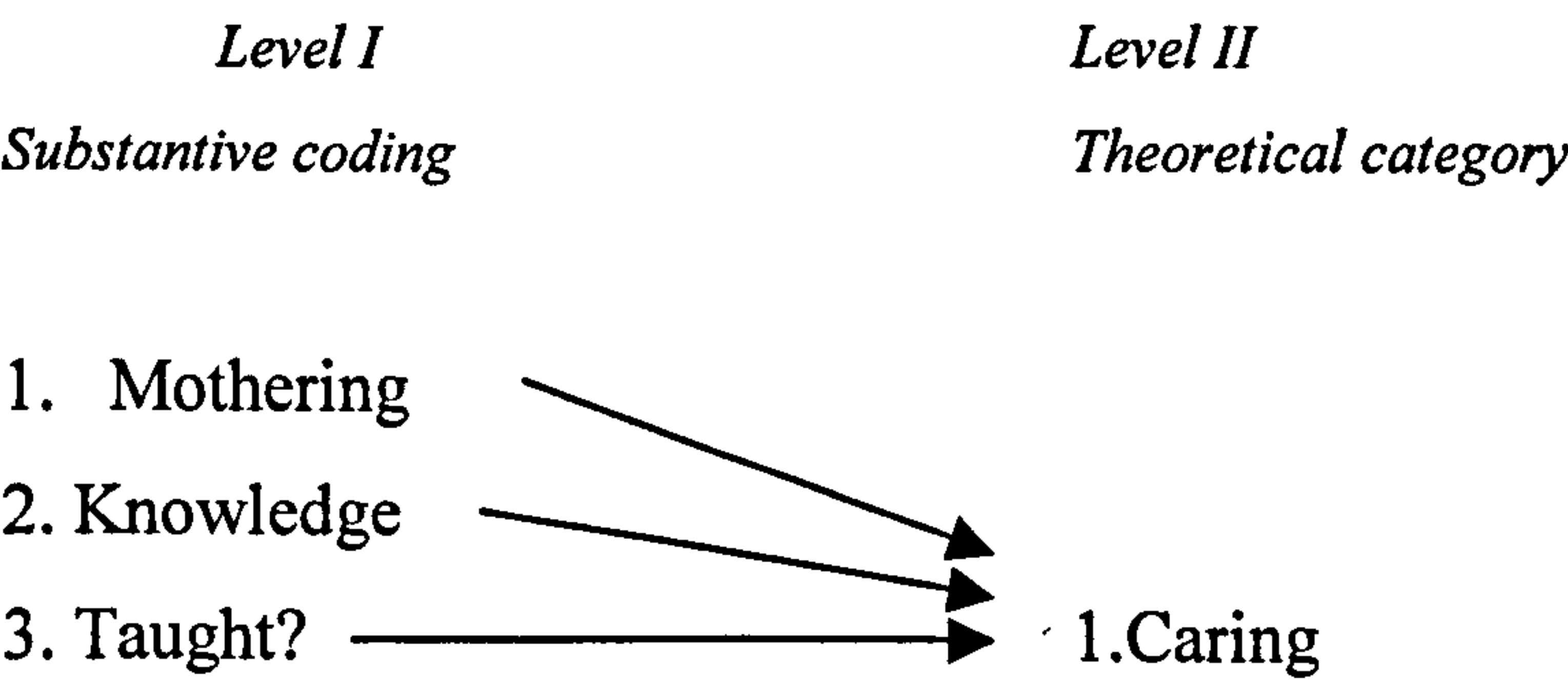
4.0 Introduction

Using the methodology discussed, I developed a grounded theory. Each interview was transcribed, analysed and coded within seventy-two hours. Examining the data line-by-line produced substantive coding. Each point made by the participants was coded using QSR NUD*IST. The use of a key word or verbatim statement gave the code its title. These were then constantly compared to each other and condensed to become categories (i.e. theoretical coding). Each category was compared to another to ensure they were mutually exclusive.

To allow for an ‘audit trail’, memos were written with each code and category to remind me of the meaning and/or rationale I had for making each code and category. Memos also contained information about the linkage to other categories, and later to the core category.

During this stage I consulted the literature as the codes and categories emerged. For example, when asked what nursing was, each focus group mentioned caring and what that meant to them. One student gave an example of mothering the patient, while others questioned whether caring could be taught, and others questioned what caring actually was. This was coded and categorised into:

Figure 2: Theoretical category ‘Caring’



I will explain the codes and categories produced from these focus groups, which provided a focus for further data collection and analysis as well as guiding the literature search. Where interview data agreed or disagreed with the existing data from the literature review, this was analysed, coded and categorised. The subsequent development of theory involved constant comparative analysis of the data until a theory developed.

4.1 Focus Group Interviews

Focus Group D1 comprised diploma students within two months of starting their programme; most had auxiliary nursing experience, some were school-leavers and some were mature students. Their code names were Anne, Catherine, Gillian, Jean, John, and Lorna (n=6).

Focus Group UG1 consisted of undergraduate students within two months of starting their programme, with very few having had previous healthcare experience; all were school leavers. Their code names were Betsy, Ellen, Liz, Margaret, May, Mhairi (n=6).

Two open-ended questions were prepared and asked during the interviews:

“What do you think of diploma/degree nursing programmes?”

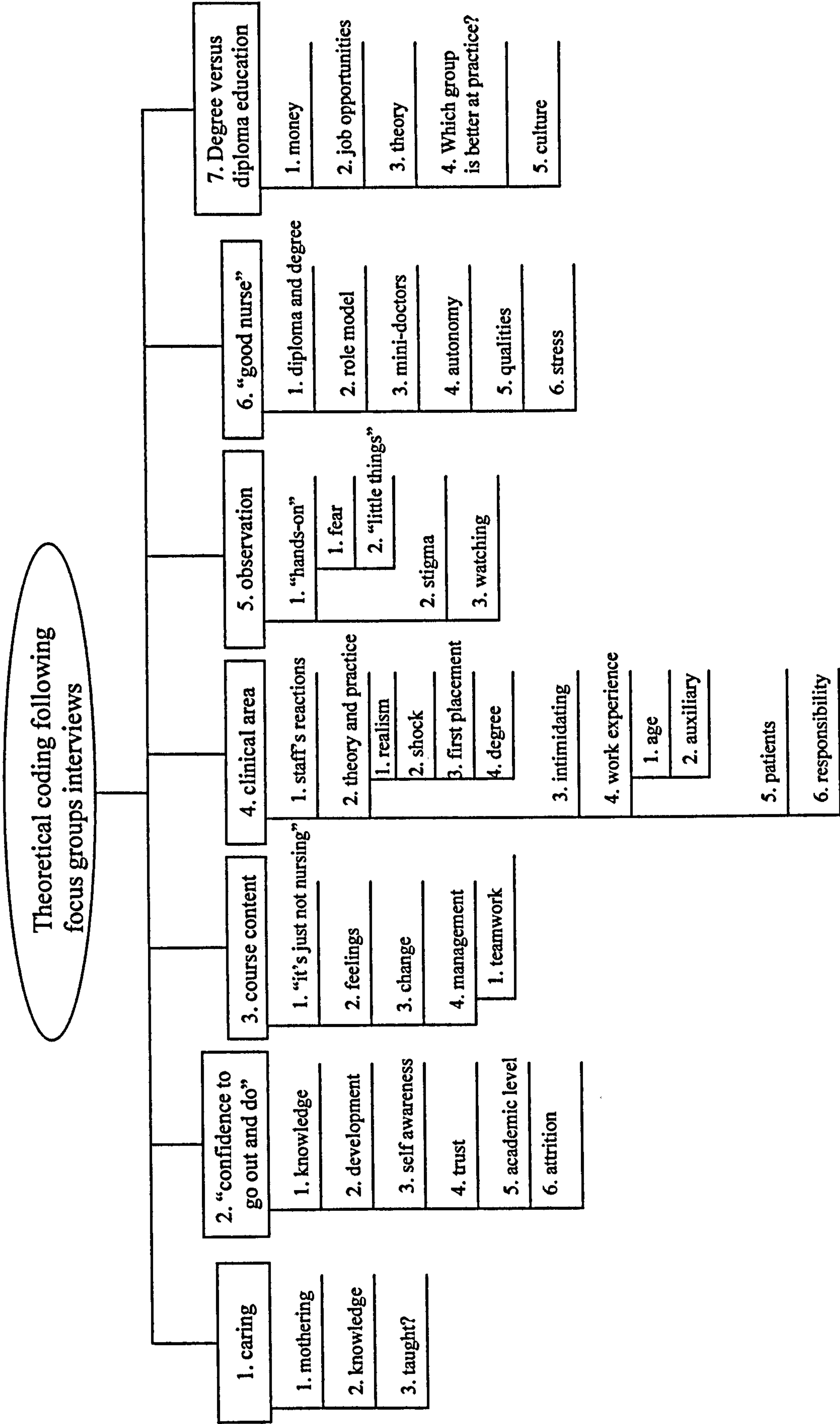
“Tell me about why you chose nursing as a career/profession?”

A summary of the initial coding and categorising can be seen in Figure 3 (p.158).

Category 1. Caring

When students were asked to identify what nursing actually was, caring was identified by both groups as one of the most important aspects (Figure 2, p. 156).

Figure 3: Theoretical coding following focus group interviews



Gillian (D1) said nursing was about having the “... *ability and knowledge to support their [patients'] needs ...*” and being a “... *caregiver ...*”, while Lorna (D1) stated that it was about having “... *compassion ...*” and “... *understanding the needs of another ...*”. Liz (UG1) said that nursing was “... *caring ... making sure you look after people and making sure they get better.*”

John (D1) also stated that nursing was different to medicine: “... *medicine is involved in the curative side, studying disease, etc... nursing is involved in care and I think if we move in that direction [i.e. curative] it would destroy nursing.*” However, Holden (1991) questioned the distinction that is often drawn between medicine and nursing: ‘nurses care while doctors cure’. Holden (1991) stated that this distinction was “ridiculous” and questioned whether this meant that caring is not curative or that curing is not carative and whether nurses do not cure and that doctors do not care.

However, some authors have stated that caring within nursing practice is being threatened (Fry 1988; Leininger 1986). Darbyshire (1994) stated nurses have become increasingly concerned that the scientific and technological aspects of nursing are in danger of overshadowing the humanistic and artistic elements, which should be an integral part of both nursing education and nursing practice.

One diploma student, Catherine (D1) reflected on her previous employment within business. She stated that the caring aspect of nursing was what attracted her to it.

“... it's people, it's people you're dealing with ... that's why I came into nursing because I used to sit in front of a computer every day thinking 'I don't want to do this'. I like people ... I like observing people, I like helping people and that's why I came into nursing because it was people-orientated ... but we are forgetting the caring aspect of nursing and that really annoys me.”

(Catherine, D1)

The concept of caring and the academic work associated with caring and nursing began to gain momentum in the mid-1980s (Leininger 1985b). Caring emerged as a central theme in nursing theories (Halldorsdottir 1990; Benner and Wrubel 1989). However, many authors have highlighted the lack of definition of caring within nursing (Farmer 1992; McKenna 1993; Koldjeski 1990; Morse, Solberg, Neander, Bottorff, Johnson 1990). Swanson (1991, p.356) described caring as “... a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility.” Leininger (1988, p.152) stated that caring is recognised as “... the central and unifying domain for the body of knowledge and practices in nursing.” It is not a single action, an emotional feeling or an attitude, but is “... a total way of being, relating, acting, and a quality of investment and engagement in the experience ...” (Farmer 1992, p.537). However, Morse et al (1990), questioned the lack of debate and critical analysis on the different meanings, and the difficulty in describing terms such as *caring*, *care* and *nursing care*.

Caring can take place in a personal, social and professional context. A professional caring relationship implies a responsibility on the part of the caregiver to use their knowledge and skills to help the recipient (Kitson 1987). The relationship is said to be directed towards sustaining and improving health and well-being (Swanson 1993; Leininger 1988). Caring actions have been classified into similar conceptual categories (Phillips 1993), including ‘knowing’, ‘doing for’, ‘being with’, ‘being there’, ‘enabling’, and ‘maintaining belief’.

Tennant (1999) investigated the perceptions of nine student nurses at the commencement of a three-year diploma programme in nursing. As part of a longer longitudinal study within the U.K., data were collected from the students concerning their perceptions of nursing. The students identified nursing as caring in the sense of doing things for others, “having the best interests of the patient in focus for everything” (Cathy, cited by Tennant 1999), looking after those who were ill, and being with the patient. These perceptions were very

similar to both diploma and undergraduate nursing students within this research and in other studies (MacKay-Greer; Holmes 1995).

Overall, neophyte students were aware that caring could involve their attitude, their professional relationship with patients, and could be described as a sense of 'doing things for others'. Both groups stated that nurses should always strive to have a caring relationship with patients.

Mothering 1.1

Lorna (D1) who had extensive auxiliary experience talked of 'mothering' the patients. She pointed out that her ward sister had told her not to do too much for the patients. She stated that promoting independence was what nurses were aiming for. They were promoting independence for the patients, but the student admitted that she was mothering them by doing too much for them.

The other students did not raise this issue.

Knowledge 1.2

The diploma students (D1) agreed that there should be equal weighting of knowledge and caring, while the undergraduate students (UG1) refuted this. There was some discussion about this among the undergraduate students, with Ellen (UG1) stating that a nurse should have caring attributes (80%) and should also be knowledgeable (20%). However, following much discussion within the group, they decided that a knowledge base would be as important, if not more important, than the caring side of nursing.

Both groups emphasised a shift to a more academic basis for nursing, but both felt there was a definite need for caring skills. Catherine (D1) pointed out that *"... you can get someone who's really, really intelligent and bright academically, and they are a terrible nurse because they haven't got the little things!"* Gillian (D1) argued that you could not do the job without knowledge

either. John (D1) also cautioned the group stating that “... *too much compassion can cloud your judgement.*”

The undergraduates had a similar discussion, with May (UG1) stating that:

“... you need a knowledge base but you can't be a nurse without being caring. ... You can have the knowledge but not the caring and that's [i.e. caring] what nursing is about.”

Liz (UG1) summarised the group's feelings, stating that “... *you need a lot of caring ...you can have knowledge but it depends how you use it ... you have to base something on knowledge.*”

Swanson (1993, p.355) explains the importance of knowledge within a therapeutic caring relationship:

“Knowing is striving to understand events as they have meaning in the life of the other. It involves avoiding assumptions, centering on the one(s) cared for, thoroughly assessing all aspects of the client's condition and reality. ... In effect, nurse knowing sets the potential for the nursing therapeutics of being with, doing for and enabling to be perceived as relevant and, ultimately, effective in promoting client well-being.”

In summary, diploma and undergraduate students felt that a nurse should have a knowledge base but there was a definite need for the nurse to be ‘caring’.

Taught? 1.3

The diploma students also debated whether ‘caring’ could be taught or whether it was an innate attribute. Gillian (D1), who had previous experience of auxiliary nursing before entering the diploma programme, talked of a special kind of person that nursing needs:

“... you’ve got to be a specific type of person to do nursing...you’ve got to have something within your heart and soul that you enjoy working with patients and you want to care for them.”

Catherine (D1) agreed that *“it’s something that’s in you”*, while Lorna (D1) stated that *“... you can’t teach someone how to be caring, if it’s not in you.”* Catherine (D1) stated that she had witnessed uncaring behaviour in nursing staff:

“... in a nursing home, that this man had messed himself and she stood at the door and this nurse walked past and she said, ‘listen keep walking because the one that finds it has to clean it up.’ Now that’s disgusting.”

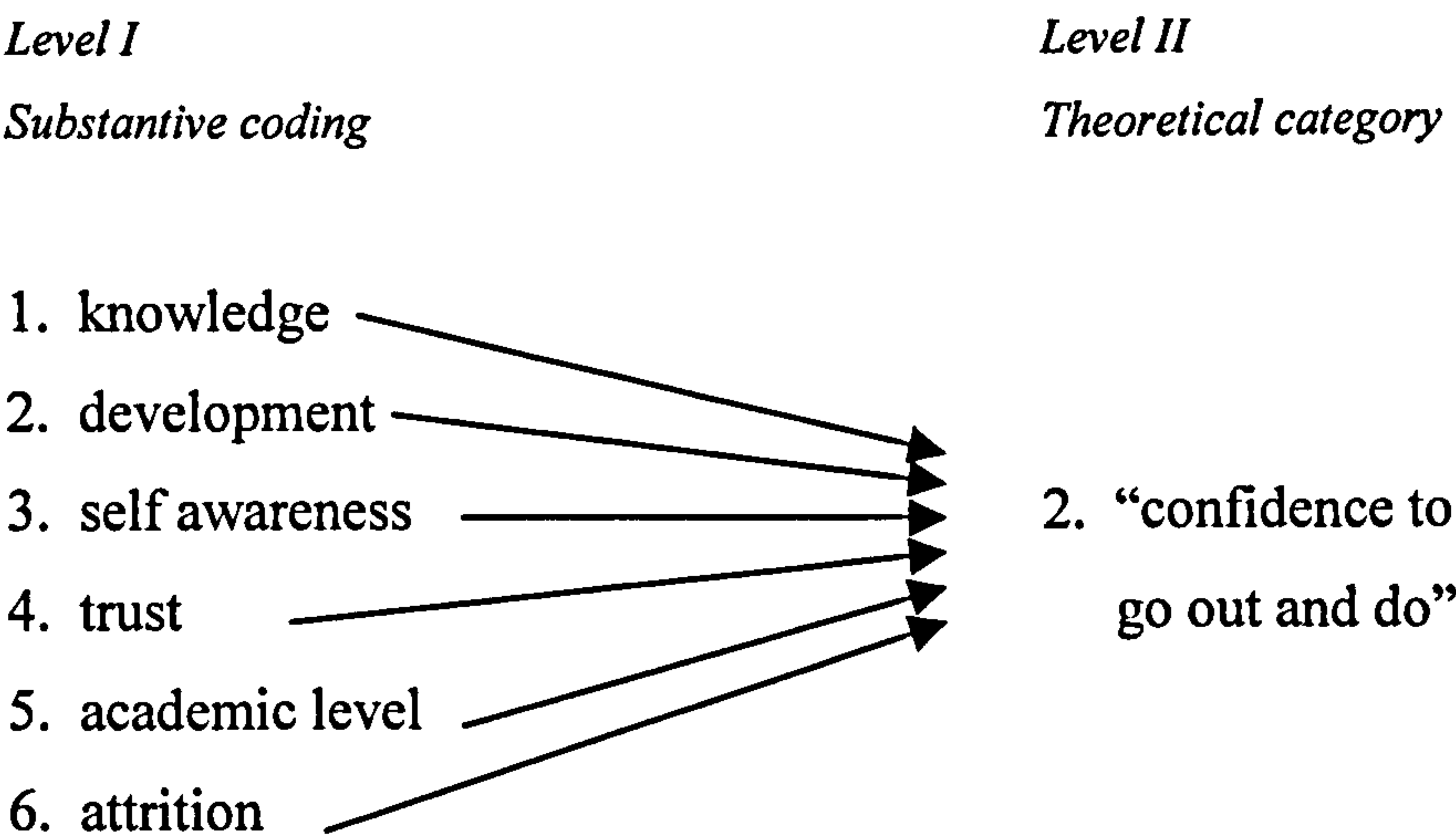
Several authors have questioned whether caring as an attitude can and should be taught to students (Dawson 1992; Swanson 1991; Jarvis 1984). However, there have been nurse educators both in the U.K. (e.g. Darbyshire 1994; 1991) and in the U.S.A. (e.g. Grams, Kosowski, Wilson 1997) who have called for the concept to be a fundamental theme within nursing curricula.

Both undergraduate and diploma students recognised that a caring nurse was a “good nurse”. Using constant comparative analysis of the data this category overlapped with later coding on the characteristics of a “good nurse”. Therefore this category was included within code six: “good nurse”. The following question was used to focus later interviews: *What are the characteristics of a “good nurse”?*

Category 2. “Confidence to go out and do” (Anne: D1)

Both groups felt that each programme should give them the confidence to go out to practice.

Figure 4: Theoretical category “Confidence to go out and do”



Knowledge 2.1

Betsy (UG1) felt that “ ... *the knowledge will give you confidence so that you know what you are doing.*” May (UG1) explains this further, stating:

“...the course gives you the knowledge behind the treatment so you know what you are doing and gives you confidence to do it ... and helps in the treatment of patients because you can sort out what you are doing.... So ... you’ve got confidence and that knowledge level ...and patients will be happy to have you treat them.”

Undergraduate students commented on the need for nurses’ knowledge-base to keep pace with medical knowledge. Liz (UG1) explained:

“... some nurses say that having a knowledge-base helps you to understand what doctors are on about, you knowyou don’t feel that

doctors are talking down to you and you are on the same kind of knowledge level.”

However, Catherine (D1) doubted that the diploma programme would make her confident enough since “... *doctors are at a much higher intelligent (sic) level ...*”.

Development 2.2

One of the diploma students recognised that the knowledge from the course was giving the student a chance to develop a nurse-patient relationship. Gillian (D1) explained:

“I think it’s [the programme] giving you the ability to develop ...it’s giving you the information to develop a nurse-patient relationship in the clinical area. Doing psychology and sociology is making you aware of the wider circle about the patient rather than just a person ... a holistic approach to the patient ... rather than just an ailment at the time.”

Self awareness 2.3

The diploma students also regarded the programme as a means to finding out about themselves. Catherine (D1) explained that she had found out some of her feelings towards health issues and stated that she “... *was finding a lot about ourselves ... I think you need to know your own values before you can help someone else.*”

Trust 2.4

Gillian (D1) agreed with the rest of the diploma group when she stated that “... *the course promotes confidence. I think when you are working with patients you need confidence to instill trust in what you are doing for them.*”

Academic level 2.5

One of the diploma students (Catherine, D1) questioned the high academic level of their programme and of undergraduate programmes. The rest of the diploma group made reference to the difficulty of their programme, and also questioned whether nurses required graduate level preparation to carry out the nurse's role effectively. Undergraduates felt that although the programme was difficult at times, they would be able to use this knowledge in practice.

Attrition 2.6

The diploma students highlighted the high attrition rates associated with their programme and blamed the low academic level of the entrance requirements required to be a nurse.

"They talk about high attrition rates ... isn't it because they are letting people in who aren't really ready to cope with the standard of education that is required to be a nurse?"

(John, D1)

Catherine (D1) also questioned the academic entry level to the diploma programme:

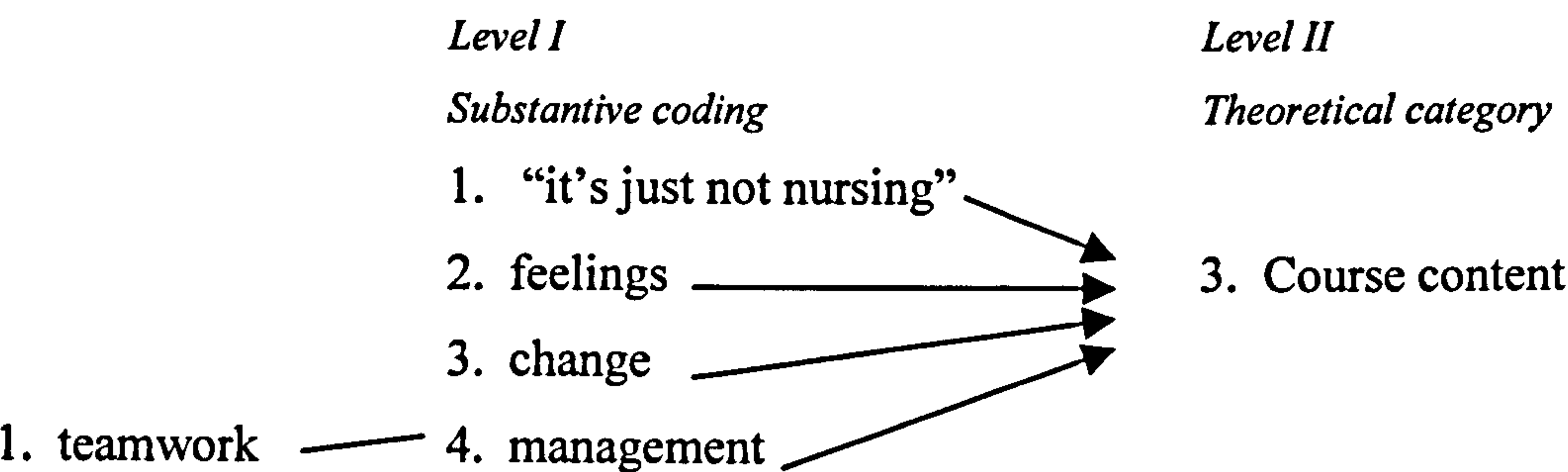
"There should be a higher standard to get in. Five standard grades ... I mean I am not being derogatory in any way, but it isn't high ... it is two Highers to get into an HND [Higher National Diploma] course!"

From the coding process, I felt that it was important to keep the questions as open as possible without leading the respondents. Therefore, the question I used to develop this area further within the interviews was: *How do you think the programme is preparing you for the role of a qualified nurse?*

Category 3. Course content

The third section of coding involved the course content. Overall there was evidence of discontent among the students due to the lack of nursing studies within the first two months.

Figure 5: Theoretical category ‘Course content’



Note: _____ demonstrates initial coding which was constantly compared to others to ensure no overlap. Following this process the code was incorporated into another code.

“It’s just not nursing” (May, UG1) 3.1

John (D1) stated that he was “...*a bit surprised about the course ...*” since Nursing Studies sessions were allocated the same amount of time in the timetable as Psychology and Sociology. He thought that on a nursing course the timetable would be “... *heavily based on Nursing Studies and that Psychology and Sociology would take a back seat and nursing would be top of the agenda.*”

However Lorna (D1) could:

“...see a pattern forming and merging together. I can see something good coming out of it ...only my perseverance of being a nurse has made me stay ...if I had wavered slightly I would have been out the door within the first two weeks.”

The undergraduate students agreed with May (UG1) when she commented:

“It just doesn’t feel as if I am doing anything ...there’s just so many different subjects, I feel as if I am doing a bit here and there. Then there is the theory of nursing which I just can’t get into ... I was expecting diseases, illness and treatment [agreement from the group]but that apparently doesn’t happen until second year, so it might be quite hard this year ...sitting there and keeping reminding yourself that you are actually doing nursing ...it’s quite hard to remember doing bits and bobs of everything and not doing anything!”

Feelings 3.2

Some diploma students felt that during the first few weeks they could have left the programme due to the lack of nursing studies and the seemingly irrelevant material within the programme.

All the undergraduate students remarked on the level of difficulty of their course and the lack of nursing subjects. They also reported the lack of knowledge in secondary school about a nursing degree and felt that the emphasis was on the diploma programme. All agreed that the workload within their course was very heavy especially if they had a weekend job.

Change to diploma programme 3.3

The diploma course was under review at the time of this study and comments were made about this, but these are outwith the remit of the study.

Management 3.4

The diploma students also remarked that they felt that they should be able to manage care effectively when they qualified:

“... we’ve got to learn ... prioritising ... a lot of nurses don’t learn that ... it does hinder. ... should I make the beds first or give out the medicines? What should I do first? Should I shower them ... that will take the whole day and then I’ve not enough time to write reports because you prioritised wrongly. I think more management should come into it [the programme].”
(Catherine D1)

The rest of the group (D1) agreed with this comment. This comment was remarkably perceptive for students at this stage of their education programme, but perhaps was due to the experience the diploma group had as unqualified carers.

I explored the development of effective care management in subsequent interviews.

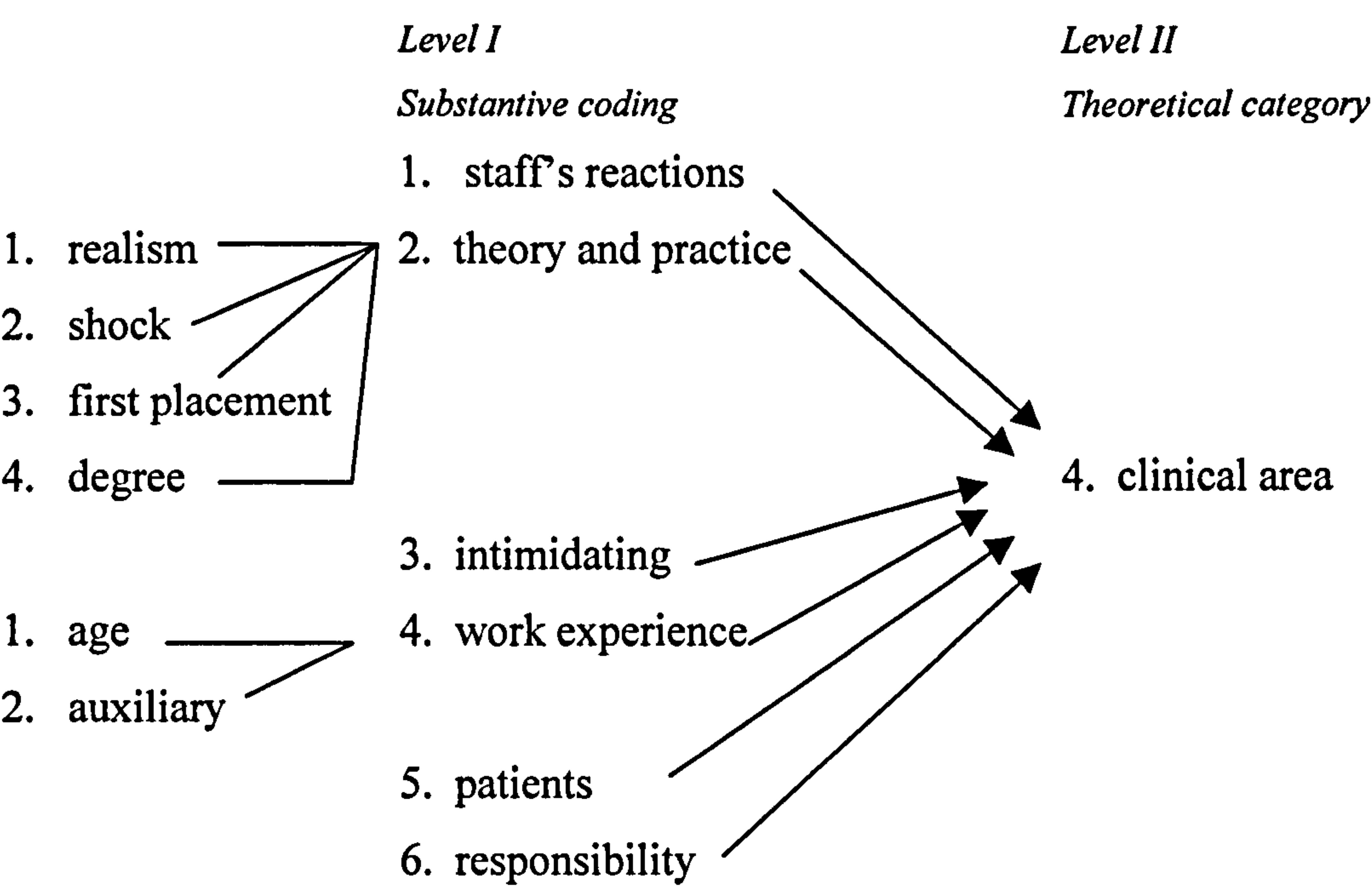
Teamwork 3.4.1

The diploma students also had some insight into the need for teamwork. One stated that there was a need within the programme to study teamwork. Therefore this was addressed in subsequent interviews with students who were more experienced with their programme and clinical areas. Using the following question, I aimed to develop this aspect of course content: *How do you think the programme is preparing you for the role of a qualified nurse?*

Category 4. Clinical area

The focus groups also discussed issues related to the clinical area despite the participants not having yet experienced this as student nurses. Both sets of students provided a lot of information as to their preconceptions of the clinical area.

Figure 6: Theoretical category ‘Clinical area’



Going into the clinical area for the first time was a major concern for the new students.

Staff's reactions 4.1

Students from both nursing programmes were concerned about the reaction they anticipated they would get from placement staff. Undergraduate students had spoken to nurses before entering the undergraduate programme and some had commented that “... *degree people don't seem to handle the practice ...*” (Margaret, UG1). However, the undergraduates felt clinical staff would have a greater expectation of their clinical performance. “*I think they might make you work twice as hard*” (Margaret, UG1).

In anticipation of her first clinical placement, Margaret (UG1) felt that:

“... if I hate the wards then I don't know ...I think we feel intimidated ... the fact that this will be your first clinical placement and they know more than you. ...OK you've got the academic background but it's not going to make a lot of

difference if you don't know. ... I think you feel a bit intimidated until you get familiar with your surroundings and the people, and the ward that you go to. ... some nurses will be all right, some will be witches and some will be really nice. ... this will affect how much you learn when you are out [in clinical placement] as well as if they are willing to teach you."

The rest of the undergraduate group agreed with this comment.

Theory and practice 4.2

Catherine (D1) felt that qualified nurses are critical of diploma students' performance in practice, and they took the view that *"They [diploma students] ... know nothing...they are straight out of school...out of a book...and they don't know a thing."*

All of the students commented on the differences between what was taught in theory and what was happening in practice despite having had no practical experience within their programme. Diploma students (D1) with previous healthcare experience agreed with Gillian when she gave an example of the difference between what was taught in theory and what was done in practice:

"... it's [i.e. theory] idealistic. I think they are not taking into account the staffing levels on the ward ...and the hardware available such as hoists and whatever is available when you are out there on the wards."

(Gillian, D1)

Despite having no auxiliary experience, the undergraduates demonstrated insight into the theory-practice gap. They anticipated more problems than diploma students in experiencing the theory and practice gap due to their higher level of theory. All undergraduates were of the opinion that the diploma programme consisted mostly of practice while their programme was the opposite. Therefore they expected that although undergraduates may lack the practical skills, they

expected to be able to apply theoretical aspects to practice. The undergraduates expanded on the theoretical and practical application stating that “... *the theory might be the same but the application may be slightly different at every turn ...*” (May, UG1) and that “... *you might have to learn to apply your knowledge in different situations.*” (Liz, UG1). Although the undergraduates anticipated the gap between theory and practice they agreed that it was “... *good to have the theory.*” (May, UG1). All of the undergraduates agreed with Liz (UG1) when she stated that she was apprehensive about “... *doing something that would be wrong ...I suppose that's partly why I want to do a degree ...to give me a deeper knowledge and a better education ...*”.

The views of the diploma and undergraduate students may be explained by Festinger's Cognitive Dissonance Theory (Festinger 1957 cited by Langley, accessed 2003). In discussion of Festinger's theory, Harmon-Jones and Mills (accessed 2003, p.1) state that:

“...much has been learned about the determinants of attitudes and beliefs, the internalization of values, the consequences of decisions, the effects of disagreement among persons, and other important psychological processes.”

Festinger's Cognitive Dissonance Theory described the free-choice paradigm, i.e. once a decision has been made, dissonance is likely to be aroused. In other words, once nursing students had decided upon which pathway (i.e. diploma or degree) to take, each of the negative aspects of their chosen alternative and the positive aspects of their rejected alternative is dissonant with the decision. On the other hand, each of the positive aspects of the chosen alternative and negative aspects of the rejected alternative is consonant with the decision (Harmon-Jones and Mills, accessed 2003). Therefore, the opinions of one group of students about the other educational programme could be explained by this paradigm theory.

All the undergraduates felt that their practice would be positively influenced by degree level study. Margaret (UG1) also stated that “*I think once we are out, theory will actually mean something ...*”.

Some of the diploma students commented that they would have preferred to have trained by the old modular system as “... *you spent far more time in the wards learning that way ...*” (Gillian, D1).

Both groups expected differences between what they had been taught and what they would practice within the clinical areas. This was explored further in subsequent interviews. More literature was analysed in relation to the theory-practice gap when later groups addressed similar issues.

Realism 4.2.1

All the diploma students remarked on the need for a realistic approach to nursing. “*When you look at nursing you could say that nursing is idealistic on paper but it's farcical in practice ...*” (Gillian, D1). This was constantly compared to code 4.2 theory and practice, where I found that there was overlap. This code was incorporated into 4.2.

Shock 4.2.2

The students with no nursing experience talked of their apprehension about going into a hospital for clinical experience for the first time. Having had previous experience as a healthcare assistant, Lorna (D1) stated that “... *if you haven't worked in a hospital or in a nursing environment I think you are in for a shock!*” She believed that students who did not have healthcare experience would be ‘shocked’ to find what was required of them as a nurse, for example, attending to personal hygiene and toileting needs, and caring for dying patients. This was also incorporated into code 4.2.

First placement 4.2.3

The diploma students expressed a wish to experience practice much earlier in the programme:

“I would say that nursing should be more practically based... We need the theory ...but I think we should be put out at the start of the course and see if you do like the ward. You know I have to sit in here [college]...I’ve been through 6 months of it. Maybe I’ll absolutely hate it ...what will I do then?”

(Catherine, D1)

Anne (D1) agreed:

“We should have a bit of experience near the start. ...it should maybe be a prerequisite of the admission that you have done some nursing in a nursing home or worked as an auxiliary or a care assistant or something like that ...so you’ve got a better idea.”

Mhairi (UG1) agreed that their exposure to placements areas “... *could have been much earlier. I do not have any nursing experience and it terrifies me!*” The rest of the undergraduate focus group expressed similar concerns to Mhairi and the diploma students.

Degree 4.2.4

Students debated the role of theory and practice in relation to undergraduate and diploma nursing programmes. Undergraduate student Liz (UG1) stated that diploma students’ education “... *is just about all practical and ours is the opposite ...*”. In support, another undergraduate felt that her programme could be “... *more practical ...*” and stated that she could imagine herself “... *going in with total theory and knowledge but hardly any placement experience, and going in and just not having a clue.*” (Anne, UG1).

Codes 'realism', 'shock', 'first placement' and 'degree' were constantly compared and were combined to form the code of 'theory and practice' (4.2).

Intimidating 4.3

Most students anticipated a feeling of intimidation at the thought of their first placement. The undergraduates expressed more concern over their first placement and what was going to be expected of them. Perhaps this was due to their lack of experience within the healthcare environment, or the lack of preparation for their first clinical placement within their programme. The level of preparation for practice for both groups was then investigated in later interviews, when students had experienced placements and were further on in their educational programme. The feelings students had were explored further as the research progressed.

Work experience 4.4

The diploma group members had a lot of previous work and/or nursing experience. During the focus group they used some work examples to explain some of their points.

Age 4.4.1

The diploma group stated that the age of the student was not an issue in nursing but their level of maturity was, in that a nurse would need to be mature enough to cope with the demands of the job.

Auxiliary 4.4.2

The diploma students disagreed about the advantages and disadvantages of having previous auxiliary experience. Gillian (D1) felt that the student could have developed "... *preconceived ideas* ..." while Lorna (D1) stated that previous

auxiliary experience gave the student the advantage of having practical experience of nursing.

However, the students expected relationship problems with auxiliaries in practice. Some of the diploma students expressed that the auxiliary nurse could act as if they were qualified nurses and it was difficult to respect these types of auxiliary nurses. Catherine (D1) stated that “... *they're not qualified ... it's like saying you can drive when you haven't got a licence.*” However others within the group felt that auxiliary nurses should be respected because of the work experience that many of them have.

Gillian (D1) explained that she perceived the difference between auxiliaries and qualified nurses as “... *being a nurse you have a greater background knowledge as well as the thing in your heart and soul that you want to be a nurse. You have the knowledge that auxiliaries don't have.*”

The diploma group also felt that it would be difficult to delegate to more experienced auxiliaries and those who were older. However, they also agreed that a major part of the qualified role was the ability to manage people. They stated that they would have to learn to “... *delegate ...*”, “... *speak to people ...*” and learn “... *how to approach different situations ...*” and “... *be able to work in a team ...*” (Lorna, D1).

None of the undergraduate students had previous auxiliary experience but all agreed that this would have helped their “... *confidence ...*” (Betsy, UG1) and would have given them the opportunity to gain “... *contact with patients ...*” (Betsy, UG1) and “... *observe nurses working ...*” (May, UG1). However, undergraduate Ellen (UG1) was cautious in that there was a chance that the student would “... *pick up bad habits.*”

Patients 4.5

Some of the diploma students spoke of their own experience of nursing as a patient or as a relative of a patient. These students appeared to appreciate that patients had individual differences.

Responsibility 4.6

Many of the diploma students expressed dismay at the amount of responsibility placed on nurses. Gillian (D1) felt that there was “... *too much responsibility given to nurses ...*” while others stated there was a lack of financial reward relative to the level of responsibility involved. Catherine (D1) compared nursing to medicine and stated that “... *I don't feel that after three years we are doing things to the same standard as doctors ...I would not feel confident.*” However, the rest of the diploma students argued that nurses should not feel inferior to doctors as they carry out a completely different function.

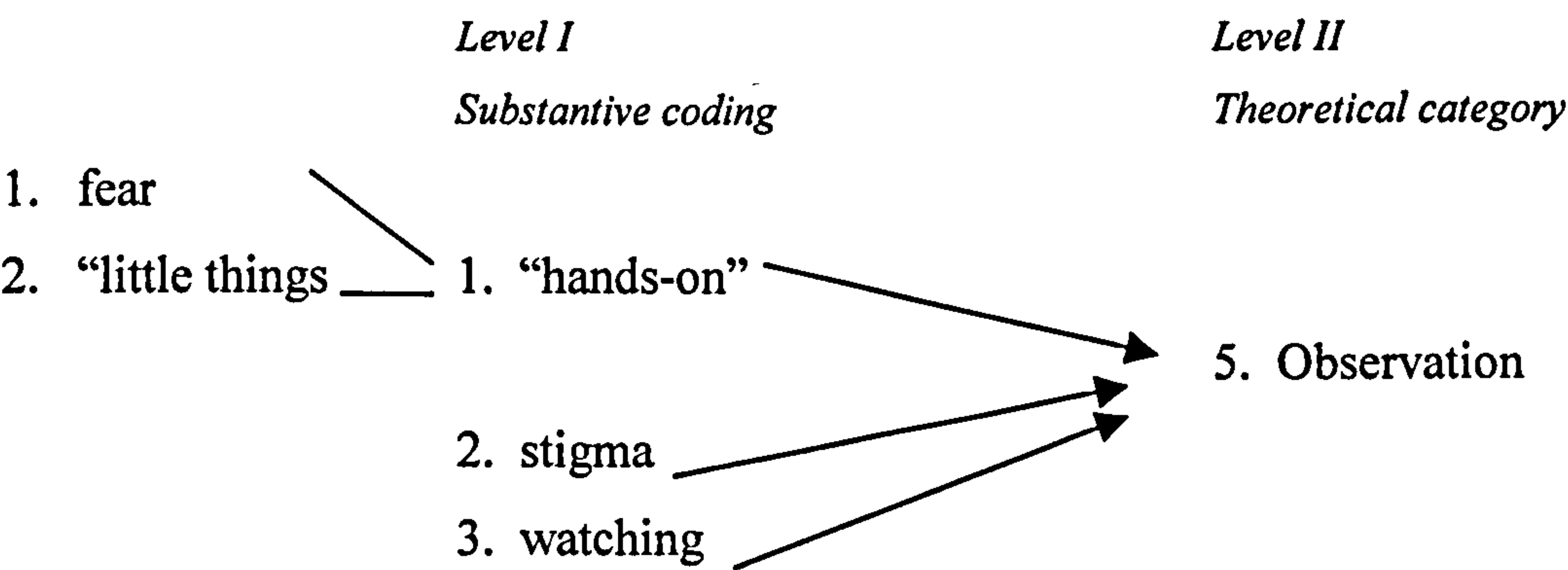
One of the diploma students gave an example of a drug being prescribed to which the patient is known to be allergic. “*If she [nurse] gives that to the patient then she is accountable for her own actions.*” (Gillian, D1). Catherine (D1) felt that this was unfair that the nurse was accountable when the doctor had prescribed it. However, John (D1) pointed out that “... *if we don't get it changed then we are letting our patients down ...*” and Lorna (D1) agreed, arguing that she “... *would not give it. I'd say ... 'it's wrong'.*”

The question I used to develop this area further within the interviews was: *Tell me about the clinical placements you have experienced ...*

Category 5. Observation

Both undergraduate and diploma students commented on the use of observation to learn about the practical aspect of nursing.

Figure 7: Theoretical category ‘Observation’



“Hands-on” 5.1

The diploma students were keen to develop a hands-on experience. Catherine (D1) stated:

“See how they [lecturers] were saying to us when we go out we’ve just got to observe, and if they ask us to clean the sluice say no – I’m not because ...I want to learn how to do it. ...I’m not going to stand back and say I’m not doing it.”

Most of the diploma students agreed with this and felt that “... nurses should be hands-on ...I think observations are nonsense.” (Lorna, D1). However one of the group members felt that it was “... irresponsible to go in there in a hands-on situation ...when you don’t have the skills.” (John, D1). The rest of the group argued that “... it was the only way to learn ...” (Catherine, D1) but John (D1) proposed that the patient has a right to expected a good standard of care and stated that “... I want to see how a ward works before I start to do anything.” The group also argued that observation would not create good working relations

with the rest of the staff and Catherine (D1) asked “*What are they going to think of him standing around doing nothing?*”

However, one of the undergraduates stated that their first placement was “... *a couple of months for observation.*” (Margaret, UG1). Ellen (UG1) also stated that “*Just watching the nurses ...you’re taking an interest in it and watching so that if they ask you the next time you can do it ...*” Observation within the clinical area seemed more acceptable to the undergraduate students than to the majority of the diploma students.

Fear 5.1.1

Lorna (D1) reflected on her first day as an auxiliary nurse as “... *unbelievable ...*” and described that she “... *had to go and wash this man and I was horrified ...*”. Anne (D1) with no previous nursing experience stated that she was “... *a bit apprehensive ...*” in coping with a mixed sex ward and being expected to carry out personal hygiene needs for older patients. Anne (D1) also stated that she was “... *terrified of cleaning and doing a dead body ...*”.

All the undergraduates were fearful of going out into their first placement and expressed similar concerns.

The fear and anxiety associated with nursing students’ first placement is by no means a new phenomenon. In a well-known early study, Olesen and Whittaker (1968) found that students often experienced sleepless and anxiety-ridden nights before their first appearance on the ward. This was also demonstrated by American research (Pagana 1988), in which students experienced stress especially in relation to feelings of personal inadequacy, fear of making mistakes, being fearful of the unknown, feeling scared and the threat of failing the placement area assessment. However, research has highlighted the reluctance of practice staff to fail students during their clinical placement (Corlett, Palfreyman, Staines and Marr 2003; Watson and Harris 1999; Duffy and Scott 1998). However, although there are numerous tools to measure of

clinical competency, some authors have suggested that there is no reliable and effective measure of competency (Nolan 2003; Chapman 1999; Lofmark, Hannersjo and Wikblad 1999; O'Connor, Pearce, Smith, Vogeli and Walton 1999; Chambers 1998; Priest and Roberts 1998). This may be one of the reasons why clinical staff are reluctant to fail students.

Later, Bradby (1990) investigated traditionally trained student nurses prior to their first placement. She also found that there was apprehension and anxiety. These anxieties ranged over providing nursing care associated with hygiene needs of a patient of the opposite sex, incontinence, altered body image, psychological problems, and very ill patients. Students felt that going into placements for the first time was exciting but anxiety-provoking. Bradby (1990) stated that there was a lack of understanding of this anxiety and apprehension on the part of staff in both practice and education, and often students were left to cope alone.

“Little things” 5.1.2

Diploma and undergraduate students commented on the “... *little things* ...” (Catherine, D1) that were important when caring for a patient. These included washing, and doing the patient’s hair and make-up. The students expected to be able to observe these ‘little things’ from practice staff.

Stigma 5.2

The diploma students (all except one) who were not in favour of observation but were in favour of ‘hands-on’ experience, commented and agreed that students who only observed care in the clinical area would feel stigmatised.

“Watching” (Anne, D1) 5.3

The diploma students felt that “*watching*” (Anne, D1) would be acceptable in some circumstances such as “... *when someone is getting a dressing renewed on*

their leg or ...catheterisation ...” but you could ask to try it once you have observed it.

The undergraduate students agreed that it was appropriate to observe qualified nurses performing in clinical skills.

“...you might want to have a go but there’s not much point because if I do something wrong someone has to come and do it again ...rather than fumbling around ...I’d like to watch and see how it is done first and do it next time ...and you have saved time in the long term ...”.

(May, UG1)

This code demonstrated considerable overlap with ‘hands-on’, and was therefore combined with it following the use of constant comparative analysis.

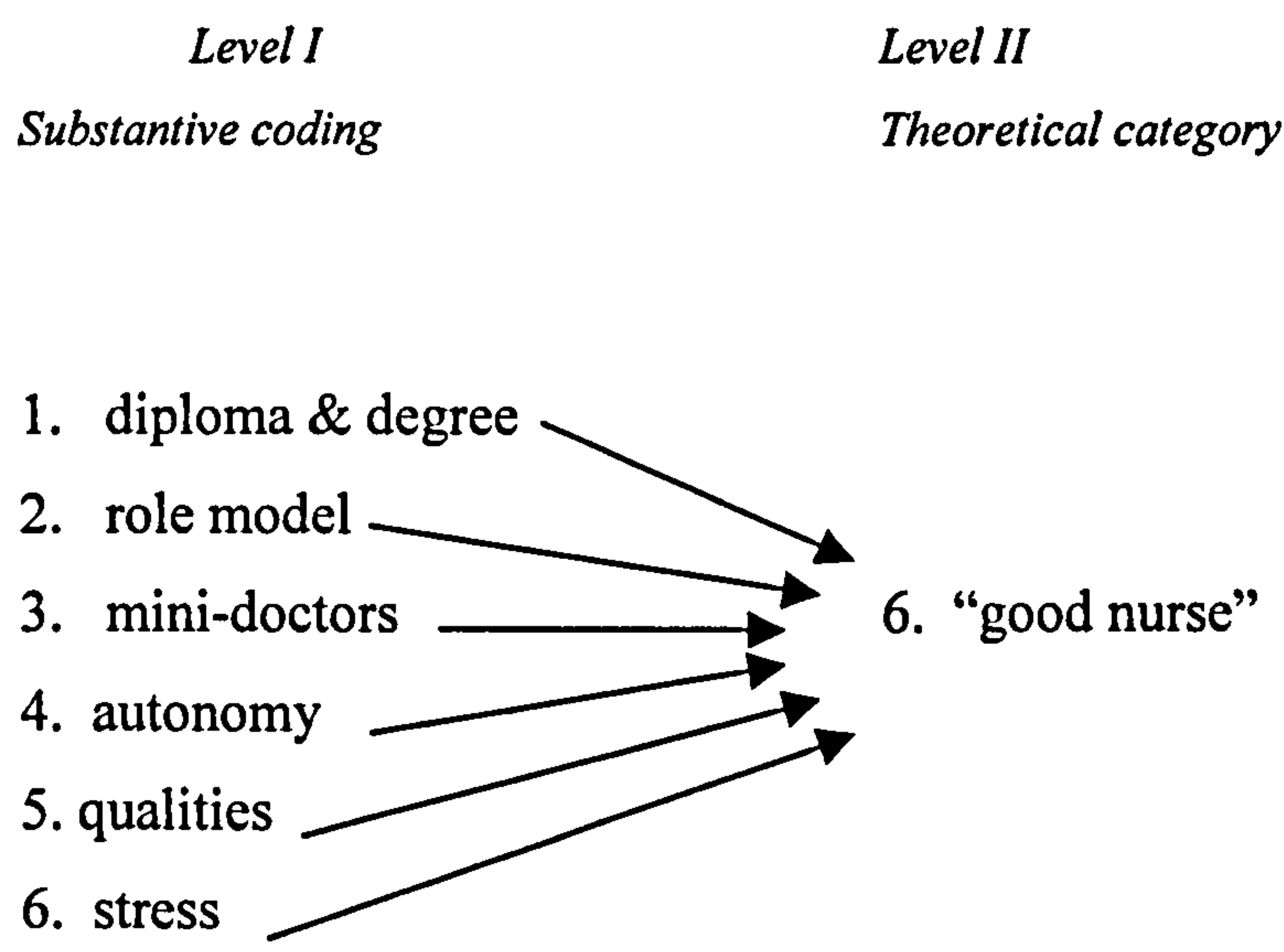
Due to the overlap with the issues discussed within categories ‘observation’ and ‘clinical area’, these were combined to form the category ‘clinical learning environment’.

The question I used to develop this area further within the interviews was: *Tell me about the clinical placements you have experienced ...*

Category 6. “Good nurse” (Lorna, D1)

Students in both groups aspired to be a “good nurse” and many stated the qualities required for this.

Figure 8: Theoretical category “Good nurse”



Diploma and degree 6.1

Lorna (D1), with auxiliary experience, used a degree-qualified nurse as her role model but stated “... *I don’t think it’s anything to do with the degree, I think if she had done the diploma she would have been equally as good a nurse ...she could be a ward manager.*” No one else from either group commented on the academic qualifications of a “good nurse”.

Role model 6.2

All the students expected to be able to identify a person within practice whom they would regard as a ‘good nurse’. They expected that they would copy behaviour and attitudes, be taught by this person, and be able to raise any concerns or fears with them. Other studies have identified significant role models and their qualities which participants felt had added to their practice learning (Fitzpatrick, While and Roberts 1996; Campbell, Larrivee, Field, Day and Reutter 1994; Wilson 1992; Wilson and Startup 1991; Morgan and Knox 1987).

Mini-doctors 6.3

The diploma students commented that nurses were becoming mini-doctors.

“Nursing is like a new academic discipline, so I think we should get rid of the image of mini-doctors. ...we are getting hauled away from the patient’s bedside. ...nursing is involved in care”
(John, D1)

The diploma students talked about the extended role of nurses and one commented that she would not feel “... *confident enough* ...” after three years of training to do jobs traditionally done by doctors as they were “... *at a much higher level in intelligence* ...” (Catherine, D1). Most of the diploma students had observed the extended role of the nurse while they worked as healthcare assistants. However, there was some dispute over their confidence and willingness to carry out these roles, which was understandable given the stage of the programme.

Autonomy 6.4

Both groups of students felt that nursing was a job in which you had to make your own decisions. Anne (D1) stated that the move away from being a doctor’s handmaiden had given nurses the opportunity to become more “... *autonomous* ...” which she felt had given nurses a “... *professional identity* ...”.

Qualities 6.5

Between both groups they agreed on a number of qualities of a “good nurse”. These are listed below:

1. “... *You’ve got to have patience* ...” (Mhairi, UG1)
2. “... *You’ve got to understand what the patient is going through ...you’ve got to have sympathy*”
(Betsy, UG1)

3. *"You can't let it affect you"* (May, UG1) Nurses must be able to carry out the job no matter what has happened.
4. *"I don't think age has a lot to do with being a good nurse. I think it has to do with the inner self ...I think it's you as a person – the communication skills with patients."* (Lorna, D1)
5. *"...have a good sense of humour"* (Anne, D1)
6. *"I think it's something everyone must be – a bit ambitious ...a lot of nurses are content ... staying by the bedside."* (John, D1)
7. *"Communication ... you can talk to someone with a problem"* (Betsy, UG1)

Stress 6.6

All the diploma students stated that they felt nursing was a stressful occupation.

"It seems to me that they [nurses] are expected to do everything all the time and are supposed to be cheerful, be caring and optimistic. I mean if you were going to some ill person or crisis you can't be upset or whatever. ...expectations on you to have the perfect personality that nurses are supposed to be ...it's quite stressful!"

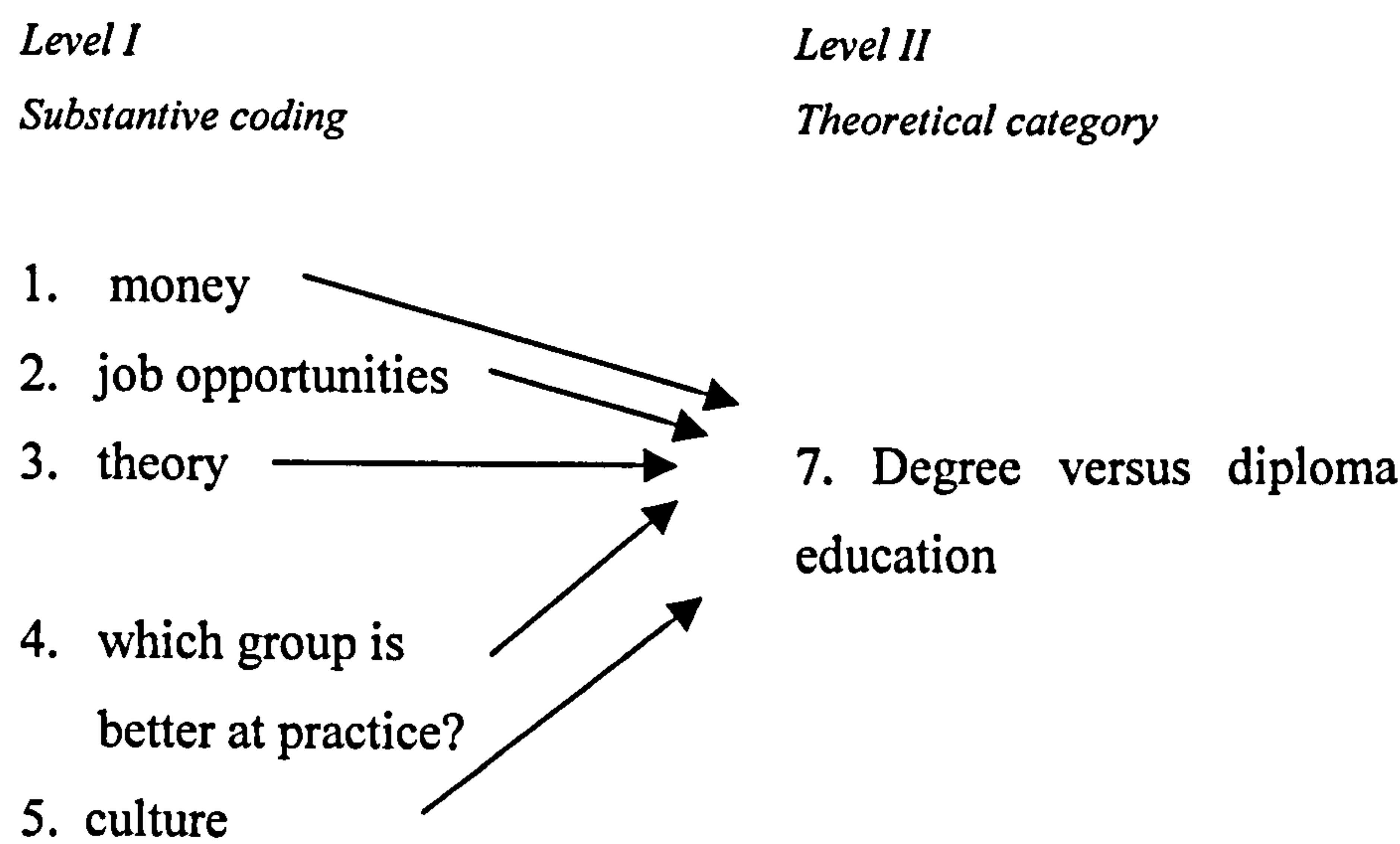
(May, D1)

The following question was used to focus later interviews: *What are the characteristics of a "good nurse"?*

Category 7. Degree versus diploma education

From the focus groups it was apparent that students had views of their own programme and others which were set at a different academic level.

Figure 9: Theoretical category ‘Degree versus diploma education’



All the diploma students wished to work towards obtaining a degree once registered. When I asked them if a degree made a difference to the way they practiced they all stated that it did not improve practice, but was viewed as important for career prospects.

Money 7.1

All the diploma students stated that the bursary was one of the main reasons for choosing a diploma rather than a degree programme. *“I wanted to do the degree but I chose a diploma because of the bursary.”* (Jean, D1). *“It’s cheaper to do the diploma course ...”* and there are no fees (Anne, D1). *“I chose a diploma course because I wanted a non-means-tested bursary and at the end of the three years I can go out and find a job and a further year of day release to get a degree.”* (Gillian, D1).

The undergraduate students felt that the bursary system was unfair. As a group they agreed that undergraduates should have better pay, promotion prospects and conditions when qualified because they had *“... more theory on which they could base their practice ...”* (May, UG1) and expected *“... quicker promotion into a management role ...”* (Ellen, UG1).

Job opportunities 7.2

Catherine (D1) expressed concern over job opportunities if graduate level education was not achieved. Gillian (D1) agreed, comparing those with a diploma to enrolled nurses, and suggested the development of a two-tier system of diploma and degree level nurses (Lorna, D1). However there was a general consensus within the diploma group that degree level education did not make a better nurse but just meant “... *that she's got a qualification ...*” (Anne, D1).

Undergraduate students expected better job opportunities than diplomates. Liz (UG1) stated that she was “... *under the impression that you had better job prospects when having a degree*”. Margaret (UG1) stated that “... *the degree was recognised worldwide ...so it's an opportunity to travel and maybe the diploma students don't have that*”

Theory 7.3

Diploma students felt that the degree programme was “... *too theory based ...I chose this [diploma] because I wanted a practical side.*” (Anne, D1). Anne (D1) also commented that the diploma course had “... *more practical ...*” and imagined that undergraduate students would go into placement with “... *total theory ...and would just not have a clue ...*”.

The undergraduates commented that their course was “... *more academic ...it takes a deeper knowledge of anatomy and physiology ...*” (Liz, UG1). She also argued that she felt the knowledge within the degree programme would help to prevent her making mistakes. The rest of the group agreed.

Which group is better at practice? 7.4

The undergraduates felt that their programme had less practical input than the diploma course. Liz (UG1) stated that “... *their training [diploma] is just about all practical and ours is the opposite.*” Margaret (UG1) stated that “... *Some*

people I have talked to that have been nurses say that degree people don't seem to handle the practice because they spend so much more time in theory."

Culture 7.5

The undergraduate students also felt that there was a lack of knowledge about degrees in nursing within secondary schools, the general public and even within the nursing profession itself.

The following questions were produced from this coding: *What do you think of diploma education for nurses? What do you think of degree education for nurses?*

4.2 Summary of focus group interview coding

The focus groups with first year undergraduate and diploma nursing students produced Level II or theoretical categories. A description of each category was produced as a memo to facilitate understanding and provide an audit trail for the coding process. The aim of the focus groups was to provide a focus for subsequent interviews. The codes and categories that were identified were further developed in subsequent stages of the research. Following constant comparative analysis, the categories are described below:

- 1. "Confidence to go out and do" (Anne, D1):** Having the confidence to go out and work as a nursing student was a concern for all neophyte students.
- 2. Course content:** Course content provided some controversial views from both sets of students, but both wished for earlier placements.
- 3. Clinical area:** This was a major source of stress and apprehension for all neophyte students. All students reported that they expected to witness a difference between what was taught and what was practiced. I anticipated that the clinical areas would be a major source of data due to the practical nature of the programmes. Following constant comparative analysis, this

was combined with the 'observation' category to form 'clinical learning environment' category.

4. **Observation:** There was a marked difference in the opinions of undergraduates and diploma students as to the role of observation within the clinical areas. This was combined with the 'clinical area' category to form the 'clinical learning environment' category.
5. **"Good nurse" (Lorna, D1):** Both groups wanted to have the qualities of a "good nurse". They identified various areas that they felt would be important qualities. Following constant comparative analysis, caring was identified by undergraduate and diploma focus groups as a quality of a "good nurse". This then became a code within the category of "good nurse".
6. **Diploma versus degree education:** Students identified positive and negative aspects of each programme.

The six theoretical categories produced were developed as key open-ended questions for the next stage of interviewing. These provided a focus for subsequent interviews.

- *What are the characteristics of a "good nurse"?*
- *How do you think the programme is preparing you for the role of a qualified nurse?*
- *Tell me about the clinical placements you have experienced ...*
- *What do you think of diploma education for nurses?*
- *What do you think of degree education for nurses?*

4.3 Individual Interviews (mid-point)

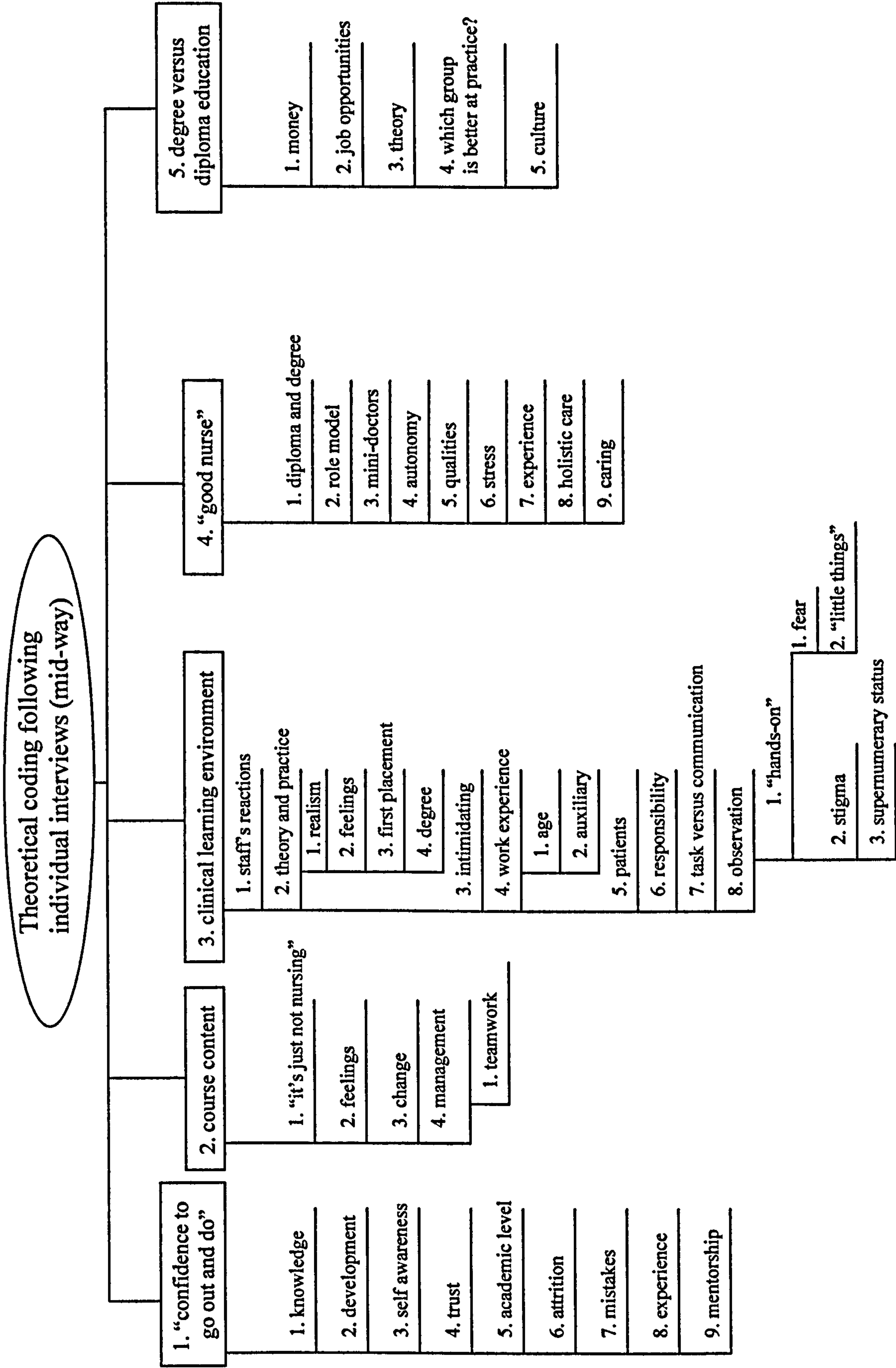
The questions developed from the focus group derived categories provided a focus for the individual interviews at the mid-point of each programme (see Table 2, p.97).

Diploma students (D2), who were 18 to 20 months into their programme, were given code names: Elaine, Joyce, Lena, Lynne, Megan, Scott, Selena, Tom (n=8).

Undergraduate students (UG2), who were 24 to 26 months into their programme, were given code names: Angela, Cara, Davie, Jack, Jane, Jenny, Nicola, Sandra (n=8).

From the individual interviews coding and categorising was completed. This included collection and analysis of data from the literature. The following section includes the new data within each code and category and identified new codes and categories where appropriate. Some codes and categories were not developed any further by these subsequent interviews. A summary of the coding and categorising can be seen in Figure 10 (p.190).

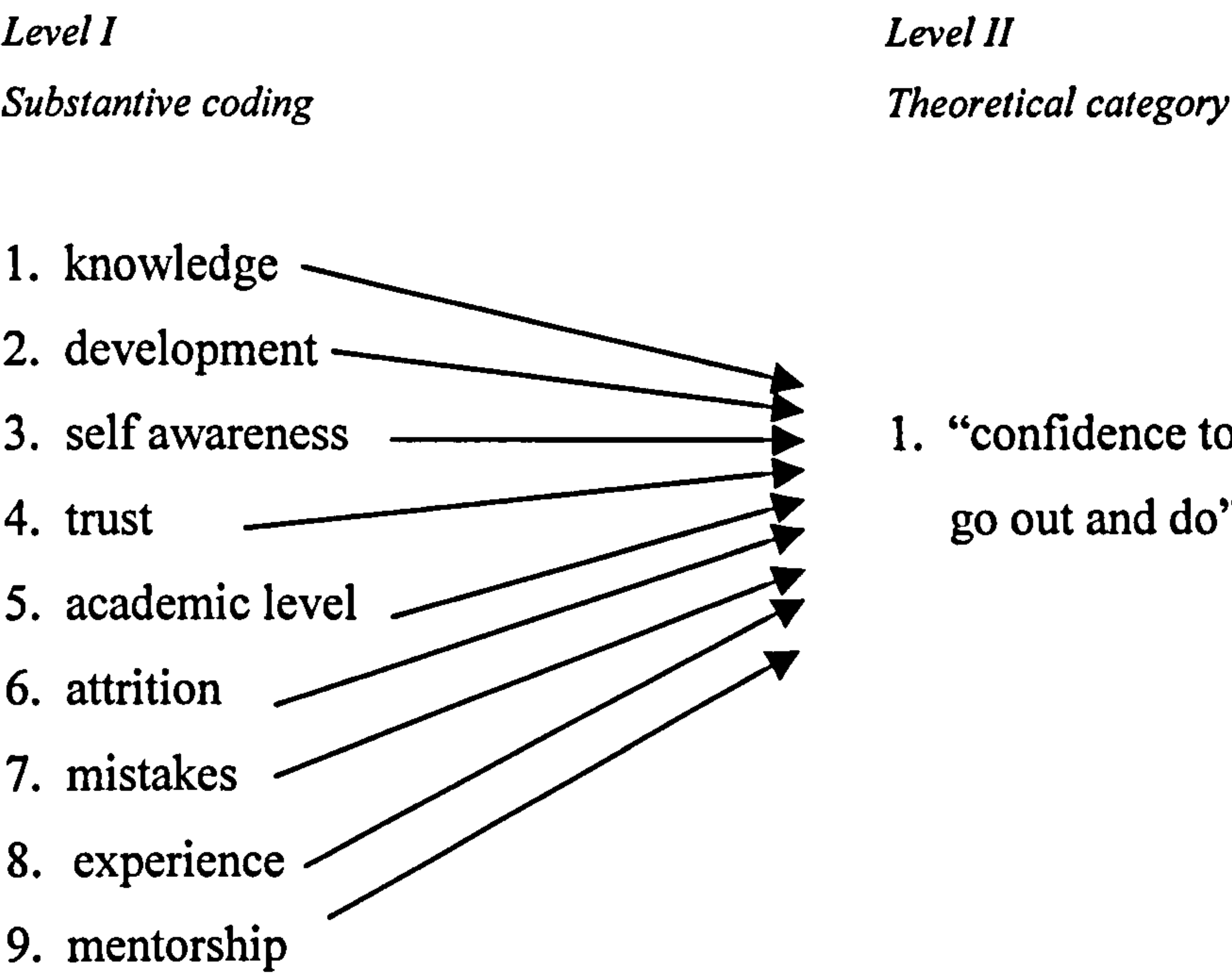
Figure 10: Theoretical coding following individual interviews (mid-way)



Category 1. “Confidence to go out and do” (Anne: D1)

Both groups felt that each programme should give them the confidence to go out to practice.

Figure 11: Theoretical category “Confidence to go out and do”



Knowledge 1.1

During one of her placements an undergraduate student stated that she had been compared unfavourably to a third year diploma student by a mentor. Cara (UG2) stated that she was compared to a diploma student who had nearly completed the three year programme but she still had almost eighteen months left of the four year undergraduate programme. She said that it “... *knocked my confidence a lot ...*” and stated that the diploma student was “... *very good at practical ...and she was definitely ahead on the practical side especially the organisational side ...*” However Cara (UG2) also stated that studying to degree level meant that “...*you’ve got the full theory behind you and you try to carry that out to the best of your ability.*”

Jane (UG2) attempted to explain the relationship between confidence and knowledge:

“I think there is a certain confidence in it – you can only have the confidence if you have the knowledge. Maybe that’s the benefit of having extra theory. Knowledge does give you that extra confidence to go off and work ...more independently.”

Jane (UG2) later expanded this opinion, stating:

“... You do understand what you are doing ...you know why they [patients] have these signs and symptoms. That does make you more confident in making decisions about their treatment or suggesting things to doctors. It is good that way, but it is not something diploma students cannot gain.”

Jenny (UG2) also agreed that undergraduates have a good knowledge base:

“They [undergraduates] have a better understanding of what to look for when things go wrong and how to spot early signs. ...maybe if the patient wanted extra information then you might be in a better position to give it. ...I’d feel reasonably comfortable in a situation like that whereas maybe if you didn’t have all the background knowledge you might think that oh, I don’t really know and might have to go and find out.”

Later, Sandra (UG2) explained:

“... it helps you get more out of the job if you know why someone has cardiac failure or pulmonary oedema. You know why – it helps you get more out of the job because you are understanding what’s causing it and why the ankles are swelling. ...it gives you a better understanding.”

Jenny (UG2) also stated that being an undergraduate had pushed her to find out answers to problems. *“... It’s not good enough that you don’t know – you’ve got to go and find out ...”*.

Davie (UG2) agreed that *“... you need to have accurate knowledge so that you can advance your practice.”*

The role of theory/knowledge will be expanded on in 5.3.

Development 1.3

The undergraduates also commented on personal and professional development which they felt they had achieved as a result of being on the programme.

Jenny (UG2) felt that the undergraduate programme had developed her in a personal way.

“... I was ... still a bit shy and immature and hesitant, but now I don’t think I’m like that. I think it has taught me how to communicate with people ...I feel more confident and I feel more confident outside nursing. ...– it’s a good course to do from that point of view as well – it improves your personal confidence.”

Self awareness 1.4

The undergraduates reflected on some of their experiences. Each felt that they had developed in some way. Cara (UG2) stated that she felt that she could challenge medical decisions and would question procedures which she felt were not being carried out satisfactorily. Jane (UG2) also stated that she felt confident enough to challenge other professionals within the healthcare setting as *“... it makes you more confident because you know you can do it ...”*. Jenny (UG2)

felt that she had learned to cope with potentially stressful situations, such as dealing with awkward questions from patients. All the undergraduates felt confident to carry out the skills required of them.

“... being confident in a ward – it’s the practical and the people skills. You can be great at practical skills but ...if you can’t speak to people, then you still aren’t going to be confident in the ward and it’s the same the other way round ...it’s a bit of both.”

(Jenny, UG2)

Both groups of students reported that they felt more confident when they had gained more experience and knowledge, as each programme progressed. Radwin (1998) also reported that qualified staff felt improved confidence as they became more experienced and had more practice at certain skills.

From reviewing the literature, I was aware that the views the students had of themselves was an important issue especially as the programmes progressed. Students felt it was important to feel confident to carry out the role at the level which was required and expected of them.

The literature revealed that our relationships with others are inextricably linked to self-concept. The development and maintenance of our self representations is based on our relationships with others which are in turn shaped by how we see ourselves. William James (1890) was one of the first writers to consider our self-concept and included in it our representations of body and mind, clothes and home, spouse, children, ancestors, friends, perceived social reputation and personal possessions. Experiences involving any of these may affect our sense of well-being and self-worth. James (1890) recognised our awareness of self developed through interaction. The self-concept consists of a range of social identities which develop and become salient in relation to particular others throughout our lives (Abraham and Shanley 1992).

When a person is subjected to constant criticism by others whose opinion matters to her, the result is likely to be a lowering of that person's opinion of herself. Lowered self esteem, in turn, affects our confidence and motivation in interaction with others. Similarly, when a person experiences constant approval, the result is likely to affect her relationships with others. She is likely to assume others feel positively about her and to feel good about herself (Abraham and Shanley 1992). The role of staff and mentors was seen as important in the development of the students' self-concept.

According to Kelly (1992a) professional self-concept is constructed through self evaluation about professional knowledge, values and skills. These are dependant on the opportunity to enact the professional role while still a student, the exposure to role models and the perceived success in the professional tasks (Kelly 1992a; Meleis 1975).

Low self-esteem and poor self-confidence has been reported among nursing students (Haffer and Raingruber 1998; Burgess 1980; Ellis 1980; Welsh 1980; Burgess 1979). Klug (1989) and Ellis (1980) actually reported a reduction in self-esteem and confidence with each year of the course. Having reviewed the literature, Olson, Gresley and Heater (1984) concluded that students identified poor self-concept to be a problem as the course progressed and in newly qualified graduates within the nursing profession in the United States. Ellis (1980) regarded this lack of self-confidence as one of the reasons baccalaureate nurses in the U.S.A. were failing to meet the expectations of both the public and the profession.

Within my study, students often gave examples of situations in which they experienced positive and negative feelings about their performance. On reviewing the literature, self-efficacy was a concept which I felt assisted in the understanding of how students feel during their educational programme.

Self-efficacy has been described as the perception of our own ability to handle events or the perceived ability to cope with specific situations (Murdock and

Neafsey 1995; Abraham and Shanley 1992; Bandura 1977a). Bandura (1977a; 1997b; 1986; 1989) was one of the first authors to emphasise the importance of self efficacy to everyday performance and behavioural change. Research-based evidence suggests that high perceived self-efficacy allows people to perform better than those with equal ability, but less faith in their ability. Broadly speaking, highly perceived self-efficacy leads people to persevere with difficult problems, to discard ineffective problem-solving strategies more quickly, and to re-examine their work for errors. People who believe in themselves have also been shown to set themselves more demanding goals and to spend less time worrying about perceived self-efficacy. In other words, those who believe themselves to have the ability to perform well are more likely to succeed.

More specifically, the concept of self-efficacy relates to the judgements people make concerning their ability to perform behaviours relevant to a specific task or situation (Pervin 1989). Bandura (1982) stated that the influence of self-efficacy includes the following five points: Firstly, self-efficacy is influenced by activities people engage in (“People avoid activities that they believe exceed their coping capabilities, but they undertake and perform assuredly those that they judge themselves capable of managing.” p. 123), and secondly, how much effort will be expended in a situation. Self-efficacy is also influenced by how long people will persist in the face of obstacles, and by the thought patterns involved in a task. Finally, it is influenced by the emotional reactions while anticipating a situation or while involved in it. Clearly we think and behave differently in situations in which we feel confident of our ability than in situations in which we are insecure or feel incompetent.

Bandura (1977b) used a microanalytic research strategy where detailed measures of perceived self-efficacy were taken before performance of behaviours in specific situations. Thus, subjects were asked to designate in a specific situation those tasks they could do and their degree of certainty about doing them successfully. Bandura (1986) noted that this method of measuring self-efficacy reflects the view that self-efficacy judgements are situation-specific and therefore any global measures would not represent this. Bandura (1986 p.41) states that global self-efficacy measures can be criticised because they “do not do justice to

the complexity of self-efficacy perceptions, which vary across different activities, different levels of the same activity, and different situational circumstances”.

Psychologists have investigated the phenomena of decision-making, making judgements, and the confidence with which people make these. During their experiments, Koriat, Lichtenstein and Fischhoff (1980) tried to determine reasons for over-confidence in judgement. They found that there were consistently two types of bias shown within the decision-making process. The first bias involved favouring positive rather than negative evidence (i.e. reasons for over reasons against). The second bias was a tendency to disregard evidence inconsistent with the chosen answer, which was also supported by later research findings (Friedlander and Phillips 1984).

A decade later, Wurzbach (1991) concluded that extensive research still continued to report that research subjects expressed subjective certainty in their decisions even when they were inaccurate (Dunning, Griffin, Miljkovic, Ross 1990; Vallone, Griffen, Lin, Ross 1990). According to Dunning et al (1990), two generalisations can be made from the research and the literature. Firstly, relatively difficult tasks (i.e. those producing low accuracy readings) tended to yield over-confidence more often than relatively easy tasks (Lichtenstein and Fischhoff 1977 cited by Dunning et al 1990). Second, high levels of confidence are usually associated with high levels of over-confidence (Fischhoff, Slovic and Lichtenstein 1977 cited by Dunning et al 1990). These findings were supported by the research carried out by Dunning et al (1990) and Vallone et al (1990).

The development of an over-confident student may be detrimental to the profession and the students’ development. Kissinger (1998) warned that overconfidence in nursing could lead to the following outcomes:

1. Clients may be misled about the clinical opinion
(Baumann, Deber, Thompson 1991 cited by
Kissinger 1998);

2. The client's role in decision-making about their own care may be lessened (Baumann et al 1991 cited by Kissinger 1998);
3. The self-scrutiny required to implement quality assurance programmes is decreased (Baumann et al 1991 cited by Kissinger 1998);
4. The clinician's likeliness to learn from experience is decreased (Einhorn and Hogarth 1978 cited by Kissinger 1998)
5. A false sense of security for the client and the clinician may develop (Voytovich, Rippey, Suffredini 1985 cited by Kissinger 1998);
6. Error may occur (Kissinger 1998; Dunning et al 1990; Vallone et al 1990; Voytovich et al 1985; Arkes 1981 cited by Kissinger 1998; Fischhoff et al 1977).

Therefore the rating of students' confidence cannot be used solely as an indicator for clinical competence (Oskamp 1965). I intended carrying out participant observation together with interviews in the next stage of the research whereby confidence and performance could be investigated simultaneously.

Murdock and Neafsey (1995, p.159) concluded that:

“... self-efficacy was derived from an individual's own successes or failures in performance, observations of the successes and failures of others, verbal persuasion from self and others, and cues from one's own physiological responses of comfort or discomfort in anticipating or actually performing a task. Further, once derived, these perceptions of efficacy influence what individuals choose to do, how much effort they invest, how long they persevere in the face of disappointing results,

and whether tasks are approached anxiously or self-assuredly.”

It has been hypothesised, therefore, that self-efficacy plays an important role between knowledge and behaviour (Bandura 1991; Bandura 1986). Davidhizar (1991) explained this further in relation to nursing. She persuasively argued that nursing students would lack confidence if their knowledge and skill in that particular area were poor. This, she argued, resulted in nursing students being incompetent. Therefore it is important that students develop the skill, the knowledge about the task, and the repeated experience of carrying out that task to gain competence.

Seldomridge (1997) stated that some student nurses underestimate their abilities and are less confident and more hesitant in undertaking certain tasks. However, others may act without caution because they overestimate their abilities - a view also expressed by Facione, Facione and Sanchez (1994).

Students therefore have their own feelings of self-efficacy. Wood and Bandura (1989) state that there are four major sources: enactive mastery experiences, modelling, social persuasion and psychological states. Each of these is important when considering the development of self-efficacy in student nurses.

Firstly the enactive mastery experiences refers to the strengthening of self-efficacy beliefs as a result of task accomplishment (Appelbaum and Hare 1996). The person is able to develop a sense of efficacy when challenging obstacles are overcome, providing them with the experience of that area. However the student will be self-assured of their capabilities only if they are allowed to deal with failures and setbacks without a large loss of confidence (Appelbaum and Hare 1996). Appelbaum and Hare (1996) suggested that it is the supervisor's role to facilitate the success of the experience, as work experience has major implications for the strengthening or weakening of self-efficacy beliefs. Subsequent interviews would explore the enactive mastery and its effect on self-efficacy.

Supernumerary status has been blamed for the lack of exposure to repeated clinical practice. As an observer, a nurse commented that “... it was interesting

to watch student nurses in their supernumerary capacity. It seemed as though they were reluctant to perform any nursing tasks – the role of observer was taken literally” (Cotterhill 1999, p.29). Supernumerary status was investigated further in subsequent interviews.

Secondly, vicarious experience or modelling is important to students’ self-efficacy beliefs:

“The model, through successful efforts, conveys to the observing person possible task strategies, a basis for (social) comparison and judgment of their own abilities, and encouragement to believe that through effort, despite setbacks, the task can be successfully accomplished.”

(Appelbaum and Hare 1996, p.36)

I will discuss role modelling in relation to comments and discussions made by the participants within the “good nurse” category as there was found to be overlap with this area following constant comparative analysis.

Thirdly, verbal or social persuasion can be important to the development of self-efficacy. Through verbal and social persuasion the supervisor can convey to the student their ability to succeed. However, unrealistically high expectations can impact negatively on the student’s self-efficacy beliefs (Appelbaum and Hare 1996).

Wood and Bandura (1989) researched business school students, investigating their decision-making processes and self-efficacy. Those who received negative feedback experienced a decline in self-efficacy judgments and detrimental performance. The self-efficacy of those who received positive feedback varied according to the feedback given. Those who were led to believe that they had easily achieved mastery tended to set lower goals for themselves compared to those who believed that they had achieved mastery through persistent effort.

Bandura (1989) also argued that students wished positive feedback on performance to improve self-efficacy. However Kissinger (1998) warned that

research studies (Grainger 1990; Einhorn and Hogarth 1978 cited by Kissinger 1998) have shown that large amounts of positive feedback from peers and other professionals may provide antecedent conditions for overconfidence to develop. Therefore nursing students should receive feedback of a positive or constructive nature, but lecturers and mentors should be aware that too much positive feedback may result in students becoming overconfident.

Fourthly, a student's perception of his/her psychological state will influence his/her judgment of self-efficacy. If they are fearful, anxious, or tense, they may judge themselves less able to carry out the tasks. Therefore efforts to reduce anxiety through reduction of stress can help self-efficacy judgments (Appelbaum and Hare 1996).

Through constant comparative analysis of this 'self awareness' code, it became apparent that there was linkage with all other codes and categories. For example, the role and function of the mentor was closely related to the students' feelings of self-concept within a professional role.

From the literature and from the comments from the students, I re-named this code 'professional self concept' and produced a category from it.

Trust 1.5

Davie (UG2) reported that he felt students often missed out on opportunities to practice skills:

"There are other things like dealing with people on the phone, with other agencies such as social work, occupational therapy, physiotherapy, and referring people to these agencies – I feel we should be given more leeway to do that sort of thing. ...Unfortunately we are not trusted to do it or it is seen as more hassle to give the student the job because the student would need more time to do it, may not give all the information, may not get as good a result when they do phone these agencies or may not get the result required. ...they're taken off you and you are

not even allowed to do them.”

(Davie, UG2)

Students often made reference to being ‘trusted’ to carry out certain procedures. Students wanted a balance between observing, being supervised doing, and doing the job independently when appropriate. In other words, they wanted to be ‘trusted’ to perform the skill or procedure when the time was right for them.

Mistakes 1.7

Davie (UG2) felt that nursing students could be expected to make mistakes but adequate supervision should help the student learn from that experience. Kleehammer, Hart and Keck (1990) stated that making mistakes was the most common cause of anxiety and stress for nursing students while working within the clinical area, and that the supervisor could help to reduce this anxiety. Research has demonstrated that nursing students tend to be more stressed during their academic preparation than they do in their first year of employment (Baldwin 1999). According to Appelbaum and Hare (1996), the student should be helped to deal with failures and mistakes by their mentor or they will suffer a large loss of confidence. Not only will the student have a failure in their own confidence, but might try to avoid the same situation again (Bandura 1982), thus affecting the student’s competence for future practice.

Yonge, Myrick, Haase (2002, p.85) suggested that student nurses may be stressed because of their preceptor, as “...two complete strangers must accommodate one another within a professional capacity.” They argue that due to the demanding nature of nurses’ work, such as life and death situations, this makes the relationship a potential source of stress. Yonge et al (2002, p.85) explain:

“If the relationship between preceptor and student is successful, it becomes beneficial to

all those involved. Should it prove to be less than successful, not only can it be frustrating and disheartening but it can result in student disillusionment about nursing and an inability to integrate and learn.”

Yonge et al (2002) argued that students may be uncomfortable and unaccustomed to critical examination of their performance by the preceptor, and may have to adjust to different teaching styles and be able to quickly grasp the requirements of a new placement and preceptor. Yonge et al (2002) suggest that these factors could cause more stress if the student is not supported by their preceptor.

Within my study, both groups of students stated that they had a fear of making a mistake, but expected that if they did, they would be supported and would learn from the experience partly through constructive criticism from their mentor.

Experience 1.8

All the undergraduate students expressed the need to gain clinical experience to help them gain confidence.

Jenny (UG2) talked about ‘difficult patients’ which her supervisor has advised her to stay away from. Jenny stated that ‘difficult patients’ were patients who had complained about the service provided or required lots of attention from nurses. However she had spoken with them and had got on well. “... *I got a lot of confidence from that because I thought that they were really difficult ...*” (Jenny, UG2). Lynne (D2) also stated that she had been advised to avoid ‘difficult patients’ but had successfully nursed one such patient. She also stated that had made her feel good about herself.

Mentorship 1.9

There was a certain degree of ambiguity over the nomenclature of the terms ‘mentor’ and ‘preceptor’. This was also noted in other studies and throughout the

U.K. (Andrews and Wallis 1999; May et al 1997; Coates and Gormley 1997; Wilson-Barnett, Butterworth, White, Twinn, Davies, Riley 1995). When searching for literature I used both terms but limited to literature investigating mentorship or preceptorship within pre-registration diploma or undergraduate programmes. The diploma students used the term 'preceptor' while the undergraduates used the term 'mentor'. However, from the students' responses in my study there was a general consensus as to what was entailed in mentorship within clinical practice.

In order to avoid confusion over these terms, I decided to use the term 'mentor' throughout the study findings and discussions. The U.K.C.C. defined mentorship as the role of providing "... support, guidance and role modelling for students in the practice setting" (U.K.C.C. 1997, p.1). The N.M.C. (2002a) described mentorship as being based on effective communication and teamwork, facilitation of learning, assessment, role modelling, providing an effective learning environment, while providing research-based knowledge and practice. The E.N.B. and Department of Health (D.O.H.)(2001, p. 9) however has made more explicit recommendations for mentors and their training, such as "...mentor preparation should normally be at a minimum of academic level three...". According to the E.N.B. and D.O.H. (2001, p. 9), the term 'mentor' should denote "the role of the nurse, midwife or health visitor who facilitates learning and supervises students in practice settings."

The E.N.B. and D.O.H. (2001) also stated that there was another role, and teaching qualification introduced in 2001, known as the 'Practice Educator'. None of the students within my study had experience of this role, and I did not peruse the literature relating to this role. This term 'Practice Educator' would denote:

"...the role of the teacher of nursing, midwifery or health visiting who makes a significant contribution to education in the practice setting, co-ordinating student experiences and assessment of learning ...[and] leads the development of practice and provides support

and guidance to mentors and others who contribute to the student's experience in practice ...”

(E.N.B and D.O.H. 2001, p. 15)

Drennan (2002) discussed the role of the ‘Clinical Placement Coordinator’ (C.P.C.) in Ireland. The C.P.C. was described as an experienced nurse who provided dedicated support to pre-registration students in a variety of clinical areas, but unlike the mentor or preceptor they did not have a patient caseload, and are supernumerary (Drennan 2002). Unlike Practice Educators who are employed by universities (E.N.B and D.O.H. 2001), C.P.C.s are employed by hospital trusts (Drennan 2002). Drennan (2002) concluded that evaluation of the C.P.C.’s role was positive in terms of student support. However, there did seem to be confusion for both clinical staff and students of the exact role of the C.P.C.. Students within my study had no experience of C.P.Cs, and I did not peruse any more literature relating to this role. I think that there may be a need for a role between that of mentor and lecturer, but these roles need to be adequately defined to students, mentors and lecturers. Also, large-scale studies evaluating the roles need to be carried out.

Some literature uses the term ‘preceptorship’ when discussing pre-registration nurse support systems (e.g. Nehls, Raher and Guyette 1997; Chickerella and Lutz 1981). Bain (1996) defines ‘preceptorship’ as the period of support when newly qualified nurses enter professional practice. The N.M.C. (2002a) describe preceptorship as “communication and working relationships enabling an understanding of how practitioners integrate a new practice setting and assisting with this process.” [p.11].

The origin of the concept of mentorship is well documented; it is said to originate from Homer’s *Odysseus*, in which Mentor, a wise and trusted friend of *Odysseus* took on the rearing of his son in his absence (Morton-Cooper and Palmer 2000). Traditionally associated with professions such as medicine, law,

and business, mentorship started to appear in nursing in the late 1980s (Andrews and Wallis 1999). However Andrews and Wallis (1999) state that the lack of a clear definition and a clear consensus as to the role and function of the mentor has meant that the picture is somewhat confused.

Morton-Cooper and Palmer (2000, p.39) define mentoring as much more than the “experienced guiding the inexperienced”, but as:

“... the building of a dynamic relationship in which personal characteristics, philosophies and priorities of the individual members interact to influence, in turn, the nature, direction and duration of the resulting, eventual partnership. ...It is these aspects that facilitate the personal development and career/professional socialisation for the mentee – leading to eventual reciprocal benefits for both parties.”

Ouellet (1993) also argued that students should be provided with the opportunity to practice cognitive and psychomotor skills, but also can learn the attitudes, values, and perceptions of the professional role i.e. the student would be professionally socialised into the role (Clayton, Broome, Ellis 1989). Clayton et al (1989) researched the influence of preceptorship programmes on the professional socialisation of student nurses. A pretest-posttest quasi-experimental design was used. Sixty-six senior students were conveniently sampled into a control group (i.e. did not have a preceptor) and an experimental group (i.e. were assigned a preceptor). The authors do not inform the reader of the number of students assigned to each group. Professional socialisation was measured using Schwerian’s Six-Dimension Scale of Nursing Performance (Schwerian 1979 cited by Clayton et al 1989). Reliability was tested on each subscale, and ranged between 0.73 to 0.96.

There were no significant differences in the pretest socialisation scores of students prior to the preceptorship experience. Immediately after, and six months after, the preceptorship experience, preceptored students scored higher in five, and four, of the six dimensions, respectively. The authors concluded that

the preceptorship experience had positive benefits in the professional socialisation of student nurses (Clayton et al 1989). However, the authors recognised that there was further research needed to study the effectiveness of student support systems in practice.

However, some have argued that there was little evidence to support the suggestion that mentorship was effective either as a support system or as a clinical teaching strategy for student nursing in the United Kingdom (Andrews and Wallis 1999; Cahill 1996). Spouse (1998) stated that the complexity of learning in practice has not been fully recognized and the resources do not exist to fully support students in practice. Ouellet (1993) also stated that much of the literature was anecdotal due to the lack of research-based literature available. Cahill (1996) argued that much more research was needed to investigate the effectiveness of mentorship for student nurses.

An early study, that I had not included in my initial literature review, investigated the role of the mentor. During discussion and interviews with 20 lecturers from two institutions in England, the attitude of the ward sister/charge nurse, supernumerary status and the mentor were commented on (Orten, Prowse and Millen 1993). Melia (1987) described the ideal ward manager as “friendly and approachable”, and someone who develops a climate in which students feel comfortable to ask questions and who is democratic. Many lecturers expressed the view that increasingly the student’s mentor was replacing the ward manager as a role model (Orton et al 1993). Lecturers described the mentor as the ‘key’ person for shaping student experience, providing support and guidance and identifying learning opportunities on and off the ward. They also believed that students benefited from working regularly with their mentors, but also benefited from working with other staff. One lecturer stated that “Mentors lead the students through the experience. They are increasingly a role model for the student.” (Orton et al 1993, p. 28).

Within this study, the role of the mentor was viewed as the key to a ‘good placement’. Undergraduates and diploma students stressed the importance of having a good level of supervision from an interested mentor.

“... You are told that your placements are what you make it, but really I think it’s about what your mentor makes of it. Obviously it’s a bit of both. If your mentor is just not interested in you compared to if they are interested – it makes a real difference They need to supervise us with our skills ... and make sure we are working to the best standard.”

(Jenny, UG2)

Lynne (D2) remarked that some senior students were more help to her learning than her mentor was. Tom (D2) explained that:

“... if you get a good mentor they will take you with them and will say about doing things. Some will go off and don’t care. Some nurses who have not been my mentor have been very good.”

(Tom, D2)

Lynne (D2) explained that she felt she should ask questions or should question what the nurses were doing, but having done that a few times, she experienced negative attitudes from qualified staff:

“I... tended not to [ask questions] because I do not want to be seen as a trouble-maker. At the end of the day it would be easy for them to say right you have failed that placement. ...they have an excellent way of making your life hell and they have done that! These are the same nurses who complain that newly qualified nurses don’t know anything!”

(Lynne, D2)

Jenny (UG2) used an example of ‘bad’ mentorship to show the effect this had on her:

“...if I did anything wrong, she was quick to pull me up on it, and if I did anything right she just ignored me. ...That wrecked my confidence because I would wake up in the morning and think that I really did not want to go in there.”

(Jenny,
UG2)

Constructive feedback to learners has been shown to improve feelings of self-efficacy (Wood and Bandura 1989) and reduce psychological problems such as anxiety, which can affect performance and ultimately competence to practice (Appelbaum and Hare 1996).

Cahill (1996), in a qualitative study using 23 traditionally trained nursing students in the second half of the final year, found that during individual interviews they stated that the quality of feedback on their performance was generally poor. Feedback, when it was offered, was often too late, destructive, personal in nature, and failed to concentrate on skill. Praise was quite rare, but fault-finding with its effect of sapping self-esteem and confidence whilst increasing anxiety was not.

Scott (D2) also felt that the mentor put too much pressure onto students, and forced them to make mistakes. He found that *“...you don’t enjoy going into placement and you don’t want to take part in procedures”*. He gave an example of helping with a catheterisation for which he had not been theoretically or practically prepared. He stated that by the end of the procedure he felt:

“...stupid when they were asking for this and that ...it was the worst experience I had. ...After that I was very nervous about doing that kind of thing again. If anything came up I stayed out of the way of it at least until I got back on my feet again. It did knock me for six ...”

He felt that his mentor should have gone through the routine, *“... telling me what everything was, what to expect and the problems that could go wrong.”* However, he partly blamed himself for not asking what was involved. This

example explains the importance of enactive mastery, social persuasion and psychological status on the development of self-efficacy and how it affected the student.

Asking the mentor questions was problematic for Scott (D2) especially during the first few weeks of a placement:

“... You are worried in case you look stupid, but until you actually get comfortable with them you cannot really ask them about their knowledge ...you are only there for four weeks. Two weeks you form a relationship and after that you start to learn. ...one preceptor said, do not ask me any questions and I will not ask you any!”

Elaine (D2) also felt that poor mentorship resulted in a lack of confidence:

“... You just get the carpet whipped from underneath you. I was at rock bottom after that placement ...I could have left nursing. I had no self-confidence at all after that placement ...”

Some students recalled good experiences with mentors.

“I ... had really good mentors who would do the practical side of it and then take you aside to talk about what you did and ... gave you hints and tips. Just talking about it really helps ...More into the theory side of it instead of just the hands on.”

(Cara, UG2)

“... When we were clearing up and getting the patient sorted she told me I had done well and that ...having never done it before, it was good. You know a bit of praise is important. There is nothing worse than ...constant criticism. ...You need to be told that you did that really well, or you know sitting down and saying you did it this way, but I would have done it that way – you know your technique was OK for this stage but you could have improved with practice.

...There's nothing worse than being put down. You need a pat on the back I think. ... she asked me how I felt about it – I think that was important – it was not just about doing it right, but also considered how you felt while you were doing it ...”

(Lynne, D2)

“... a good nurse is someone who can recognise a worried patient and try to implement things to relieve that anxiety. It is the same for students – a good nurse should be able to spot when a student is not happy with something and say to them that they clearly have a problem with that.”

(Lena, D2)

Lena (D2) felt that a good role model made a good mentor:

“... if you get a bad one it is still a role model but one you do not want to look up to! ...if you get a good role model you think well that's what nurses should be like.”

Scott (D2) stated that the level of supervision provided by the mentor varied depending on where the student was placed and the mentor involved.

“...a lot of the time the mentor was more interested in passing you onto others. I think there is only one mentor who took time out of her day to try to get me to tag along and get me to take part in the work. There were lots of times the mentor was more interested in the ward than you ...you were just a pair of hands. You were definitely under their feet ...”

(Scott, D2)

In Orton et al's (1993) study, lecturers identified one of the problems of mentorship was that students often had more than two mentors during the placement due to insufficient number of qualified mentors, 'off' duty, night duty,

annual leave and lack of mentor study days for those requiring places. Students in my study stated that the availability of mentors was problematic at times.

In a study exploring the perceptions of preceptors (n=134) of pre-registration nursing students in Australia, Usher, Nolan, Reser, Owens and Tollefson (1999) found that preceptors were positive towards the preceptorship model when there was support in their role as a preceptor, they were rewarded for their efforts and an attention given to their development as a preceptor.

Although Lankshear (1990) suggested that qualified staff welcomed questioning and innovative students with new ideas, and who are willing to challenge practice, this was not the view of the students in Cahill's study (1996) or Craddock's study (1993) or within my study. Scott (D2) spoke of the stress of trying to fit into the ward team:

"... maybe they are more interested in whether you have the right attitude and can be part of the workforce. ...You are under pressure the whole time to be part of the team and the last thing you want to do is to stand out ..."

The pressure of being a student in the ward was raised by Lena (D2):

"...you have to try to impress them all the time. It puts a huge pressure on. A lot of the time I would say you try to be part of the ward team when maybe you should not be ...you try to please someone at the same time as trying to learn. You should be there to learn but you want to be part of the teamYou miss out on a lot because you have had no time to reflect on what you have done and you are exhausted at the end of the day. So far I have tried to impress mentors by doing the work like bathing, but I haven't learned much. ...I have also found a problem going into the environment and the mentor is asking you questions and you do not have a clue because they do not know what level you are at."

However Joyce (D2) stated that she “... *asked questions on the first day that I already know the answer to ...so that I seem interested. Then they have the right opinion of me.*”

Many other studies have reported the importance of the students' fitting into the clinical team, and the stress associated with new placements (Timmins and Kaliszer 2002; Yonge et al 2002; Lindop 1999; Mahat 1998; Hamill 1995; Beck 1993a; Clark and Ruffin 1992 cited by Timmins and Kaliszer 2002; Kleehammer et al 1990). Nolan (1998, p. 625), in an Australian study investigating clinical placement learning for student nurses, also noted:

“One of the biggest challenges, which set the scene for active participation and subsequent learning on clinical placement, was the need for students to fit into the social environment ...and be accepted by staff and clients. The new setting brought with it feelings of fear and anxiety, which in turn affected the students' responses to their learning environment: one student commented: ‘Yes, you are so scared and wondering, oh God, I want to do this right’.”

During the focus group discussions in 1991, of four intakes to the C.F.P. and one adult Branch, Orton et al (1993) found that students commented on staff attitudes, mentorship, teamwork, supernumerary status and practical skills.

The authors used volunteers from each group, having initially met the whole group [which varied in size from 20-80 students] to discuss the project and purpose of the focus groups. The researchers also recruited C.F.P. lecturers and held two focus groups. They explained that each session would last approximately one hour and would be tape-recorded. How the volunteers were selected is not clear from the report, but each focus group comprised between five and nine individuals. Branch focus groups involved three sessions before and one after rostered service. Due to the possibility of bias during sample selection, the results from this study were viewed cautiously (Polit and Hungler 1995).

Orton et al (1993) pointed out that most of the volunteers were mature students, and despite further efforts the authors found it difficult to recruit younger students. However, how the authors tried to recruit younger students is not discussed. The mature students and the authors felt that their views may have been different to those of younger students.

Students reported that placements were too short so that by the time they were settling in, it was time to move on. One Branch student explained the importance of having the 'right attitude' and making themselves acceptable to ward staff as soon as possible, by getting along with the mentor and carrying out as much work as possible.

Orton et al (1993) identified six characteristics of a good mentor from the focus groups as someone who was: supportive, enthusiastic, positive about the role, knowledgeable about the programme, interested in teaching, and who made time for the students. One student reflected that a mentor "... colours your whole experience. If you get a good one it's a good experience: if you don't then it can be terrible." (Orton et al 1993, p. 80).

Orton et al (1993) stated that when students were faced with poor mentorship, they described staff who disliked the role and who did not make time for them. One of the reasons stated by the students for poor mentorship was the lack of qualified staff. Cahill (1996) also found that traditionally trained student nurses (n=23) had problems with the lack of time available to spend with mentors. However, inadequate preparation for the mentor role and the lack of formal selection of qualified staff (often mentors not by choice) have also been highlighted within the literature as possible reasons for poor mentorship (Andrews and Wallis 1999; Watson and Harris 1999; Atkins and Williams 1995).

At this stage I examined some of the literature to determine the mentor's role and function.

In a letter to the Trust Nurse Executive Directors, Heads of Nursing Faculties and Regional Nurse Directors, the Chief Nursing Officer/Director of Nursing gave feedback from government meetings on nurse service and education. It was proposed that there should be a clear understanding of the supervisor's role within nurse education, including roles, responsibilities and an appreciation of the time involved. The letter proposed planned and longer clinical placements for students sufficient to enable them to observe, practice and refine clinical skills with a systematic induction, preceptorship and support for newly qualified staff (Moore 1999).

There seemed to be a consensus between previous research reports and the feelings of the students within my study with regard to the role of the mentor. Although the level of support could vary from placement to placement (May et al 1997), there was a consensus of what the role should entail (Watson and Harris 1999; May et al 1997; Atkins and Williams 1995; White et al 1993; Darling 1984). The mentor should plan and organise students' learning experience and should participate and provide time for teaching and reflection. The mentor should supervise the student during practice and should assess the student's competence. Students expected the mentor to be a positive role model, provide a good learning environment, be enthusiastic, supportive and have a good knowledge of the programme.

Atkins and Williams (1995) explored registered nurses' experiences (n=12) of mentoring undergraduate students within a single health authority in England. Participants were purposively sampled and were nurses, midwives and health visitors from hospital and community areas. All had acted as a mentor for at least two students during the year of the study. Semi-structured, tape-recorded interviews were used. Data were analysed, and developed into codes and categories. The authors state that reliability and validity measures were taken, but fail to explain how these measures were carried out. This makes the reliability and validity of the findings susceptible to researcher bias. However,

the authors provide verbatim statements to support points made throughout the article, adding to the 'truth value' (Guba and Lincoln 1981).

Mentors emphasised the importance of supporting the student by being present for the student to access them. However, they also stated that this could be emotionally demanding, difficult to carry out in practice because of shift and holiday rotation, and also having the time to, for example, reflect on the experience and/or listen to the student's difficulties, was difficult (Atkins and Williams 1995). Nolan (2003) also found that mentors had insufficient time to allocate to students. However, due to shift pattern, mentors noted that they often had more time on weekend or night shifts to spend with students, but the students were rarely assigned to these shifts (Nolan 2003).

Atkins and Williams (1995) also stated that although mentors had spoken of the difficulties in providing effective mentorship, all spoke of the personal satisfaction gained from facilitating the development of the student. The positive benefits of mentorship and preceptorship roles have been well documented (Dibert and Goldenberg 1995; Bizek and Oermann 1990; Wright 1990; Usher et al 1999; Shogan, Prior and Kolski 1985). Participants had identified ways in which they felt their own learning and professional practice had been enhanced as a result of mentoring. The student could question them, and provide them with information about up-to-date clinical practice and educational developments.

Not surprisingly, mentors stated that they did have difficulty in coping with the extra workload generated by the mentoring role. Earlier studies had also stated this problem (Wright 1990; Wilson 1989), and later studies indicate that this problem still exists (Ohrling and Hallberg 2001; Usher et al 1999). Atkins and Williams (1995, p. 1012) also stated that participants who had "...less control and flexibility in their working day, for example nursing within hospital environments with acutely ill patients, seemed more disturbed by the burden of conflicting roles and responsibilities than their colleagues with more flexibility and control."

Therefore, although there seemed to be consensus as to the role of the mentor, the reality of the actual role in practice may be different to the ideal and perhaps may be difficult to sustain.

Morton-Cooper and Palmer (2000) described this role in more detail:

- a. **Adviser:** The mentor offers support and advice in both career and social terms. This should be in view of the mentee's merits and abilities. This process should aid the building of the student's self image and confidence;
- b. **Coach:** The mentor sets mutual guidelines with advice and constructive feedback. The mentee can then test such feedback in different practice situations;
- c. **Counsellor:** The mentor acts as a listener and sounding-board to facilitate self-awareness and encourage independence;
- d. **Guide/networker:** As a supportive guide, the mentor introduces the mentee to the helpful contacts within the organisation. The mentor should also facilitate introductions to the values and customs of the organisation, including socialisation to the mentee's own occupational, professional and social groups;
- e. **Role model:** As a role model, the mentor provides an observable image for imitation, demonstrating skills and qualities for the mentee to emulate;
- f. **Sponsor:** The mentor should influence and facilitate entry to the organisational and professional cultures;
- g. **Teacher:** The teacher function involves sharing knowledge through experience and critical inquiry, facilitating learning opportunities, and focusing on individual needs and learning styles to promote ownership and responsibility for continuing professional education.
- h. **Resource facilitator:** The mentor should share experiences and information, as well as providing access to resources.

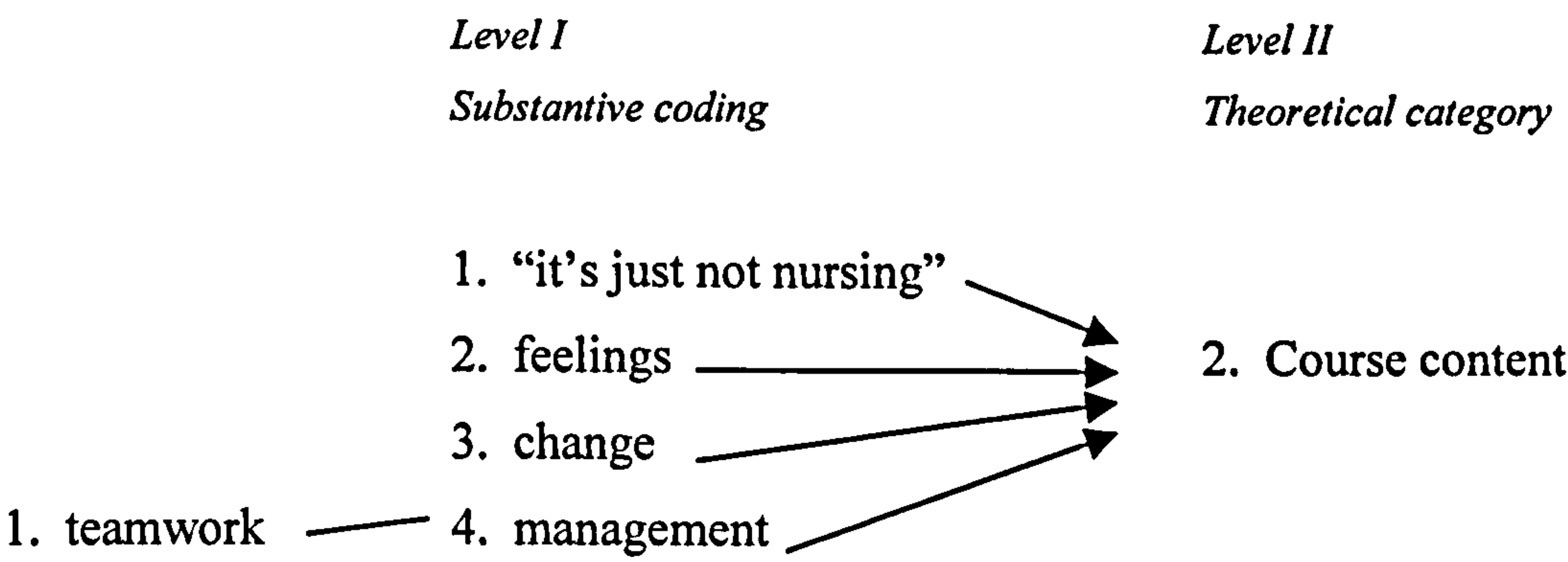
It became apparent that students within my study were looking for all of these helping roles from their mentor but were often disappointed. The main problems included lack of enthusiasm and interest of the mentor, lack of constructive feedback from the mentor, lack of availability of the mentor (especially within hospital areas), with poor levels of supervision, resources and teaching. Students were often disappointed in the standard of care provided by poor role models to which they had been exposed. However, when these mentor attributes were positive, the student found that the experience they had gained was also positive. Within my study, if students had a good experience of mentorship they often referred to themselves as 'lucky'. Students who had poor mentorship often found themselves falling behind other students' level of competence, while students with experience of good mentorship often found that their level of competence was equal to or even better than that of their student colleagues at the same stage.

It is interesting to note that none of the students brought up the role of the lecturer within practice. Perhaps the students did not feel that the lecturer had an important effect on practice learning.

From this category, the following questions were asked within the next set of individual interviews: *How are you feeling about being qualified soon? Tell me about the mentors you have had in practice*

Category 2. Course content

Figure 12: Theoretical category ‘Course content’



“It’s just not nursing” 2.1

By the mid-point of the undergraduate programme, the students had begun to understand the integration of subjects:

“A lot of it has to do with anatomy and to do with different things like the pancreas and the gall bladder. You need to know the anatomy and physiology and why it stops working and what happens. I think that is useful and relevant. It gives you a better understanding when you go out into the wards.”
(Jenny, UG2)

“It’s only in third year – it is true it comes together because you are out and actually doing your adult nursing. ...I think in first and second year you are feeling a little bit lost because you don’t see. [In third year] ...you do see things coming into play when you are out in the wards.”

(Sandra,
UG2)

Jane (UG2) agreed with Jenny (UG2), that third year of the undergraduate course becomes more practical with greater subject integration. *“...you get human disease and you like that more because it is more practical. ...it all comes*

together ...it is only when you are out in the wards that you appreciate how much you value what you have done in first and second year."

A study by Kinsella, Williams and Green (1999) investigated student nurse satisfaction with the C.F.P.. The authors argued that this area needed to be investigated due to the high level of attrition within the C.F.P., mainly due to the disillusionment of students. The study involved 315 students in four entry cohorts in the University of Wales (1995-1996). Within the sample 10% (n=32) were male, 16% (n=50) were enrolled on a degree programme and a proportion within each cohort were taught at another campus (24% of 1995 cohorts and 29% of 1996 cohorts). As student opinions were expected to change, data were collected from the 1995 cohorts and the 1996 cohorts at five and 18 months after enrolment respectively.

Each student was given 45 minutes to complete a questionnaire which was distributed by a teacher not involved with the C.F.P. within that college. The questionnaire had been piloted on students who had recently completed the C.F.P., but the number used in the pilot was not documented. This could introduce researcher bias (Polit and Hungler 1995) and the authors do not state what changes if any were made to the questionnaire following the pilot study. The authors also fail to report a number of important aspects of research methodology, including how the subjects were approached to take part in the study and whether any ethical issues were considered. The questionnaire response rate was not reported. There was no discussion of any feedback or improvements made as a result of the study. Therefore possible bias (e.g. poor response rate) and ultimate limitations of the study (e.g. confidentiality and anonymity assurances may have made the answers more truthful) are not considered by the authors when they report the results.

The questionnaire used Likert-type responses on a 5-point scale: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree. The reliability of Likert scales tends to be good but the most serious criticism leveled at this type of scale is that it is difficult to reproduce the same results: the same total may be

obtained in different ways (Oppenheim 1992). Therefore it could be argued that such a score has little meaning or that two or more identical scores may have completely different meanings. With regard to the neutral point on the scale, it must be argued that this is not necessarily the midpoint between the two extremes.

Data analysis was carried out using a Formic scanning device and a computer statistical package (S.P.S.S.) for analysis using chi-square, Mann-Whitney U and Kruskal Wallance tests, and A.N.O.V.A. tests for statistical significance.

A summary of the findings relevant to this study will be addressed. Eighty-seven percent agreed that the C.F.P. could be better organised, while nursing interventions, bioscience and sociology were rated higher than subjects such as research and social policy. Students indicated that they would have liked fewer lectures (60%) and more small group/tutorial work. Thirty eight percent of students were of the opinion that the C.F.P. was of a much higher academic level than expected. A high proportion of students (84-85%) disagreed that the clinical component of the C.F.P. was too great. The majority of the opinion was that preparation for practice was not sufficient, with 60% agreeing that they sometimes felt ill-prepared for the practical demands made of them during placements.

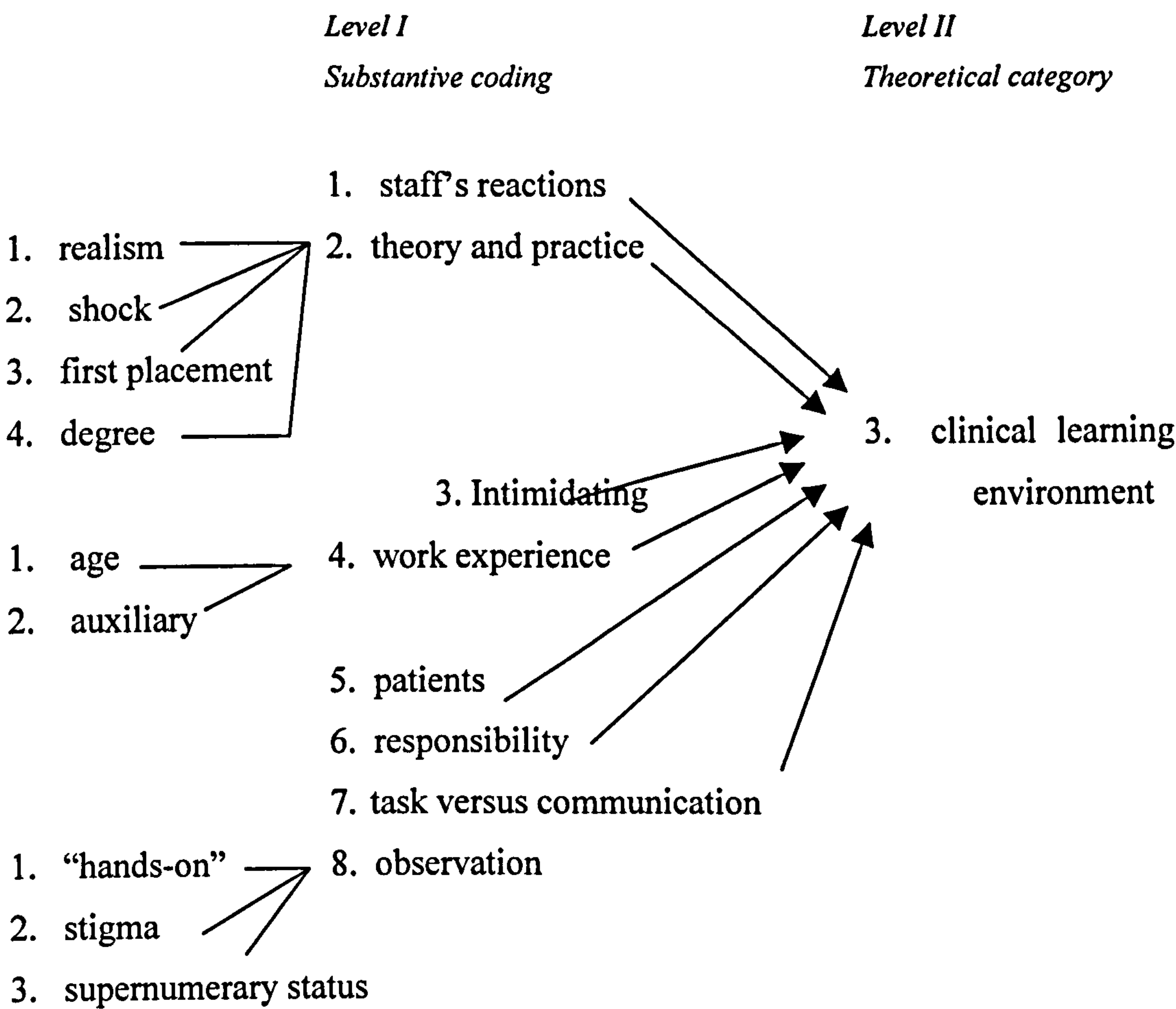
The undergraduate students within my study stated that, whilst difficult, they appreciated the academic content and the academic level of their programme. They viewed theory as being essential to adequately prepare them for practice, while diploma students stated that they could “...*do much more learning on the wards ...*” (Joyce, D2) and could have more clinical placements because “...*that’s where you learn.*” (Elaine , D2).

This category was later compared to ‘degree and diploma education’ category. I found overlap between the two and combined them to become a new category: ‘level of theoretical knowledge’.

Category 3. Clinical Learning Environment

Both sets of students provided a lot of information about their perceptions of the clinical area.

Figure 13: Theoretical category ‘Clinical learning environment’



The above substantive codes were combined to form a theoretical category named the ‘clinical learning environment. Data from the literature which included Orton et al (1993), Neary (1996) and Dunn and Hapsford (1997), provided support for the emerging category within my study. My study agreed with the findings of these studies.

During Orton et al’s study (1993), all participants completing the questionnaire were asked to identify what they felt were the three most important features of a

good learning environment. Content analysis clustered the responses in seven broad categories as follows:

- **‘Friendly and supportive staff’** – this category covered all responses that related to how supportive, approachable, friendly and encouraging ward staff were to students. Included were such responses as: friendly atmosphere, friendly and helpful staff who do not see students as a burden, encouragement from ward staff, and good support and advice from staff.
- **‘Learning opportunities’** – this category described the availability of learning resources in a ward situation. It included both clinical opportunities and such assets as a resource room for students to use. Typical responses were: plenty of opportunities to learn practical skills, easy accessibility to good resource material, plenty of good learning opportunities, plenty to learn and do, resource room and time to use it, and adequate numbers of trained staff.
- **‘Good staffing levels’** – This referred to the adequacy of staffing on the ward. Typical responses were: staffing levels are adequate and staff/student ratio is correct, and adequate numbers of trained staff.
- **‘Teamwork’** – This category referred to the positive functioning of both the nursing team and the multi-disciplinary team on the ward, and the inclusion of students. Characteristic responses were: being part of a team, working together as a team, to be included in the team, not treated as an outsider, enthusiastic teamwork approach to nursing, and good multidisciplinary team practice.
- **‘Good mentor system’** – This referred to a situation in which mentors are supportive and willing to spend time with students. Examples of responses put into this category were: working closely with the mentor, informed and experienced mentors, adequately prepared mentors, good mentorship and personal contact with the mentor.

- **‘High staff morale’** – This category described the frame of mind or spirit of staff on the ward. A typical response was good staff morale.
- **‘Well-informed staff’** – This category related specifically to the awareness and knowledge the ward staff have of the diploma course. Among such responses were staff knowledge of Project 2000, understanding of Project 2000 students’ needs and better educated staff re Project 2000.

(Orton et al 1993, p.70-71)

Findings by Orton et al (1993) are supported by findings from my study and a number of other studies. Following a research study, Neary (1996 p. 101-2) also stated that a good learning environment has a warm and friendly atmosphere, approachable staff where students are valued by qualified staff where staff were respected for their personal attributes as well as their experience and qualification and up-to-date knowledge. The delivery and management of care to agreed, collectively maintained standards within which learning opportunities for students were aligned with educational objectives as part of an agreed curriculum, were viewed as aspects of an ideal learning environment. Also, there had to be appropriate interaction between teaching and service staff, which would maximise the potential correlation in terms of time and content of what is taught in college and its application to practice. This, Neary (1996) argues, should be matched by clear understanding by students, service staff and college staff as to how student practice is to be maintained and addressed.

Both Neary (1996) and Orton et al (1993) identified the same criteria as students in my study. However, students in both groups within my study explained that in some placements they were dissatisfied with the relationship they had with staff, mentors and/or the nurse manager. In some cases, students highlighted examples of varying standards of patient care, and staff morale, which also impacted on their satisfaction with the clinical learning environment. A study by Dunn and Hansford (1997) identified these factors as having an effect on students’ satisfaction with the clinical learning environment. Dunn and Hansford (1997)

invited all students from second and third year of an undergraduate nursing programme in Brisbane, Australia, to participate in their study. The students had a clinical placement of one day per week for a period of eight weeks in areas such as surgery, medicine, paediatric, maternity, cardiology, and rehabilitation. Two hundred and twenty nine students volunteered: 128 in second year and 101 in third year. The sample consisted of males (15%) and females (85%). Over 72% (n167) of the sample were aged between 19 years and 22 years, with a range of 18-38 years, and a mean of 22 years and two months.

The researchers used qualitative and quantitative methodologies to integrate empirical, interpretive and critical research paradigms. Triangulation, the authors argued, provided validation of the findings through the use of different methods with different biases to investigate the same concepts with convergent approaches. Also the use of different approaches gives a more complete picture of the study than using a singular method (Streubert and Carpenter 1999).

The Clinical Learning Environment Scale (C.L.E.S.) (Dunn and Burnett 1995 cited by Dunn and Hansford 1997) was used to collect quantitative data on students' perceptions of their clinical learning environment. The C.L.E.S. is a 23-item instrument with five sub-scales: staff-student relationships, nurse manager commitment, patient relationships, interpersonal relationships and student satisfaction. Although the researchers stated that reliability and validity had been tested previously on 423 undergraduate students, they did not test it on this population making the reliability and validity of the findings questionable (Polit and Hungler 1995).

Qualitative data were collected via focus group interviews. Theoretical sampling was used to select 42 students who were on units which had been identified during the pilot study as having extremely good and extremely poor clinical learning environments (i.e. the top 5% and bottom 5%). Students were asked to describe their impressions of their unit as a clinical learning environment, and comment on its characteristics. All interviews were conducted, audiotaped and transcribed by the researcher. Students were assured of anonymity and

confidentiality prior to providing written consent. Analysis of the quantitative data were carried out using the Statistical Package for Social Sciences (S.P.S.S.) using analysis of variance. A level of significance of 0.05 was adopted. Qualitative analysis involved the creation of themes.

Staff-student relationships

Staff-student relationships were highlighted as a major part of providing a good learning environment. Items with the highest factor loading included: 'Our questions are usually answered satisfactorily' (0.82); 'All staff on the unit, from nurse manager to the newest student, feel part of the team' (0.77); and 'This was a happy unit for both patients and staff' (0.75). The authors concluded that these items highlight the importance of the willingness of the registered nurse to teach students while allowing them to become accepted members of the team.

Qualitatively the students identified the warmth and rapport demonstrated between staff, the support provided in gaining access to learning experiences, and the willingness of the participants to engage in a teaching relationship, as attitudes which were important.

Nurse manager commitment

Nurse manager (NM) commitment was highlighted as a major factor in providing a good learning environment. Items with the highest factor loading included: 'The NM devotes a lot of her/his time to teaching nursing students' (0.90); 'The NM attaches great importance to the learning needs of nursing students' (0.84) or a contrary note, 'The NM here was too busy with more important matters to be able to spend time with us' (0.63). The authors noted that qualitatively and quantitatively the nurse manager played a pivotal role in providing a good learning experience. This was also noted during the early 1980s (Orton 1981; Fretwell 1980; Pembrey 1980). Dunn and Hapsford (1997) also found a moderate correlation between NM commitment and 'staff-student relationships'

($r=0.64$, $p<0.001$), 'patient relationships' ($r=0.42$, $p<0.001$), and 'student satisfaction' ($r=0.48$, $p<0.001$).

For the purposes of comparison with my study, I coded any comments that involved charge nurse/sister level and above as relating to the role of the NM. Both groups of students (UG2, D2) within my study identified clinical areas in which the NM provided varying levels of support and teaching to students:

"I did not see the ward sister. She had lots of other things to do ...I think your mentor is better for support. The sister does not do a lot of practical things on the ward so I don't think it would be useful for her to take students with her. ...I don't really know what she did."

(Lynne,
D2)

"... the charge nurse was brilliant. He was an excellent role model and had loads of experience. He would talk through each patient and what was wrong with them ...and then ask you questions. It got you thinking! ...I felt really good when I left that area."

(Angela, UG2)

Patient relationships

Patient relationships were highlighted as major factors in providing a good learning environment. Items with the highest factor loading included: 'Nursing care is individualised for each patient on this ward' (0.72); 'Patient allocation, rather than task allocation, is practice on this ward' (0.67); 'The patients' needs really are given first priority' (0.66). The authors noted that the attitude towards patient care often seemed to reflect the qualified staff's attitude towards the nursing students which was identified in staff-student relationships.

Both groups of students (UG2, D2) within my study enjoyed placements in which care was patient-orientated rather than task-orientated. Jack (UG2) stated

that he had participated in the total care of a few patients and reported that this had made him:

“... see the importance of providing holistic care. ... I managed to carry out a variety of skills like I.V. [intravenous] fluids, bed bathing, and pre-operative checklisting and taking the patient to theatre. ... I could see the importance of doing all these tasks for the one patient. I checklisted the patient for theatre and looked after him when he came back. I knew he had angina, so I was extra careful in checking his observations and asking him if he had chestpain. I would not have known him so well if I was just taking his obs [observations of vital signs] without knowing the patient.”

Student satisfaction

Student satisfaction was highlighted as a major indicator of a good learning environment. Items with the highest factor loading included: ‘I am happy with the experience I have had on this ward’ (0.95); ‘This was a good unit for my learning’ (0.92); and ‘The work I did was mostly very interesting’ (0.86). This sub-scale demonstrated the highest reliability and factor loadings, and was significantly related to all other sub-scales ($p < 0.001$) (Dunn and Hansford 1997).

The study showed the C.L.E.S. sub-scale ‘student satisfaction’ to have the highest inter-sub-scale correlation with the ‘staff-student relationships’ sub-scale ($r = 0.71$, $p < 0.001$), supporting Orton’s (1981) recognition of the importance of staff attitudes in influencing the learning experience. However, the authors rightly warn the reader that this has not been proven as a cause and effect.

This study was conducted outwith the U.K. with undergraduate students whose pattern of clinical placements is different from that of the U.K.. Therefore the generalisability of the findings to the U.K. would not be appropriate, especially with the relatively low number of participants. However, the findings do suggest that there could be a positive correlation between a good clinical learning environment and staff-student relationships, nurse manager commitment and

student satisfaction. Findings from my study would seem to support these findings by Dunn and Hansford (1997).

Staff's reactions 3.1 and Intimidation 3.3

Within my study, students at the mid-point of both programmes stated that there had been occasions throughout their programme where they would feel apprehensive about commencing a placement, especially if they had heard from other students that the staff were not pleasant. Students also talked of feeling intimidated and/or stressed, especially when staff were too busy to give them proper supervision and support.

Theory and Practice 3.2

Neophyte students (UG1, D1) expected to witness differences between what was taught in theory and what they saw/did in practice. By the mid-point of both programmes, students had developed further views of the theory-practice gap. Jenny (UG2) felt that the degree programme had prepared her well for practice:

"I don't think I have been taught anything where you think 'that will never happen'. I think they have got to teach you about most possibilities and teach you how to handle that. I don't think I have been taught anything which has no point."

Jenny (UG2) stated that she would challenge practices that she felt were inappropriate or contrary to what she had been taught, even if it meant she would not be assessed favorably by her mentor: *"...if I really felt that this was an important thing, I'd rather get a rubbish assessment than just let it go. ... it might make a difference to that patient."*

In contrast, Scott (D2) felt that it would have created a problem for him if he had voiced his opinion.

"Telling them that they [auxiliaries] cannot do that ...it would cause a lot of friction. Personally speaking I would observe and make comment, but to a large extent I would go with the flow. If you start to create waves it will come right back at you. I know you are supposed to stand up for the patient and all that, and even for yourself, but it could cause a lot of bother. ... you are just a visitor."

(Scott, D2)

Some students felt too intimidated to voice opinions:

"...although we've been taught the right way to do it, and what not to do ...when we go into the wards everyone is doing it the wrong way as far as you are concerned. ... and you are just the student saying hold on a minute! I confess I don't always do things the right way because everyone else does not. They are the ones with the experience ...but I should really say."

Cara (UG2)

In their Project 2000 proposals the U.K.C.C. (1986) stressed the need for nurses who would challenge the status quo, and would introduce changes in practice. Cara (UG2) gave moving and handling as an example. *"...I should do it right because it has been proved that this is the right way and that's going to damage your back. You are only putting yourself and the patient at risk. I should stick up for myself!"* Cara (UG2) explained that there was pressure on students to conform when the mentor had a responsibility to assess students' performance. However Cara (UG2) stated that *"... I think you should always be trying to do your best anyway whether you have an assessment or not ...you should still act the same."* Sandra (UG2) stated that she did not feel restricted in saying what she felt even although the mentor was assessing her:

"I get my views across but ...are you prepared to put yourself in the firing line and stand up and be counted and say I don't agree with that! I want to do it this way. ...I don't think I am going to get a bad assessment from saying what I think and what I've been taught."

All students commented on the link between theory and practice. Cara (UG2) stated that she felt that theory was learned “... *from the books. Only once you know the theory behind it, can you go out and apply it to practice. Then you can make your mind up about whether it works or not.*”

Lynne (D2) felt that what she learned in college was:

“... more thinking things than doing things. You learn a lot in College and then it is nothing like that when you go out onto placements. I mean I’ve had people telling me that I am very task orientated – you don’t think of the whole person. The same person then came up to me later and asked me if all the dressings on that side of the ward were done!”

Lena (D2) gave an example of differences between theory and practice:

“... we got a lesson on catheterisation and I could picture this quite well. ...However one nurse will have a slightly different technique to the other – one nurse will put on two pairs of gloves and then take one off, and the other will put on one pair of gloves and take those off and put on another.”

Almost all students gave examples of differences between the way in which qualified staff carried out various procedures. They stated that it was important to apply the principles of theory, for example aseptic technique, but the actual practice may be slightly different, for example in using gloves differently. This confused students at this stage of their programme as they were unsure as to whether they were witnessing the correct practice which used the theoretical aspects they had learned.

McCaughtery (1991) describes two fundamental reasons why student nurses perceive a gap between theory and practice. Firstly, there are characteristics of ‘theory’ (books and nursing curricula) that lead to it being an imperfect representation of nursing ‘practice’. Upton (1995) expressed this version of the

theory-practice gap as “reality versus the ideal”. Books can be referred to as ‘knowledge by description’ (Russell 1967 cited in McCaugherty 1991). This is in contrast with ‘knowledge by acquaintance’ i.e. that which we gather through direct experience. McCaugherty (1991) identifies that knowledge by description gives us the opportunity to conveniently inform us and gives us a feeling for things that are beyond our own personal experience.

Secondly, there are characteristics of nursing practice that make it more complex and varied than any theoretical descriptions. Scott (D2) stated that his experience on placements had made clear to him a difference that existed between theory and practice: *“When you physically handle patients there are a lot of things that you do where moving and handling techniques do not apply ...you cannot use them.”* Undergraduate students (Cara, Jane and Jenny (UG2)) and other diploma students (Lynne (D2) and focus group (D1)) also expressed this view. Most nursing books describe, for example, nursing care of a patient undergoing a partial gastrectomy. The book, and also classroom teaching, will cover most, if not all of the general principles the student needs to know. However a full understanding of the principles does not guarantee their application to patient care: “knowledge (theory) is one thing, doing (practice) may be another” (McCaugherty 1991). McCaugherty (1991) explains that lectures and textbooks identify general principles but the unique psychological and social dimensions of individual patients are missing. The student needs to identify these when nursing patients and the move from these generalisations to the specifics of patient care can require a leap across the theory-practice gap.

Also, when students experience patients undergoing, for example, surgery, each patient may develop different complications which will contribute to building a unique picture of each patient. Thus from the student’s viewpoint, practice (i.e. patients) may appear quite different from theory (i.e. books and lectures) (McCaugherty 1991). Witnessing something in practice is far more understandable than an abstract, general principles. However, the student must also learn to apply these underlying principles or theory in practice (Hesook 1993). Hislop, Inglis, Cope, Stoddart and McIntosh (1996) explained that the

student nurse, as a novice, might not be able to link the theory with practice. For example, the student is taught the salient features of a clinical diagnosis. The main problem, however, is that the novice might not even recognise such features within clinical practice.

Davie (UG2) also noted the importance of applying theory to practice:

“... It is only when you meet a patient with a specific set of problems or set of diagnoses or set of social problems that you can apply what you have learned and relate it to that person. That’s where learning takes place. I don’t think the learning takes place in a classroom - you get told what is relevant but you really learn when you are out on placement.”

The N.H.S. Executive report (1998) explained that due to the change in role of nurse lecturers, practice-based education is often left to practice staff, where inexperienced nurses are frequently left with the responsibility for integrating theory and practice through demonstration, supervision and guiding reflection on and in practice. There also seemed to be questionable levels of preparation practice staff received for this role. Some students within my study highlighted practice staff’s lack of knowledge about each programme, which made the integration of theory and practice much more difficult, particularly when the actions of qualified staff were different from what they had been taught. Reed and Procter (1993), MacKenzie (1992) and Cook (1991) also noted this. Lynne (D2) stated that she found it difficult to work with supervisors who had no personal experience of diploma programmes:

“They [qualified nurses] are not quite sure where I am in my training and what I have done and what I haven’t done. They ask me to do things and I have to say that I am not quite sure how to do that.”

Orton et al (1993) investigated the clinical learning environment using 359 diploma students (three to 18 months into the programme), 253 traditional

students, 21 undergraduate, 72 qualified staff, 38 support workers, and 33 lecturers. A questionnaire was used to identify opinions of the groups about the diploma programme. It sought biographical data of each respondent, and their beliefs and opinions about Project 2000 with a Likert scale. The respondents were then asked to identify the three most important features of a good learning environment with students focussing on their most recent clinical placement. A pilot study, using 35 students from two institutions not involved in the study, resulted in some rewording of questions. The report provides the reader with a copy of all questionnaires used.

Most response rates for the questionnaires were satisfactory (i.e. >60%) (Polit and Hungler 1995): 45-100% for diploma students; 98-100% for traditional students and Bachelor of Arts (B.A.) students. The authors stated that the high response rate for the latter groups (i.e. 98-100%) was due to the fact that these questionnaires were handed out and collected when the students were in class, whereas the diploma groups were given their questionnaire in class and a stamped addressed envelope to return it. The authors also allowed time to provide feedback at designated sessions.

Data collected in 1991 revealed a difference of opinion between lecturers (n=20), diploma students (n=220) and qualified staff (n=72) as to the appropriateness of theory taught. Sixty five percent of lecturers, 35% (n=77) of diploma students and 15% (n=11) qualified staff felt that the ratio of theory to practice was 'about right' but in 1993 only 38% (n=5) of lecturers thought so. There was also concern regarding the level of practical skills diploma students develop. Lecturers were also interviewed again in 1993. In 1991, 80% (n=16) of lecturers, 43% (n=95) of diploma students and 29% (n=21) of qualified staff felt that theory learnt in college was a relevant preparation for ward placements, but in 1993 only 62% (n=8) lecturers agreed with this opinion. In 1991, 55% (n=11) of lecturers expressed concern, but by 1993 this percentage had risen to 69% (n=9). The authors concluded that this was an indication that lecturers were increasingly sharing the concern expressed by some of their service colleagues as to the 'fitness for purpose' of nurses educated via the diploma course.

However, the physical separation of theory and practice, i.e. nursing lecturers in higher education and nurses in clinical areas, has been highlighted as a possible cause of the gap between theory and practice (Bushby 1997; Ferguson and Jinks 1994; Miller 1985a). Miller (1985a) identified further barriers to the integration of theory with practice and vice versa. Nurse theorists write and teach about ‘nursing as it ought to be’, whilst practitioners deliver nursing care within the constraints of the system and perceive nursing ‘as it is’ – and generally give good reasons why ‘nursing as it ought to be’ would never work in their particular area.

Miller (1985a, p. 422) questioned the academic component of nursing programmes:

“... They [nursing students] have to ... swallow very large doses of theory, and one suspects that if they internalise the knowledge, values and attitudes of the theoreticians they will subsequently encounter difficulties if they attempt to use ‘ideal’ nursing in the real situation.”

The literature yields multiple definitions of the term ‘theory’ (Upton 1999), and the exact nature, purpose and utility of nursing theory continues to be debated (Pryjmachuk 1996; McCaugherty 1992; Garbett 1995; Draper 1991; Ingram 1991; McFarlane 1977). Chinn and Jacobs’ (1987) definition combines the main characteristics of other definitions. They suggest that nursing deals with a wide range of complex events that demands a broader view of theory and theory development. They define theory as “a set of concepts, definitions, and propositions that projects a view of phenomena by designating specific interrelationships among concepts for purposes of describing, explaining and predicting phenomena.” Ingram (1991) argued that the purpose of developing a nursing theory should lead to enhanced nursing practice and therefore better patient care. Marriner (1986) identified multiple benefits from developing a nursing theory in that theory provides knowledge, enhances nurses’ power, aids deliberate action and provides rationale when challenged, and also professional autonomy by guiding practice, education and research.

Hardy (1994) stated that nurses in the U.K. jumped on the theory 'bandwagon' during the 1970s and 1980s with theories developed in the United States. These theories, she argued, had little empirical support. However, Nolan, Lundh and Tishelman (1998) argue that despite nursing theory being a relatively recent innovation in nursing, it is being viewed as increasingly irrelevant. The authors conclude that nursing theory has failed to fully inform nursing practice, due to the abstract and global nature of many theories. This had earlier been stated by Miller (1985b) as one of the main reasons nursing theory has failed to fire the imagination of most practitioners, in that they have difficulty understanding it and applying it. Scott (1994) argued that the use of jargon and verbosity within nursing theories make it more difficult for the practitioner to make sense of theory, and as a result the gap between theory and practice widens. In summary, nursing theories have been criticised due to lack of clarity, lack of applicability, or the lack of apparent significance to the nurse's sphere of practice.

However, there have been some arguments for the use of nursing theories. Nolan (1996) summarised the benefits of applying a nursing theory to practice as being that it can improve patient care, enhance professional status, improve communication between practitioners, and provide guidance for research and education.

Students at the mid-point of both programmes had developed their own opinions on the role and usefulness of the theory they had been taught. Jenny (UG2) stated that students had to learn the theory before going onto practice:

"...they [lecturers] ... teach us the theory before they send us out on practice, so we are prepared for it in a way. I think that's actually a good idea because ...you don't know what you are going into on placement, but you know what is behind it. You maybe have a bit more knowledge."

Prymachuk (1996) and Lindsay (1990) stated that since nursing is an emerging discipline a theory-practice gap is inevitable, and is an indication of its growth, development and progression. Rafferty, Allcock and Lathlean (1996) suggested

that the theory/practice gap can never be sealed entirely and is essential for change to occur in clinical practice. Rolfe (1996a) and Cook (1991) argued that other professions such as social work (Barbour 1984) have not succeeded in closing the gap despite their efforts.

Lindsay (1990) questions those who advocate that nursing should be taught from a position of current practice i.e. from someone credible in current practice. He questions whether we should be teaching from this viewpoint in that if we did nursing theory and practice would stand still. In other words, students may return from practice having witnessed out-dated practices or may see the ideal as unachievable in the present climate. He maintains that there should be hope that it may be implemented tomorrow. Hislop et al (1996) stated that by teaching new recruits the latest values and ideals it can be assumed that these will eventually permeate to practice as these students become qualified. Therefore the education system will influence the clinical area. However the authors also point out that novices are usually anxious to gain recognition and fit into the team, which may weaken the influence of theory against the pressure of occupational socialisation. Maben and MacLeod Clark (1997, p.57) also stated that "...many students described the attitudes of colleagues as a barrier to implementation of research ...". This pressure to fit into ward teams is apparent from both diploma and undergraduate nursing students within my study.

However, Severinsson (1998) suggests that models of supervision may be a means of reducing the gap between theory and practice as practice supervisors may inform students and vice versa, and academic colleagues may inform practice supervisors/ students and vice versa. However, the models of supervision available need to be properly evaluated as the advantages and disadvantages of such are often antedotal.

Davie (UG2) stated that he felt that in some circumstances he could carry out theory in practice but was often prevented from doing so by other staff:

“... if you choose to push your point of view, people in general know what the proper system of work is.... People know what the correct system is, but whether they choose to follow it or not is another question. ...I would try to use sliding sheets, hoist and various other bits and pieces, to make the job more safe but again you are challenged by people who have been doing the job for a long time and are unwilling to change.”

Students (UG2 and D2) often gave moving and handling issues as an example of the theory-practice gap. They stated that what was taught in theory was either not realistic and/or the clinical areas did not have the knowledge/expertise or equipment to carry out the technique safely, and using current guidelines which they had been taught in class.

Eraut, Alderton, Boylan and Wraight (1995) explained that nursing theories can be more abstract principles that can be applied to practice. However nursing students cannot apply these principles until they have had clinical experience. Therefore students regard theory as knowledge they cannot use. “Students can use theory to evaluate current practice, but it is best done in the safety of an essay, rather than risk upsetting qualified staff in their placements.” (Eraut et al 1995 p. 9).

It has been argued that nursing actually needs a theory-practice gap as it provides new goals for practice by developing new concepts and ideas intended for the improvement of care (Draper 1991 and Lindsay 1990). Rafferty, Allcock, Lathlean (1996) emphasised that the relationship between theory and practice should be reciprocal, i.e. so that practice informs theory as much as theory tests practice. Looking at the theory-practice gap positively, Lindsay (1990) proposed that theorists and practitioners should be working together to bridge the gap between ideals and reality. He argued that in order for the positive view to work theorists must show an awareness of current practice, demonstrating the knowledge of the boundaries and constraints within which nursing care must take place. At the same time practitioners must make themselves aware of current theoretical issues. He also stated that practitioners should remove their attitude

of being 'real nurses', while describing theorists as living in 'ivory towers' with no appreciation of the realities of nursing practice.

Davie (UG2) stated that some nurses were better at implementing research findings in practice than others:

"...the research course that we learn in theory is difficult to see coming into practice. Extremely dedicated nurses ...have taken on board research findings, for example wound dressings. ...people get dressings stripped down and they are left waiting for a length of time before being re-done which allows the wound to cool. You see the more up-to-date nurses doing the dressing there and then. ...I felt that there was one nurse I worked with that when I had taken the dressing down it was an extreme hassle for her to renew it."

Upton (1999) suggested that nurses in the clinical environment rarely take advantage of knowledge derived from research findings because the clinical environment in which patients are cared for ensures that the values of practice dominate (Hewison and Wildman 1996). Research is viewed as removed from practice (Burrows and McLeish 1995) and nurses lack the skills to understand and implement the findings (Garbett 1995). Rolfe (1996b) argued that nurse researchers have been blamed for not asking the questions to which practising nurses require answers which has caused research to be viewed as impractical.

The N.H.S. Executive (1998) and Allmark (1995) summarise three versions of the theory-practice gap. Firstly, practice fails to live up to theory, i.e. when students are unable to transfer classroom theory or research knowledge to practice. Secondly, there is a relational problem between nursing colleges and clinical areas (Elkan and Robinson 1993) especially since nursing moved into Higher Education sector (Fairbrother and Ford 1998; Garbett 1995). Andrews and Reece-Jones (1996) blamed the differences in priorities within the education and the practice sectors. N.H.S. Executive (1998, p.6) stated that "... educationalists accuse service colleagues of a lack of understanding about educational processes in higher education, and service colleagues accuse

educationalists of unrealistic expectations about what can be achieved in practice.” Thirdly, theory is irrelevant to practice. This has been related to complaints about obscurity of academic language, the irrelevance of nursing models, and the lack of reality within theories, theorists and models. The irrelevance of theory has also been stated by authors such as Bowskill (1997), Rolfe (1996a), Eraut et al (1995), Young (1995), Scott (1994), Lindsay (1990).

The link between theory and practice for nursing students is not a new phenomenon, and it was apparent throughout the interviews with diploma and undergraduate students (UG1, UG2, D1, D2). The N.H.S. Executive (1998, p.1) summarises the current view of the theory-practice gap in nursing:

“The theory-practice gap in nursing is a subject of a vast literature and is an issue which has attracted considerable comment and opinion in the professional press. ...Yet the issue remains largely unresolved despite a number of changes to nurse education, some intended specifically to address the problem.”

Realism 3.2.1

Students (UG2 and D2) stated the need for theory to be a realistic presentation of practice. Other students stated that the theory taught was not applied to practice since it was unrealistic in terms of staffing levels, resources available and the preference to go along with what had been done for years before (Davie, Jenny, Cara UG2; Tom, Lena, Lynne D2). (Also see code 3.4.2)

Degree 3.2.4

Davie (UG2) stated that he felt that there was more theory in the undergraduate programme than the diploma programme, but found this theory difficult to implement at times:

“...you are fighting against years of indoctrination and also years of apathy. ...so it can be quite

difficult to implement theory that you know is correct, ... other people choose not to see as being worthwhile because it takes you extra time to do."

The time lapse between blocks of theory and practice was expressed as a difficulty of the programmes:

"...there is a difficulty – there is a time lag between learning the theory in block ...and then going to placement. It is somewhat difficult to remember what you learned maybe a few months previously and try to apply it"
(Davie, UG2)

In an article written by a Project 2000 student (George 1999), the author stated that the course failed to adequately link theory to practice. He pointed out that being taught a subject for six months without being able to consolidate this in practice was of limited value for students. There needed to be consolidation of learning with regular clinical placements.

Auxiliary 3.4.2

Some students felt that auxiliary experience would have given them a more realistic view of nursing:

"... it would be easy to come onto a course like this and think it's all going to be lovely on the ward. I think if you did that then the first time you were on a ward you would have a shock. You need some idea of what it is like out there."
(Sandra, UG2)

Cara (UG2) stated that she had not been employed as a care assistant before commencing the undergraduate programme, but did work in a nursing home now. She stated that although she could pick up bad habits, the positive aspects were *"... experience ...in washing, getting patients up and dressed, and toileting*

patients ...” and “... it is good people practice – and watching the staff nurses and what they are doing ...”

Davie (UG2) agreed with Cara (UG2) and Jenny (UG2), when he stated that he could have picked up bad habits as a nursing auxiliary.

Task versus communication 3.7

Jane (UG2) felt that students were often asked to complete tasks quickly and gave the following example:

“...we had to get all the obs [observations] done for the doctors to see them on their rounds. Basically I ran round and dived in to the room. ...They got all the same speeches as I went in room after room and did all the blood pressures and all the temps [temperatures] ... I did not really know how any of them were doing. I couldn’t have told you whether they felt better or not. ...You weren’t getting the same patient contact. ...I started going in and out quicker because I started to think that they [the staff] would think I was dead lazy.”

Many students reported feeling pressurised and even demoralised when they were asked and/or expected to carry out tasks quickly at the expense of providing holistic care and/or communicating with their patients (Davie, Jack, Jane, Jenny, Nicola, Sandra UG2; Lena, Lynne, Megan, Tom D2). Providing holistic care and communicating with patients had been advocated within theoretical sessions, i.e. what was taught in theory was not what was being seen/done in practice.

Supernumerary status 3.8.3

Davie (UG2) stated that he felt that supernumerary status was at times difficult to maintain. Recalling one placement, Davie (UG2) stated:

“... I have to say when my mentor was there the mentorship was excellent – she was keen, informed

and she wanted me to do well and introduced me to a variety of experiences. When she was not there, there was a great deal of the ward staff [trained and untrained] ...treated me as though I was in the numbers. My tutor came and took me off the ward and I said to someone that I was away. The ward sister grabbed me afterwards and told me I was counted in the numbers."

According to Orton et al (1993) lecturers commented that service staff had difficulty understanding the concept of supernumerary status with some staff still regarding the students "as part of the workforce". One of the lecturers accounted for this explaining that these staff had not trained under this status.

Orton et al (1993) found that 77% (n=169) of 220 diploma students, 75% (n=54) of 72 qualified staff and 100% (n=20) of 20 lecturers agreed that supernumerary status was an essential feature of the diploma programme. However, 75% (n=15) of lecturers and 66% (n=145) of diploma students thought that they were not always treated as such on the wards. Ninety percent (n=18) of lecturers and 74% (n=163) of diploma students felt this was due to the lack of agreement over the meaning of the term 'supernumerary status'. This was acknowledged by a smaller proportion of the qualified staff (43%, n=31).

The questionnaire was re-administered to a smaller group of diploma students (n=139), traditional students (n=103) and lecturers (n=13) in 1993. Orton et al (1993) found a difference between students and qualified staff in their view as to whether students were sometimes asked to do unnecessary or inappropriate tasks on the ward. Seventy percent (n=72) of 'traditional' students and a large minority of diploma students (46%, n=64) thought this to be the case. However only a small proportion of qualified staff (10%, n=7) thought this to be the case. The authors also found that only 17% (n=12) of qualified staff compared to 46% (n=64) of diploma students thought that students should have the option to decline to do nursing tasks which they regarded as unsafe or inappropriate.

Orton et al (1993) concluded that there may be differing definitions of an 'unnecessary or inappropriate' task, but students appeared to perceive their

supernumerary status as conferring a right to refuse to do any task that they did not feel confident or proficient to carry out. This may be contrasted to a small number of students who felt that they had the right to refuse any request indiscriminately. Therefore the lack of clarity of supernumerary status meant that students and qualified staff were not in agreement. Orton et al (1993) argued that this was hardly surprising due to the lack of agreement over the definition of supernumerary status.

In 1993 (Orton et al 1993), some important differences were noted on re-administration of the questionnaires to thirteen lecturers who had been involved in the 1991 study. Whilst three-quarters (n=15) of lecturers in 1991 thought that students were sometimes asked to do unnecessary or inappropriate tasks on the wards, this had fallen to 62% (n=8) in 1993. Whereas only 30% (n=6) of lecturers in 1991 felt that students should have the option to decline to do nursing tasks on the wards, this had risen to 54% (n=7) in 1993. The authors concluded that these findings might be explained by an increase in confidence about the appropriate role for students to adopt in the ward situation. However, although the percentage of lecturers had increased, the number was only an increase on one. The authors should have noted this in their findings and their explanation for the increase.

Within my study, I explored with students the lack of definition of supernumerary status. This varied from 'doing nothing', to 'not being counted in the numbers', to 'not touching anything', and from 'being there to observe' to 'hands-on' nursing care and 'having the freedom to learn'. Neither curriculum document for Bell College (School of Nursing and Midwifery, Bell College 1995) or Glasgow University (Department of Nursing and Midwifery Studies, University of Glasgow 1995) defines supernumerary status. Therefore the definition(s) passed onto students by lecturing staff may also have lead to confusion over its meaning.

According to Elkan and Robinson (1993), some Branch students noted that some ward staff misunderstood their actions as using supernumerary status to avoid

some of the roles in nursing. The authors concluded that students described supernumerary status as a move away from being 'counted in the numbers' to one of increased opportunity to observe and participate in learning activities.

Orton et al (1993) identified feeling 'part of the team' as being essential to a good clinical experience. However, in order to become part of the team many students were prepared to compromise their supernumerary status and adopt a 'traditional' student role. This involved doing 'practical things' with one Branch student commenting "I'd rather be a pair of hands and work than people not have the time to teach me anything." (Orton et al 1993, p. 84).

Lankshear (1998) noted that there was still confusion amongst both students and practice staff regarding supernumerary status and the differentiation between rostered and unrostered service. She argued that the title of 'supernumerary' should be dropped, giving examples of other professionals such as student doctors, lecturers and social workers who are simply students, not supernumerary students. They are expected to assume a caseload and teach classes in pursuit of the achievement of skills they will require in their profession. During their period of placement they have their learning opportunities addressed through observation, and practice under supervision, and reflection on their experiences.

However, within the literature some nursing students have reported positive experiences of supernumerary status. For example, Goose (2001) stated that supernumerary status had allowed her to gain experience in other parts of the patient's care and allowed more time for learning within the clinical area.

As part of a larger study, Neary (1996) carried out a smaller qualitative and quantitative study because she felt that students and assessors were ill-prepared for their role and there was poor understanding of supernumerary status. The study commenced in 1991 with the first cohort of students in three large Colleges of Nursing and Midwifery in Wales, and used both qualitative and quantitative approaches: interviews, questionnaires, and participant observation. The focussed interviews provided the researcher with emerging concepts which

helped in the formation of the final piloted questionnaire. The questionnaire contained a mixture of open, closed and Likert-style questions, which was completed following each interview. The questionnaire explored the motivations and reasons for the responses. The participants were invited to give their name and address on their questionnaire. However, lack of anonymity on the questionnaire, and the use of volunteers for the interviews, may have caused the answers to be biased. Polit and Hungler (1995) state that the promise of anonymity can produce 'social desirability response bias' [p. 350]. The interviews at this stage took the form of a focus group due to time constraints but the researcher pointed out that this could prevent personal matters from arising. Assisted by the use of field notes and memos, the researcher carried out content analysis of the data (Glaser and Strauss 1967). Triangulation of data collection methods also helped to improve the reliability of the data (Streubert and Carpenter 1999).

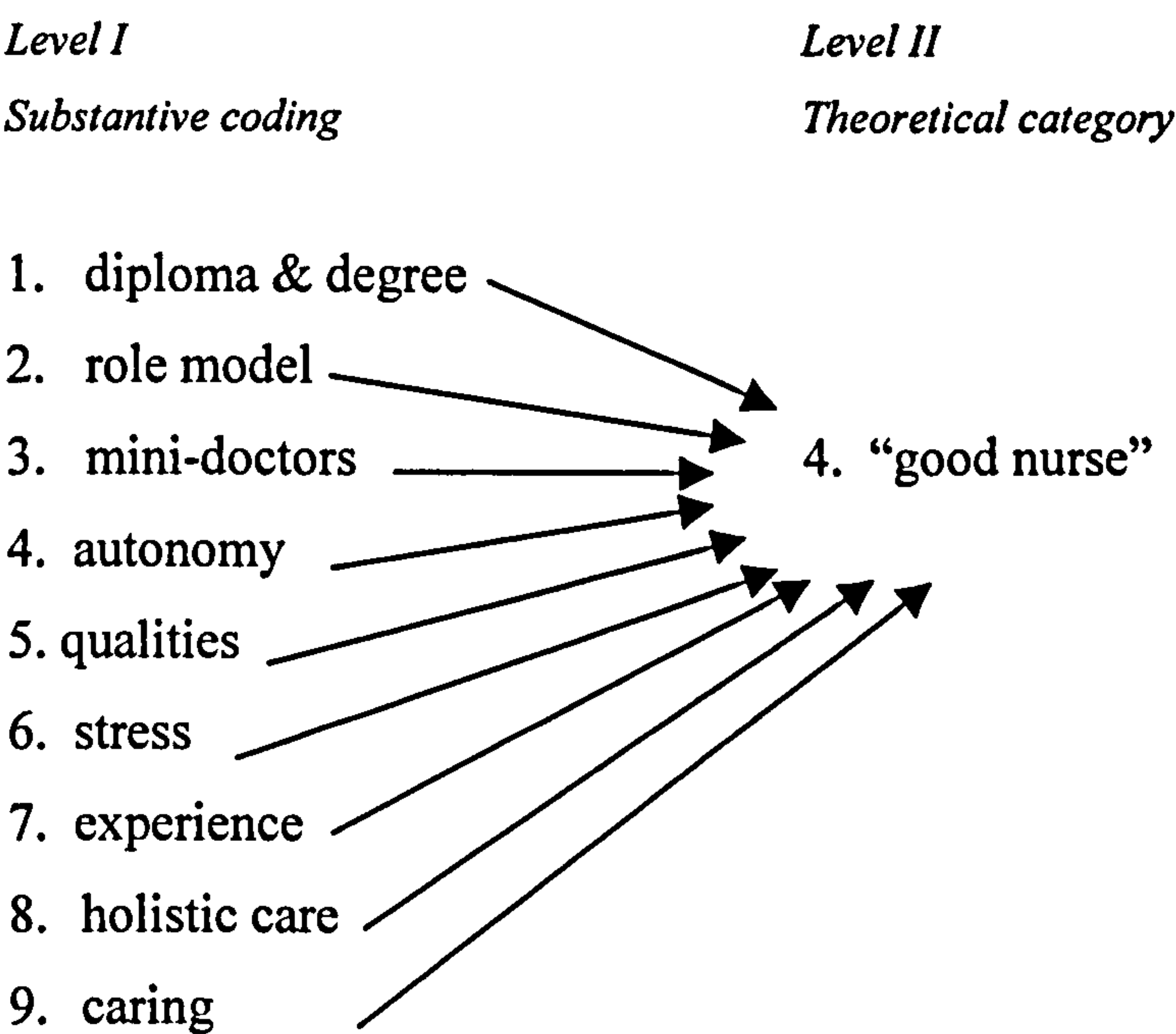
The questionnaire was distributed between the eighth and the 10th month of the C.F.P.. One hundred and 50 students responded (Response rate = 98%) and 120 assessors responded (100%). How the assessors were sampled or recruited is not clear and is therefore potentially biased (Polit and Hungler 1995). Only one-third of students (n=50) felt that placements were long enough to meet their learning needs. Eighty-four percent (n=126) stated that they had had no preparation in practical skills, for example clinical observation, hygiene needs, medication, and bed-making prior to going out onto the wards, yet they felt that staff still expected them to have some knowledge and practice as these were viewed as 'basic skills'. Supernumerary status was also problematic. Eighty-four percent of students felt that they did not know what it really meant. Only 28% of assessors felt that assessors were adequately prepared for the role, while 26% of assessors felt that students were adequately prepared for placement. Almost one-half of assessors (47.5%, n=57) felt that the theory taught in college was not relevant to practice. Ninety percent (n=108) of assessors felt that students needed to be taught nursing skills before being able to give them a fair assessment of their clinical practice.

Seventy (47%) students who completed the questionnaire volunteered for interview at the end of the C.F.P.. The author measured the frequency of themes as they arose. Eighty-seven percent (n=61) of students felt that they lacked hands-on practice, and 87% (n=61) felt that they needed exposure to better role models. Students consistently reported lack of time with their tutors and the lack of time tutors spent assessing them in the 'real world'. My study's findings at this mid-point phase supported the findings of Neary (1996).

From this category, I asked the following question within the next set of individual interviews: *Tell me about the clinical experiences you have had*

Category 4. “Good nurse” (Lorna, D1)

Figure 14: Theoretical category “Good nurse”



Role model 4.2

All the undergraduate and diploma students spoke of and gave examples of incidents in which they witnessed a good role model, and identified role modelling as extremely important within the learning environment.

Jane (UG2) spoke of two ward sisters who had different professional attributes and were role models:

“In my placement one of the ward sisters was so nice and lovely to patients, ... and ... went round and saw all the patients in the morning. She took five minutes to sit down and asked them all how they were doing. I just thought that was fantastic!”

However the other ward sister did not communicate with patients but was better in the managerial aspects of her role:

“She was good at her job as well ...she would keep calm ..., both were good at the technical side of the job, but the other sister would go away and work on her own a lot more. She would get things done her own way and document them. She had everything done but ...she would not chat to them [patients] a lot. Well everyone has their good and bad points but I would not say any of them were less caring ...they both did a good job.”

(Jane, UG2)

Qualities 4.5

The students felt that there were different qualities which made a “good nurse”. These included:

- a. *“Communicating with patients”* (Cara, UG2 and Jane, UG2) and *“being open with them”* (Jenny, UG2);
- b. *“...there are two sides to it. You have to be a caring nurse, but there is a practical side to it as well ...”* (Cara, UG2). Jane (UG2) also stated that this was a necessity;
- c. *“I think it is all very well having your bed-baths done by 9 o’clock ... it does make you a good nurse but it doesn’t mean that you have actually helped that patient. They are seen as more efficient but I don’t think it means that you are doing your job well ...”* (Jenny, UG2). Therefore Jenny felt that a ‘good nurse’ should be efficient, but not at the detriment of caring side;
- d. *“...building a relationship between the nurse and the patient.”* (Selena, D2);
- e. Lynne (D2) stated that she felt a good nurse *“has to be someone who can relate to students - they are students, they need to learn, they need experience and we all make mistakes. ...It is someone who can say ...don’t worry about it and put your fears at*

rest. A good nurse is someone who realises that you are a student and that you have limitations. ...There is a lot more to being a nurse than doing nursing things like giving out injections and putting a bandage on ...it's also about teaching students.”;

f. Scott (D2) felt that a ‘good nurse’ was “... interested in the patients’ welfare. ...they would question the actions of the doctors and their seniors. They are interested in the patient ...”;

g. Scott (D2) commented that having a ‘good nurse’ role model was advantageous to learning as “... I observed him and tried to learn from him ...”

Davies (1993) also identified similar characteristics which students had identified as their perception of a good role model.

Experience 4.8

Lena (D2) felt that experience was not the only factor involved in making a good nurse.

“...It is not only experience. ... It is something you have inside you ...there are some nurses who have it and some don’t. Some don’t because they just want to do their job and leave. You find the ones that care and the ones that it is just a job and nothing else.”

Many students spoke of the innate quality of being a good nurse, and they often used examples of ‘good’ nurses who were not as experienced as other nurses in the placement, but in their opinion, had special qualities that made the nurse stand out from others. This code linked well to the following code, ‘caring’.

Caring 4.9

The definition of the concept of care is still debated within the literature. The concept of care in healthcare terms was provided by Blustein’s work (1991). He

suggests that there are four uses of the word care: *to care for, to have care of, to care about and to care that*. For the purposes of this code, ‘caring’ was used to denote all uses of the concept. However students discussed at length the qualities of a good nurse and the importance of being caring. This concept covered many areas of nursing, including attitudes, experiences, innate human characteristics, and the skills and knowledge required to carry out the nurses’ role effectively.

All students interviewed at the midpoint of their programme commented on the importance of holistic care being given to patients. This was a feature of being a ‘caring nurse’ as Scott (D2) explained:

“Caring is taking the time to look at the whole person, not just the medical condition – it is the holistic approach. Some nurses don’t want to communicate with the patient and just want the patient up on their feet and out ...They don’t find out about the real person. They don’t look at the whole. They are cold.”

McKenna (1993, p.75) argued that all qualified nurses were safe and competent, but it “... is the accompanying attitudes and emotions that differentiate between performing nursing tasks and providing holistic nursing care.”

Cara (UG2) felt that, in her experience, caring was about doing your job to the best of your ability. *“I think caring is also about working to the best of your ability.”* This was also stated by Davie (UG2), who felt *“... that it’s [caring] doing my job the best way I see possible.”*

All the undergraduate students raised the issue of being caring when nursing. For example:

“I think it’s being interested in people, and ...because you are genuinely interested. You want the best for them – you want to know all you can and do all you can to make your care as good as possible.”

(Cara, UG2)

Jane (UG2) made a comparison with Medicine and stated:

“It’s patient contact because we are the ones in the ward all the time with the patients. ...we are the ones who organise all their treatment and ...we go over and chat to people. ...other professions are not there. ...I think it’s more time ...with the patients. The duration of time that we see people and you are more likely to build up a really good relationship with them instead of doctors or anyone else. ...if I’ve gone in in the morning and have made a difference, then I’m happy.”

Jenny (UG2) stated:

“I think it really means striking a balance ...basically treating the patient as an individual and not just a disease. ...basically just not being a robot who goes and does things, but trying to be a bit more personal with someone. Speaking to them and letting them speak to you, rather than I’m just here to do a job and I don’t really care.”

Jenny (UG2) also agreed with Jane (UG2) when she stated that nurses are:

“... with the patients for longer ...they are the ones the patients really get to know. It puts you in a position of trust and responsibility – you have to be aware that you are the first person that patient may come to with a problem or if they are worried about something. I think that is what sets you apart from other health professionals – you are with the patients.”

Lynne (D2) reported that nurses have to have caring attributes:

“...you have the physical needs to care about and you have to empathise with them. ...caring is trying to make the person realise that ...we are going to take care of them. You have to build up a therapeutic relationship with them.

...caring is about realising that the person has got more problems than they are letting on about. It's the physical, the psychological and the social aspects of caring ...you know that encompasses everything. ...but it's the physical aspect of caring that gets most attention."

The students who now had experience of practice placements, talked of episodes of uncaring behaviour they had witnessed. Cara (UG2) felt that nurses could have spent more time with patients *"... explaining things and just generally talking ..."*. She gave an example of a patient who had experienced chest pain all night but it was the nurses on the early shift who found out about it because *"... he did not want to say to the night shift because they were so busy. That was awful."* Cara (UG2) stated that she had read *"...quite a lot of research on chest pain that stated that patients don't report it because staff are too busy. The nurses wanted to get on with other things – you know getting the drugs out, I.V.s and antibiotics ..."* She questioned the night nurses' caring skills when she asked *"Was that his [patient] own doing because he did not say or was it the nurses because they didn't ask him if he was in any pain?"*

The exposure to uncaring attitudes and behaviours is not new (Kelly 1992b; Chipman 1991), and was experienced by all students in my study.

Jenny (UG2) also reported an episode of care which she felt was uncaring.

"I was in a situation where a patient was asking for information about her disease and I thought she had been told what was wrong with her. I wasn't completely certain ...but I said I would find out for her. I said to one of the Registered nurses ...that she was asking and she wants to know. She told me not to tell her any more. I think it was anything for a quiet life ...I was told she would see her later and don't get her in a state. I thought that was uncaring – I've got a busy shift, I can't be bothered with this woman, so don't tell her. I thought that was quite uncaring."

Jenny (UG2) also reported that she remembered an episode of uncaring behaviour:

“... a patient was going for surgery who was really upset and really worried. It was my first placement and I was new to it all... I didn’t have much to do ...and some of the other patients were saying it was terrible that that woman was sitting there and no one was paying any attention. I thought that was uncaring ...but you know if you see a patient who is obviously upset then all you need to do is speak to them. Ask them what they are worried about ...and reassure them. They [nurses] didn’t seem to care, they bustled past her and ignored her.”

Davie (UG2) also stated that he witnessed uncaring attitudes from nurses:

“...you see people not doing their job properly, people overly harsh, overly authoritative with patients, people doing their job through numbers rather than the most appropriate way that could have benefited the patients, ... It’s a common thing that a good worker gets the job done before teabreak – which isn’t a good thing as this leads to sore backs and things getting missed. It also leads to care that is not tailored for the individual – it’s a blanket level of care ...it’s just for everybody not the individual.”

Lynne (D2) also had similar views of the need for individualised, holistic care for patients.

Jane (UG2) felt that good communication skills were another attribute of caring, but could not be the only attribute of the nurse:

“...People skills are important in any job that you do, but I would say in nursing it is quite important. It makes things a hell of a lot easier for people, but at the end of the day it’s not the only thing. If it’s a choice between killing someone [for example, making a mistake or an omission of care that has major implications for the patient and the nurse]

and having a chat with them ... then to hell with the chat!"

Coates (1997) argued although there was a need to conduct patient outcome and cost effectiveness studies, there should be more of a focus on evaluating the quality of the process of care. All the students recognised the value of safe, effective and efficient practice, but were also aware of the process of care. However, McKenna (1993) argues that the value of caring is difficult to quantify and is "... more noticeable when absent than present." It has been argued that the lack of research and interest in the caring area has been caused by society's perspective that 'caring work' is not recognised socially or financially (Benner and Wrubel 1989; Leininger 1986; Oakley 1984). Jane (UG2) summarised her feeling about caring and nursing *"...it's a very mixed job. It's like the science and the art thing – that's how to describe it!"*

Episodes of caring and uncaring behaviour identified by the students could have been categorised into the five characteristics of caring, as described by Roach (1984). These characteristics included 'compassion' that allows for participation in the other person's experiences. 'Competence' is required such that a person has the knowledge and skills necessary to respond appropriately to the demands and responsibilities of the profession. 'Confidence' was identified as the attribute that fosters trusting relationships and 'conscience' as the state of moral awareness, while 'commitment' is the convergence of one person's desires and obligations (Roach 1984).

Beck (1993b) also categorised the caring experiences of 22 undergraduate students in the U.S.A.. The students were asked to write anonymously about any caring experience. The study took a hermeneutic phenomenological approach. Five themes were produced which agreed with the types of experiences students in my study had, and with Roach's categories (1984). Firstly, the authentic presence is the caring interaction between student and patient, which was indicated by terms such as 'being with', communicating, 'listening', and 'shared thoughts'. Secondly, competence is the knowledge and skills of the student.

Thirdly, emotional support for the patient included advocacy, autonomy, encouragement, and reassurance. Fourthly, physical comforting for the patient included personal care, touch, and comfort. Fifthly, positive consequences for the patient and the student included giving confidence, handling difficult situations, and doing the 'little things'.

All students (D1, D2, UG1, UG2) identified that taking time to do the 'little things' for the patient, such as doing the patient's hair and attending to their personal hygiene, was a good caring practice. This was identified by an earlier study (Kelly 1991). "Taking time to do the little things" (Kelly 1991) was highly regarded as an essential quality of the role model for students within this study.

Using constant comparative analysis, there was obvious linkage to the concept of care to other categories and codes within the theory development. For example, students discussed the issues of their developing competence and confidence in themselves, which was often expressed as a particular scenario in which they had witnessed good or bad caring practices.

The diploma and undergraduate students had similar discussions about the concept of care. Their discussion identified the aspects discussed within the literature. The concept of care has received attention from nurse-academics since the mid-eighties. Morse et al (1990) provided a summary of theorists' views of the concept of care, which can be used to compare caring attitudes and behaviours identified by the students within this study.

Caring has also been described as a 'human trait'. From this perspective, caring can be viewed as an innate human trait. Although all humans have the potential to care, this ability is not uniform. Education of nurses can influence this ability to care, depending on their life experiences, through the acquisition of skills and knowledge.

Caring has been described as a moral imperative or ideal. From this perspective, caring can be described as a moral ideal for nursing. It is not a specific

behaviour, nor does it encompass what nurses do, but it is the commitment to maintaining the individual's dignity and integrity. The theorists agree that caring provides a basis for nurses' actions.

Theorists who define caring as an affect emphasise that the nature of caring extends from emotional involvement with, or an empathetic feeling for, the patient experience. The nurse-patient relationship is seen as the essence of caring (Kitson 1987; Leininger 1986; Leininger 1985b). During a nurse-patient relationship, caring involves specific actions such as listening, patient teaching, advocacy, or caring being included in all nursing actions (Darbyshire 1994; Phillips 1993; Farmer 1992).

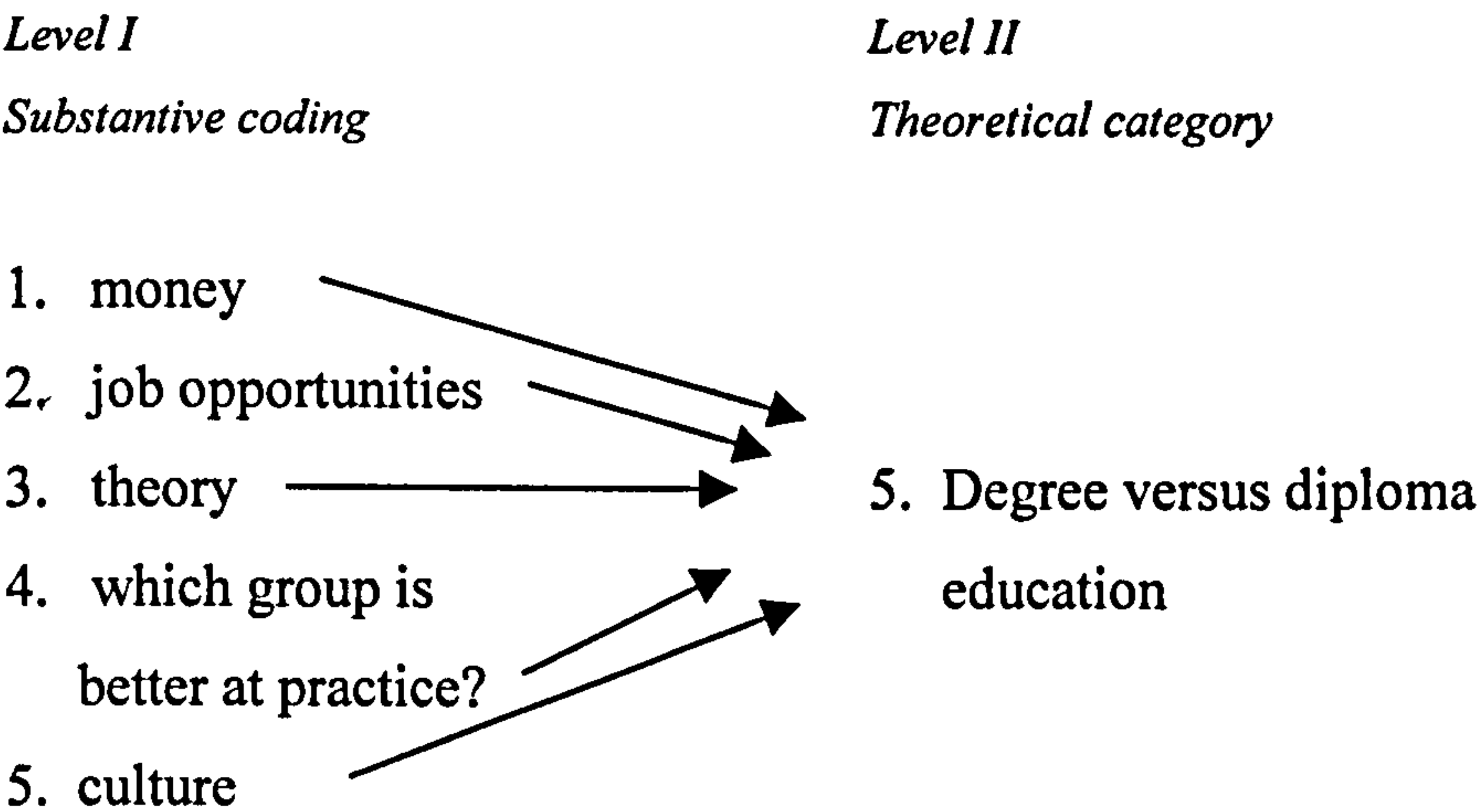
Students within this study did not define or discuss caring in such a way that it could fall specifically into any category defined by Morse et al (1990), but discussed it as a mixture of the theorists' views.

From this category, the following questions were asked within the next set of individual interviews: *What do you see are the qualities of a good nurse? How did this role model influence your learning?*

Category 5. Degree versus diploma education

Both groups of students had views on diploma and degree level education for nurses.

Figure 15: Theoretical category ‘Degree versus diploma education’



Money 5.1

The bursary system was a major consideration when applying to a nursing programme, as demonstrated previously by the focus group interviews. In fact some of the diploma students stated that it was the only reason they had opted for the diploma rather than the degree.

“I thought about doing a degree, but I did the diploma because you get more money in the form of a bursary. If you do a degree you have a means tested student grant.”

(Megan, D2)

Although the bursary was seen as a means of attracting students to the diploma programme, undergraduates were undecided as to whether they should be paid more than diploma nurses following qualification.

“... [degree qualified nurses] are ...more prepared and more able to take on the responsibility [than diploma nurses]. ...I think they would be more

equipped to take on extra roles because they have a bit more confidence in what they are doing and why they are doing it. Whether they would want to or not without getting a pay increase would be a different story."

(Jenny, UG2)

However, undergraduates stated that they felt the need to gain 'D-grade' experience following registration:

"I don't think they should start at an 'E' as opposed to a 'D' grade – everyone has to start to learn the basics ... They have to put in that time otherwise you would end up with mistakes. It's people's lives you are dealing with."

(Davie, UG2)

In summary, both groups of students felt that there should be a bursary system available for all types of nurse education in Scotland. Undergraduates were undecided as to whether as newly qualified undergraduates they should begin on a higher wage than diploma students.

Job opportunities 5.2

Jack (UG2) stated that for "... the majority ...of the class ...definitely the minimum aim is a ward sister or charge nurse. We see that as realistic ..." He continued that he felt that this was partly due to the degree programme:

"Right from first year the majority of the class realised that the course was geared to teaching you about management. You've been taught all that so you could attain it. ... I should move up the ladder faster. ...Our theory base is a lot better than a diploma student."

(Jack, UG2)

Jenny (UG2) agreed with Davie (UG2) that she would feel apprehensive about starting as an 'E-grade' but that it was not unreasonable that graduate nurses "... should be promoted quicker ..." as long as they could apply theory to practice.

“If you have proved yourself able enough, then that would be fair enough - you can’t put one nurse ahead just because they have a degree. I think it really matters if they can apply it properly ...” (Jenny, UG2).

Tom (D2) explained his thoughts on undergraduate preparation:

“I think their priorities are different. I think they see themselves advancing really quickly and going into management. The diploma students know exactly what to expect ...that they are going to work their way up but it is going to take a long time. Their expectations are different.”

Lynne (D2) questioned whether graduate nurses had better job opportunities than diplomate nurses:

“At the end of the day your employer has your C.V. [Curriculum Vitae] and everybody is a qualified nurse with no experience, so there is not much to distinguish them. ...I don’t think it is going to matter that you have a degree or not. I want to do a degree but I will do my diploma first and maybe work for a year and do it part-time. I think it is better that way because nursing is mainly about practical things.”

However Megan, Selena, Scott and Lynne (D2) felt that as diplomates they would *“... not get anywhere [i.e. promotion] just on experience ...”* (Lynne, D2). *“... I do intend to do a degree ...I need it if I want to advance.”* (Scott, D2). Jenny (UG2) stated that she wanted to do a degree because *“I wanted to do it to the highest standard. ...I know a few people who are registered nurses and they told me that this was the way it was going and at some point there would be a cut-off point where you would have to do a degree.”* Both diploma and undergraduate students felt that having a degree would lead to better job prospects.

Theory 5.3

Cara (UG2) stated that she expected that diploma students would be “*very good at the practical side.*” However she did explain that the degree programme was “*... good, it’s very in-depth, so that’s the good thing about it.*” These views were shared by all the undergraduate students.

Scott (D2) explained his perceptions of undergraduate students:

“... I have heard that they are totally unprepared for it – walking into a ward. ...they are more inclined to sit back and observe rather than get their hands dirty ... I do not think that they are prepared for it.”

The undergraduates found the theory covered within their programme academically challenging. They also received feedback from their mentors on the level of their theoretical knowledge.

“Maybe the diploma course is not as good because the entry requirements are not as high. ...the feedback I have had about my course has been good. The last mentor I had preferred university [undergraduate] to diploma students because ...they know a lot more. If he says what does this drug do? He says that you will say that it blocks the molecule or this enzyme but the diploma student would say that it’s for slowing the heart down. I like knowing those things. I would hate to be doing a job not knowing what I am doing. ...it’s not good enough to know that that tablet is for reducing blood pressure. Patients have multiple problems and drug reactions ... You know things may go wrong and that’s better for the patient.”

(Jane, UG2)

Which group is better in practice? 5.4

Jenny (UG2) regarded her theoretical education as good preparation for clinical practice. *“...I think it is useful and relevant. It gives you a better understanding when you go out to the wards.”*

Jenny (UG2) and Nicola (UG2) stated that they felt there were differences in knowledge between diploma and undergraduate students:

“I think that at the level of the patient they shouldn't function differently but we have a better understanding of what to look for when things go wrong and how to spot the signs early. ...maybe only if the patient wanted extra information then you may be in a better position to give it. ...I feel reasonably comfortable giving a patient information but maybe you would struggle if you did not have the same background knowledge. ...Hopefully I will be able to retain it and be reasonably confident.”

(Jenny, UG2)

“... It helps you get more out of your job if you know why ...because you have a better understanding and you're not just thinking that that patient has heart and lung problems. You know what is causing it and why the ankles are swelling ...”

(Nicola, UG2)

Cara (UG2) explained that at certain times of the programme undergraduate students had less practice experience. For example by the end of third year a diploma student had completed the programme while an undergraduate still had a year of full-time practical/theoretical input. Jenny (UG2) pointed out that by the end of each programme, students have completed the minimum number of practical hours required for registration.

Overall, undergraduates seemed eager to voice their opinion on their level of practical ability. They stated that since their knowledge was at a higher level than diploma students, their level of practical and theoretical ability should be better than diploma students by the time they had reached the end of their programme. However diploma students were critical of the practical skills of undergraduate students:

“... they [undergraduates] go into the wards and they do not have a clue about practical things. I haven’t had experience of it myself so I cannot say ...but so many people have said in articles and research as well that there must be something behind it. The theory is all good and well but if you do not know how to put it into practice ...”

(Lynne, D2)

The third year undergraduate students felt that they could understand practice better than other students whose programmes were not as in-depth:

“My last preceptor showed me an X-ray and asked me to tell him what was wrong with it. ...I got it right. I’m glad that I know. I’ve done a lot of anatomy, physiology and biochemistry – I think in that way we are well qualified. When the doctors are standing talking I know what they are talking about.”

(Sandra, UG2)

Cara (UG2) explained the benefits of knowledge:

“You get a lot more insight into your patient care. You know why all the different treatments are going together, you know all about it and what signs to look out for – like what’s going to go wrong or generally how the progress is going along. ...If you know about something you can say maybe you should be testing for this or that. I have no hesitation in saying to the doctor what about this or that.”

Jane (UG2) also felt that there were benefits to having a good knowledge base:

“... you do know what you are doing and why. There’s a certain confidence in it. ...you can only have confidence if you have knowledge. Maybe that’s the benefit of having extra theory. Knowledge does give you that extra confidence to go off and work a bit more independently.”

Following constant comparative analysis, I felt that these aspects of this category overlapped with the ‘course content’ category. Therefore a new category was made using both categories, entitled ‘level of theoretical knowledge’. Other data which made comment on the level of practical ability were analysed, coded and categorised into another category, entitled ‘development of competence’. From this category, the following questions were asked within the next set of individual interviews: *What are the advantages of degree or diploma level study? What are the disadvantages of degree or diploma level study? Do you feel that you are competent to take on the qualified role?*

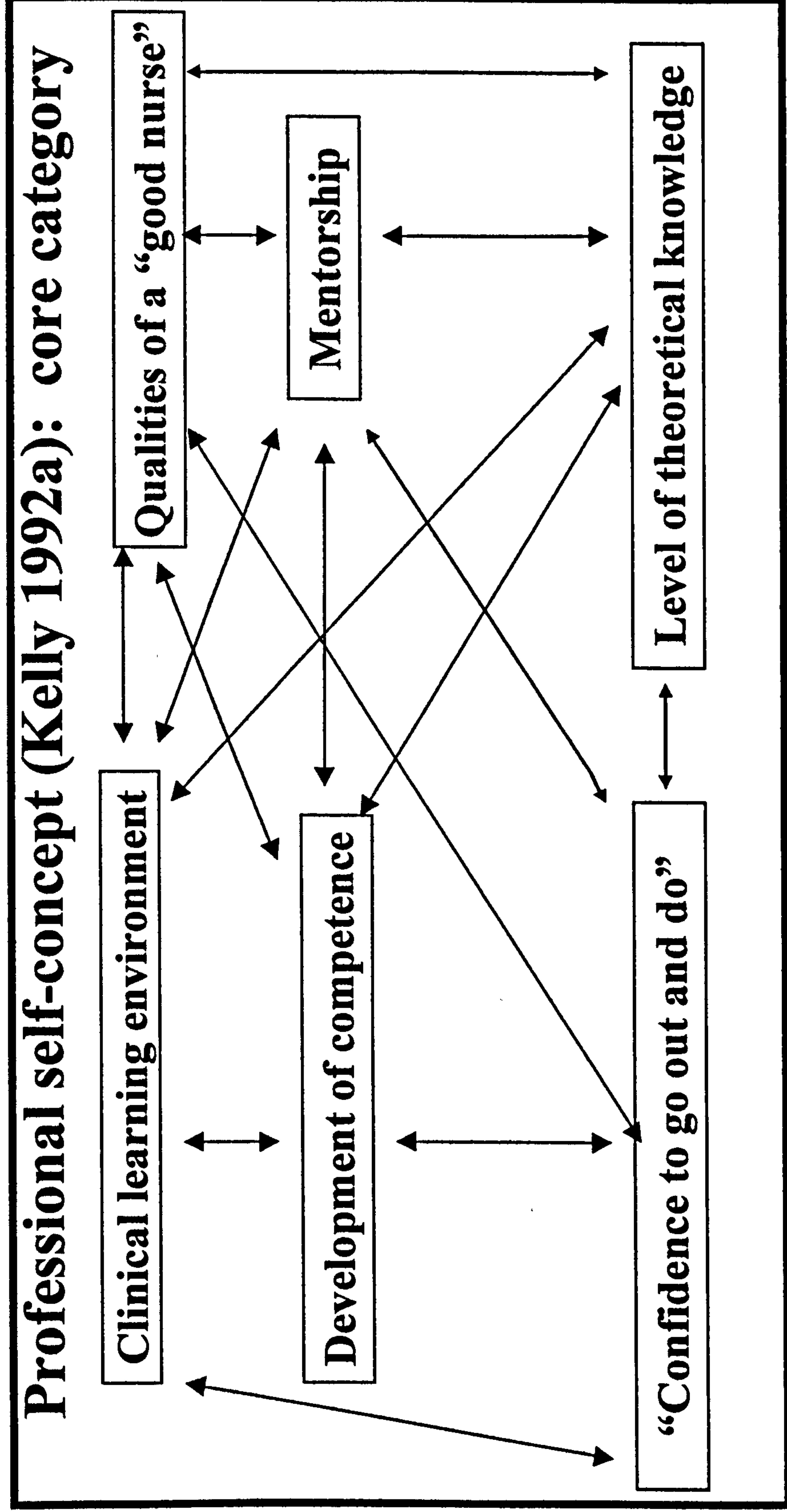
4.4 Summary of individual interview coding (mid-point)

Constant comparative analysis of individual interview data produced seven categories. However one category (professional self-concept) was shown to be integral to all others and appeared to occur most frequently within the data (Holloway and Wheeler 1996). It was central to all other categories and provided some explanation of the linkage between categories (Strauss 1987). The analysis of the data demonstrated that one area linked all the categories together. This resulted in the production of the core category. This is shown in Figure 16 (p. 266). The arrows demonstrate the two-way link between the other six categories. All categories existed within the core category of professional self-concept (Kelly 1992a). However, since I was still collecting data, I was aware that there could have been premature closure of the project. Therefore I kept asking myself questions asked by Glaser and Strauss (1967): What is the focus of the study? What is the relationship of the data in the study? What is going on in the data?

A description of each code, category and core category continued to be produced in the form of a memo, thereby providing an audit trail of the coding process. The categories, and the integration with the core category, are described below:

1. **“Confidence to go out and do” (Anne, D1):** Having the confidence to go out and work as a nursing student was a concern for all neophyte students. At the mid-point of each programme all students felt that their programme had helped to develop their confidence. However, diploma students (D2) were more confident in their practical ability, while undergraduate students (UG2) were more confident in their theoretical ability. However, at this stage there was no research data to support or refute these claims: i.e. which group performs best?

Figure 16: The development of the core category and diagrammatic representation of the links between categories following individual interviews (mid-point)



Professional self-concept is linked to the level of confidence the student has in their own ability (i.e. self-efficacy (Murdock and Neafsey 1995; Abraham and Shanley 1992; Bandura 1977a), the level of knowledge the student has, and the trust they have in their mentor to identify their strengths and weaknesses.

Following constant comparative analysis, 'mentorship' emerged as another major area of discussion for the students. Therefore I decided to make this a category in its own right as there were strong links to other categories, such as clinical learning environment.

The development of competence was introduced as a new category since it was expected that participant observation would produce information regarding the competence of both groups of students.

2. **Clinical learning environment:** This was a major source of stress and apprehension for all neophyte students. Both groups (D2 and UG2) stated that the clinical learning environment had had a major impact, both positive and negative, on their level of practical competence. Professional self-concept is linked to the clinical learning environment since this was seen by students as having a significant effect on their level of competence.
3. **"Good nurse" (Lorna, D1):** Students wanted to have the qualities of a "good nurse". They identified various qualities that they felt would be important in nursing. Both groups (D2 and UG2) of students stated that they had learned from examples of a "good nurse". Professional self-concept is linked to the qualities of a "good nurse" as this provided students with a good role model on which to base practice attitudes, behaviours, knowledge and skills (Kelly 1992a).
4. **Level of theoretical knowledge:** Students identified positive and negative aspects which they felt each programme had. Course content provided some controversial views from both sets of neophyte students (D1 and UG1). By

the mid-point of the programme undergraduate students (UG2) stated that they had begun to see the integration of subjects and commented on the benefits of having a better level of theoretical knowledge than diploma students. It has been argued that the level of theoretical knowledge is linked to students' professional self-concept, in that if students' knowledge is poor, they will be incompetent and lack in confidence (Davidhizar 1991).

5. Mentorship: All students had experience of both good and bad mentors. They explained how this had affected the integration of theory with practice, had 'shaped' their learning experience, and had resulted in differing degrees of supervision and feedback. Positive, constructive, feedback has been shown to improve performance (Wood and Bandura 1989), but too much can result in overconfidence (Kissinger 1998). Students explained that they had had feelings of fear, pressure and stress of work, worry, lack of confidence, and were 'used as a pair of hands'. They had experienced negative (e.g. poor role models, lack of supervision, lack of support) and positive attitudes (e.g. enthusiasm and motivation to teach) from mentors. When there was a lack of available mentors and/or a poor standard of mentorship was delivered, self-efficacy beliefs diminished, thereby reducing the students' confidence and willingness to carry out skills (Appelbaum and Hare 1996). They felt that role modelling was a good way to learn, but it was not always their mentor who had those special qualities. They were often disappointed by the lack of availability of mentors especially within acute areas due to shift work, holidays and internal rotation. None of the students mentioned the role of the lecturer within practice.

6. Development of competence: All students at the mid-point of their programme were anxious about their lack of practical skills (this was supported by other studies, such as Carlisle et al 1999), and the lack of opportunity to link theory to practice. However, undergraduate students felt that they were much more able to understand the rationale for practical skills than diploma students, while diploma students felt that they were much more able to carry out a wider variety of skills and were more competent at

carrying out that skill than undergraduate students. At this stage of the research these were the perceptions of students, but their actual performance was not investigated. Therefore what they said happened in practice might not have been what actually happened in practice.

These six theoretical categories which were developed led to key open-ended questions which provided a focus for the next stage of interviewing:

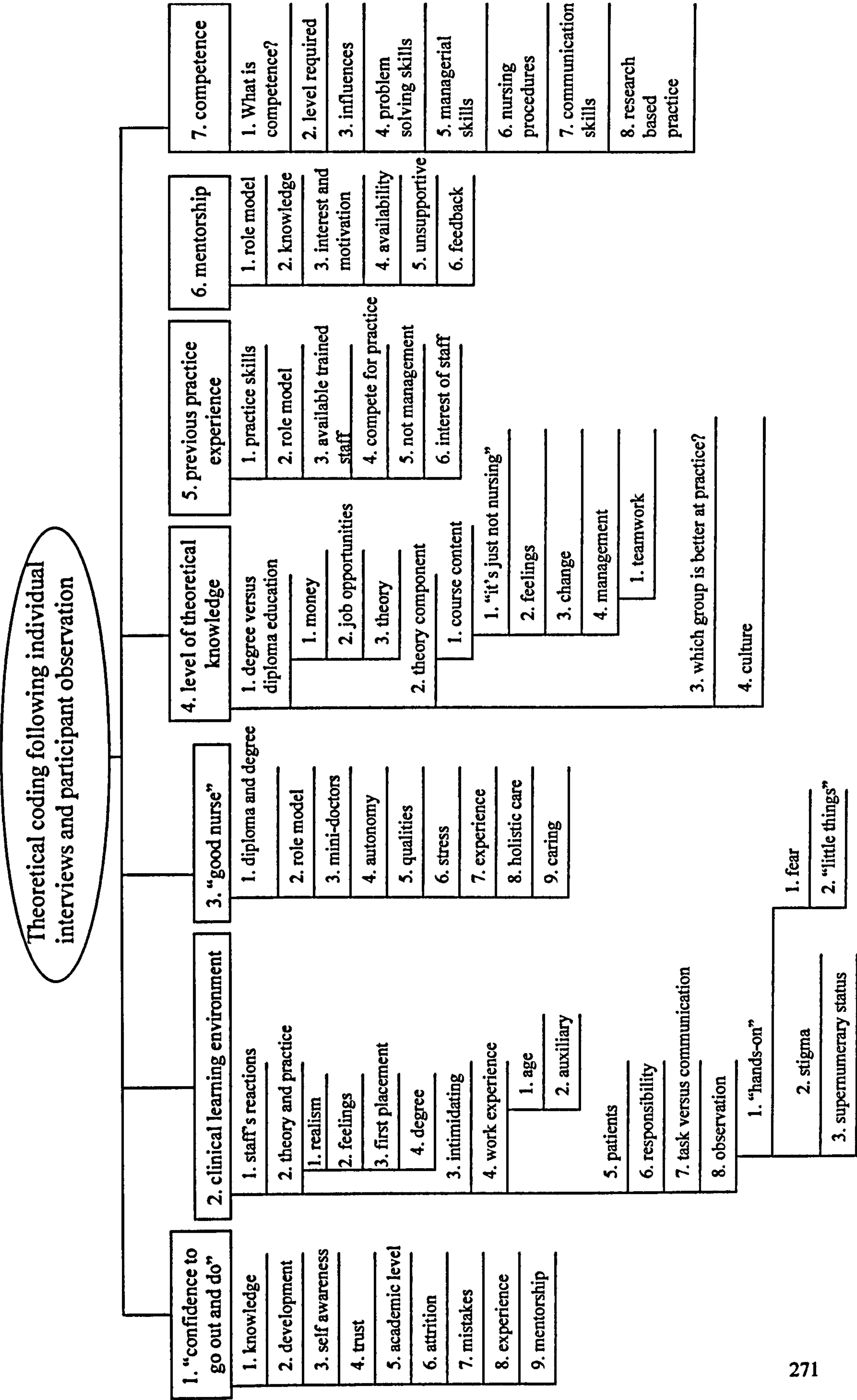
- *Tell me about the mentors you have had in practice*
- *How do you feel about being a qualified nurse soon?*
- *How do you think the programme has prepared you for the qualified role?*
- *Tell me about the clinical experiences you have had*
- *What do you see are the qualities of a good nurse?*
- *How did this role model influence your learning?*
- *What are the advantages of degree or diploma level study?*
- *What are the disadvantages of degree or diploma level study?*
- *Do you feel that you are competent to take on the qualified role?*

4.5 Individual Interviews and Participant Observation (end-point)

The questions developed following mid-point interviews provided a focus for the individual interviews, and participant observation, at the end-point of each programme (see Table 2, p. 97). Diploma students (D3) were given code names: Alistair, Carole, Caroline, June, Janette, Marie, Maureen, William (n=8). Undergraduate students (UG3) were given code names: Helen, Jonathan, Kathy, Cameron, Molly, Sharon (n=6). A difference in the number of participants used reflects that theoretical saturation had occurred. I was of the opinion that further interviews and observations would not have yielded any new or conflicting data.

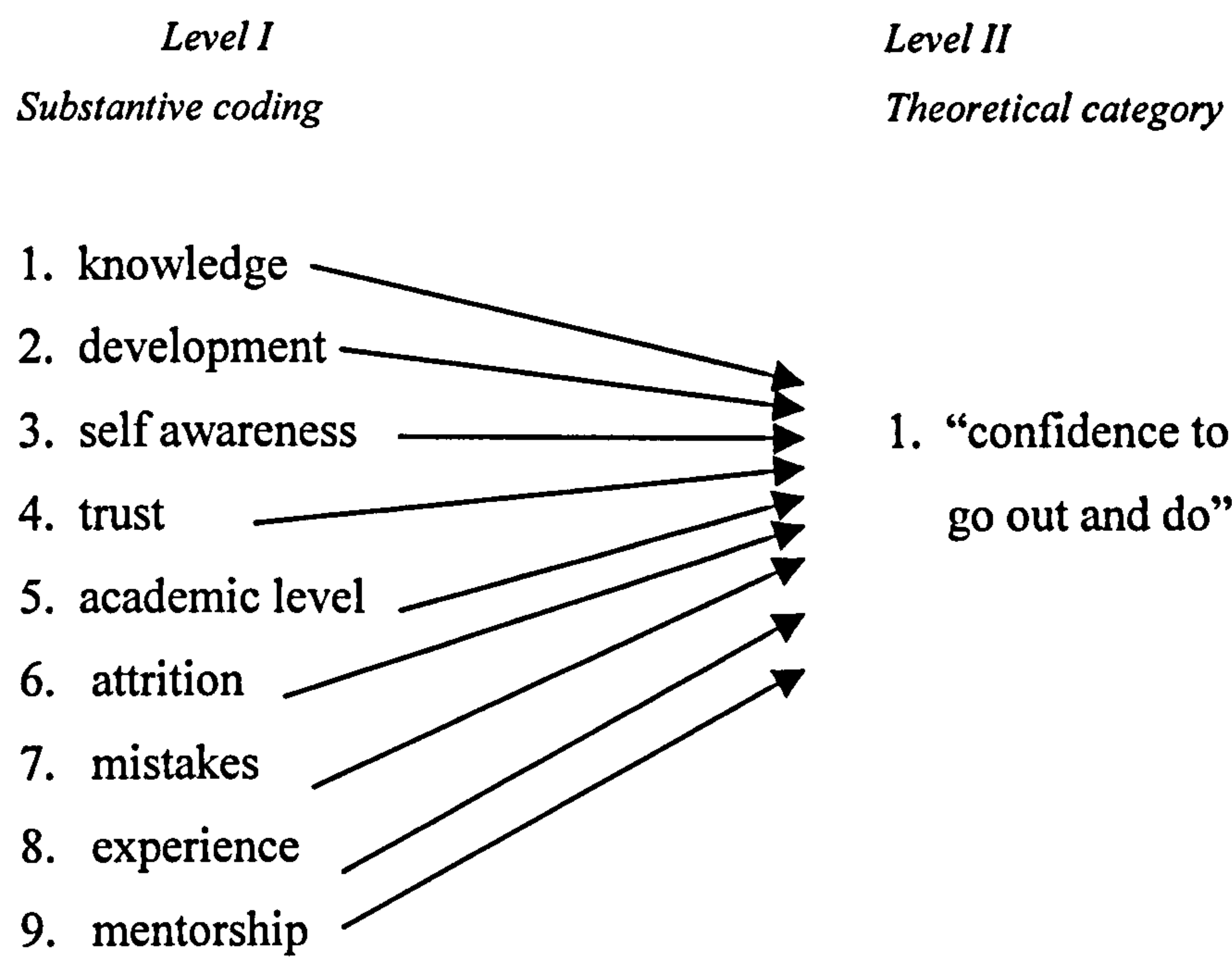
Data gathered from the individual interviews and participant observations was analysed, coded and categorised. The data included literature sources. The following section includes the new data within each code and category and identified new codes and categories where appropriate. A summary of the coding and categorising can be seen in Figure 17 (p.271).

Figure 17: Theoretical coding following individual interviews and participant observation



Category 1: “Confidence to go out and do” (Anne, D1)

Figure 18: Theoretical category “Confidence to go out and do”



Diploma students (D3) appeared much more apprehensive than undergraduates at this stage of the programme. They stated that they wanted to feel competent within the clinical areas, but that they lacked knowledge and practical skills, and were ultimately fearful of making mistakes. Their confidence was affected by these factors and all stated that they would expect to be in their first post for at least six months before they would feel comfortable.

The U.K.C.C. Commission for Education (U.K.C.C. 1999 p.43) pointed out that students would benefit from a formal period of consolidation of practice, but there were different views about when it should take place (i.e. whether this should be done pre-registration or post-registration). The U.K.C.C. Commission for Education (U.K.C.C. 1999) recommended that to help the student make the transition from student to registered practitioner, students should undertake a period of consolidation with role-related outcomes before the end of the pre-registration programme.

In contrast to the diploma students (D3), the undergraduates (UG3) were much more confident about the transition to staff nurse. They were “... *looking forward ...*” (Helen, UG3) to being qualified, while the diploma students were “...*dreading it.*” (Caroline, D2). Helen (UG3) stated that she was “... *looking forward to the added responsibility and accountability. ...I am ready for that now.*” In contrast, William (D3) stated that:

“... I feel that I am going freak out the day someone passes the buck onto the staff nurse and that is me! I don't know if I am ready to handle the responsibility of being qualified. I feel I need more experience and I'm afraid I will be left to sink or swim ...”

The stress, anxiety and often distressing experience of newly qualified nurses in the U.K. has been well documented, for graduates, diplomates and those who have completed traditional methods of nurse training (i.e. prior to P2000) (Greenwood 2000; Charnley 1999; Jasper 1996; MacLeod Clark et al 1996b; Horsburgh 1989; Vaughan 1980). This problem has also been apparent in other countries such as Sweden (Kapborg and Fischbein 1998). Within my study, undergraduates did not seem to experience the same level of anxiety and apprehension as diploma students in relation to making the transition from student to staff nurse. Molly (UG3) stated:

“I think the whole idea of being accountable – there is just no way anyone can prepare you for that. There is not really any feasible way of doing that as a student. It is just one of those things where you have to be chucked in and get on with it. ... but I am not worried about becoming a Registered Nurse.”

Helen and Kathy had similar feelings to Molly:

“I feel confident, but at the same time I feel a little apprehensive ... incase I make a mistake ... but I think I can do the job.”

(Helen, UG3)

“I am quite enthusiastic and I am ready now after four years. I am ready to move on to being responsible for my actions.”

(Kathy, UG3)

However, diploma students had different views:

“I am scared someone will come up and ask me to do things I do not know about. My preceptor [mentor] keeps reminding me that I am nearly qualified and I should not be doing things I don't feel comfortable with, and I will be responsible for my own actions. ...it is scary.”

(Alistair, D3)

“I do not think the diploma course has given me the theoretical knowledge to be confident in any decisions I would be required to make in the first few months I will be qualified. ...I am unsure how and why patients develop complications and what to do about them. I feel completely out my depth if patients become unwell. I don't know what to do!”

(William, D3)

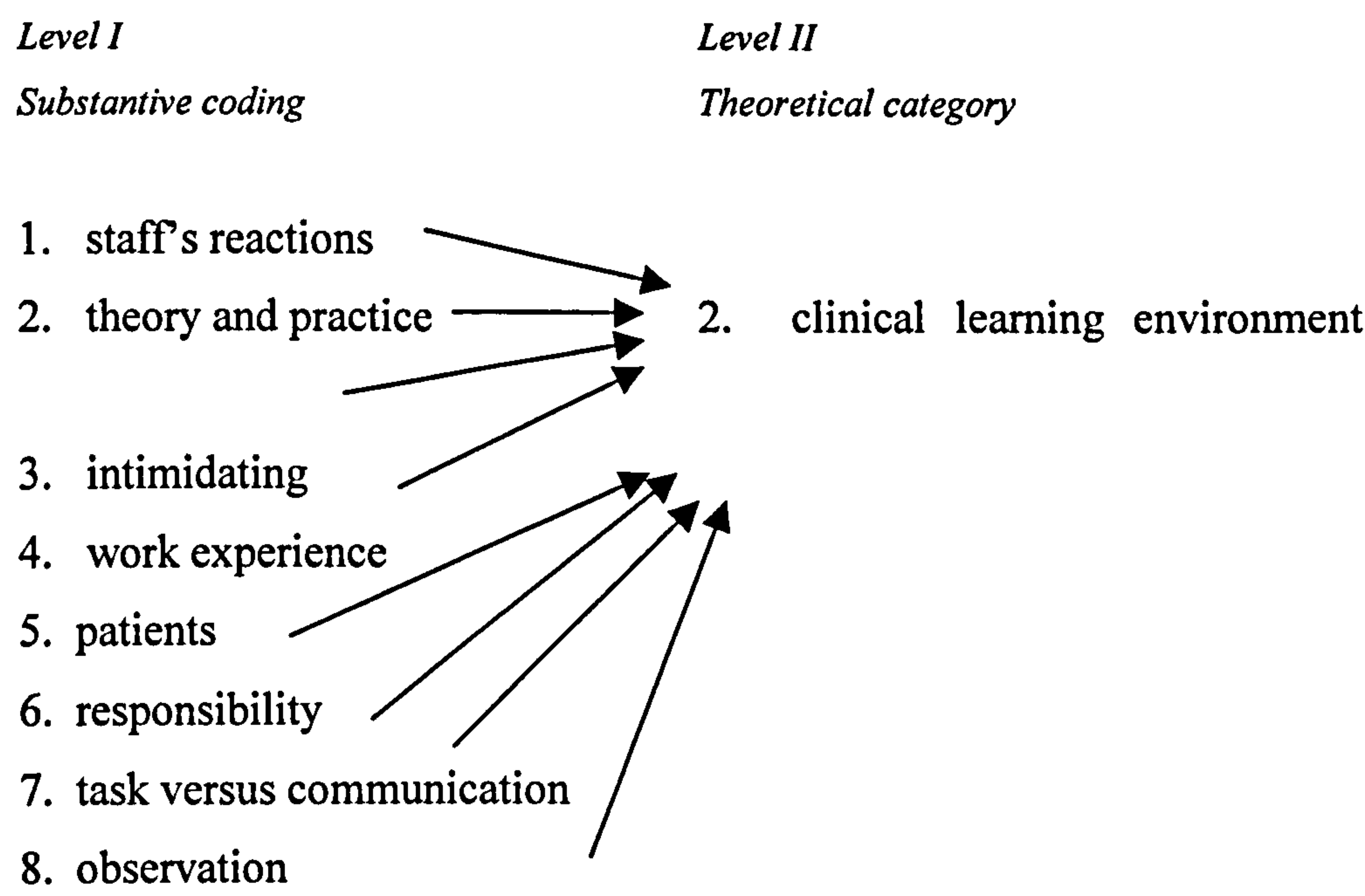
Maureen (D3) summarised the feelings of the diploma students: *“I think the responsibility just hits you. It's scary stuff!”*

Further exploration of these feeling of both groups, together with the results from the participant observation, did reveal some practical and theoretical gaps in the skills and competence of diploma students in particular. These will be discussed further within other categories.

Category 2. Clinical Learning Environment

Both sets of students provided a lot of information on their perceptions of the clinical area.

Figure 19: Theoretical category ‘Clinical learning environment’



The clinical learning environment was considered to be very important to gain the necessary skills within the last two months of the programmes. Previous aspects of the clinical learning environment already discussed were reiterated by these groups. However, other problems did surface, especially for the diploma students.

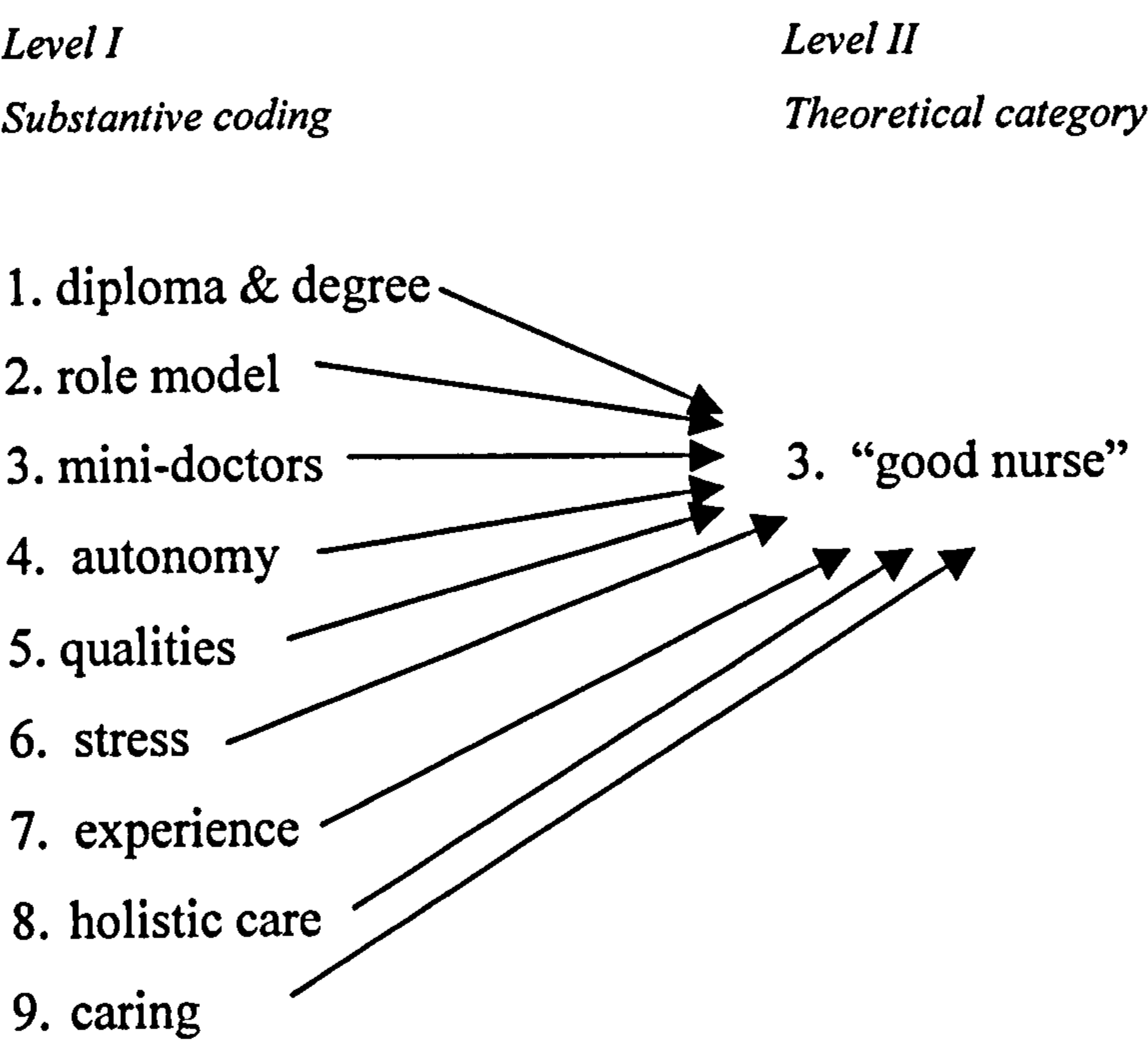
Overall, there was inconsistency in the quality of experience available within rostered service. Many students expected further development of clinical skills, including leadership and management. Diploma students stated that the availability of experience to develop these skills was dependent on the clinical learning environment. According to the students, units were often under-staffed. If there was a shortage of qualified staff, students were left unsupervised, felt anxiety, and frequently were uncomfortable in some situations in which they were left. Marie (D3) stated that:

“Since there was a staff shortage I was sent to coordinate one of the ward teams with two auxiliary nurses. There was a variety of surgical patients and I felt that some were very unwell. I was afraid that I would do something wrong or even would forget to do something. I was totally stressed. ...the doctor came in and I went on the ward round – they had never allowed me to go on one before. I hadn’t a clue what was going on – it made me feel like an idiot. It took a while for my confidence to come back after that day.”

Within my study, if there was a lack of staff, diploma students within rostered service often stated that they were expected to work unsupervised and complained that they did not have the opportunity to develop skills that would be expected of them once they were qualified.

Category 3. “Good nurse” (Lorna, D1)

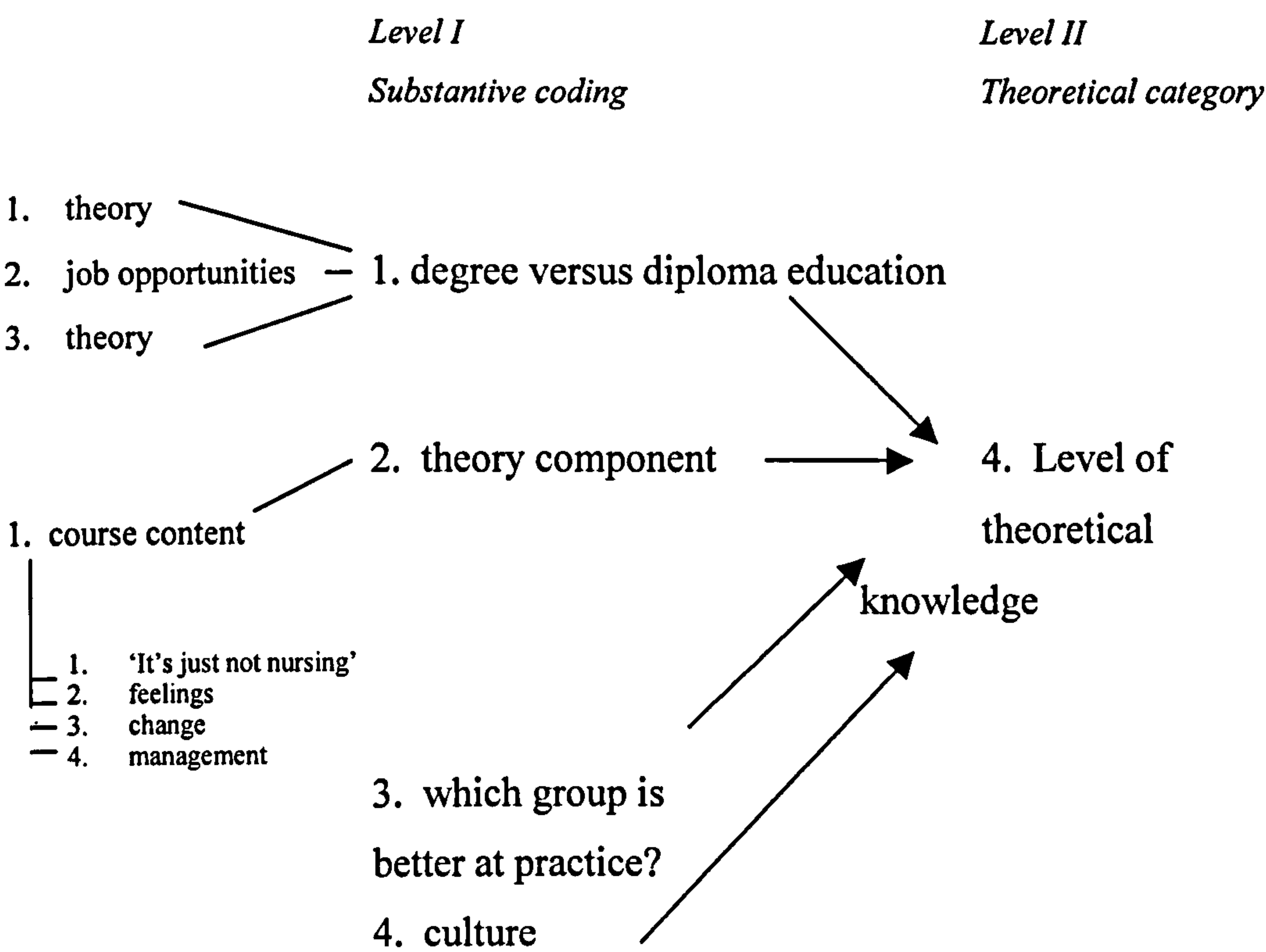
Figure 20: Theoretical category “Good nurse”



Both groups (UG3, D3) had similar thoughts about the qualities they looked for in a ‘good nurse’. These qualities have already been discussed within previous interviews. Overall students were looking for examples of ‘good’ nurses in order that they could base their practice on the role models’ positive attributes.

Category 4. Level of theoretical knowledge

Figure 21: Theoretical category ‘Level of theoretical knowledge’



According to MacLeod (1996) knowledge can be separated into theoretical and practical knowledge, i.e. knowing-that and knowing-how (Ryle 1949, cited by MacLeod 1996). Early comments on nursing knowledge have authors further dividing the aspects of knowledge. Carper (1978) proposed that nursing knowledge is made up of empirics (i.e. the science of nursing), aesthetics (i.e. the art of nursing), personal knowledge (i.e. knowledge of self), and ethics (i.e. moral knowledge). However, Carper also argues that the subsections cannot be viewed individually as they are interrelated and interdependent in the sense that, for example, ethics can influence the science and vice versa. Some explain

nursing as a science, or an art, or a combination of science and art (Lafferty 1997; Kitson 1993; Curl and Koerner 1991; Aita 1990; Parse 1989; Benner 1984).

MacLeod (1996) explains that the relationship between theory and practice has been debated and it has been suggested that theoretical knowledge provides the 'basis' of nursing practice (e.g. Rogers 1970 cited by MacLeod 1996), that theory 'guides' the nurse in action (e.g. Jacox 1974 cited by MacLeod 1996) or that the nurse 'applies' theory to practice (e.g. Johnson 1968 cited by MacLeod 1996). Despite these connections, empirical evidence about how nurses actually use or apply theoretical knowledge in their ongoing, everyday practice is scarce in the nursing literature. From reviewing the literature, and from the issues identified by the students in relation to theory and practice issues, I concluded there was a need to investigate how students used theoretical knowledge, how theoretical knowledge influenced practice, how practical knowledge developed and influenced theoretical knowledge. Also, given that the undergraduate group had a higher academic level of theoretical knowledge, I wanted to investigate how this had influenced their practice.

Degree versus diploma education 4.1

Whether pre-registration nursing should become solely an undergraduate education programme is still under debate within the U.K.. The U.K.C.C. Commission for Education (U.K.C.C. 1999 p. 56) recommended the expansion of graduate preparation for nursing and midwifery because of the nature of clinical decision-making required, and the current demands of service providers, particularly for workforce-flexibility and role-diversity and the close approximation of current diploma preparation to graduate level. This would be in keeping with government targets for participation in higher education (Scottish Executive 2001), but would need to take into account the increasing demand for graduate nursing places but the limited supply of places.

All the undergraduate group (UG3), together with previous undergraduate groups (UG2, UG1), stated the benefits of undergraduate preparation for nurses and the positive comments from these students (UG3), together with the findings of the participant observation (reported later), indicate that there may be theoretical and practical advantages.

Theory component 4.2

Undergraduate students (UG3) commented in favour of the theoretical component of the programme, and viewed theory as a means of rationalising practice. Literature has explained the use of theory in practice in five ways: practising from theory; practice as applying theory; theory as a pointer; using and transforming formal knowledge; and theories-in-use (MacLeod 1996).

One view is that nurses practice from a theory or a set of theories. Kitson (1986) argued that nurses practice from broad, normative knowledge, for example a model of nursing. One of the diploma students (June, D3) explained that one of her placements was very organised and the nurses worked towards a common goal, through the use of a nursing model. Nurses can use theory to guide practice, where nurses would work from the prescriptive, normative theory, applying it as a template to their practice. Any mismatch between practice and theory would constitute a testing of the theory and thus the theory could be revised and new formal knowledge created (MacLeod 1996, p. 18).

Benner (1984) suggested that theory is useful for pointing to an area of practice and for guiding the novice. Students in my study felt that they sometimes had to use theory to guide them through practice especially when left unsupervised. Benner (1984) believes that theoretical knowledge may be useful to practitioners, but it is derived from practice. MacLeod (1996) argued that in an area such as nursing where there are still areas of practice which do not have adequate development of theoretical knowledge, practice knowledge has been the guiding principle.

Freidson (1986) suggests that formal knowledge, in the everyday situation is employed inconsistently and informally, and calls this the transformation from formal theory to “working knowledge.” Theories-in-use are a “kind of knowing-in-action” (MacLeod 1996, p. 18). Theories-in-use was first described by Schon (1987,p 256) as being constructed or reconstructed through “... reflecting on the directly observable data of ... actual interpersonal practice...”.

According to the literature, not only may theory be used in different ways, but it may also be derived through different means. I investigated how students used their theoretical knowledge and how this knowledge influenced practice and vice versa (see Category 7, p. 312).

Which group is better at practice? 4.3

Melia (1987) argued that practical knowledge has been given a much lower value in nursing than formal knowledge. Benner (1984) was one of the first authors to address the issue of practical knowledge, which she referred to as ‘knowing-how’. This knowledge developed through experience.

Goodchild (2001) has argued that having a degree is no guarantee of competence in key skills such as communication, information technology, numeracy, team work and problem-solving. However, all the undergraduates’ comments contrasted with this view. In agreement with undergraduates from other groups (i.e UG1, UG2), undergraduates near qualification (UG3) felt that having a higher level of knowledge had a practical benefit:

“You know what you are doing and why you are doing it. When you are taught things you can question them a bit more. You can go back to the research and critically evaluate it as to whether it is valid or not.”

(Helen, UG3)

“I think ...when someone asks you why you are doing something, you can actually reply what you

are doing and why you are doing it."

(Cameron, UG3)

"You can tell the difference between a diploma student and a degree student ...you know when you start questioning them ...you see their level of knowledge is higher in degree students."

(Sharon, UG3)

Recently, Greenwood (2000) argued that there was an international trend to render pre-registration nursing education more 'theoretical' and to elevate the academic award it attracts. This, she argues has led to differences in opinion regarding the readiness of new graduates to enter the workforce as competent Registered Nurses. Greenwood (2000) argued that the service sector complained that newly-qualified nurses (both diploma and degree) were inadequately prepared for practice, while nurse educators retort that the expectations of the service sector are unrealistic.

Diploma students were in agreement with Goodchild's (2001) comments:

"... it's [degree-level preparation] no guarantee that you will be a good nurse. You could have the theory, but you might not be able to put it into practice ..."

(William, D3)

"They [graduates] cannot put it into practice. They might have the theory, but they will not have a clue. ... we [diplomates] will have better practical skills ..."

(Janette, D3)

Bartlett, Simonite, Westcott and Taylor (2000) compared the measurement of nursing competence of graduates and diplomates from two U.K. nursing programmes. Using a structured tool, graduates' and diplomates' perceptions of their competency were measured and then compared on graduation, and six and 12 months post-qualification. Supervisors completed a questionnaire on their

perceptions of their students' competence. The perceptions of the supervisors were then compared to those of the diplomates and graduates.

On graduation, diplomates (n=28) and graduates (n=51) volunteered to be included within the study following information about the study within class time. Mentors of diplomates (n=17) and graduates (n=40) volunteered for the study. Questionnaires were return by mail and the respondents were assured anonymity. At six and 12 months, only diplomates and graduates were sent a repeat questionnaire by mail. The questionnaire contained a competence instrument adapted from a Hong Kong study of graduate nurse performance (Bartlett et al 1993 cited by Bartlett et al 2000). The instrument consisted of 78 items, organised into eight constructs including leadership, professional development, assessment, planning, intervention, cognitive ability, social participation and ego strength. The authors provide a brief description of each construct. Competence was rated by asking subjects to state how frequently they performed each of the competencies listed. Responses were recorded using a four-point scale, where one = never, two = occasionally, three = usually and four = always. The instrument was piloted on 12 graduates from a previous cohort. Minor alterations were made to the wording of some questions.

However, I would argue that the frequency of performing a task does not necessarily equate with competence. In other words, a person may carry out the task once and do it well, but another may carry out the task six times but may not have mastered the task. A reduction in competence could also be explained if the nurse was not practicing the skill regularly, and therefore mastery of the skill would be reduced. I will discuss the competency of the students within my study later (Category 7, p.312).

A panel of nurse academics and senior practitioners assessed content validity of the instrument. Internal consistency of the instrument produced an alpha coefficient of 0.95. Each construct was also tested individually which produced an acceptable level of internal consistency (i.e. between 0 and +1) (Polit and Hungler 1995).

Responses were obtained from 63% (n=32) of the graduates, 68% (n=19) of the diplomates, 78% (n=31) of the graduates' mentors and 77% (n=13) of the diplomates' mentors. Response rates were very good initially thereby limiting the potential for bias within responses (Polit and Hungler 1995). However response rates were poorer as the longitudinal study progressed: after six months 42 graduates (52%) and 25 diplomates (47%) responded and after 12 months 38 graduates (47%) and 21 diplomates (51%) responded. The authors evaluated the potential bias introduced by non-responders by investigating the conclusions made based on the data analysis earlier in the study. Mean scores for students on graduation for the eight constructs did not differ significantly between responders and non-responders ($p = 0.101$).

The study found that on graduation, with the exception of leadership where diplomates scored higher, there were no significant differences between the competence of diploma and degree graduates. The longitudinal analysis showed that this difference was not maintained, in that a reduction in the diplomates' leadership scores occurred. 'Leadership' was defined as the 'ability to lead and make decisions', but the items used to make this construct were not detailed in the report. Therefore I am unable to comment on how well I felt the items measured 'leadership'.

The authors expressed concern over the lack of leadership shown by new graduates and stated that there was a need to look at the reasons for this. They suggested that a programme longer in length (one year, i.e. a four year programme) should provide time for the graduates to develop more leadership skills and that the content of the curriculum should provide theoretical and practical preparation for leadership. However, the practical areas graduates were using could have presented them with less opportunity to apply leadership skills.

Six months after graduation, graduates had significantly higher scores in three areas of competence, namely professional development, assessment and ego strength. Professional development was described as the 'participation in

continuing education and upgrading of professional standards'. Assessment was described as the 'ability to observe and diagnose client needs.' Ego strength was described as 'confidence and assertiveness.' A criticism of the report would be the lack of clarity over how the items making up the constructs were devised and how well they measured the constructs. However, one year after graduation the only difference found between the groups was in relation to professional development. The authors argue this suggests that graduates participated more in continuing education and enhancement of professional standards than diplomates.

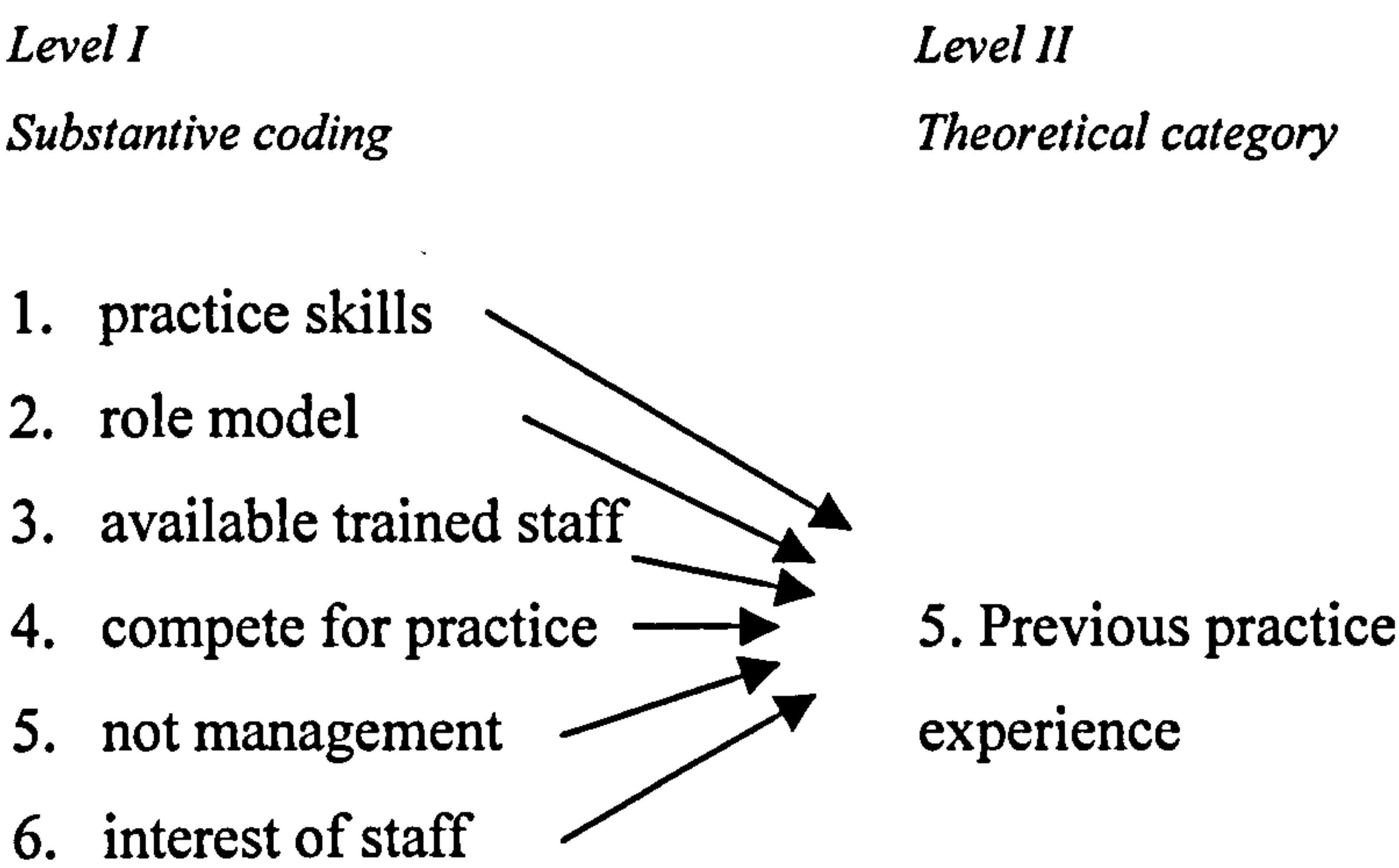
Upon graduation, students' mean scores for each construct were compared to their mentors' scores for each construct using analysis of variance. There were no significant differences between students' and mentors' scores ($p=0.299$). Therefore the self-rating competencies were supported by mentors. The consistency found within the scores, for both sets of students, suggested that diplomates and graduates are under no illusion of their abilities. Students within my study were also asked about their readiness for the qualified role. The authors stated that although a small sample was used and therefore the results were not conclusive, there were some similarities and differences between diploma and degree-prepared nurses. In summary, they concluded that over time graduates may overcome any initial limitations and indeed become more competent than the diplomates in certain areas, and suggest that there are certain possible advantages associated with degree programmes over the diploma programme (Adult Nursing Branch). However, as discussed, the assessment of competence may need to be measured and perhaps rated using measures other than frequency of task performance alone.

Bartlett et al (2000) stated that there was a need for changes to the nursing curriculum to include leadership and management. The authors researched a four-year undergraduate programme, and stated that with the change to three-year degree programmes the opportunity to include these areas may be greatly reduced. The authors also stated that the support afforded to newly qualified staff nurses needs to be tailored to meet the needs of the student. Employers also

need to be more aware of the continuing professional development needs of diplomates if they are to achieve the same competence as graduates within the first qualifying year.

Category 5. Previous practice experience

Figure 22: Theoretical category ‘Previous practical experience’



Practice skills 5.1

All students in my study stated that the practice of clinical skills was variable depending upon the availability of trained staff, how many other students were within the same unit, and the interest and motivation of staff. These findings were also found by Dolan (2003). The teaching and assessing of practical skills were also very variable. Some students stated that they had no demonstration of skills, others that they had demonstration but then had no supervised practice, while others expressed dissatisfaction when they were over-supervised or not allowed to do something they had been successfully doing in their previous placement. Ideally students were looking for demonstration(s), followed by supervised practice, eventually leading to independent practice. Morton-Cooper and Palmer (2000) and Earnshaw (1995) had advocated this type of mentorship model.

Role model 5.2

Role models within previous practice experience were seen as important in shaping students' values, beliefs, attitudes and knowledge. Although not always the students' mentor, the role model was a valuable resource to learn from. This will be discussed later in this chapter.

Available trained staff 5.3

The availability of trained staff, including the mentor, had a major impact on the students' level of practical and theoretical knowledge. Most students recognised that, especially in acute care, there appeared to be a lack of trained staff. This left students feeling vulnerable to making mistakes during unsupervised practice, and students expressed concern over their lack of practical skills.

"I had a mentor in one ward, but I only met her once or twice. The staff were so busy ... I was left on my own to do things ...like changing dressings. I didn't know why I was putting a certain dressing on. I hadn't even seen the wound before!"

(Sharon, UG3)

"I felt vulnerable ...I had no idea if I was doing it [documentation] right. ...I missed something out from the form and I felt terrible. The staff were not pleased with me but I was trying to do my best when they were so short staffed. ...Maybe I should have asked someone to check it."

(June, D3)

"... I felt that I fell behind other students in my class after that placement. I was hardly ever on with my mentor and just didn't get enough practice at skills like drug administration ..."

(Marie, D3)

A report in 1996, (Phillips et al 1996) had highlighted and warned of the worsening problem in England of providing an adequate number of placements, and mentors to supervise within these areas. The U.K.C.C. (1999) identified the lack of availability of mentors, but my study highlighted that mentors and other qualified staff need to have time to supervise students in practice. Students near to qualification, stated that they had often relied on primary care placements to provide adequate supervision and teaching. Acute areas were especially low in staff to provide this essential role.

Compete for practice 5.4

A number of diploma students remarked on the number of other students within the placement at the same time. This often meant that the availability of trained members and the number of learning opportunities were limited. However, if the student was having difficulty within the placement, having another student to talk to or to ask for advice was often seen as positive.

Not management 5.5

Perhaps, due to their final module being called a 'management module', the undergraduates (UG) had had much more 'managerial experience' than diploma students (D3). Both groups (UG3 and D3) expected that their final two months in the clinical area would involve them taking charge of a group of patients, ordering drugs and supplies, going on ward rounds (and being asked for their opinion), carrying out procedures independently, and liaising with other members of the multidisciplinary team such as social workers, district nurse liaison officers, bed managers and physiotherapists.

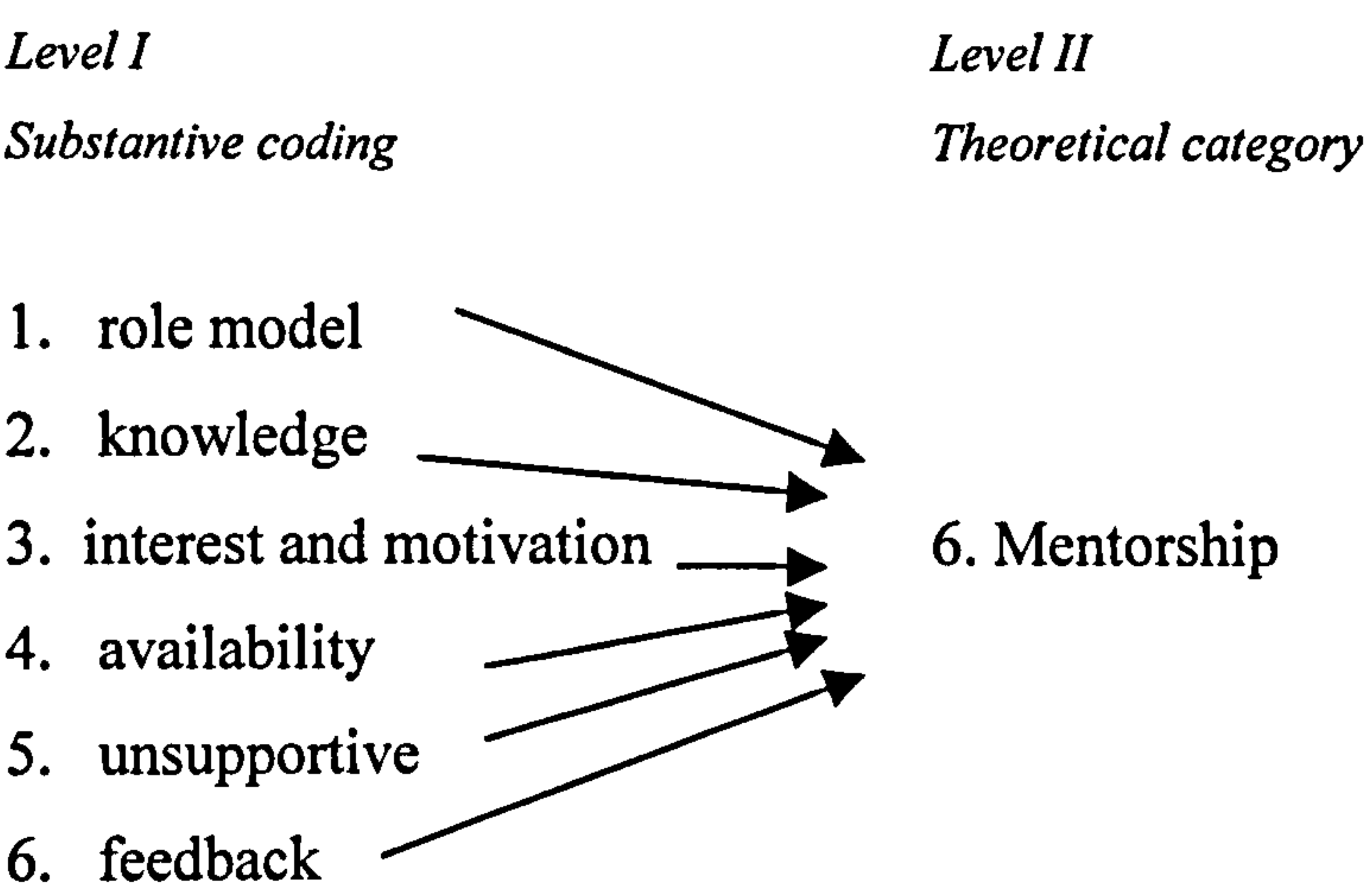
Some diploma students reported that during their rostered service, they had been unable to practice essential nursing skills such as administering drugs, doing patient referrals or managing nursing care for a group of patients. Students explained that the lack of staff was often the reason for this. Lack of trained staff meant supervision was haphazard, and lack of healthcare assistants meant that

students undertook care carried out by this group (e.g. attending to personal hygiene needs, distributing food to the patients), which left little time to practice skills associated with the qualified role.

This lack of care management experience will be discussed later together with the findings of the participant observation.

Category 6. Mentorship

Figure 23: Theoretical category ‘Mentorship’



Watson and Harris (2000) investigated the support students received during practice placement. Only those results which are useful for this study will be documented and analysed. Students, mentors and lecturers participated in the study which used triangulation of data collection methods, i.e. postal survey and follow-up, focus groups and follow-up. Thirty-two focus groups were conducted, which comprised 10 groups of students, 12 groups of lecturers and 10 groups of mentors associated with each academic institution (n=11) in Scotland. Forty-nine students, 40 mentors and 23 lecturers took part.

All groups agreed on the following points. General support of the student included introductions with the mentor at the start of the placement, being made

to feel welcome and getting visits from lecturing staff. Teaching was also seen as an essential role of the mentor and a crucial part of students' learning. It was seen as good practice if the mentor identified the student's learning needs with the student, set goals and provided opportunities to achieve those goals and for reflection, while providing constructive feedback and assessing competence. Practising of a skill was seen as much more beneficial if the student could see that skill as part of the overall package of care.

Watson and Harris (2000) stated that on a practical note, student support should involve identifying what the student already knew and could do before starting the placement and helping the student to identify what they could learn on the placement. The mentor should help the student to identify their goals for their placement, including arranging placement-related visits, facilitating reflection on student's practice and helping the student to link theory to practice. The mentor should act as a role model, by analysing their own practice in order to explain it, and helping students to use a research-base for practice. During this relationship, the mentor should help to build the student's confidence by judging when to allow the student to work more independently and by giving the student feedback on their performance. In order to maintain safe practice, the mentor should intervene when students are practising unsafely. Assessment should involve deciding whether students have acquired specified competencies (i.e. if they should pass or fail their placement assessment). Overall the mentor should have a positive attitude towards the student's learning and assessment.

A qualitative study carried out by Ohrling and Hallberg (2000a and 2000b) using a sample of 17 nursing students from one final year class in Sweden found similar results to Watson and Harris (2000). The study used a small sample size thus making the results difficult to generalise (Polit and Hungler 1995). The authors fail to state how the sample was chosen which makes the results susceptible to researcher bias (Polit and Hungler 1995).

Ohrling and Hallberg (2000b) found that within the preceptor-preceptee relationship, pre-registration students wanted a 'space for learning' which

involved having time and places to work in confidence with the preceptor which encouraged questions, and gave access and practice to nursing care actions. 'Preceptorship' is term used within this study for the supervision and support of pre-registration student. Students wanted the preceptor to wait and work at the pace of the student. Similar to students within my study, these students also wanted to have 'concrete illustrations' where the preceptor would act as a role model. As this role model the students expected the preceptor to work as a nurse, talk and narrate before, during and after nursing situations, talk in general and give hints and practical advice to them. The importance of reflecting on practice and relating theory to practice was seen as important to provide a deeper understanding of practice, thus increasing the value of learning. Ohrling and Hallberg (2000b) also noted that students wanted the preceptor to take responsibility for patient safety and student learning.

The health care environment seems to be under increasing pressure to deal with an increasing throughput of patients who are more acutely ill, despite shortages in staff. Watson and Harris (2000), Naughton and Nolan (1998), N.H.S. Confederation (1998) and May et al (1997) have identified that there is less time for practice staff to supervise and mentor students. Watson and Harris (2000) concluded that placement staff should ensure that students' and mentors' on-duty time coincides by not less than 50% of the students' time on placement. They also recommended that service providers should allow mentors dedicated time for their support role with students. However Gordon and Grundy (1997) stated that nurses have consistently experienced difficulty in caring for patients while at the same time having to cope with the increasing educational demands of students since the introduction of Project 2000. It should be noted however that Gordon and Grundy (1997) provide no research evidence for this statement.

During a two year study funded by the English National Board for Nursing, Midwifery and Health Visiting, Twinn and Davies (1996) examined the teaching, support, supervision and role modelling in student clinical learning within Project 2000 programmes. The study aimed to (a) analyse the concepts of teacher, supporter, mentor and supervisor both in the literature and as seen by

individuals involved in facilitating learning, (b) explore the perceptions and interpretations of the value of these roles by those involved in the adult and mental health branch programmes and (c) make recommendations about the appropriate preparation for practitioners undertaking such roles in the clinical learning environment.

The first stage of the study involved the use of semi-structured taped interviews with practitioners and students. The second stage of the study involved six case studies which identified and explored issues which arose from stage one of the study. The sample was chosen from three colleges of nursing from the first 13 centres in England to provide Project 2000. For stage one of the study, a purposive sample of 53 students, 37 practitioners, and 25 tutors were chosen.

Twinn and Davies (1996) found that there were different levels of supervision available, and different titles given to practitioners such as 'mentors' or 'practice supervisors'. While some practitioners demonstrated a highly committed statement, others stated their ambivalence to their role. Again the burden of teaching students and caring for patients was highlighted as a problem – the authors found many examples from students and practitioners. Practitioners also noted that their preparation for the role was 'too little too late' or with little or no preparation at all. The authors also stated that there were differences in the understanding of supernumerary status, there were conflicting views over the expectations of students' practical skills and the level of supervision required. Although this study highlighted findings which were not new, it does provide some evidence that practitioners were finding it difficult to provide adequate supervision while providing quality care to patients. These findings were also supported by other literature (Spouse 2001; Bishop 1998).

Students within my study were aware that on some occasions practitioners did not have time or resources to spend with them and some even stated that the patients should come first. Innovations such as the introduction of peer support from senior students has been implemented and evaluated to help overcome the

lack of practitioners in placements (Aston and Molassiotis 2003). These initiatives have still to be used and researched thoroughly in the U.K..

The U.K.C.C. Commission for Education (U.K.C.C. 1999) highlighted that nurses' morale was low as they felt pressurised, unappreciated and unsupported and, as a result, the level and quality of supervision and support to students was variable and often uncoordinated. They stated that short, poorly planned placements can prevent students from developing even basic skills such as taking blood pressures, giving injections and carrying out dressings. However, Watson and Harris (2000) stated that part of the mentor's role should include coordinating the student's total placement experiences as well as supervision of the student. Students within Watson and Harris' study (2000) also felt that mentors should be aware of the individual's learning needs so that appropriate experience could be planned.

Role model 6.1

Role theory proposes that individuals perceive their identity in relation to those with whom they associate, those who have related roles and those who affect or are affected by the individual's identity and performance (Green 1988). A basic premise of Social Learning Theory is that the observer's behaviour can be "...substantially modified as a function of witnessing other people's behaviour and its consequences for them" (Bandura 1977a, p. 30). Bandura (1965 p. 33) argued that people generally adopt the standards of self-reinforcement exhibited by exemplary models. People then evaluate their own performance relative to that standard and then serve as their own reinforcing agents.

Students in my study often commented on the importance of a good role model:

"...she [role model] was everything I was looking to become. I left that placement hoping that I would be a nurse like that when I qualified. ... I learned how to do lots of skills. It was just what I needed at that time ..."

(Molly, UG3)

Bandura's theory of modelling involves four interrelated concepts. Firstly, merely exposing the observer to modelled behaviours will not ensure that behaviours are attended to, recognised or differentiated. Bandura argues that in order for learning to occur, observers need to be repeatedly rewarded and the modelled behaviour needs to be reinforced. Bandura (1974) found that by informing observers in advance that they would be asked to reproduce the modelled behaviour, they were more likely to watch more closely. Observational learning can be represented by imagery and verbal coding (Bandura 1977a). Some behaviour is retained in imagery. Bandura (1977a) argued that imagery plays an important part in learning, especially during the early stages of development. Imagery can also be important when learning behavioural patterns that do not transfer easily into verbal coding. Verbal coding is the predominant method of retaining modelled behaviour. Observers code modelled activities into words, labels or imagery. There is also a limit to the amount of behaviour that the observer can process at any one time. If the model cues are presented too quickly or at an overly complex level, learning will be limited and fragmented. In situations where modelled behaviour is complex, repeated presentations are necessary to produce complete and accurate learning. Wiseman (1993) argued that many nursing skills are complex and may require repeated demonstrations before the student is asked to tackle the skill. William (D3) described what he was looking for from his role model:

"... we needed the mentor to demonstrate the aseptic technique and talk us through the procedure. Then we needed her to supervise us and give us feedback on our performance ..."

(William, D3)

Secondly, Bandura (1977a) stated that the ability of the observer to retain the observed behaviour is crucial. Two mechanisms can aid the retention. Initially there is a rehearsal of the behaviour i.e. practice of the behaviour. Nursing students can practice behaviours in clinical laboratories, or within the practice

areas. Following this, symbolic coding operations occur when the student codes and recognises and classifies elements into familiar and easily remembered patterns.

Thirdly, Bandura argued that the student must be able to convert what they have observed into an appropriate action. Mastery comes from successful performance. However, Wiseman (1993) argues that some actions in nursing such as moral/ethical beliefs, are difficult for the student to observe in some instances. Reproduction of the learned behaviour will also depend on whether the individual has the necessary skills to reproduce that behaviour. Wiseman (1993, p. 22) uses an example of:

“...when a students observes the demonstration of a complex procedure, understands it and retains it, but when an attempt is made to demonstrate the procedure finds it difficult to smoothly coordinate the necessary movements. Skill is not perfected through observation alone.”

Fourthly, what and how much the student will learn from the observation will depend on their incentive and motivation to do so. However, Wiseman (1993) states that the student will retain the behaviour if it is perceived as important rather than because of the individual's incentive or motivation. However, Wiseman (1993) argues that incentives such as positive feedback can be offered which can act as a means to reinforce and incorporate positive behaviour.

Bandura (1977b) states that role modelling is much more than imitative behaviour, but is a major influence in the observer's behaviour. When exposed to different methods, observers rarely pattern their behaviour exclusively after a single source, nor do they adopt all attributes even of preferred models. Rather, observers combine aspects of various models into amalgams with different observers adopting different combinations of characteristics.

Early work by Bucher and Stelling (1977) identified five types of models necessary for professional role models: partial, charismatic, stage, option and negative. Partial role modelling is the most common type, with roles selected

because they demonstrate a single skill or characteristic that the observer desires to imitate. Charismatic models are those who inspire the student, while a stage role model provides the student with a level to which they should aspire when they get to that level e.g. newly qualified. Option models provide a forum for alternative professional views. Negative models represent a variant of all the types of models, since each model can provide the observer with negative opinions and actions.

Students in Watson and Harris' (2000) study identified the importance of having a good role model within practice areas to reinforce good practice. This was problematic at times due to the lack of availability of the mentor or qualified staff. Watson and Harris (2000) found that students, mentors and lecturers stressed the importance of having a role model involved in practice teaching. Practice teaching, they argued, should include areas such as showing the student practical skills, explaining what they did, relating theory to practice and giving the student the opportunity to practice what they have been shown. English (1993) and Barr (1980) also warned that negative attitudes and behaviours can easily be imitated by the student, and can be difficult to reverse. English (1993) and Murphy (1987) argued that caring behaviours such as giving information, and being supportive to patients, can be role modelled.

Within my study, all students stated that the standard of teaching, including demonstration, supervision and allowing the student to carry out practical skills independently, was inconsistent between clinical areas and even between qualified staff in the same clinical area. For example:

"... sometimes I was looked after. My mentor would show me how to do something, then talk me through it and then let me do it on my own. But at other times, staff wouldn't allow me to do what my mentor had taught me the week before ... I couldn't get the practice at the skills I needed."

(Marie,
D3)

Many students within my study noted that they wanted their mentors to ask them questions and also provide the opportunity for the student to ask the mentor questions. Phillips and Duke (2001) investigated the questioning skills of clinical lecturers and preceptors of undergraduate students in Melbourne, Australia. A comparative descriptive design was used in which participants were given three acute care scenarios, and asked to identify the questions they would ask the student in relation to the scenario. The authors argued that to assist students to apply knowledge and develop critical thinking skills, questioning is required to be an integral part of the teaching role. According to Bloom (1956) higher level questioning facilitates the development of critical thinking skills requiring application, analysis, synthesis and evaluation. The questionnaire used a scenario appropriate for third year students, and the preceptors were selected if they had experience of facilitating student's learning at this stage of their programme. Ethical approval was sought from university and hospital committees.

Phillips and Duke (2001) provide examples of the data analysis, categorising questions. Two raters independently coded 10 randomly selected questionnaires and 94% agreement was reached. The findings relevant to my study will be discussed. Using 14 clinical lecturers and 14 preceptors, the authors demonstrated that clinical lecturers significantly asked more questions than preceptors. More significantly both groups asked more lower level questions (knowledge and comprehension) than higher level questions (application, analysis, synthesis and evaluation). Preceptors asked a much higher percentage of lower level questions than clinical lecturers.

The authors recommend further evaluation and research using a larger sample that could be spread over a wider geographical area. Due to the small sample size and the origin of the research, further research in the U.K. would be required to further investigate these areas in order that the results could be generalised. As most areas in the U.K. no longer use clinical lecturers, the research could not be repeated, but could involve investigating mentors' ability to question at different academic levels. Also I would argue that the questioning skills of mentors may

influence the learning of the student and therefore should be incorporated into mentorship preparation programmes.

However, Myrick and Yonge (2002) argued that preceptors are in the ideal position to use questioning as part of the teaching and learning process within the clinical area. "Questioning can be used to direct the thinking process, promote interest, stimulate and challenge the student ...[and] promote discussion ..." (Myrick and Yonge 2002, p. 176). Boychuk (1999) and Schell (1998) also argued that the use of questioning in nurse education can promote learning. May, Butell, Doughty and Langford (1999) and Siegel (1985) suggested that questioning can promote critical thinking in student nurses.

Although students within my study did not discuss the types of questions used, Myrick and Yonge (2002) suggest that questions should be used which, firstly, requires memory or recall (i.e. knowledge questioning), secondly, requires the application of recalled knowledge to a specific context (i.e. application questioning), and thirdly, which requires applying knowledge to solve problems (i.e. problem-solving questioning) (Bowling 1979 cited by Myrick and Yonge 2002). Perhaps the reason the differences were found between lecturers and preceptors in Phillips and Duke's (2001) study was that preceptors had not been taught about the level of questioning that could be used. Therefore, I would suggest that questioning techniques should be included as an aspect of the mentor preparation courses.

Spouse (1998) suggests that practitioners find it difficult to articulate their activities to students, and as a result are unaware of the learning needs of the student. Chabeli (1999), using a purposive sample of 10 final-year student nurses in South Africa, who were following a course which led to a diploma in nursing (general, community health, psychiatry or midwifery), conducted a consented, anonymous interview using two focus questions: What are your learning needs in the clinical learning units? How do you expect these learning needs are to be met? (Chabeli 1999). The data were analysed using content analysis, which produced eight categories. The category of role modelling was pertinent to the

findings of this study. Chabeli (1999) stated that the participants had identified role modelling as one of the most important characteristics from which student nurses can learn. Chabeli (1999) stated that the findings obtained were truthful in that the study ensured credibility, transferability, dependability and confirmability. However, as the way in which these principles were achieved is not apparent from the literature source, I would question the reliability and validity of the methodology and findings.

Langridge and Hauck (1998) studied a purposive sample of 21 senior nursing students using tape-recorded focus groups and semi-structured questionnaires. The purpose of the study was to investigate the meaning and significance of role modelling to student learning in the clinical area. Data were analysed into six themes: the role model is someone who: a) valued teaching and learning, b) was committed to the profession of nursing, c) was a knowledgeable and skilled practitioner, d) was an effective communicator, e) valued individuals and was f) open and approachable. Literature and verbatim statements supported each theme. However, there was no attempt to establish reliability or validity of the methodology or findings.

Role modelling has a "... major influence on the professional socialisation of individuals through the transmission of knowledge, skills and attitudes." (Savage 1998a). Savage (1998b) stated that the three dimensions to role modelling are observational learning, participant modelling and the frequency of contact between learner and the role model. Observational learning is the demonstration of nursing practice by the competent role model. Campbell et al (1994) and Davies (1993) argued that the demonstration of good standard of research-based holistic care was the hallmark of a good role model. Participant modelling involves the hands-on learning with supervision as the integral part of the process (Savage 1998b). In an earlier study, Savage (1996, cited by Savage 1998b) concluded that student nurses changed their requirements of the role model the further into the course they progressed. Junior students were dissatisfied with clinical placements if they were given too much responsibility without the supervision. As students progressed, they wanted more

responsibility and greater independence. Savage (1996) concluded that promoting student independence was a characteristic of a good role model. Students within my study wanted a role model who would provide supervision when required, but would also 'trust' them enough to carry out skills on their own if they felt competent to do so:

"It was great! My mentor showed me how to do something and then supervised me. Once I felt confident, and she knew that I was competent, I was allowed to do it on my own."

(Cameron, UG3)

Cameron (UG3) demonstrated that although it was important to feel that the staff trusted him to carry out skills on his own, he also realised that mentors and other staff had a professional and legal responsibility to ensure students were carrying out practices safely and effectively. Maureen (D3) also agreed:

"... getting to do things on my own meant that I felt that they trusted me ... I wanted to get experience by doing things independently. However, I knew that the staff had to make sure that I could do these things safely before 'I could go it alone'!"

(Maureen, D3)

However, Bandura (1986) argued that the influence of the role model would be related to the frequency with which the student was exposed to the experience. A favourable clinical learning environment is characterised by frequent and quality contact with trained staff who are role models (e.g. Fitzpatrick et al 1996; Neary 1996; Davies 1993; Orton et al 1993; Howie 1988; Melia 1987; Fretwell 1982). The professional socialisation of nursing students has been associated with the availability of practice-based role models (Fitzpatrick et al 1996; Dotan, Krulik, Bergman, Eckerling and Schatzman 1986; Ogier 1981; Orton 1981). Students within my study agreed, and gave some examples:

"I watched him – he was excellent. He explained everything to the patient, and he sat

down and gave the impression that he had loads of time to spend with the patient before his surgery. ...I learned from what he did and what he said to the patient. I practiced admitting patients whenever there was a patient coming into the ward ... it was what I needed to do to become competent."

(Helen, D3)

In 1999 (Savage 1999), a study of 120 student nurses investigated the clinical learning environment, of which role modelling was seen as one of the most important factors. The sample was stratified equally into first, second and third year students. Each participant completed a questionnaire. Reliability and validity was tested and proved adequate. The response rate was 85%.

Over three-quarters of the respondents (77%, n=79) indicated that staff nurses demonstrated the application of theory to practice. Staff nurses were described as 'brilliant to watch' with 'expertise that was impressive'. However two thirds of the respondents (62%, n=62) were in disagreement that staff nurses repeatedly demonstrated new procedures to them prior to their being allowed hands-on experiences. Savage (1999) demonstrated a statistically significant relationship between the amount of supervision received by students and the ward learning environment. 'Too much' supervision was reported by third year students. One student commented that she wanted to be trusted with more responsibility, while others suggested that a greater level of supervision allowed them to develop more confidence and better decision-making skills (Savage 1999).

"Too little" supervision was reported by first and second year students. Almost half of first and second year respondents (49%, n=49) reported spending less than 40% of their time working with staff nurses, and all of this group reported an unfavourable learning environment. In contrast, all respondents who reported spending over 60% of their time working with staff nurses (43%, n=44) viewed their ward placement favourably (Savage 1999). This supports Bandura's theory (1986) which states that the frequency of contact with the role model is of significant importance to students' learning.

Overall, students within my study were looking for a mentor who was a good role model, involved in clinical teaching and who was interested and motivated enough to spend time with them.

Knowledge 6.2

All students within my study highlighted the importance of the mentor being knowledgeable about their subject area and using research-based nursing practice. Mentors should also be knowledgeable about the level at which the student is required to work depending upon their stage within their educational programme. This required some knowledge about each programme and its structure.

Interest and motivation 6.3

Since mentors' attitudes have a crucial impact on student learning, Watson and Harris (2000) recommended that mentors who are motivated and value learning should be selected for the role and that the added responsibility of mentorship should be recognised by financial reward, time being made available, and through honorary lectureships with academic institutions. Students within my study agreed that they wanted an interested and well-motivated mentor.

In a study investigating preceptors' perceptions of the benefits, rewards, supports and commitment to the preceptor role, Dibert and Goldenberg (1995) stated that the potential benefits of the role, such as increased job satisfaction and recognition, were anecdotal. Other literature had highlighted the possibility of 'burnout' within the role (Turnbull 1983 cited by Dibert and Goldenberg 1995). The study involved preceptors of nursing students and newly hired nurses. A convenience sample of 59 nurse preceptors in a 400-bed urban teaching hospital in Canada was used. Each participant completed the Preceptor's Perception of Benefits and Rewards Scale, the Preceptor's Perception of Support Scale, and a demographic questionnaire. The scales used Likert-type scales but the validity

of the scales were not considered for this study population. Reliability coefficients for each scale were satisfactory.

Correlations between scales revealed some interesting findings. Preceptors who perceived benefits and rewards associated with the role were more committed to the role. When preceptors felt that they were supported in the role, this related positively to their commitment to the role. These correlations were statistically significant. Even when the preceptor had repeated experience of the role, this did not affect their commitment to the role.

Dibert and Goldenberg (1995) recommended further research to identify the benefits and rewards of the role and strategies to promote preceptors' access to these rewards. Perhaps within the U.K. there should be further investigation into the positive and negative aspects of the role, while providing some added rewards to those who carry out the mentors' role to a high standard.

None of the students within my study discussed the role of the lecturer within clinical placements. The U.K.C.C. Commission for Education (U.K.C.C. 1999) stated that the physical separation of academic learning from the clinical practice causes problems for lecturers, practice staff and students. Practice staff stated that lecturers were out of touch with developments in practice, policy and service. Watson (1998b) also found that practice staff did not feel adequately prepared for their role as mentors.

Duffy, Docherty, White, Winters, Greig (2000) surveyed a convenience sample 150 mentors (a response rate of 47% was achieved, n=71) investigating the effectiveness of current arrangements for mentor preparation and ongoing mentor support provided in adult placement areas in Greater Glasgow Health Board. Having reviewed the questionnaire following a small pilot study (n=5), they obtained ethical approval. Participants were issued with a letter informing them of the research, a consent form and the questionnaire.

However, Duffy et al (2000) indicated that although mentors were generally satisfied with the level of preparation provided, the on-going support from managers and academic institutions/staff was problematic. Sixty-eight respondents (96%) felt that they had no constructive feedback regarding their performance as a mentor from academic staff. Overall, mentors wanted visits from academic staff (also stated by Delong and Bechtle 1999) to support and provide them with feedback on the role they were providing, especially in relation to the documentation of the assessment (also stated by McGregor 1999), and in providing the staff with up-dates regarding the educational programme (Duffy et al 2000). The author supports these statements with the use of verbatim quotes from the comments obtained in the questionnaire. Duffy et al (2000, p.38) recommends that mentors should be given "...sustained and structured..." support from managers and academic staff. O'Malley and Cuncliffe (2000) support this view.

Davies, Neary and Phillips (1994) stated that learning objectives set by lecturers did not always translate into learning opportunities for students on practice placement, and mentors were not always able to link general learning objectives to specific experiences in the practice context. The U.K.C.C. Commission for Education (U.K.C.C. 1999) recommended that academic and service partners need to define responsibilities for supporting learning in practice, monitoring the quality of practice placements and negotiating placement outcomes.

Availability of clinical placement support 6.4

Within my study, students identified the availability of mentors as a major problem within clinical practice. Interestingly, none of the students throughout the entire study made comment on the role of the lecturer.

Lloyd Jones and Akehurst (1997) as part of a larger study, investigated the effectiveness and efficiency of the Project 2000 system for clinical placements. They assessed the amount of time spent by University of Sheffield School of Nursing and Midwifery staff (n=118) in fulfilling the clinical link in relation to pre-registration placements. The exercise took place over a four-week period.

The lecturers were asked the most suitable time to investigate this, and identified a time in terms of clinical link. They completed a daily diary on the amount and type of clinical link they provided. The lecturers were informed of the students and mentors who were also involved in the study. The authors hoped that the link-lecturers would encourage the relevant students and mentors to complete their diaries.

Eighty four link-lecturers (71%) responded and completed diaries relating to all aspects of clinical link activity. This included planned student contact (visiting the placement area with the intention of seeing the student), and unplanned student contact (if the student contacted the link teacher about his/her placement either while the link teacher was in the placement area for another purpose or elsewhere). The lecturers recorded how long they worked with a student (working alongside the student in the clinical area on activities related to patient care). Planned staff support (visiting the placement area with the intention of seeing staff in relation to the placement) and unplanned staff support (i.e. if a member of staff contacted the link teacher about a placement if either the link teacher was in placement area for another purpose or elsewhere) were also noted within the diaries. Unaccompanied clinical activity (working clinically in activities related to patient care without a student present in any capacity), preparation (any preparation undertaken in anticipation of planned student or staff support) and placement assessment (all time spent on the assessment of the progress and achievement of student in a placement and with which the link teacher linked (including verification)) were documented. Time spent carrying out educational audit (all time spent in relation to the educational audit of clinical placement areas) and other activities (any other activities associated with clinical link e.g. administration, communication with personal tutors, etc.) were recorded within the diary. All time spent travelling to those clinical areas with which the link teacher linked in order to carry out any of the activities listed above was also listed.

The authors found that the average time per working day spent on clinical link was 90 minutes for lecturers and 72 minutes for senior lecturers. Broadly

speaking the authors concluded that approximately 20% of lecturers' time was spent in activities related to clinical link. However, this could have been an over-representation of time as the participants knew what the aim of the diary was, and this could have biased the responses. Behaviour could also have been affected by the research (i.e. Hawthorne effect) (Polit and Hungler 1999). The students also had an average contact with the link lecturer of less than one percent of the time spent in the placement area. Like students, mentors also noted that they would have liked more contact with the link lecturer. Mentor diaries indicated that less than one percent of time during the week was spent in contact with the link lecturer. If this is an average representation of lecturers' time in clinical placements, it perhaps explains why none of the students within my study mentioned the role of the lecturer within the clinical area.

Gilmore (1998) suggested that the role of the lecturer in practice seldom extended beyond liaison: negotiating placements, conducting educational audits, providing pastoral and academic support to students and ward staff, and conducting assessments. The U.K.C.C. Commission for Education (U.K.C.C. 1999) stated that anecdotal evidence suggests the lecturer's role has become more restricted in practice since the move to H.E.. It also stated that they had found evidence that H.E. institutions had failed to support lecturers in practice. Lecturers had been forced to prioritise classroom commitment and research publication (Day, Fraser, Mallik 1998).

Within my study, the contribution of the mentor to the clinical placement experience was, in contrast to the contribution of lecturers, extremely important to all students. As already stated, the availability of trained staff was problematic, especially within acute areas.

Lloyd Jones and Akehurst (1997) also carried out an analysis of student activity which aimed to assess the contribution made in clinical placement by pre-registration student nurses and midwives in relation to patient care, and the qualified staff time lost to the service provider because of the presence of

students on placement. A sample of 270 second and third year pre-registration nursing and midwifery students were chosen with their mentor for the activity analysis over one week. Of the sample, 100 were on rostered service, 37 were second year Branch students (almost all of whom were in primary care), 91 were second year C.F.P. students (the majority of whom were in ward-based and residential placements), and 42 were second and third year midwifery students (split between ward-based and community-based placements).

The student diary contained information relating to patient-related activities (to include all activities relating to patient care, such as treatment of patient, patient assessment, record keeping, case-conference/liaison, dealing with relatives, teaching relatives/patients) and education-related activities. The mentor diary contained information relating to patient-related activities (to include all activities relating to patient care, such as treatment of patient, patient assessment, record keeping, case-conference/liaison, dealing with relatives, teaching relatives/patients) and education-related activities. The overall student response rate was 46%, ranging from 29% in the C.F.P. and 81% in second year Branch students. The overall mentor response rate was 43%, ranging from 29% of mentors of midwifery students and 68% of mentors of second year Branch students.

The authors commented on the under-representation of ward-based placement responses from both students and mentors. The response rate from community based placements was 68% for students and 58% for mentors compared to 42% for students and 40% for mentors from ward-based placements. The authors concluded that the higher response rate in community-based placements were likely to be due to the fact that in these settings there would be an opportunity to complete the diary for the preceding period. The authors also commented that these results would probably be an underestimate of the time spent by staff since those who did not complete their diaries were too busy to do so (and some even stated that this was the case).

Using the student and mentor diaries the authors calculated the proportion of time spent by the student in different activities. The authors used non-parametrical statistical significance tests (Mann –Whitney U-test and Kruskal-Wallis test) which avoided any distributional assumptions about the data. Lloyd Jones and Akehurst (1997) concluded that students in adult placements spend an average of 43-62% on direct patient care. The data were collected within the early stages of the placement and therefore the amount of time spent on direct patient care could have been underestimated, due to the time taken for students to settle into the placement.

The authors noted that a large proportion of students' time was spent working under indirect supervision (25%) or unsupervised (19%), which may be appropriate when the student reaches the end of their programme, but a major concern is that the student must be aware of his/her lack of knowledge and/or skill in order to seek help and guidance. The authors argued that during the first two years students were unlikely to have the confidence and skill to cope with indirect supervision or unsupervised experience. More concerning was that during the study the authors found students within the first two years were least likely to have the opportunity to work with their mentor.

Within my study, students within two months of qualifying identified that working independently was important, but some stated that they had had problems with this:

*“I had done a few catheterisation procedures,
but it was only when my mentor came in to help
me that I realised I had been doing it wrong ...”*
(Caroline, D3)

*“I felt pressurised ... to cope with things on my
own at this stage. Sometimes I wanted someone
to talk through the problems ... or to supervise
me. I sometimes wanted supervision if I had not
practiced the skill for some time ...”*
(William, D3)

Lloyd Jones and Akehurst (1997) also commented that students were not always able to work with their named mentors for all of the time they were on placement. Even when the study showed that the mentor and student were known to have completed the diary on the same week (n=79 cases), the mentors were only present in the placement areas for 248 days out of a possible 324 days, i.e. mentors were only present for approximately three-quarters of the days students were in placement. However, the authors do not report how much of this contact time was actually spent with the student. I feel that mentors could have over-estimated their contact with students because they were being observed, and could have been more conscientious when looking after the student i.e. the Hawthorne effect.

Findings from my study indicate that the time spent with students can be variable. For example, in one community placement, Cameron (UG3) noted that he had almost constant contact with his mentor, but on one acute placement he worked with his mentor on only two occasions. He questioned the accuracy of assessment he gained from a placement in which he was in contact with his assessor (i.e. mentor) for such a short time.

Watson (1999) also found that mentors and students complained of the lack of preparation for the mentor's role and also the lack of time mentors had in placement to provide adequate teaching to students. Watson (1999) used a phenomenological study to investigate the experiences and perceptions of diploma and degree students of their mentorship experiences. A group of students (n=35) from one pre-registration programme and their mentors (n=15) were interviewed using a tape-recorded semi-structured questionnaire. Mentors were employed on seven wards of local hospitals. The author recognised that the small, non-random sample size, and having considered students from only one programme, were the main limitations of the study. The authors advise the reader that the results should not be generalised.

Having modified the questionnaire following a small pilot study using two students and one mentor, the researcher gained access to the students and

mentors via the heads of departments. Anonymity and confidentiality was assured. Data was analysed and coded. The author stated that the reliability and validity of the data was examined but does not provide evidence as to how this was done. The reliability and validity of the data is therefore questionable.

Interestingly, all students had reported interrupted periods of mentoring. Watson (1999) reported that students had difficulty receiving continuity of mentorship due to the staff's shift patterns, holidays and sick leave, or being moved to other units. Students felt that mentors needed protected time to train, or be prepared, to being mentors. Students also felt that managers should ensure that mentors are on the same shifts as the students they are looking after, although they appreciated that staff shortages was the main problem.

The U.K.C.C. Commission for Education (U.K.C.C. 1999) pointed out that students are now regarded as the responsibility of H.E. institution and it is sometimes not clear who is responsible for learning in a practice context. In agreement with Watson and Harris (2000), the Welsh National Board (W.N.B.) standards indicate that students should work with their mentor for a minimum of 50% of the placement (W.N.B. 1999). N.H.S. Education for Scotland (N.E.S.) (2002) do not make specific recommendations as to the amount of time students should spend with mentors. However, N.E.S. specify that it is the academic institution's responsibility to ensure practice supervision is suitable, and has a sufficient number of trained mentors. The academic institution should also provide adequate preparation and on-going support for mentors (N.H.S. Education for Scotland 2002).

Unsupportive 6.5

Again, within these groups of students (UG3, D3), there were plenty of examples of students being unsupported by their mentors within the clinical areas. A few examples are given below. Janette (D3) explained that her mentor was *"...completely unsupportive. She would leave me to sink or swim – that was hard!"* Jonathan (UG3) stated:

“... the patient took a turn for the worst ... I didn't know what to do. My mentor just took over and didn't explain what he was doing ... I was left feeling hopeless. The patient died and I wanted to feel that I had done all that I could have, but I didn't. ... When I questioned him [mentor] about it, he said he was too busy to take time and explain it.”

When students experienced mentors who were unsupportive, many of them stated that they tried to avoid working with them:

“... she didn't have a pleasant manner with me or the patients. I was terrified of her!, So much for her supporting me through my placement – I did everything to avoid her ...”

(William, D3)

Spouse (1996) investigated the qualities that students were looking for in a mentor. In a longitudinal naturalistic qualitative study of eight nursing degree students during their four-year degree programme, she investigated and described the relationship students had with mentors and the influences this had on their learning. Data were collected via unstructured tape-recorded interviews, although the author does not describe when, or how many, interviews took place. Additional information was taken from students' assignments, reports of critical incidents, and during visits in clinical placement to observe practice. However, the author does not describe in detail any aspects of data collection, which may make the results susceptible to researcher bias.

Content analysis of each transcript was carried out (Spouse 1996), but the inter-rater reliability of the coding process was not completed. This may make the results susceptible to researcher bias. The five categories identified were: befriending, planning, collaborating, coaching and reflection.

According to the students it was important that they were befriended by the mentor. This included the mentor initiating social interactions, the mentor having an openness and a keen interest in the student's welfare such that the

student did not feel a sense of 'being a burden'. Spouse (1996) argued that befriending was an important function of the mentor, as this promoted the student's confidence and helped them to adjust to the new placement.

The planning activity is concerned with designing a programme to meet students' educational needs. This included providing a menu of experience available in the clinical area, helping the student to identify relevant areas of interest and learning, and selecting suitable patients and other staff for the student to work with (Spouse 1996). Watson (1999) and Atkins and Williams (1995) have similar findings. The whole experience could also be improved when the mentor collaborated with the student to provide them with a focussed learning experience. For example, the mentor would share his/her own experiences and knowledge about certain care needs or skills.

Spouse (1996) stated that there was no doubt that students benefited from coaching from the mentor, which included the mentor supporting the student's performance by providing specific guidance related to skills practiced. Students also wanted mentors to ask them questions or to consider their actions and/or beliefs. Students needed evaluation of their performance to be discrete and to take place away from the patient.

In agreement with students from my study, Spouse (1996) also noted that students would avoid their mentor if their relationship was 'fragile'. She also noted that students would not be so keen to challenge practice, or be asked questions by the mentor, when the relationship with the mentor was not based on trust.

Feedback 6.6

Following on from earlier groups, both groups (UG3 and D3) reported the need for constructive feedback in order to improve competence and skill, while promoting self-belief and confidence.

“... I needed to have constructive feedback. I didn’t need to be shouted at in the middle of the ward in front of patients and other staff. ... My confidence hit rock bottom!”

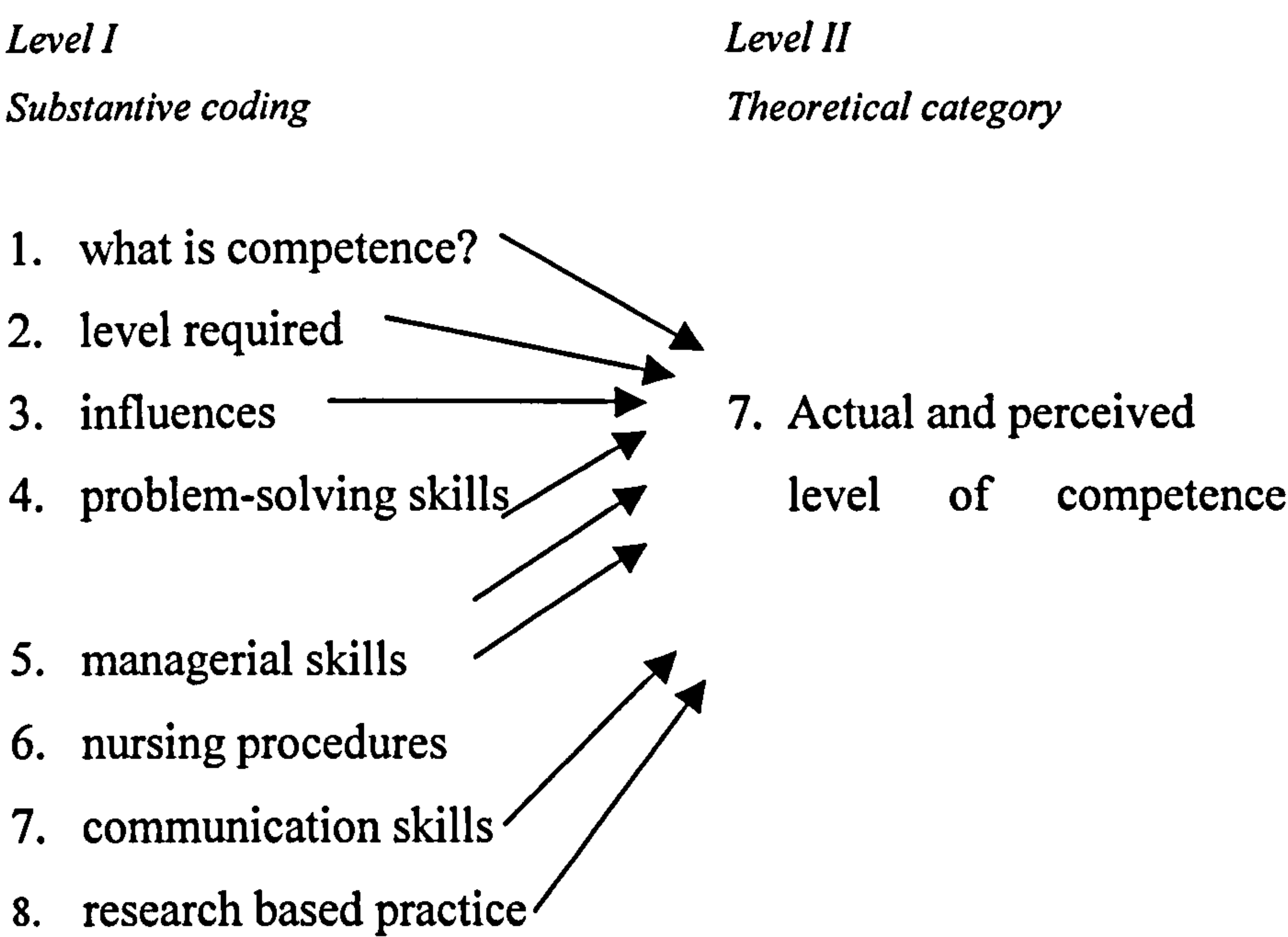
(Sharon, D3)

“... She talked me through the aseptic technique. The next day she supervised me doing it. Once we were away from the patient, she congratulated me on my performance, but also gave me tips on how to make the skill easier ... that was constructive. It was great!”

(Kathy, UG3)

Category 7. Perceived and actual level of competence

Figure 24: Theoretical category ‘Actual and perceived level of competence’



Students discussed the issue of their clinical competence, and this became a category during the data analysis of the interviews and participant observation findings.

What is competence? 7.1

Students within my study and literature I had reviewed discussed the issue of competence in nursing. At this stage of the data collection, I realised that there was some debate over the term 'competence' (code 7.1, p.313), and at what level of competence newly-qualified diplomates and undergraduates should be working (code 7.2, p.318).

Authors have stated that there has been debate in nursing over the use of the word competence (Milligan 1998; Chalmers 1998; Bradshaw 1997; Jinks and Morrison 1997; While 1994; Girot 1993; Ashworth and Morrison 1991; Runciman 1990; Short 1984). Benner (1984) used the term competence in the sense that it is something that qualified staff need to achieve. Girot (1993) argued that on the whole, the literature on competence appears confusing and contradictory, the term being described as overdefined rather than ill-defined.

Short (1984) postulated that there are four aspects of competence. Performance may be measured for competence regarding specific behaviours. Competence can be viewed as having command of pertinent knowledge and/or skills, and may be seen as indicative of a degree of capability deemed sufficient in a particular activity. A holistic conceptualisation of competence includes knowledge, skills, attitudes, performances and levels of sufficiency.

In 1996 the U.K.C.C. Commission for Nursing and Midwifery Education began to consider the effectiveness of pre-registration education, including the clinical competence of nursing students. The Commission, chaired by Sir Leonard Peach was composed of 10 Council members and five non-Council members representing the interests of service providers (acute and primary), the four Branches of nursing, midwifery, health policy, higher education, consumers, the National Boards and government health departments. The president and Chief Executive of the U.K.C.C. and the Chairs of the U.K.C.C.'s three professional committees had automatic right to attendance. Due to the short time given to the Commission (12 months) it was recognised that it also needed information on the

effectiveness of existing programmes, attrition rates and the future nature of health care needs. Therefore the following projects were commissioned before the first meeting of the Commission: a large-scale survey to seek the opinions and perceptions of the level of preparedness of newly qualified staff (British Market Research Bureau International Ltd (B.M.R.B.) 1999); an initial appraisal of attrition rates and an analysis and reporting of contemporary thinking about the future of health care in the U.K. in the period to 2010 (Warner, Longley, Gould, Picek 1998).

The Commission also appointed experts/external advisors. A list of participants is provided within the report. Evidence was gathered by: searching the literature; commissioning particular pieces of work; undertaking surveys; consulting professions and consumers; inviting stakeholders to enter dialogue with the Commission; and inviting oral and written evidence. In addition to the work already commissioned, the Commission also made use of other reports such as the "Report of the analysis of the literature evaluating pre-registration nursing and midwifery education in the U.K." (Gilmore 1998).

Survey work for the Commission was carried out by B.M.R.B.. The survey sought the views of registrants with regard to fitness for practice. It targeted all final year nursing and midwifery students on both degree and diploma programmes (n=14000), all registrants who qualified in the previous 12 months (n=10000), and a sample of experienced practitioners (n=60000). The response rate was 46-48%.

Across the U.K., 24 consultation seminars took place that included university lecturers, clinical staff, service managers, students and consumers. The report states that attendance was lower than expected especially within the consumer group. The attendance rates are not recorded within the report making it difficult for the reader to judge the reliability and validity of the findings from this section of data collection and analysis (Polit and Hungler 1987).

In order to achieve consistency the same questions were posed at each seminar: What are the strengths and weaknesses of pre-registration education? How well

does training prepare practitioners for their future role? What ideas do you have for future pre-registration education?

Forty staff from the independent sector also took part in a forum. Consumer views were sought from the Association of Community Health Councils for England and Wales and further represented in the written and oral evidence to the Commission. What questions posed are not submitted in the report. How a sample of consumers and independent staff were chosen is also not apparent from the report. Therefore there are potentially a number of reliability and validity issues with the methods of data collection and analysis.

Stakeholder organisations were invited to participate in discussions with the Commission on pre-registration education. The two-hour discussion was confidential and raised a number of key issues. The number of people used is not noted in the report. The reader is not aware of how the data were analysed and what key issues were raised. The reliability and validity of the data collection and analysis could therefore be questionable (Polit and Hungler 1987).

The Commission established three sub-groups to consider and make recommendations about particular issues. Firstly, competence for practice was to be considered with a move to a competency framework (using vocational/occupational standards), identifying the elements that constitute competence for practice, practice assessment and methodologies, and the preparation for lecturers. This was to include inter-professional approaches to teaching and learning and the integration of nursing and midwifery into H.E..

Secondly, the entry and exit to nursing programmes were considered with a move towards a multiple entry and exit approach, considering levels of competence and academic award, and fitness for award. The group was to identify the nature of awards and the move to graduate exit.

The third group was to consider the development of collaborative working approaches between the N.H.S. and higher education sector to create an environment that supports improvements in pre-registration education and promotes lifelong learning. Consideration was to be given to the effects of the

N.H.S. contracting process, new technology (for teaching and usage in health services), and recruitment and retention.

Each sub-group was asked to identify the key issues and the strengths and weaknesses of current arrangements and building on best practice. They were also asked to assess the most suitable long-term and short-term policy alternatives. The groups were asked to make recommendations to the Commission for new approaches and their implementation. Interim reports, draft recommendations and refining were carried out by discussion with others in the group. The recommendations which are pertinent to this study are discussed.

The Commission concluded that there were problems with the C.F.P.. The C.F.P. was criticised for being too long, with too much emphasis on adult and acute nursing. This was based on oral and written evidence gathered during the project together with research study findings (May et al 1997; Sainsbury Centre for Mental Health 1997; Norman et al 1996; McEvoy 1995; Cash et al 1994; Elkan and Robinson 1994; White et al 1993). Students within my study agreed with these findings.

The Commission concluded that a one-year C.F.P. followed by a two-year Branch programme would provide a higher concentration within each specialty and more continuity with clinical placements. The C.F.P. will have outcomes for theory and practice comprising 50% theory and 50% practice with accreditation for both components clearly defined. The C.F.P. aims to provide a firm foundation for the rest of the programme. The C.F.P. was to be outcome-based where theory taught will support practice and be shaped by individual student's prior academic and/or experiential learning. During the first year, the programme would provide study skills and information technology training. On completion of the C.F.P. the student, regardless of age, background, experience on entry, or progression will be able to demonstrate achievement of common outcomes. Problems identified within my study, and from the literature reviewed, indicate that these changes were required to address the issues identified by students, qualified nurses and educators.

The Commission recommended that stakeholders in nurse education should agree learning outcomes to cover knowledge, understanding, skills, abilities and values expected of newly qualified nurses and midwives. The U.K.C.C. has defined 'outcomes' that are to be achieved for entry to the Branch programmes and 'competencies' for entry to the Register. The term 'outcome' was used at the end of the C.F.P. as it was recommended that competency would not be achieved by such an early stage in the programme. With the publication of U.K.C.C. outcomes and competencies (Norman 2000: Registrar's Letter 17/2000), Rule 18A(2)(S.I. 1989 No 1456) has been superceded (N.B.S. 2000). In other words the newly-qualified nurse should be competent, i.e. have the skills and ability to practice safely and effectively without the need for direct supervision (U.K.C.C. 1999). Pre-registration education, the Commission argued, should prepare the student to apply knowledge, understanding and skills when performing to the standards required in employment (U.K.C.C. 1998). The term competence can be used "to describe the skills and ability to practise safely and effectively without the need for direct supervision." (U.K.C.C. 1999, p. 35). In other words, students should be fit for practice, fit for purpose, fit for award and fit for professional standing (Appendix VII).

From the findings of the *Fitness for Practice* (U.K.C.C. 1999) report, the newly formed Nursing and Midwifery Council (N.M.C.) (2002b) printed a revised version of the *Requirements for Pre-registration Nursing Programmes*. This report (N.M.C. 2002b) reflected the changes to be made in course structure, and in providing courses with a balance of theory and practice. Students were to achieve practice outcomes by the end of the C.F.P., and practice competencies by the end of the Branch programmes.

From the findings of my study, students had different degrees of supervision and were often assessed by a mentor with whom they had had little contact. Therefore, although the agreeing of outcomes and competencies is useful to standardise nursing students' levels of competence, the actual level of competence will only improve and be better monitored by interested and well motivated mentors, who have time to teach and assess students properly. During

participant observation, students within my study were observed within clinical practice and revealed some areas of competence and incompetence. These are discussed later within codes 7.3 to 7.8.

The Commission concluded that pre-registration nurse education programmes were failing to facilitate the development of practice knowledge and skills. They cited the House of Commons Health Committee (Health Committee 1999, p.31 cited by U.K.C.C. 1999) which stated that Project 2000 programmes have “resulted in nurses’ direct experience with patients being delayed”. The U.K.C.C. Commission for Education (U.K.C.C. 1999) stated that 72% (n=324) of organisations and individuals they were in contact with identified lack of practical experience and basic skills as a weakness of the education programme. During the attitudinal survey, 59% (n=1250) of recent registrants believed that more practice and less theory was required in the first year of their programmes, while only one-third (n=8000) of experienced staff in contact with Project 2000 nurses considered them to be very/quite well prepared in terms of essential practical skills. Eighty-four percent (n=23184) of experienced staff believed that Project 2000 nurses were very/quite well prepared in terms of understanding nursing theory. Therefore, the U.K.C.C. acknowledged there was a problem with the competence of newly qualified nurses (both diploma and degree).

Level required 7.2

During my study, I investigated the perceptions of nearly-qualified students in relation to their preparation for the qualified role. These perceptions will be discussed with the literature consulted on this area.

A study designed to investigate employers’ and qualified nurses’ views of the skills of newly qualified staff nurses from Project 2000 Diploma programmes in Scotland, from June 1997-January 1998, revealed some interesting findings (Runciman, Dewar and Goulbourne 1998). Information was gathered from managers at all levels above charge nurse grades and preceptors – registered

nurses in D-grade to G-grade posts who had responsibility to support newly qualified diplomates in their first staff nurse posts.

Preceptorship was defined by Runciman et al (1998) using the U.K.C.C.'s Registrar's Letter (1993), i.e. the period of support for newly qualified nurses. Preceptors "are responsible for acting as a role model, for teaching and providing feedback, for guiding, supporting and motivating, and for providing new diplomates with opportunities to observe experienced practitioners at work" (Morton-Cooper & Palmer 1993 cited by Runciman et al 1998 p. 17).

In 2003, Robinson et al stated that most of the diplomates and graduates wanted preceptorship on qualifying (97%, n=1462 for diplomates and 94%, n=90 for graduates), and had a large proportion of these students had received preceptorship (85%, n=1090 for diplomates and 90%, n=95 for graduates). However, over one third of both graduates and diplomates who received preceptorship indicated an unmet demand for several aspects of preceptorship, particularly those concerned with the development of new skills. One hundred percent (n=92) of graduates and ninety-nine percent (n=1482) of diplomates rated 'constructive feedback on my clinical skills' as very or quite important. The demand for feedback of clinical skills was higher for graduates (52%, n=406) than diplomates (42%, n=31).

The study was carried out in the N.H.S. and independent health care sectors in Scotland. In the N.H.S. sector, all 15 health boards participated, including hospital and community. At the time of the study only four of 22 trusts/units providing community services had Project 2000 staff nurses in employment. Respondents with knowledge of Adult, Child, Mental Health, and Learning Disabilities diplomates provided information. In the independent sector, information obtained related to newly-qualified nurses in three of the 10 private hospitals in Scotland and in 10 of the 80 nursing homes in one health board area.

Data were gathered from 80 N.H.S. preceptors via a postal questionnaire, from 59 N.H.S. preceptors at audio-recorded focus group discussions (n=17) and from

individual audio-recorded interviews with 43 managers. The managers comprised 25 N.H.S. nurse managers, four N.H.S. practice development coordinators, 10 nursing home managers and four private hospital managers. The interviews and questionnaires sought information regarding general impressions of newly qualified staff nurses, their strengths and limitations, their knowledge and skills, the competence and readiness for employment and about the contextual issues such as employment opportunities and preceptorship. Runciman et al (1998) state that rich qualitative data were obtained from the interviews, while the questionnaires yielded both qualitative and quantitative information. However, the response rate was very low (27%).

Five themes emerged from the data: knowledge and its use, practical skills, managerial and organisational skills, communication and interpersonal skills, professional attitudes and attributes. Runciman et al (1998) state that their findings are strikingly similar to those of Luker et al (1996) who studied Project 2000 diplomates in England. Strengths of the newly qualified nurses included a good theory and knowledge base, with a questioning approach and an interest in research. They were considered to use initiative in taking forward ideas and projects to improve practice, were able to focus on individual needs and circumstances in planning and providing care but also showed awareness of a person's wider social environment. In addition, they proved to be good communicators, and able to contribute within teams. Newly qualified nurses were said to be enthusiastic, committed, confident, well motivated to further learning and had a professional approach, demonstrating an awareness of personal limitations and willingness to seek help. Overall, they were flexible and adaptable.

However Runciman et al (1998) identified two areas in which newly qualified nurses needed a considerable amount of help when first employed: practical skills, and managerial and organisational skills. Although it was generally accepted that nurses could develop specialist skills after registration, there was a consensus that diplomates should have developed a set of core skills before registration. However, Runciman et al (1998) identified the need for consensus

on what constitutes essential and desirable core skills. The authors note that short clinical placements during diploma programmes provided limited opportunities for repeated practice with feedback on core skills, and that the value of such practice was not always recognised by students. Students within my study agreed with Runciman et al (1998) in that they wanted longer placements. However, they also seemed to recognise the importance of repeated practice of skills:

“I felt in all my placements I was just starting to fit in and I was getting to know the routine, when it was time to move on ... I wish I could have stayed longer. ...I wanted plenty of practice at various skills.”

(William, D3)

“I needed to practice aseptic technique even at this stage of my training. Even though I was nearly finished I knew I couldn’t do it right ... or quickly enough. Some things I picked up straight away and didn’t need as much practice ...”

(Sharon, D3)

Although Kathy (UG3) seemed to realise the advantages of repeated practice, she also felt that it was important to gain experience and repeated practice particularly in those skills in which she needed practice:

“... he sent me to do the observations all the time . I could do those ... I needed more practice with other things like catheterisation and admissions ...”

As the participant observation in my study was carried out in the acute areas, I will focus on Runciman et al’s (1998) findings from those areas. Due to the higher throughput of patients within acute areas, a larger number of acutely ill patients and seasonal fluctuations (with the winter months being particularly busy in some acute settings), managers and preceptors were aware of the increase in demands on staff. In these circumstances, the presence of the newly qualified

staff nurse, particularly those in need of a good deal of support, was an added pressure. One manager also reported a reluctance to 'trust' the newly qualified Project 2000 staff nurse and reluctance to give them a free rein to assume the responsibilities of a registered nurse.

Runciman et al (1998 p. 43) found that some preceptors expected more from the newly qualified nurses, for example a "higher level of analysis and assessment". Other preceptors expected "... them to lack experience and not be able just to come in and just do as we had done when we were first qualified". Managers also had a mixed picture of the newly qualified nurses, stating they expected diplomates to pick things up more quickly but found that in fact they needed more support. However, some managers identified that it was an "... unrealistic expectation ... to come in and start functioning from day one." All students within my study expected that they would have a period of consolidation and supervision when they started their first job.

Managers and preceptors of newly-qualified nurses in all care settings commented about the nurses' knowledge and theory base. Runciman et al (1998) concluded that most interview comments were favourable and it seemed that the strength in theory could act as a compensatory factor for the weaknesses in skills in the early stages of employment. Managers and preceptors regarded the ability and willingness to consider an individual approach to care as a strength. An individual and holistic approach to care resulted from the skills of assessment and the ability to use the knowledge acquired from the assessment. Overall, managers and preceptors suggested that newly-qualified staff nurses were aware of the need to consult experienced staff, to admit lack of knowledge and skill, and to seek help. However there were examples of some problems. One preceptor explained that their actions could be "... very much textbook and everything is the way it's written down and they don't take anything else into consideration." Examples of the students' performance in practice within my study demonstrate these positive and negative attributes of newly qualified nurses (see codes 7.3-7.8).

There was a dilemma for the experienced nurse in judging when to allow the new staff nurse to act independently and 'to make her own mistakes'. Safety of patients had to be considered and this could be more of a problem if the preceptor was not readily available.

Lack of practical skills appeared to cause the greatest concern among employers. Runciman et al (1998) acknowledged the lack of definition and used the terms basic, practical, clinical and technical skills interchangeably. During the interviews and questionnaires, managers and preceptors were asked to comment on the practical skills the nurses were able or not able to perform satisfactorily, the factors they identified as influencing nurses' abilities and what measures were in place to deal with skills deficits.

Areas of strength and limitations in practical skills were identified during the interviews of preceptors and managers. Areas such as wound management were regarded as areas of strength. Drug administration was a key concern in the interviews, where knowledge of drugs was regarded as good but the safe administration of drugs (i.e. giving the correct drug, and the correct dose to the correct patient) was problematic in all areas. Preceptors from the adult acute Trusts suggested the need to give more time during rostered service to skills in drug administration. Within my study, interviews demonstrated that diploma students (D3) were "*... dreading the time when they had to give a drug on their own. I am afraid I will give the wrong drug and not know what it is for. The patient might ask me questions ...*" (William, D3). Practical examples of this will be discussed later (codes 7.3-7.8).

A number of procedures that new staff nurses had not undertaken or were unsure about were identified. These included, passing a nasogastric tube, catheterisation, feeding techniques for people with special needs associated with profound physical and mental handicap, suture removal, drain removal, intramuscular injection, intravenous infusion, operating a syringe driver (Runciman et al 1998). During my interviews with individual students, both

diploma and undergraduate students also gave the above examples of practice which they had not observed, and/or practised either enough or at all.

Runciman et al (1998) found that there appeared to be an expectation that those areas in which 'high-tech' equipment was used, such as intensive care and theatres, new staff would not come equipped with the necessary skills. As a result in these areas they would be supervised closely and taught 'on-the-job'. Knowing the theory of the procedures and indeed having the opportunity to carry out the procedure was regarded as a baseline requirement in skill acquisition. Mastery of the skill and procedure is dependent on repeated practice in a range of situations. It was suggested that the value of repeated practice in developing skill was not sufficiently recognised by students (Runciman et al 1998). In contrast, students (UG3 and D3) within my study expressed concern at the lack of opportunity to carry out repeated practice of skills, despite having had the theoretical input for the skill. However this inconsistency between my research findings and that of Runciman et al (1998) was perhaps due to responder bias (Polit and Hungler 1995).

"... I just haven't seen anybody being catheterised. How am I supposed to get the practice when the situation isn't there? ... I think I will feel terrified when I get left to do it or staff expect me to be able to do it once I am qualified ..."

(Cameron, UG3)

However, Glen (2000) questions the practical exposure students get within a nurse education programme. She argued that students' exposure to and practice of skills should be planned (Spouse 1998), and students should not be forced to undertake repeated practice of 'fundamental' skills when they should be practicing more technical areas of care.

In agreement with other research (May et al 1997; Luker et al 1996), Runciman et al (1998) found that many of the managers and preceptors noted that this initial lack of practical skills was quickly resolved.

Influences 7.2

Practice staff influence on students' learning and standard of practice continued to be apparent. During participant observation, I witnessed a number of episodes of care in which there was a clear influence on the student's behaviour and practical skill.

For example, a patient had developed a pressure blister on their left heel. Janette (D3) had found this the previous day and had documented that a blister was present. However, when I questioned the student further the holistic care of the patient was haphazard. I asked the student what the patient's pressure areas risk assessment score had been, but it had not been completed for six days. She scored the patient's risk assessment and noted that the patient's pressure area risk assessment score had changed from nine to 15. Neither the size of the blister nor the state of the surrounding skin had been documented. Following a discussion with the student, I stressed the need for pressure-relieving equipment to be used, monitored and evaluated. However, when the student asked the ward sister about a higher-grade mattress, she was told that there was none available. The student did not question this. I intervened and explained the situation to the ward sister and the patient received a mattress from another ward.

During this observation, I realised how difficult it was for students to carry out holistic care for the patient when they lacked supervision, feedback and good role models on which to base their practice. Although the student knew that the mattress was going to be beneficial for the patient, there was still a problem in being assertive with that knowledge with the ward sister. The influence of the ward staff, the clinical learning environment, and the need to fit into the nursing team was apparent. Again, documentation within the ward area was problematic and the student had obvious difficulty realising what was required when practice staff had not been carrying out 'best practice'.

One of the undergraduate students also expressed that staff often over-ruled students' requests even although they and the student knew it was best practice.

For example, Molly (UG3) assessed a patient with chronic pancreatitis. The patient was complaining of pain, and Molly asked him to describe it to her. She asked about the effectiveness of his analgesia, how long the pain had been there, and what intensity it had. She explained to me that she thought he was in pain, and felt that pain should be 'what the patient says it is'. She questioned the use of six-hourly analgesia, when there was no reason why the patient could not be getting the analgesia four-hourly. She explained that the effectiveness of the drug used was within the four-hour timeframe. Molly approached the staff nurse who phoned the doctor for a change of prescription. The analgesia prescription was changed, and the drug was administered to the patient. Molly explained afterwards that she had asked this before and she had been told to tell the patient that he would need to wait. She felt it had been changed because I was observing practice. Molly stated that she had learned from this experience – that the patient's pain needed to be believed and a nurse has to have good understanding of the actions of drugs, and should be assertive enough to act as the patient's advocate.

Problem-solving skills 7.4

During participant observation, there were a number of clinical problems which presented themselves to students.

During the one of the first observations I carried out, I was observing Carole (D3) within an acute surgical area. One of the patients had undergone unsuccessful surgery for a pancreatic tumour the previous day. During the patient's bed-bath, Carole took the opportunity to interact and build a relationship with the patient. However, when Carole renewed the patient's I.V. fluid bag, she duly recorded this on the fluid balance sheet and fluid prescription sheet, but failed to recognise that the patient had only passed sixteen millilitres of urine in the last two hours while she had been on duty. I pointed this out to Carole who expressed concern, but could not solve the problem independently. I explained that it would be important to look at the fluid balance chart for the previous day and night, check the patient for signs of fluid overload (she had had

four litres of fluid during and after surgery), and commence recording of hourly urine volumes. Carole could identify the signs of fluid overload when asked about this. She later referred the patient to the doctor when urine volumes remained at less than thirty millilitres per hour and the patient had become chesty. I also had to prompt Carole to document her actions, but she was unsure what to write.

Due to the rapid growth in information technology within practice and education (D.O.H. 1999; Warner et al 1998; D.O.H. 1994), the N.H.S. Executive (1999) stated that nurses must be competent in the use of information technology to improve care provision and for professional development. The U.K.C.C. Commission for Education (U.K.C.C. 1999) also concluded that information technology should be available for students to use in practice and in academic settings. Students should develop information technology skills to assess health care needs and record care provision, and should also develop an understanding of the ethical and legal issues surrounding information technology in practice. All of the diploma students had problems with achieving accuracy of documentation of the care they had provided. They stated that they had had problems accessing patients' records within this acute area because the patient records were held on computer, to which they were denied security access. The diploma students complained that this had reduced the amount of practice that they could have. Therefore their care planning skills and general knowledge of the patient were sometimes patchy.

While observing William (D3), he was asked to go on a ward round for the team which he was leading. Initially he had refused, stating that he was not sure of what to say, what to document, or how to make referrals or appointments. He was on the ward round and was asked about a patient who was near to discharge. He did not know the patient's social history – the patient was from a nursing home and the discharge process could have been quicker since there were nurses in the nursing home available to dress the patient's wound. Following the ward round, any referrals had to be made by a qualified nurse who had access to computer files. Therefore, William (D3) did not have the opportunity to

discharge patients, and consequently had not developed the necessary skills to do this. All diploma students stated that they had no idea what information had to be given for each referral.

Helen (UG3) referred a patient with newly-diagnosed oesophageal cancer to the dietician for a soft diet. She passed on information about the patient's diagnosis and prognosis, his previous and current dietary intake/problems, and other relevant physical history such as weight and Body Mass Index (B.M.I.). Helen included the patient's social and psychological history.

One of the diploma students (Maureen, D3) was observed within an emergency/elective orthopaedic ward. Although she was not acting as team leader, she stated that she had had experience of it in previous semesters. On several occasions during the observation, she consulted the team leader for information on what was needing done within the team. During observation of nursing procedures, her manual dexterity was excellent. However, providing rationale and explanation of events/interventions was somewhat difficult. Maureen explained that she did not know if there was anything interesting for me to observe because she had been left "*just to do the obs*". This involved vital sign recording of specific patients within the team. One patient, Mrs X, an elderly lady, had undergone surgery the day before. Maureen could not tell me what operation she had had. She took the observations of Mrs X, during which time Mrs X was pale, sweating, confused, agitated and uncooperative. Vital signs (i.e. blood pressure, pulse, respiration and temperature) appeared stable using the automated blood pressure monitor. Maureen documented this and went to move to the next patient.

I questioned Maureen as to her overall impression of Mrs. X's condition. She recognised that she was confused and agitated. However, I suggested to her that she had pulled her oxygen mask off, she was agitated, confused and uncooperative with staff – what did that suggest? Maureen could tell me nothing of Mrs. X's social background (e.g. housing, staying alone, shopping, cooking, cleaning), previous medical history (e.g. osteoarthritis, but no other serious

medical conditions before hospitalisation for hip replacement), or nursing problems which had been identified post-operatively. Upon further investigation, there was no mention of Mrs. X becoming agitated and confused, and her admission notes suggested that she had been lucid on admission. Mrs X had not been referred to medical staff.

I advised Maureen to check Mrs X's pulse manually for irregular rate, and also her oxygen saturation. Maureen found that the patient's pulse was irregular and her oxygen saturation was 76% (normally >90%). I asked Maureen what she would do next, and she stated that she would get the patient to keep the oxygen on and then she would recheck her oxygen saturation. I advised her to contact medical staff. However, Maureen was unsure how to explain what was wrong with the patient. Following medical assessment, an electrocardiograph (E.C.G.) and full blood count (F.B.C.) was carried out. A cardiac arrhythmia was identified, and the patient was found to be anaemic for which she was given four units of blood. My observations of Maureen made me aware of the inadequate knowledge and problem-solving skills of the effects of anaemia, and subsequent hypoxia and cardiac arrhythmia. Although Maureen had the manual dexterity required to carry out the skill of measuring and recording vital signs, there was an obvious lack of understanding of vital signs and this relationship to the patient's underlying conditions.

Another example of the difficulty diploma students had in developing problem-solving skills, was that provided through participant observation of June (D3). June was working within a male, elective surgical unit. A patient (Mr. Y) with diverticular disease was in the ward for investigations of abdominal pain. Mr. Y appeared to be in pain. June identified this using non-verbal cues and when she asked the patient, he stated that he did have abdominal pain. June asked the qualified nurse (doing the drug round) to issue analgesia. I asked June if she had felt that she had assessed the patient's pain. She asked me what I would have done. I advised her to go back and fully assess the patient. On examination Mr. Y had a swollen abdomen, but she was unable to identify the bladder as a possible cause (as he was in for bowel investigations). I advised her that the

bladder was in that region, and due to the advanced age of the patient, it was possible that he had a retention of urine. We scanned his bladder which revealed one thousand millilitres of fluid. Mr. Y was catheterised and commenced on a fluid balance chart. I advised her to document the above.

The mentor did not work with any of the students during the participant observation so I was unable to assess their input into the level of support and supervision provided. However, there did appear to be aspects of the qualified role, such as documentation, which students appeared less comfortable with. In the above example, June made no reference to the guidance (or not) she had received from mentors. Later June stated that this was an example of where she could find practice difficult when qualified. She described it as “ *‘lateral thinking’ – of taking everything into account and using a problem-solving approach.*”

The undergraduate students (UG3) also experienced clinical problems, but appeared to recognise these problems and find solutions to them. For example, Cameron (UG3) asked a young, male patient (Mr. C) if his patient-controlled analgesic device was effective for the pain associated with his recent abdominal surgery. Cameron asked the patient pertinent questions, such as where the pain was, whether Mr. C had had pain like this before, and whether Mr. C thought that his analgesia was effective. Mr. C expressed that the analgesia had been effective but had ‘worn off’. Cameron checked Mr. C’s intravenous line and found that the vein had collapsed. He explained to Mr. C that the drug was ineffective because the vein being used to administer the analgesia had collapsed. Cameron (UG3) contacted the on-call doctor and intravenous access was re-established and later, Cameron re-checked the effectiveness of the device.

Overall, undergraduates did not express any apprehension about being able to solve clinical problems.

According to Whiteside (1997) and Reilly and Oermann (1992), clinical decision-making and the ability to make clinical judgments requires knowledge of the clinical situation, and the knowledge of appropriate strategies for effective problem-solving. In other words, in order for the student to make a correct and effective clinical decision, they must be able to recall relevant knowledge and in turn, translate and interpret that knowledge in the light of particular situations (Oermann 1998; Wink 1993). However, Myrick and Yonge (2002) argue that this critical thinking ability depends on the mentor asking questions that will promote this ability to make clinical decisions. Oermann (1997) and Wink (1993) suggests that the mentor should assist the student to ascertain which knowledge is unnecessary or irrelevant, and to focus on cues that point to significant pieces of information. As the student interprets the situation, they should be analyzing the data and developing a nursing diagnosis to make action plans (Myrick and Yonge 2002).

Therefore the questions students are asked by their mentors may have a profound effect on the student's level of critical thinking and consequently, the effectiveness of their clinical decision-making (Oermann 1997). As already discussed, the level of questioning is also important (Bowling 1979 cited by Myrick and Yonge 2002), and this could account for the difference in decision-making skills between diploma and undergraduate students within my study. Perhaps undergraduates have a better ability of applying their knowledge to clinical situations because of their increase level of knowledge/theoretical input within their educational programme, but could also be caused by mentors asking higher level questions of them than diploma students. However, these hypotheses have not been supported or refuted within the nursing literature.

Managerial skills 7.5

Runciman et al (1998) had identified that newly-qualified nurses had poor managerial skills. All students within my study identified the importance of having managerial skills including “... *managing the patients' care on your team*

...” (Sharon UG3), “... *delegating, ... giving priority ..., managing time ...*” (Carole, D3).

During the participant observation phase of the research, I observed Carole (D3) within an acute surgical area. She explained that she had never been a team leader before, but the nurses had decided to allow her that experience since I was coming in to do research. Throughout the observation, Carole demonstrated some positive aspects of practice, including very good communication skills and rapport with patients. Observing Carole during this time of being a team leader was particularly useful in seeing some of the problems students experience with unsupervised, undirected, and poorly planned experience. During the time I observed her, she was unaware of what the nursing auxiliaries were doing or where they were, nor did she direct them to carry out specific duties. She had no idea what had been done or what still had to be done within her team. At one point another team had started to use one of the auxiliaries for their team! There was no evidence of prioritising of care within the team. Carole found that delegating to others was difficult for her, but since she had never been a team leader before, this had not been addressed.

Molly (UG3) was the team leader during the time I observed her. She stated that she had carried out this role for some time, and had developed some experience of it:

“... I got to take a team in most of the placements I have been in during fourth year. This is our management module, so it is what I am supposed to be doing. ... at first I found delegating to auxiliaries quite difficult, but I have to do it ... I try to be fair. My mentor here showed me how to keep track of my work as the team leader. She says I have developed my management skills while I have been here”

During my observation of Molly (UG3), she demonstrated that she could prioritise patient care, delegate work to others and demonstrated a good knowledge of the patients within her team. However, I think this obvious

difference between Carole (D3) and Molly (UG3) could have been due to the experience Molly had of being a team leader. Also, the undergraduate programme specifically named this module 'management module' while the diploma programme named this 'rostered service'. Therefore, the practice staff may have been influenced by the naming of each module.

Nursing procedures 7.6

Many students identified areas in which they felt very competent (e.g. wound dressings and aseptic technique), but there were many nursing procedures where they identified shortfalls in their competence. In contrast to Runciman et al's (1998) findings, undergraduate (UG3) and diploma students (D3) stated that they lacked knowledge of actions and side-effects certain drugs, and diploma (D3) students stated that they were having difficulty administering drugs. However, undergraduates (UG3) did expect to have a better understanding of the actions of drugs than diploma students. Both diploma and undergraduates identified some degree of apprehension with regard to administering drugs:

"I don't have a huge amount of experience in it. ...with the names of drugs changing constantly you need to be doing them all the time to keep up-to-date. I am sure it will be a steep learning curve when I qualify. I think you get supervised for the first few days before you break out on your own – I am sure I will be looking at the B.N.F. [British National Formulary] until I get to know them and what they are."

(Helen, UG3)

"... I am dreading it ...there will be no one there to check you are doing it right. I hope I don't make a mistake ... I don't really know what many drugs do or why they are given ..."

(Alistair, D3)

"... I think having a degree will give you a better understanding of why you are giving a drug and ... I will be able to explain that to patients. I suppose it will take a bit of time before I can do that without

having to double check every drug ... the drug round will take me ages at first!"

(Jonathan, UG3)

All students expressed the difficulty in practising nursing procedures within clinical areas:

"... a lot of the wards you go to you just don't get to do the nursing procedures. You are a pair of hands. You are an auxiliary. You don't get to do anything. I feel that ...there are a lot of things that I have not done or even seen."

(Maureen, D3)

Nursing students in other studies have identified the lack of practice of nursing procedures. For example, Roberts (2001) stated her lack of practice at certain skills:

"...I can make beds – 15 in half an hour – but I can't monitor blood glucose levels. I can admit patients, but please do not ask me to discharge any of them. I can bed-bath a patient, but don't ask me to join the doctor's round"

Maureen, Caroline and William (D3) experienced difficulty in carrying out the administration of a blood transfusion, and in the care of the patient receiving the blood transfusion. Caroline (D3) stated that she had only ever observed a nurse administering a blood transfusion, and she wanted to have *"... lots of practice at it. Someone will check it with me and I should be able to do it. I suppose I need to see and do as many as I can ..."* None of the diploma students could identify the signs of sensitivity/reaction to blood, and none remembered that there could have been a life threatening reaction to blood. Only one of the undergraduates was involved in the administration of blood. Jonathan (UG3) identified the need for close observation of the patient due to the risk of anaphylactic shock and other reactions. He explained that temperature and pulse should be carried out every hour to assess for early signs of a reaction.

Students identified the lack of repeated practice as a major issue affecting their competence. They realised that practice skill developed with repeated practice. Many complained of only observing or participating in clinical skills 'once or twice', with little or no demonstration or supervised practice offered. Again demonstration, and supervised practice leading to independent practice were seen as an appropriate teaching strategy employed by good mentors.

An interesting study carried out in Sweden in 1999 (Ohrling and Hallberg 2000a and 2000b) used a phenomenological approach to understand the student experience of preceptorship within hospital wards. Tape-recorded interviews of 17 students' lived-experience of the preceptor-preceptee relationship were carried out. Their experience of learning revealed three themes. These were (a) directed learning; (b) learning in practical action and (c) feeling in learning.

Thirty-two students from one final year class in Sweden were given oral and written information explaining the nature of the study. All consented to participate in the study. The authors fail to state how the volunteers were sampled and therefore could be open to interviewer bias (Polit and Hungler 1995). Within Ohrling and Hallberg's study (2000a), students also stated that there was a need to move their learning towards increasing competence and also the responsibility associated with that competence. This involved negotiating their learning experience to suit their own goals and being able to depend on their preceptor as the need arose. Ohrling and Hallberg (2000a, p. 19) stated that:

"The dependence was seen as positive for students' learning when the preceptor could see, understand and react to their dependence. It seemed to follow maturation in action, and when the student nurses felt more confident in action they became more independent."

Students within my study also wanted their mentor to be supportive in their learning by allowing them to carry out skills independently. However, if this independence was given too quickly, the students felt stressed and lacked in self-

confidence. If students were given this responsibility too slowly, they felt that their mentor did not feel confident in their ability. Developing a positive self-concept was reliant on students feeling confident to carry out the skill and the mentor seemed to have a major impact on the development of the students' self-concept.

Pierce (1991) used 29 first-level and 15 second-level undergraduate nursing students at the University of Columbia, to investigate their experience of preceptorship and to assess the differences in perceptions between the two levels of students. Data was collected via an anonymous questionnaire, which used open-ended questions. The author does not document any methods employed to assess reliability and validity of the questionnaire, thus making the questionnaire susceptible to bias. Due to the small sample size and limited geographical location, the results are not generalisable.

A number of findings were noted, but it is interesting to note that the perceptions of the first-level students were different to the second-level students. First-level nurses were keen to 'feel like a nurse' and to 'see the real world of nursing'. As students became more experienced, there was more emphasis on the student having independence, but at the same time having enough access and direction from the preceptor when required. Second-level students wanted to learn something new, and have a planned experience, including planning patient's care, and wanted to feel that they had organised care effectively. Pierce (1991) recommended that the role of the preceptor through the professional socialisation of the students warrants further study.

A few Canadian studies have evaluated the effect of a pregraduate preceptorship programme on the competence of baccalaureate students (Laschinger and MacMaster 1992) and on the transition to the professional nursing role of diploma (Jairath, Costello, Wallace and Rudy 1991) nursing students.

Jairath et al (1991) used a quasi-experimental study to determine the effect of a 17-week pregraduate preceptorship programme upon diploma nursing students' (n=22) performance of the professional nursing role. The sample consisted of 22 consenting nursing students from the final-year three-year diploma programme. Nine students selected the preceptorship programme (i.e. the experimental group) and 13 student volunteers received the standard clinical experience (i.e. the control group). How the sample was chosen is not considered, thus making the sample susceptible to bias (Robinson 2002).

Appraisal of student performance was done via the faculty advisor and student self-appraisal. Student self-appraisals were carried out at zero (i.e. prior to), four, and 17 weeks, and the faculty advisor appraisals were at four and 17 weeks. Performance of the professional nursing role was measured using the 6-D Scale (Schwerian 1978 cited by Jairath et al 1991). Its six subscales measured nursing performance within the domains of leadership, critical care, teaching/collaboration, planning/evaluation, interpersonal relations/communication, and professional development. Although the developer of the scale previously established test-retest reliability and content validity, Jairath et al (1991) did not test these aspects on their sample of students. Thus, there is a lack of proof of reliability and validity of the scale for this sample (Polit and Hungler 1995). Also, the authors do not describe each domain nor do they discuss how each domain was measured. Therefore the authors claim to have measured, for example, 'professional development', but the reader is unsure what this term actually meant or how the domain was measured. Again the reliability and validity of the scale would therefore be questionable (Polit and Hungler 1995).

Scale and subscale scores over time were analysed using *t* tests and analysis of variance (ANOVA). From the faculty advisors' perspective, the preceptorship programme had some benefits. Changes in the teaching/collaborating subscale demonstrated that the experimental group had significantly higher scores than the control group by week 17. From the students' self-appraisals the preceptorship programme was not associated with significant increases within the experimental

group compared to the control group. The authors concluded that there appeared to be no consistent pattern regarding the effects of preceptorship programmes on nursing performance. They recommended further research to consider the effects of preceptorship programmes as they were costly as well as labour intensive. However due to the lack of proven reliability and validity of the scale, I would question whether the authors were actually measuring the correct domains. Perhaps other aspects of the students' performance or indeed other aspects of their self-appraisals would have been effected by the preceptorship programme.

Laschinger and MacMaster (1992) compared student perceptions of nursing practice and recorded student self-ratings of skill on learning competencies prior to and following a senior preceptorship experience. A convenience sample (n=50) of senior students of a Canadian four-year basic B.S.N. programme were selected. Twenty students were available for the pre and post-tests. Students were placed on the same rotation as their preceptor, although the authors do not state if this is common practice within the placement areas.

Two instruments, the Adaptive Competency Profile (A.C.P.) and the Environmental Press Questionnaire (E.P.Q.) were used. However, the authors fail to provide the developmental source of these questionnaires. The A.C.P. asks subjects to rate their level of skill on each of the 20 competencies on a seven-point Likert scale. Laschinger and MacMaster (1992) state that the developers of the A.C.P. tested and provided evidence of construct validity. However this difficult to prove since the authors fail to state the source of A.C.P. development. Reliability coefficients for the A.C.P. within this study ranged from 0.69 to 0.80.

The E.P.Q. was developed to measure environmental press perceptions of learning environments. Respondents rated the importance of each of the 20 competencies within the A.C.P. using a seven-point Likert scale. Reliability coefficients for the E.P.Q. ranged from 0.68 to 0.79.

Laschinger and Mac Master (1992) present the results in the form of a table. Differences in pre and post-test preceptorship scores reflect some of the effects of preceptorship in terms of the adaptive competencies and the students' perceptions of the importance of these competencies. Students rated themselves higher on all competencies following the preceptorship experience. The authors state that 'most' competencies showed a significant increase post-test. However, only eight of the twenty competencies showed a statistically significant increase within the E.P.Q. (i.e. $p < .05$). Competencies, such as the 'testing of theories and ideas', 'creating new ways of thinking and doing things', 'experiencing new ways of doing things', 'making decisions', showed statistically significant results within the E.P.Q.. This meant that students had ranked these as being important competencies. However, students did not rank other competencies with as much importance. These included 'being sensitive to people's values and feelings', 'gathering information', 'choosing the best solution', and 'setting goals'.

Using the A.C.P. students rated their level of competence to be statistically higher in 11 of the 20 competencies. These included competencies, such as 'gathering information', 'organising information', 'dealing with people', 'choosing the best solution' and 'being personally involved'. There were discrepancies between achieved competencies and the perceived importance of them (although the authors did not note this). Therefore in some cases competencies were rated as being achieved but were not seen as important (e.g. building conceptual models), while some competencies were rated as important but were not achieved (e.g. 'creating new ways of thinking and doing things'). Some competencies were achieved and were viewed as being important (e.g. 'testing theories and ideas'). The authors concluded that preceptorship had "significant effects on senior students' adaptive competency development" (Laschinger and MacMaster 1992, p. 263). However, I would question the accuracy of this statement due to a number of factors. Firstly, the study used a small sample size in one year of a B.S.N. programme in Canada. Therefore the results could not be generalised to the rest of the nursing population. Secondly, the source of development of the A.C.P. and the E.P.Q. was not given within the reference list of the article. This potentially could bias the findings as it is not

clear how these scales were developed. Thirdly, from the results it would appear that students rated themselves and the importance of each competency such that there were a few discrepancies between achieved competencies and level of importance given by students. Fourthly, the authors do not suggest ideas to improve competence and the perceived importance of certain competencies that would seem imperative to nursing (e.g. 'being sensitive to people's values and feelings). Fifthly, the changes in perceived importance and actual competence could have been due to the experience gained in placement or other factors rather than purely the effect of the preceptor. The authors make no recommendations for future research, but using two groups of students, one group having a preceptor and one group not, would allow the researcher to compare these values which may be attributable to preceptorship.

However Laschinger and MacMaster (1992) did raise an important issue. The effect of preceptorship on students' competence does need to be further researched and evaluated.

Communication skills 7.7

Diploma and undergraduate students had built a good rapport with patients and staff in the wards I visited. Verbal and non-verbal communication was very good. However, undergraduate students (UG3) were more confident in providing health education, information to the patient about the disease process and progression of care.

7.8 Research-based practice

Ashworth and Longmate (1993) stated that the implementation of Project 2000 had brought an increased focus onto nursing theory. They stated that "given the relatively short exposure to clinical settings, every experience must be made rich for the student: rich with meaning, not just rich with unreflected incident." (Ashworth and Longmate (1993, p.327). They argued that theory is not inseparable from practice since it informs the nurse's interpretation of events and

builds experience. Therefore theoretically-driven practice must be taught along with reflective skills within Project 2000 (Prymachuk 1996; Ashworth and Saxton 1992).

Diploma students exhibited some very good research-based practices. While observing, Marie (D3) explained why she was using a particular wound dressing and discussed the need for aseptic technique. Her motor skills were excellent, but she had to be reminded to carry out documentation of that care. She expressed anxiety and lack of experience in documentation, since in the wards she had worked in she had documented care at the end of each shift (often documenting care which was not actually carried out by herself). The patient had a necrotic area on the right heel – the presence of the pressure sore had been noted within the nursing notes, but its size, black/red areas, and pus, had not been documented. Therefore Marie (D3) did not observe ‘good’ research-based practice, and the standard of documentation of care was poor. Hence, Marie (D3) did not have ‘good’ standards on which to model her practice.

Overall, in areas where practice was research-based, students witnessed and experienced good standards of nursing care. However, there were cases where students were being shown or told to carry out nursing care which was not based on evidence of good practice.

4.6 Summary of individual interview and participant observation coding (end-point)

Constant comparative analysis of the data collected and analysed during this stage produced seven categories. Professional self-concept (Kelly 1992a) emerged as the core category to these seven categories. Figure 25 (p. 344) represents the two-way links between the categories. A description of each code, category and core category continued to be produced in the form of a memo, thereby providing an audit trail of the coding process. The grounded theory developed is described using the categories identified with the integration of the core category.

1. **“Confidence to go out and do” (Anne, D1):** By the end of the programme, undergraduate students (UG3) seemed more confident than diploma students (D3) about making the transition from student to staff nurse. The verbatim statements made during the course of the interviews supported this. During the participant observation, this confidence was evident. For example, the undergraduate students gave more information about disease processes to the patient than diploma students did. Professional self-concept is influenced by the perceived success in professional tasks (Freilburger 2002; Arthur and Thorne 1998; Kelly 1992a), leading to a feeling of self-efficacy (Bandura 1977). Feelings of positive self-efficacy can be enhanced by enactive mastery of experiences, using good role models to influence practice, verbal or social persuasion, and the student’s psychological state (Bandura 1977).
2. **Clinical learning environment:** This was a major source of stress and apprehension for all neophyte students. All groups (D2, D3, UG2 and UG3) stated that the clinical learning environment had had a major impact on their level of practical competence, and ultimately affected their professional self-concept.

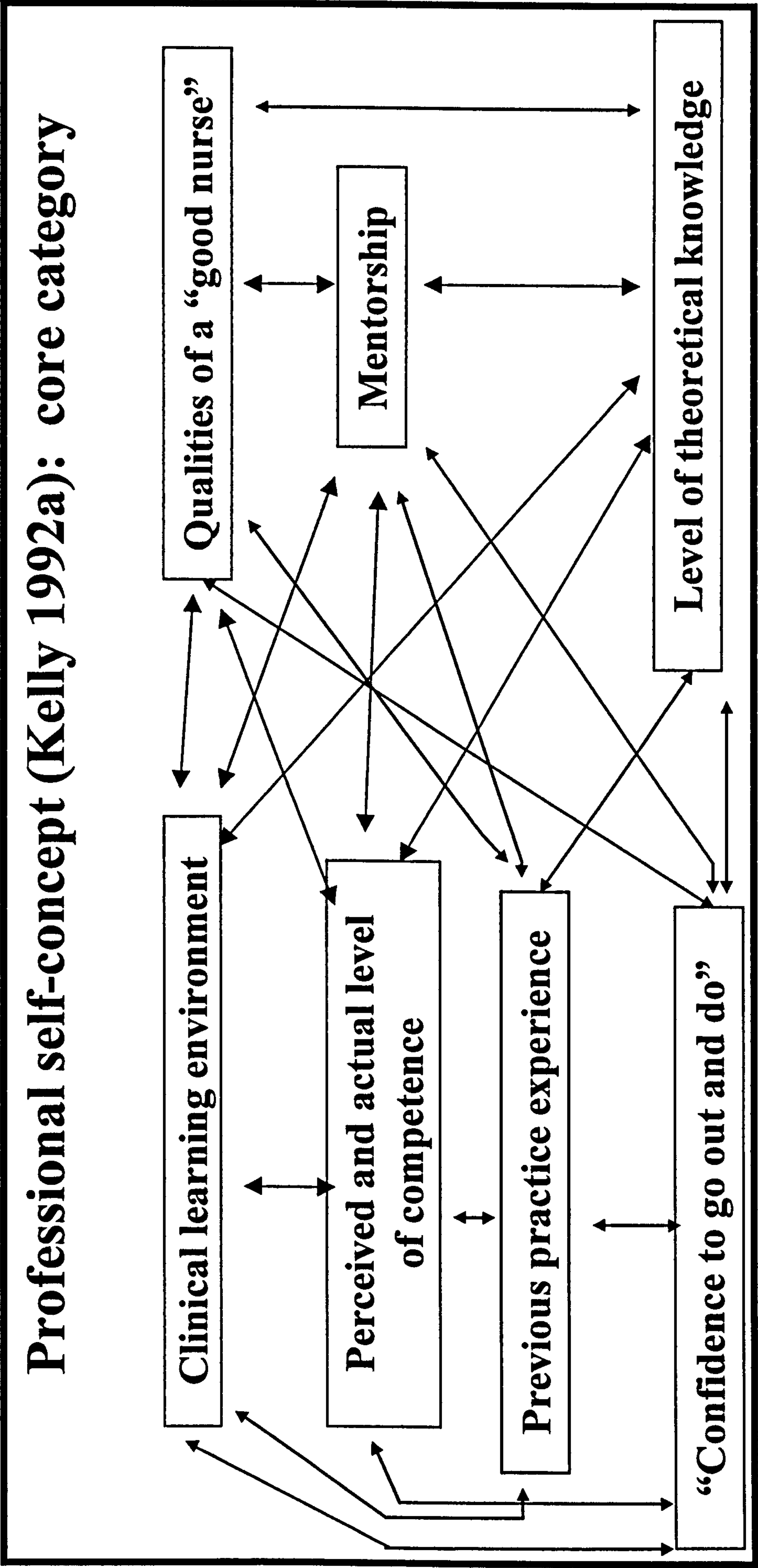
However, there was inconsistency in the quality of experience available throughout both programmes, due to variations in clinical staffing levels, and variations in the amount of qualified staff available, leading to different levels of supervised practice. There appeared to be poor development of diploma students’ (D3) management and leadership skills within rostered service.

3. **“Good nurse” (Lorna, D1):** Students wanted to have the qualities of a “good nurse”. They identified various areas that they felt would be important qualities. All students stated that they had learned from examples of a “good nurse”. Observing qualities of a “good nurse” provided students with a good role model on which to base practice attitudes, behaviours, knowledge and

skills, thereby affecting the students' professional self-concept (Kelly 1992a).

4. **Level of theoretical knowledge:** Neophyte students wanted to experience clinical practice as early as possible in their programmes. Undergraduate students (UG2, UG3) stated the benefits of theoretical preparation to degree level, including a better understanding of patients' conditions, development of a questioning approach to practice, and a good understanding of research. Diploma students (D1, D2, D3) agreed that undergraduates would have a better theoretical understanding, but felt they would lack the practical skills of a diploma student. It has been argued that if students' knowledge is poor, they will be incompetent and lack in confidence (Davidhizar 1991). Observing students during participant observation demonstrated that the undergraduate students had a better level of theoretical knowledge than diploma students. As diploma and undergraduate students expected, undergraduates demonstrated a deeper knowledge-base than diploma students.
5. **Previous practical experience:** All students complained of 'bad luck' when they had been sent to practice placements that were not 'good'. The standard of teaching, role modelling, the availability of and interest of trained staff were major factors influencing the student. When students (D2, D3, UG2, UG3) completed placements within these poor-quality areas, they were concerned about their lack of competence to practice, especially as they got closer to registration. However, when students completed 'good' placements, they stated that they felt confident in their own ability, and compared themselves positively against other students. Therefore, the student's professional self-concept was affected by the quality of their previous placements.

Figure 25: Theory development: core category and the links between categories



6. Mentorship: All students had had experience of good and bad mentors. They explained how this had affected the integration of theory and practice, had ‘shaped’ their learning experience, and had resulted in different degrees of supervision and feedback. Positive constructive feedback has been shown to improve performance (Wood and Bandura 1989), but too much can result in overconfidence (Kissinger 1998). The questioning skills of mentors may influence the development of critical thinking and consequently, influences effective decision-making (Myrick and Yonge 2002; May et al 1999; Phillips and Duke 2001; Boychik 1999; Schell 1998). Undergraduate students (UG3) seemed more able to solve clinical problems than diploma students (D3). However, the more effective clinical decision-making skills demonstrated by the undergraduates could be explained by the questioning technique used by mentors and/or could be explained by the additional theoretical knowledge of the degree programme.

Students explained that they had experienced feelings of fear, pressure and stress of work, worry, lack of confidence, and were ‘used as a pair of hands’ by mentors. They had experienced negative and positive attitudes (e.g. enthusiasm and motivation to teach (Dolan 2003)) from mentors. When the level of mentorship was poor, students’ professional self-concept diminished, thereby reducing the students’ confidence and willingness to carry out skills (Appelbaum and Hare 1996).

They felt that role modelling was a good way to learn, but it was not always their mentor who acted as a role model. They were often disappointed by the lack of availability of mentors especially within acute areas due to shift work, holidays and internal rotation. None of the students mentioned the role of the lecturer within practice.

7. Perceived and actual level of competence: All students at the mid-point of their programme explained their anxiety as to their lack of practical skills,

and the lack of opportunity to link theory to practice. Undergraduate students (UG1, UG2, UG3) felt that they were much more able to understand what, why and how they were doing practical skills than diploma students. However, diploma students (D1, D2, D3) felt that they were much more able to carry out a wider variety of skills and were more competent at carrying out that skill than undergraduate students.

Findings from participant observation indicated that there were varying degrees of competence between undergraduate and diploma nursing students. Diploma students (D3) exhibited the manual dexterity required to carry out nursing skills, but there was a lack of problem-solving skills and linking of theory to practice. Both groups identified administration of medicines as a shortfall in their competence. However, not obtaining adequate supervision and lack of repeated practice of skills were reported in my study as causes of the lack of competence of newly-qualified staff nurses. Undergraduate students (UG3) were much more confident in providing health education, information about the disease process and the progression of care.

Diploma students had the manual dexterity to carry out a clinical skill but often demonstrated a lack of understanding and the problem-solving skills associated with the task. In contrast to the beliefs of earlier groups, undergraduates within my study did not demonstrate a poorer level of practical skill than diploma students. From my observations, undergraduates were able to apply theory to practical problems/situations and to practical skills. Overall, undergraduates (UG3) demonstrated a deeper theoretical knowledge and a better level of competence to practice than diploma students (D3).

Overall, diploma students (D3) appeared to have a perceived level of competence which was higher than their actual level of competence. Undergraduates (UG3) however, tended to rate diploma students as having a better level of practical competence. During this study, I did not observe this, and in fact, found that the undergraduates (UG3) had a higher level of

both theoretical knowledge/understanding and practical ability than diploma students.

Arthur and Thorne (1998) researched the differences in professional self-concept between nursing students. The Professional Self Concept of Nurses Instrument (PSCNI) was developed by Arthur, and applied to samples of undergraduate in second (n=32) and fourth (n=27) year of a four-year programme, post-basic (i.e. traditionally trained') (n=28) who were enrolled on a Bachelor of Science programme, and graduate students (n=28) who were enrolled in a Master of Science programme in a Canadian university nursing programme. The sample represented a response rate of approximately 50%.

The PSCNI contained a 27-item instrument reflecting three scales or dimensions: professional practice; satisfaction; and communication (Arthur 1995 cited by Arthur and Thorne 1998). Respondents were asked to rate each item on a Likert-type scale of one (disagree) to four (agree). Reliability coefficients are provided for each of the three scales.

Following one-way analysis of variance testing, Arthur and Thorne (1998) demonstrated that those with more experience and particularly those pursuing a Masters degree, had a statistically significant difference (i.e. had a stronger professional self-concept) in terms of professional practice, particularly when compared to undergraduate students in year two who had little nursing experience. The fourth year undergraduate students had the lowest level of satisfaction. There were no significant differences found in communication.

Arthur and Thorne (1998) stated that the study demonstrated that as students progressed through their educational programme and then onto the qualified role, their professional self-concept became stronger. They also suggest that students from different academic programmes may demonstrate differences in professional self-concept. The findings of this study support the findings from my study.

Arthur and Thorne (1998) warn against generalizing the result due to the small sample size used. They also suggest further study of the PSCNI and other instruments that quantify professional self-concept.

Having produced a summary of the data collected, I used outsider validation to confirm or refute the emerging categories.

4.7 Outsider Validation

In addition to a conference presentation (Appendix VIII) and paper (Donaldson and Carter 2001), outsider validation was achieved by distributing a short summary of the findings (Appendix IX) to 15 undergraduates and 15 diploma students, who were within two months of qualifying as a Registered Nurse (Adult) from the same institutions used in the main study. For ease of distribution, a postal questionnaire was used to gauge responses to the theory.

Response rates were 40% (n=6) for undergraduates and 20% (n=3) for diplomate students. One of the difficulties of distributing the postal questionnaire was that the students were on placement. The questionnaires were sent to their placement areas, and a stamped addressed envelope was included. Anonymity and confidentiality was assured.

Despite the poor response rate, students identified with the grounded theory and produced some interesting comments. All the students agreed that as neophytes they had experienced feeling of stress and apprehension before their first placement. However, as with the study, this was more noticeable within the undergraduate group who blamed the lack of nursing content of their programme at that stage made them feel unprepared for practice. As expected, most comments were made about the differences between the programmes. Undergraduates commented that they felt they did have more knowledge than the diploma student. One student commented that as an undergraduate he/she felt more able to use his/her knowledge to influence practice and was “... *more able to provide knowledge of the patient’s social and nursing needs, ... giving*

explanations and reassurance ... and feel confident in my knowledge of drugs, medical conditions and documentation.”

However, diploma students regarded their practical ability as superior to undergraduates, explaining that undergraduates “... *were not prepared for practice.*” One diploma student stated that during the participant observation diploma students must have been influenced by my presence and that was the reason for their poor performance.

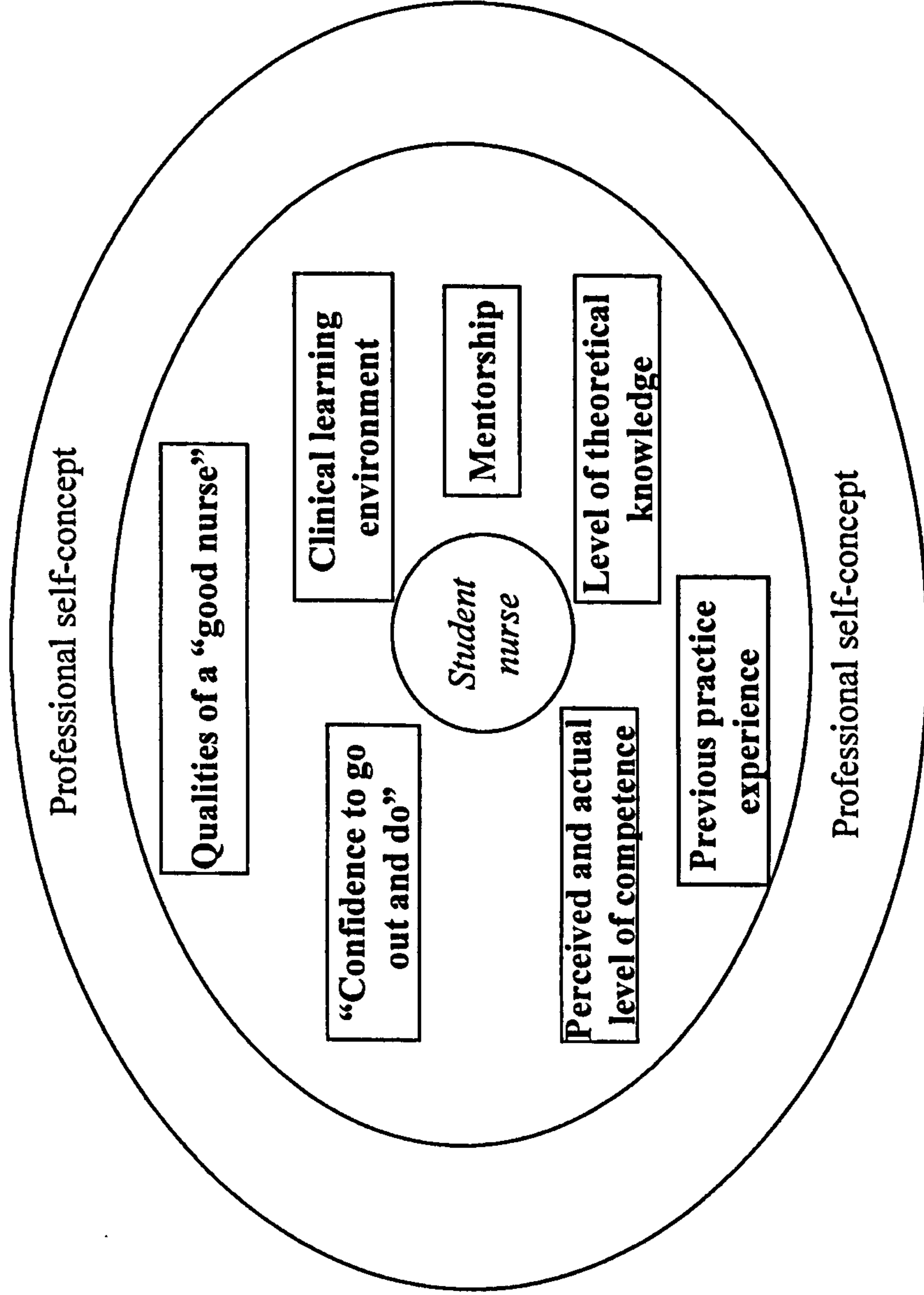
All students agreed that mentors were the most important figures within the clinical learning environment, and were looking for the qualities of a mentor, a role model and a good clinical learning environment I had identified during my study. In fact, one undergraduate commented that students would always be heavily influenced by “... *a number of factors including previous placements, mentors, frequency and teaching of practical skills.*”

Overall, there seemed to be agreement with the categories produced from the nine respondents used within the process of outsider validation. These categories produced a grounded theory (section 4.8, p. 349), which will need to be tested in further studies. Therefore recommendations and considerations for further studies are considered as a result of the findings and formation of the grounded theory (section 4.9, p.353).

4.8 Grounded theory

Following the development of the codes, categories and core category, a grounded theory was developed. Figure 26 (p. 350) details the grounded theory model that I developed from findings of my study.

Figure 26: Grounded Theory: The development of professional self-concept in diplomate and undergraduate nursing students



Diploma and undergraduate nurse education programmes need to be able to provide students with a sound level of theoretical knowledge, while providing them with the practical skills required of a qualified nurse. As students commence, progress and complete nurse education programmes, they develop a professional self-concept, which is influenced by a number of external factors. Students' knowledge, values and beliefs, and practical competence are shaped by their experiences during clinical placements. Throughout their programme students have noted the qualities of 'good' and 'bad' role models and based their practice on what they feel are 'good' qualities. Also, students can learn behaviour through observation or doing, and can base this behaviour on the standards set within clinical areas. Therefore, if standards are poor, this practice can be passed on to the student, and can become their standard of work.

Managing the clinical learning environment in which the student has to work and learn is a major part of the education provided for nurses. Despite the variable quality of clinical placements, students believe that most of their learning, and applying theory to practice, should take place in a 'real' clinical setting. Competence develops as clinical placements progress, and the student learns new skills and consolidates practices already learnt. However, this can only occur if a high standard of teaching and learning is available within the clinical learning environment. If the clinical learning environment does not have the ideal characteristics which students value, students often feel that they lag behind colleagues who have experienced 'good' placements, and results in reduced competence and confidence to go out and practice. Therefore, a newly-qualified nurse may have different levels of competence due to their pre-registration clinical placement experiences.

Mentors can influence students' professional self-concept by providing a planned learning experience, with opportunity to practice skills, and by providing students with support and constructive feedback, while being good role models on which students could base their practice. Students require and want adequate support and supervision, but the availability of trained staff and/or mentors is variable across placements, especially in the acute areas. As the programme

progresses, students feel that they should be given enough support and supervision, while equally they should be encouraged to work independently when both they and their mentor feel that they are effective, efficient and safe.

While undergraduate and diploma students had similar views on their needs from practice, they had different views on the role of theory within a nursing programme, and the effect theory would have on their clinical competence. As already stated, although diploma students had the manual dexterity to carry out a clinical skill, they often demonstrated lack of understanding and problem-solving skills required for holistic patient care. Diploma students consistently over-rated their level of practical skill, while undergraduates consistently under-rated themselves, in this area. In contrast to the beliefs of both groups, undergraduates did not demonstrate a poorer level of practical skill than diploma students within my study. From my observations, undergraduates were more able than diploma students to apply theory to practical problems/situations and to practical skills. Overall, there was deeper theoretical knowledge and better levels of competence to practice among undergraduate students. Therefore, my study would suggest that undergraduate programmes produce qualified practitioners with higher levels of knowledge and a higher level of competence to practice, i.e. a newly-qualified graduate has a higher level of professional self-concept than a newly qualified diplomate.

During the course of the study, I was aware of certain aspects of the model that could have had more significance to the development of professional self-concept than other aspects of the model. The role of the mentor appeared very strong, and perhaps was the most significant category in the development of professional self-concept. For example, the students highlighted the role of the mentor in their previous clinical placements in that they had had an affect on their level of knowledge, and their perceived and actual competence. Mentors, who were viewed as 'good', questioned students about their theoretical and practical knowledge, and facilitated the linkage of theory to practice. This meant that students could carry out a range of practical skills and solve clinical problems, which ultimately gave students the confidence 'to go out and do'.

When the mentorship experience was good, students valued this and commented on the fact that it created a good learning environment.

However, I do not believe that mentorship is the only factor involved in making students' professional self-concept strong. If this were the case, there perhaps would have been differences in students' professional self-concept who had experience of 'good' or 'bad' mentors, but there would not have been an overall difference between diploma and undergraduate students. In other words, the differences in diploma and undergraduate students' self-concept could not be explained by mentorship alone. I would suggest that this could be due to other factors such as the graduates having a deeper theoretical knowledge, or better educational qualifications on admission.

I have speculated some suggestions about the linkage or hierarchical structure of the model, but due to the small sample size used and the qualitative nature of the study, I would caution readers about the strength of evidence presented to support these tentative links of categories within the model, and further research and evidence would need to be carried out to support or refute these links.

4.9 Limitations, Recommendations and Future Studies

Following reflection on the knowledge and experience I had gained during the study, I formed a number of opinions on the use of grounded theory, the methodology I had chosen, and the findings of the study. Throughout this reflection, I put forward positive and negative opinions.

I considered the use of research aims, the choice of a qualitative research method, the effect of the researcher within the study, and the use of the first person in academic writing. On reflection, I also formed thoughts on the transcription of interview data, the formation of interview relationships, the use of participant observation, the reliability and validity issues considered, and the data analysis I employed within the study.

4.9.1 Research aims

I felt that the aims of the study were wide enough to facilitate emergence of participants' ideas and comments on their nursing programme, as suggested by Streubert and Carpenter (1995), Glaser (1992), Glaser and Strauss (1967). Although the aims of the study remained consistent throughout, more focussed and detailed questions were asked within the interviews as codes and categories emerged. Therefore previous interviewees influenced the questions I asked in subsequent interviews – this allowed the development of the participants' comments, as suggested by Hutchinson (1993) and Strauss and Corbin (1990).

4.9.2 Choice of qualitative research method

Using a qualitative method to achieve the research aims was appropriate. I would agree with the literature (Streubert and Carpenter 1999; Parahoo 1997; Polit and Hungler 1995) that qualitative methodology does allow a deeper understanding of phenomena, especially using data collection methods such as interviews and participant observations. Within this study, I wanted to develop knowledge and understanding of the participants' thoughts and feelings. This would have been difficult using quantitative techniques due to a number of factors. Firstly, it would have been more difficult to explore any issues raised by participants' answers within a quantitative data collection method such as a questionnaire. Secondly, due to the lack of literature on the study topic, I felt it was impossible to write and test a hypothesis. Thirdly, qualitative data collection methods allowed me to observe students in the natural context of the phenomena of interest. It is my opinion that this added value and meaning to the grounded theory produced. Fourthly, the qualitative data collection methods I used allowed me to use a large number of commentaries from the participants, thereby enabling me to convey exactly what participants had said.

From the choice of data sources (i.e. comparison of students from different institutions studying to a different academic level), variation in the opinions between graduate and diploma students could have been caused by a number of

factors other than the type of nursing programme the student was on. For example, the data could have been influenced by institutional variance such as standards of teaching, and that there were smaller groups within the graduate programme. Another variance was the entry requirements for the programmes – there was a marked difference between the educational requirements of the two programmes. Therefore it may be useful to repeat this study in the following circumstances: (1) using students studying to diploma and degree level within the same institution; (2) on students studying to diploma and degree level from the same institution, taking into account their previous proven educational ability.

Due to the time constraints, a cross-sectional approach was used to compare how students' perceptions changed as the programmes progressed. This was recognised as a limitation of the study design at outset as it assumed that students in later cohorts started with the same preconceptions. Therefore, the study could be repeated using a longitudinal approach.

4.9.3 Researcher-effect

During the study, I was conscious of the effect I (i.e. the researcher) was having on the participants and the shaping of the whole study. Using the process of reflexivity allowed me to document these effects in memos, field notes and within my personal journal. I found this reflexivity to be beneficial for a number of reasons:

- (1) it allowed me to have a better understanding of decisions I had made;
- (2) I was able to look back at the notes I had made, and it provided part of the 'audit trail';
- (3) I was able to document any preconceived ideas and hunches;
- (4) I documented any questions I wanted to ask the next participant;

- (5) I found it useful for identifying mistakes and/or areas where changes were made future interviews or observations (e.g. the wording of a question).

4.9.4 Writing in the first person

I debated whether to write in the first person before I commenced the study. In the literature the rationale for writing in the first person is largely anecdotal, but I felt that to do so was in keeping with the values and beliefs of grounded theory, symbolic interactionism, verstehen and reflexivity. Following my experience of writing in the first person, I am of the opinion that it helped me to convey the extent and depth of my involvement in data collection (i.e. focussed interviews and participant-as-observer observation) and ultimately in the theory produced. The use of the first person does convey a much more subjective nature of involvement within the research. Using quantitative data collection methods such as questionnaires, a researcher is involved within the research, but not within the 'real world' of the participants. Therefore, I am of the opinion that writing in the first person was appropriate for this study, but perhaps would be more difficult to rationalise if it were to be used in a quantitative study.

4.9.5 Grounded theory

The use of grounded theory demonstrated some positive and negative aspects of this qualitative methodology. I found the methodology to be suitable for learning and developing a theory from the data collected. However, I did have a problem initially in interpreting grounded theory methodology from Glaser and Strauss (1967). I investigated research studies within nursing to gain examples of the methodology in use (Melia 1987; Benner 1984). One of the major problems I found was in the understanding of how the grounded theory was developed: each research article had slightly different ways of producing and presenting/reporting the theory produced. However, the principles of grounded theory production were apparent. Data was generated through interviews, participant observation, field notes, journals/books and other literature. Data was analysed into levels

one, two and three, with the production of the core category and the description of the grounded theory. I worked on the basis that anyone who read the thesis would need to be provided with the 'audit trail' and understand how and why each code was produced, combined into categories and linked to the core category. A diagrammatical representation was included as it had aided me in the coding and categorising, as well as in the writing and explanation of the theory.

Secondly, from a logistical point of view, grounded theory was time-consuming and produced a large mass of data. Broad aims and open-ended questions were used which resulted in an enormous amount paper, and time required for transcription and analysis. Transcription followed by a proof read, with the tape running, proved very time-consuming. I needed ten hours to transcribe each focus group and seven hours to transcribe each individual interview. With each transcription, there was a requirement to write memos and make post-interview notes. I found that this process required strict time management – each interview had to be transcribed and analysed before the next interview. This process allowed me to ask pertinent questions of each subsequent interviewee, but was difficult due to the requirement to transcribe and analyse while, at the same time, undertake further data collection.

There was also a time restriction on when the students were available. For example, group UG2 was available for two months due the study's criteria of interviewing these students at the mid-point of their programme – if this had not been completed, I would have had to hold the study until the following year until the next cohort of students was available. However, I was aware of this before the study commenced and had found it useful that I had produced a realistic, albeit tight schedule for the overall study.

4.9.6 Transcription of interview data

Self transcription, as advocated by Holloway and Wheeler (1996) and Swanson (1986), was beneficial in that I had a clear understanding of the context of each

statement, and was able to link the statements with non-verbal cues I remembered from the interviews. I was able to write memos that were attached to each participant, code and category following each interview. I documented personal hunches, ideas, future questions, any improvements I would like to make in subsequent interviews within my personal journal. However, self transcription may not always be possible if there are time constraints, and I did struggle at times to cope with the demands of self transcription and the schedule of interviews and observations.

Personally I found transcriptions easier when it was an individual interview, but it was dependent on how fast the participant spoke, and how much clarification or summarising of points was needed. My skills and confidence certainly improved as time went on. As the focus groups were noisy and argumentative at times, I found it difficult to control the group and allow everyone to speak, due my lack of experience. I had not pre-tested the interview technique (see p.133) and therefore I could not practice interview techniques and skills. This has the disadvantage, and potentially unethical approach, of the participant being interviewed by an inexperienced researcher. Therefore, I would agree that pre-testing would be beneficial for inexperienced interviewers. However, my confidence, skills and overall experience of interviewing improved as the study progressed. Perhaps I would have found interviewing easier if there had been more direct questions in the beginning rather than the broad aims that were available – allowing the participant to talk freely, made me question (and worry) whether I could keep the interviews focussed on the aims of the study. This could be a possible disadvantage for inexperienced researchers using grounded theory and interviews.

4.9.7 Interview relationships

Building a trusting relationship where the participants felt confident enough to pass on information to me was difficult. As stated previously, the literature highlights that building this relationship is important, but does not give sound explanation as to how to actually achieve this. I felt that if participants passed on

information, which was either personal, controversial, or their inner thoughts, then this was a good indication that the relationship was working. However, from a practical point of view, meeting the participants at the first informal meeting and then again at the interview gave me only a short time to establish a relationship in which each participant felt comfortable.

On a practical level, I felt that I should carry out the interview like a 'normal conversation'. This involved using verbal and non-verbal cues, which is in contrast to Polit and Hungler's (1999) suggestion that the interviewer should sit passively and should not express any emotion, either verbal or non-verbal. I felt that this would be not only impossible to achieve, but also may give the impression that I was not interested in what was being said.

I also found that the use of non-verbal and verbal cues could be useful in analysing the transcriptions. Use of non-verbal and verbal cues often helped to put the statement into perspective. I used field notes and memos to record these, and also found that self-transcription of the interviews in the immediate post-interview period provided me with good opportunity to remember and note these.

Within the interviews and especially in the post-interview discussions with the participants, I was often asked my views, values and beliefs on the areas we were or had been discussing. I had not expected or considered this before I started interviewing students. I was aware that this could have biased their responses within the interviews, but I felt that if I had avoided the questioning, this may have had a negative effect on the researcher-participant relationship. Parahoo (1997) and Wilde (1992) argued that these 'disclosures' help to build a trusting relationship, and the participant views the interviewer "as less of a professional and more of a human being" (Wilde 1992). Parahoo (1997) also argues that some researchers intentionally divulge information about themselves as this type of 'give and take' can help bring the researcher and the participant closer, especially when the participant realises that the researcher has some experience and/or knowledge of their experience. In some interviews and post-interview discussions, I did not disclose any of my opinions – I answered questions

honestly when asked, but I did not volunteer information as I felt I had to avoid biasing the participants as much as possible. Most of the disclosures I made were within the post-interview discussions, by which time I had most, if not all, of the information I wanted from the participant. Therefore, these disclosures had not influenced the participants' responses.

As advocated by Morse and Field (1996), I asked the participants if there was anything they would like to ask me at the end of each interview. They often asked for my own perspective of graduate nursing, but I was aware of the potential bias I could have caused. Therefore, it was best to keep this question to the end of the interview as it often led to quite lengthy discussions on graduate-level preparation, and could have biased students' thoughts. Having double-checked the interview transcripts with my post-interview notes, I found that none of the students reported any different feelings on the subject than they had had in their original discussion. I would suggest that researchers should check transcripts for bias following a disclosure by the researcher.

4.9.8 Participant observation

Participant observation was used to gain an understanding of students' actual performance near to qualification. Using this method of data collection with interviews (i.e. triangulation of data collection methods) added value and depth of understanding to the phenomenon under investigation. As demonstrated by the selection of scenarios described within the previous chapter, I was able to observe nursing interventions by the participants. I observed and questioned the participants on a number of issues: (1) their rationale for carrying out those interventions; (2) their underlying knowledge of research findings; (3) their level of competence; (4) the linkage of theory to practice; (5) the role of the mentor in the teaching, observing and practising of these interventions. My experience reflected Johnson's (1997a) opinion, that participant observation allowed the researcher to follow up leads and hunches, and also to experience the social world of the participants.

The data produced from the participant observation aided the explanations the students gave within their interview and vice versa. This supports Johnson's (1997a) opinion that participant observation gave an opportunity to construct an account of the phenomena in terms of the person directly, rather than from journal articles or case reports, which was viewed as an advantage of doing participant observation. For example, diploma students were much more anxious about their level of competence near to qualification, and the participant observation demonstrated that there was a definite lack of underlying knowledge underpinning some of their nursing interventions.

I felt that on testing the emerging theory continuously in the 'real world' (Johnson 1997a), I could add to the reliability and validity of the emerging theory. It could be argued that the theory was tested as it emerged within the field. This means that the theory was produced by the data, but as it emerged it was also tested for competing theories via the participant observation.

Using the participant as observer role was appropriate for this study. Following my experience as a researcher and also as a Registered Nurse, I would have serious concerns about using either the observer only or observer as participant role when using student nurses as participants. During the study, students within two months of qualifying routinely worked independently. There were times where I had to intervene in the care patients received from students working without supervision. I would also argue that, as students, they were not accountable for the patients' care and it would have been inappropriate for the students and patients within this study if I had worked in any other capacity. Therefore, reflecting on this decision, I was able to use this role to the advantage of the participants, patients and myself as researcher.

Some researchers have commented on the difficulty of participating and observing at the same time. During this role I participated in care delivery, met patients and other staff, conversed within the team, read background and current nursing and medical casenotes on patients, and questioned participants as they worked within their 'real world'. I would argue that by using an observing role,

the researcher would not have had as much of an understanding of the world in which the students were working. Rather than finding it more difficult using participation and observation simultaneously, I would argue it is easier to understand the whole picture of the participants' situation. For example, since I was aware of patients' underlying medical/nursing problems, I could ask pertinent questions relating to the rationale for carrying out nursing interventions and/or I could understand why a participant had asked a particular question or had intervened in that way.

Since I was working in a participant as observer role, I did not experience role conflict, as Kite (1999) did as an observer. Perhaps this was due to the fact I had stated that I would work with the participants. The participants and staff knew that I would only direct the participants if I felt that in my professional judgement, it was in the best interest of the patient. This set the ground rules for my role with the participant and made it clear that they were leading the care delivery. The aim of these ground rules was to provide the observer with a role, while not biasing the participant's normal performance unless it was thought to be dangerous, or against the patient's best interests or wishes.

Observations were carried out within acute practice areas (e.g. surgical and medical hospital wards) between the hours of 0700 hours and 1500 hours. I decided to make the time of day constant, in order that I would be comparing similar nursing interventions between the study groups. I also decided to observe the student on a once-only basis due to the time constraints. This may have been stressful for the participants, and I was aware that the day I had chosen may have been a particularly good or bad day for the participant or that the participant may have worked better or worse at other times of the day. I stated that the observation sessions would be flexible and would range between two to five hours, although the maximum would be seven and a half hours. In reality, I usually worked the maximum amount of time with each participant as there was time required to orientate myself and the participant to the patients, and it allowed time for me to observe the participant's performance during documentation of care, and handing over to the next shift.

4.9.9 Reliability and validity

Reliability and validity issues were addressed within the methodology. Outsider validation was achieved as reported in the previous chapter. On reflection of this process, I did not fully appreciate at the outset how I would be able to do this. This was partly due to my inexperience with grounded theory and qualitative research, nor had I fully appreciated at the outset of my study how other researchers, such as Gray (1997), had achieved this. When the theory was written, the findings contained lots of verbatim quotes, and reports from key literature sources. I had a problem of producing a report that was understandable but also short enough to produce a reasonable response from the students I had sent it to.

Internal validation was achieved by summarising the findings at the end of each interview and observation. I decided that the views of the participants would have changed by the time the whole theory was written as they would have moved on within their education programme, and perhaps would not have the same views as they had at the time of the interview and/or observation. I would argue that the theory was constantly tested through the use of subsequent interviews and observations until theory saturation was reached.

4.9.10 Data analysis

Data analysis was an on-going event throughout the research. I generated a considerable range of thoughts, feelings and hunches due to the close and constant contact maintained with the data during transcription, coding, categorising and developing a theory. Substantive, methodological and analytical field notes were kept, not only for participant observation, but also for interview notes. However, it was important to establish where each type of information would be kept prior to commencing the data collection, as I had carried out some interviews before commencing the use of my personal journal, which meant I had to recall information from three interviews.

Using a computer package to code and categorise the data was very beneficial. QSR*NUDIST was easy to learn, saved time and could code and categorise more efficiently than a paper system. For example, combining codes, adding notes to memos, and obtaining a copy of the category with each code within it were some of the functions of this package.

The use of the literature within a grounded theory study is very different to other research methods, as already stated. For the purposes of this research, I used a small literature search to establish that the work was original, and to provide a rationale for the study. This aided in the setting of the broad research aims, and I would question the reliability of these aims had I not investigated the literature. Moreover, there would have been no point 'reinventing the wheel' i.e. to carry out research in a field in which there may have been a well-established theory. Therefore, I would advocate that a small literature review should be carried out prior to a research study using grounded theory.

The use of the literature within a grounded theory study was summarised by Strauss and Corbin (1990). They stated that the literature could make the researcher aware of ideas that they can check against the data. An example of this use of the literature was when the students raised the issue of confidence. Participants were of the opinion that the development of confidence was important as practice placements and their programmes progressed. However, upon investigating the literature there was also the issue of overconfidence and the problems it could have on performance. Therefore, in later interviews I questioned participants about any problems they could anticipate if the student became overconfident. Participants highlighted some of the problems they associated with being overconfident, which agreed with the literature on the topic. I used this as an example of where the literature was used to stimulate the theoretical sensitivity of the emerging theory. The literature was also used in this example to pose questions to subsequent participants (Strauss and Corbin 1990).

However, although there are many uses of the literature within grounded theory, the ongoing data collection, analysis and reading the literature can be problematic. Time restrictions between data analysis, searching and locating the literature, and then reading the literature before the next participant is interviewed can sometimes be impossible. There were times where I would interview the next participant before I had even located or read the literature from the findings of the previous interview/observation. This could be a potential disadvantage of using the literature in this way. However, if I had waited until I had completed the literature review after each participant, I would have not been able to interview as many participants within the two-month time-frame allocated. This is a factor worth considering when setting up future research timetables using this method.

Following coding and categorisation, I identified the core category and the relationship between categories. In order to explain these links, I used diagrams (Figure 16 p.266, Figure 25 p. 344, Figure 26 p.350) to facilitate the explanation of the theory produced. However, text was also required to explain why and how these links were made, and what the relationship was between the categories.

The core category occurred frequently in the data (Strauss 1987), linked the categories together (Holloway and Wheeler 1996; Strauss 1987), and was central in the formation of the grounded theory (Holloway and Wheeler 1996; Strauss 1987). In agreement with authors who have used grounded theory, I did not identify the core category until the later stage of the research (Holloway and Wheeler 1996; Strauss 1987; Corbin 1986; Hutchinson 1986). Once identified, I found that it did take time to refine the exact nature of the core category in relation to the other categories (Strauss 1987).

Following the data analysis, a grounded theory was produced. This theory was a formal, middle-range theory. I would agree that grounded theorising is a blend of inductive and deductive reasoning (Blaikie 1993). The grounded theory emerged from specific observation and interview data i.e. inductive reasoning. However, the theory, although not tested empirically within this study, was

tested on other participants to look for agreement, or competing or rival themes, through the use of theoretical sampling and sensitivity, i.e. deductive reasoning. However, the theory would need to be tested empirically on a large sample size before it could be generalised and used within the nursing profession.

I asked myself if the theory developed was useful (May 1986). I think the theory was useful as it did raise a number of questions for further research, and also raised a number of issues involved in the educational preparation for nursing students within the U.K..

4.9.11 Further study

Following the completion of the study, I identified a number of areas for further study, and made recommendations from the findings.

From the opinions of the students within my study, I identified areas in which programmes and practice areas should be changed. Firstly, neophyte students identified feelings of stress and anxiety associated with their first placement, and wanted clinical experience earlier in their programme. The U.K.C.C. Commission for Education (U.K.C.C. 1999) recommended and initiated a requirement for earlier clinical experience within a shortened (12-month) C.F.P.. However, my study indicates that there may be a need for better and closer supervision and support for neophyte students. Secondly, neophyte students had often chosen the diploma route for financial benefits, but this situation had changed within Scotland during the time of this study. Therefore, it would be interesting to record recruitment and attrition rates from diploma and undergraduate programmes now that the financial inequalities have been addressed. Thirdly, the retention within the C.F.P. has been poor, and this needs to be continually monitored now that the C.F.P. has changed. As already stated, institutional differences in the recording of recruitment and retention across Scotland and the U.K. makes it impossible to make regional or institutional comparisons (Buchan et al 1998). Therefore I would recommend that these

figures should be recorded with parity such that fair comparison of institutions/regions can be made.

I would also recommend larger scale quantitative and qualitative comparative studies of undergraduate and diploma students, and further studies to test the grounded theory developed. A limitation of my study was the small sample size used, which makes the findings ungeneralisable (Polit and Hungler 1999). There could also have been bias within my findings, as the most motivated and most confident students were most likely to volunteer for the study, especially within the participant observation phase of the study. Findings from my study and a limited number of British studies suggest that there could be advantages in degree-level preparation for nurses. However, sound research-based evidence to support any such move to an all-graduate profession is required.

I also noted that although undergraduates had a higher professional self-concept than diploma students, they consistently rated practical skill of diploma students higher. This may be due to the perceptions of graduate nursing that graduates would go into management and teaching posts, rather than clinical posts, and would lack practical competence. Students may have been aware of this opinion, and therefore rated themselves lower than they actually were. My study did demonstrate a low self-belief in practical skill, but it also demonstrated that undergraduates did not have the same fear of becoming qualified as did diploma students.

A criticism I have of my study, and subsequent grounded theory model, is that it gives no account of the most important aspect, namely the formation of professional self-concept. In other words, I demonstrated that there was a link between categories, and to the core category, but I could not quantify the strength of each link. Therefore, further research would be required to formulate the strength of the links within the model. This type of research may also help future nurse education programme designers to produce a newly-qualified nurse with a high professional self-concept.

My study suggested that diploma students may require more support than undergraduate students in making the transition from student to staff nurse. Also, due to the difference in the quality of practice areas and the difference in academic levels of nursing programmes, it cannot be assumed that students have the same level of competence at the point of graduation. Therefore, this study suggests the need for a structured preceptorship programme to meet the individual needs of the newly qualified staff nurse. In agreement with Runciman et al (1998), and U.K.C.C. Commission for Education (U.K.C.C. 1999), I would advocate that diplomates and graduates should be competent in core skills required of registered nurses.

Research within nurse education needs to continue and include large-scale studies, especially with the current changes to programmes that are being implemented. However the findings from these studies also need to be disseminated together with sound and realistic recommendations for change.

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Appendix I

Nursing demographics within the U.K.

Percentage of ‘1992’ 3-year diploma students failing to complete training*
(Scottish Office 1997)

Branch	Year 1 of training	Year 2 of training	Year 3 of training	Total **
ADULT Cohort				
1992/93	10.1%	10.0%	2.3%	20.9%
1993/4	9.2%	7.6%		
1994/5	8.6%			
MENTAL HEALTH Cohort				
1992/93	14.3%	10.9%	13.1%	34.4%
1993/4	8.7%	8.4%		
1994/5	10.8%			
MENTAL HANDICAP Cohort				
1992/93	18.5%	16.5%	3.5%	34.1%
1993/4	17.0%	10.2%		
1994/5	5.3%			
PAEDIATRIC Cohort				
1992/93	18.3%	16.8%	4.5%	35.1%
1993/4	11.7%	13.3%		
1994/5	8.1%			
MIDWIFERY Cohort				
1992/93	12.6%	10.0%	3.5%	24.0%
1993/4	11.5%	7.8%		
1994/5	10.7%			

* yearly percentage = wastage during each year/numbers at beginning of each year

** total percentage = wastage numbers over entire course/intake numbers to course

Percentage of nurse students successfully completing ‘traditional’ training in 1989/1990

(NBS Statistical Bulletin 1990/1)

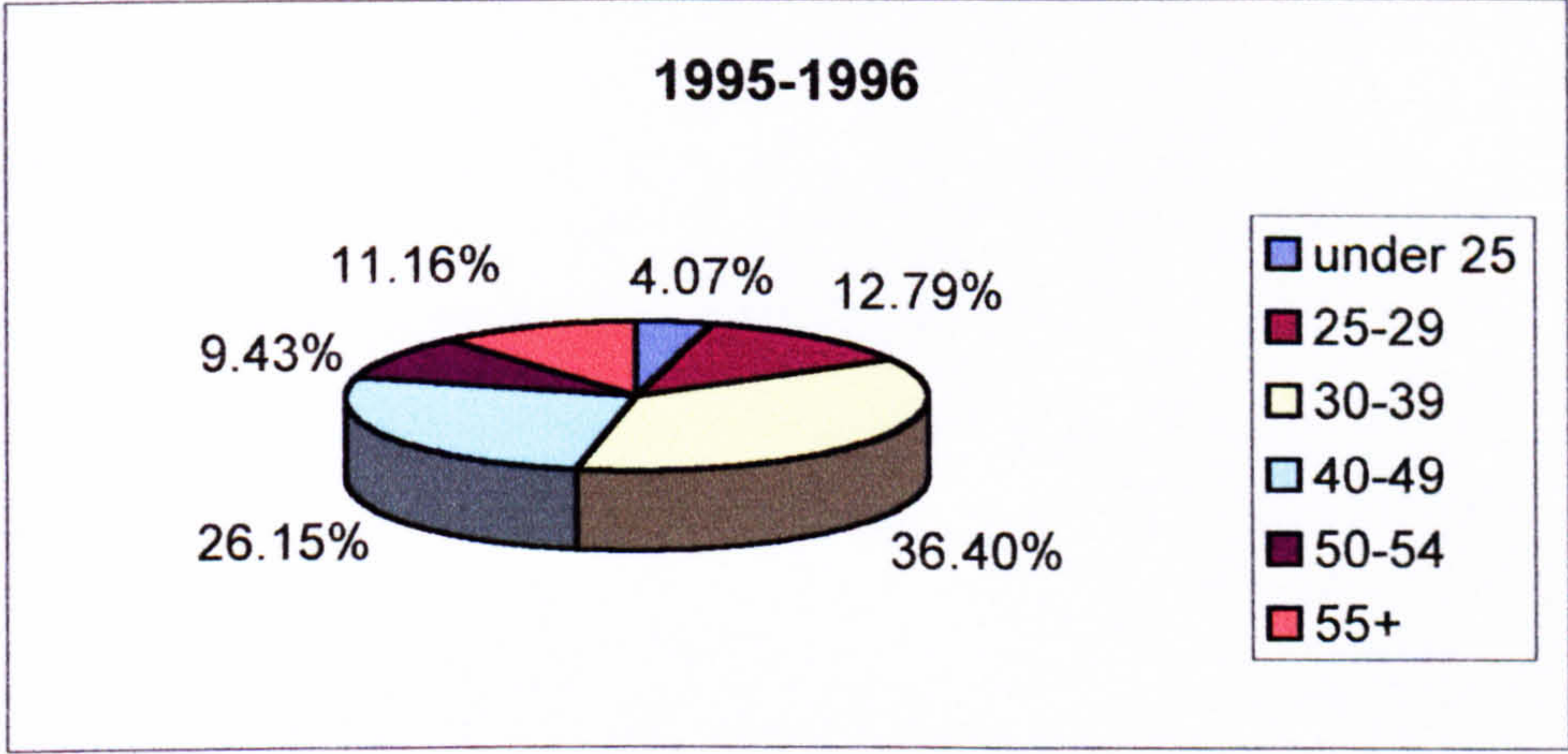
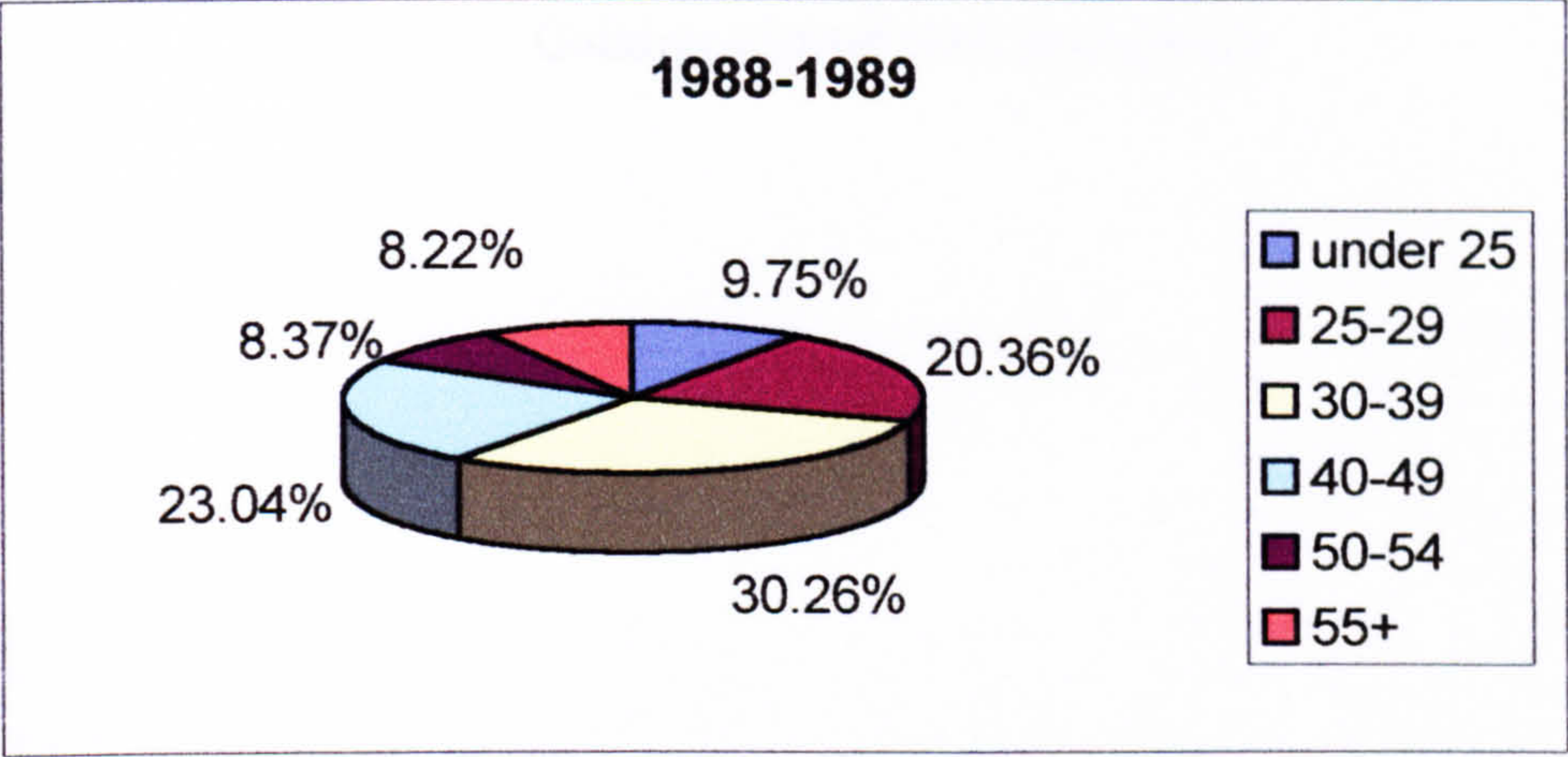
Percentage of nurse students successfully completing courses in 1989/1990	
General Nursing	85.1%
Mental Illness Nursing	81.5%
Mental Handicap Nursing	72.9%
Sick Children Nursing	84.2%

Entries to degree and non-degree nursing programmes, 1987/1988 to 1997/1998, by country (from UKCC Commission for Education 1999)

Country	England *	Scotland	Wales	Northern Ireland
1987/88				
Deg		146		20
N/D		2492		0
1988/89				
Deg		138		20
N/D		2596		0
1989/90				
Deg		166		22
N/D		2671		0
1990/91				
Deg		157		27
N/D		2622		287
1991/92				
Deg		162	48	32
N/D		1984	324	596
1992/93				
Deg		179	46	32
N/D		2146	899	615
1993/94				
Deg		199	64	34
N/D		2178	804	494
1994/95				
Deg		265	96	32
N/D		1965	906	432
1995/96				
Deg		222	79	33
N/D		1987	596	443
1996/97				
Deg		248	100	30
N/D		2138	602	422
1997/98				
Deg	1114	225	160	39
N/D	14536	2142	1000	420

- *Figures not available
- Deg = degree level
- N/D = non-degree level
- Source: National Boards

Changing age of registered nurses (Cole 1997)



Appendix II

Gaining contact with institutions

Tel: (01501) 821514 Exr.253
e-mail: JDonaldson@bellcnms.u-net.com

31st July 1998

Ms. Di Carter,
Senior Lecturer
Nursing and Midwifery School,
68-70 Oakfield Avenue,
University of Glasgow,
Glasgow.

Dear Ms. Carter,

I am writing to ask for permission to access the undergraduate nursing students in your department for a research study. The information pack provides an outline of the study, including its purpose and the general timetable proposed.

Please do not hesitate to contact me if there are any details you wish to discuss further.

I look forward to receiving your reply in writing.

Thank you.

Yours sincerely,

Jayne H. Donaldson. M.N., B.N., R.G.N., P.G.C.E.

Proposed Outline

Ph.D. study

The proposed study will use grounded theory methodology to investigate student nurse perceptions of nursing and the reasons for choosing their method of education.

The timetable attached shows the proposed timescale for this cross-sectional approach, and the groups of students I hope to interview.

Due to the nature of grounded theory, I am unable to suggest a sample size or any research questions. However, the initial aims of the study are:

- (1) What preconceptions do undergraduate and diploma students have about their course and the nursing profession?
- (2) How do these preconceptions develop as the courses progress?
- (3) How do undergraduate and diploma students perceive their preparation for the qualified role, and how does this match to their performance in the clinical area?

I hope to gain access to students from one undergraduate and one diploma program from different institutions.

The timetable also points out that I propose to use focus and individual interviews, and participant observation as data collection methods. The use of these methods will help to obtain the students' perspective on these issues and also help the researcher to understand their 'world'.

Months	Year	Course	Research method	Stage of course (months)
Sept-Oct	1998	Diploma Group D1	Focus Group Interview	0-2 months
Oct-Nov	1998	Bachelor Group UG1	Focus Group Interview	0-2 months
Jan-Mar	1999	Bachelor Group UG2	Individual interviews	24-26 months
Mar-May	1999	Diploma Group D2	Individual Interviews	18-20 months
Dec- Feb	2000	Diploma Group D3	Individual Interviews + Participant Observation	34-36 months
May - July	2000	Bachelor Group UG3	Individual Interviews + Participant Observation	46-48 months

Proposed Timetable for PhD Research
Jayne Donaldson

Course Director: Bachelor of Nursing
Miss Diana E. Carter, BA, MSc, RGN, RM, RNT



**UNIVERSITY
of
GLASGOW**

10 August 1998

Mrs Jayne Donaldson
Lecturer
Bell College of Technology
Almada Street
Hamilton
Lanarkshire
ML3 0JB

Dear Jayne

**PhD study
Access to Undergraduate Students**

Thank you for your letter of 31 July 1998 and the accompanying information pack which confirms the details of our recent discussions about your PhD study.

I am happy for you to approach Bachelor of Nursing students about participating in your study. Professor Smith has passed her copy of your letter to me - she also has no objections to you accessing Bachelor of Nursing students.

Kind regards

Yours sincerely

Diana E Carter
Course Director - Bachelor of Nursing

Tel: (01501) 821514
Ext. 253
e-mail: JDonaldson@bellcnms.u-net.com

31st July 1998

Mr. Michael Jamieson,
Associate Dean,
Bell College of Technology,
Shotts Campus,
Shotts.

Dear Mr. Jamieson,

I am writing to ask for permission to access the undergraduate nursing students in your department for a research study. The information pack provides an outline of the study, including its purpose and the general timetable proposed.

Please do not hesitate to contact me if there are any details you wish to discuss further.

I look forward to receiving your reply in writing.

Thank you.

Yours sincerely,

Jayne H. Donaldson. M.N., B.N., R.G.N., P.G.C.E.

Proposed Outline

Ph.D. study

The proposed study will use grounded theory methodology to investigate student nurse perceptions of nursing and the reasons for choosing their method of education.

The timetable attached shows the proposed timescale for this cross-sectional approach, and the groups of students I hope to interview.

Due to the nature of grounded theory, I am unable to suggest a sample size or any research questions. However, the initial aims of the study are:

- (1) What preconceptions do undergraduate and diploma students have about their course and the nursing profession?
- (2) How do these preconceptions develop as the courses progress?
- (3) How do undergraduate and diploma students perceive their preparation for the qualified role, and how does this match to their performance in the clinical area?

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Mar-May	1999	Diploma Group D2	Individual Interviews	18-20 months
Dec- Feb	2000	Diploma Group D3	Individual Interviews + Participant Observation	34-36 months
May - July	2000	Bachelor Group UG3	Individual Interviews + Participant Observation	46-48 months

Proposed Timetable for PhD Research
Jayne Donaldson

Your reference:

Our reference:

MJ/ML

Date:

2nd September, 1998

Almada Street
Hamilton
Lanarkshire
Scotland ML3 0JB

Telephone: (01698) 283100 Extn:
Facsimile: (01698) 282131

Mrs J. Donaldson
Lecturer
School of Nursing

Dear Mrs *Donaldson* Donaldson,

Re Research Input - Higher Degree Programme

I refer to the above in terms of your correspondence of 31st July 1998, which provided details about access/methodology which will relate to your study process.

College Mission Statement

To provide high quality education, training and advice at Higher Education level by a variety of modes and in a range of disciplines to cater for local, regional, national and international needs and in support of the economic development of Lanarkshire, South West Scotland and beyond.

In response, I would indicate institutional approval to progress this work on the basis that standards will be maintained, in context of informed consent/accessing sample groups (RCN Code - Ethics of Research).

I trust this information is of value.

Yours sincerely,

M. Jamieson
M. JAMIESON (MR)
Associate Dean - Shotts Campus



Appendix III

Flowcharts of diploma and bachelor programmes:
location of practice hours

**DEGREE OF BACHELOR OF NURSING
CLINICAL PRACTICE 1998-1999**

[illegible]

ORIGINAL APPROVED YEAR 4 BACHELOR OF NURSING

[illegible]

Process of Nursing IV degree exam
Philosophy & Ethics assignment
Nursing IV degree exam
Option degree exam
Care study

PROPOSED REVISED YEAR 4 BACHELOR OF NURSING

[illegible]

S = Study week
C = care study week
T = Option Theory week

Process of Nursing IV degree exam
Philosophy & Ethics in Nursing Practice assignment
Nursing IV degree examination
Care Study
Primary Health Care Nursing/Critical Care Nursing essay

22.2.99

19.3.99

19.4.99

4.5.99

28.6.99

SCHOOL OF HEALTH STUDIES

COURSE TRANSCRIPT

UKCC. PIN:							

NATIONAL INSURANCE NO:							

Title: Mr/Mrs/Miss/Ms

Surname:

Maiden Name:

Forenames:

Date of Birth:

Course: Diploma of Higher Education: Nursing (Adult) (~~Mental Health~~)

Award Achieved: ☒ **Date:** 08/09/02

/ Complete 08/09/02

Not Achieved: ☐

Awarded by: University of Strathclyde

Start Date: 06/09/99

End Date: 08/09/02

Completed. 08/09/02

End Date:

Discontinued.

Reason for Discontinuation. e.g. Failure in Examination

TOTAL ABSENCES:

ABSENCE (Hours)

Introduction

Semester 1

Semester 2

Semester 3

Semester 4

Semester 5

Semester 6

Total

THEORY

PRACTICE

TOTAL

EC Requirements*

Met these minima:

**Total
Hours**

General and Specialist Medicine

300

General and Specialist Surgery

300

Child Care and Paediatrics

150

Maternity Care

150

Mental Health and Psychiatry

150

Care of Old and Geriatrics

150

Home Nursing

60

***apply to general care (Adult Nursing) courses**

but stated for other courses in case they should apply in the future.

COURSE STRUCTURE

COURSE LENGTH: 135 WEEKS 5062.5 HOURS - (excluding annual leave)

THEORY:	WEEKS	HOURS
Total	67	2512.5 (include. 1wk. Induction)
CFP	43	1612.5
BRANCH	24	900

PRACTICE:	WEEKS	HOURS
Total	68	2550
CFP	24	900
BRANCH	44	1650

OVERALL STRUCTURE : Semesterisation: Six Semesters (1 -6) with a Theory and Practice Element.
THEORY AND PRACTICE

	S1			S2		
SEMESTER	WEEKS	HOURS		WEEKS	HOURS	
PRACTICE	4	150		8	300	FOUNDATION
THEORY	19*	712.5*		14	525	
TOTALS	23*	862.5*		22	825	

* Includes 1week induction

	S3			S4		
SEMESTER	WEEKS	HOURS		WEEKS	HOURS	
PRACTICE	12	450		12	450	DEVELOPMENT
THEORY	10	375		10	375	
TOTALS	22	825		22	825	

Subjects

S1 - S6
S1 - S3
S1 - S3
S1 - S3
Nursing Studies
Health Studies
Sociology and Psychology
Life Science

	S5			S6		
SEMESTER	WEEKS	HOURS		WEEKS	HOURS	
PRACTICE	12	450		20#	750	ENHANCED
THEORY	10	375		4	150	
TOTALS	22	825		24	900	

Rostered Service Contribution

NATURE OF EXPERIENCE - PRACTICE ELEMENTS

	S1	
SEMESTER	WEEKS	HOURS
PRACTICE	4	150
Broad Based (Hospital) (1 * 4 weeks) Either Medical/ Surgical/ Elderly/ or Mental Health		
	S2	
SEMESTER	WEEKS	HOURS
PRACTICE	8	300
Community/Hospital (2 * 4 weeks) Community/Mother and Child		
	S3	
SEMESTER	WEEKS	HOURS
PRACTICE	12	450
Acute Services, Mental Health, Elderly (3 * 4 weeks) Adult/ Mental Health/ Elderly		

COMMON FOUNDATION PROGRAM

BRANCH PROGRAM

	S4 (ADULT_		S4 (MENTAL HEALTH)		
SEMESTER	WEEKS	HOURS	SEMESTER	WEEKS	HOURS
PRACTICE	12	450	PRACTICE	12	450
Acute Services (Hospital) (2 * 6 weeks) Medical/ Surgical			Acute (Hospital/ Community) (2 * 6 weeks) Acute and/or Community		
	S5 (ADULT)		S5 (MENTAL HEALTH)		
SEMESTER	WEEKS	HOURS	SEMESTER	WEEKS	HOURS
PRACTICE	12	450	PRACTICE	12	450
Acute/Non-Acute/Speciality (3 * 4 weeks) High Dependency Nursing/ Elderly Care/ Speciality Care/ Community Care Nursing			Rehabilitation/Community/Speciality (3 * 4 weeks) Rehabilitation/ Community/ Speciality		
	S6 (ADULT)		S6 (MENTAL HEALTH)		
SEMESTER	WEEKS	HOURS	SEMESTER	WEEKS	HOURS
PRACTICE	20	750	PRACTICE	20	750
Hospital and Community (2 * 10 weeks) Hospital Care/ Community Care			Hospital and Community (2 * 10 weeks) Community Care/ Addiction - Hospital Care/ Care of Elderly Mentally Ill		

Appendix IV

Usage of terms in evaluating qualitative research

Appendix IV: Usage of terms in evaluating qualitative research (Gray 1997 p. 125)

Term	Term used by	Definition	How achieved
Credibility	Lincoln and Guba 1985 Leininger 1992, 1994	Credibility is said to measure how vivid and faithful the description of a phenomenon is (Beck 1993). It also refers to the truth, value or believability of the findings (Leininger 1994)	Accomplished by taking data and interpretations to the study participants and ascertain whether they believe the findings to be plausible (Guba and Lincoln 1981; Borman, Le Compte Goetz 1986; Yonge and Stewin 1988; Koch 1994), that is, member checking (Mariano 1995). When other people read the report and recognise the experience (Glaser and Strauss 1967; Sandelowski 1986) that is outsider validation.
Confirmability	Lincoln and Guba 1985 Leininger 1992, 1994	Confirmability exists when the researcher has demonstrated that the findings are fully grounded in the data (Avis 1995). Confirmability is a criterion for neutrality (Yonge and Stewin 1988; Chalmers 1992).	If the participants and others believe that findings are meaningful to their 'lived experience' then confirmability has been achieved (Yonge and Stewin 1988; Chalmers 1992; Leininger 1994). Also called member or respondent validation. For a study to have confirmability, methods must be described in detail, an audit trail and reflexivity of the researcher should be evident and negative cases should have been explored (Huberman and Miles 1994).
Meaning in context	Leininger 1992, 1994	"Refers to the data that have become understandable within holistic contexts or with special referent meanings to the informants or people studied in different or similar environmental contexts" (Leininger 1994 p. 106)	Achieved through member validation (Leininger 1992, 1994)
Recurrent patterning	Leininger 1992, 1994	Refers to instances, events or experiences that reoccur over time either in the same or different contexts (Leininger 1994)	Established through member validation (Leininger 1994)
Saturation	Leininger 1992, 1994	Detailed exploration of phenomenon until knowledge gained is comprehensive (Leininger 1994)	The adequacy of the data is assured by saturation of categories (Morse 1991) which is an important aspect of grounded theory methodology (Glaser 1992)
Dependability	Lincoln and Guba 1985	Included in recurrent patterning (Leininger 1992). Is independent on credibility (Holloway and Wheeler 1996).	Established through member validation (Leininger 1994).
Transferability	Lincoln and Guba 1985 Leininger 1992, 1994	Transferability refers to how findings can be transferred from a representative sample to another similar context or situation whilst preserving meanings and interpretations from original study (Lincoln and Guba 1985; Leininger 1994; Holloway and Wheeler 1996)	Henwood and Pidgeon (1993 p. 27) consider this issue of transferability and grounded theory when they state "in our view, rich and dense grounded theory, which is contextually sensitive at diverse levels of abstraction, will in itself suggest its own sphere of relevance and application".

Appendix V

Gaining access to clinical areas

18th October 1999

Mrs. J. Barclay
Clinical Nurse Manager,
Surgical Directorate 'A' Block,
Law Hospital,
Carlisle.

Dear Mrs. Barclay,

I am writing to inform you that I will be researching Bell College nursing students (semester 6) during their surgical placements. This will take place during their normal clinical visiting by myself. The overall aim of the study is to find out how prepared students feel for the qualified role and to actively assess this during the participant observer stages. The session would last approximately 2 hours and I would like to start them in January 2000.

I would be happy to meet with you to discuss the study further, please contact me.

Yours sincerely,

Mrs. Jayne Donaldson
Lecturer, School of Health Studies
Bell College, Hamilton

Outline of PhD study

<u>Participants:</u>	Bachelor of Nursing Students – within 2 months of qualification
<u>Time:</u>	26th June – 22nd July 2000
<u>Clinical area:</u>	Acute nursing care

Research aims:

- **To explore the perceptions of Bachelor of Nursing students as to their preparation for the qualified role;**
- **To compare their actual performance with their perceived performance within the clinical area near to qualification.**

Focussed individual interviews and participant observation are the data collection methods used within this grounded theory study. The following contains an extract from the Ph.D. thesis explaining rationale for participant as observer role.

Participant Observation

Participant observation was chosen as it was important to obtain information from the inside about a phenomena of which little is known (Jorgensen 1989). The differences and/or similarities in performance could be observed within an everyday work environment.

Participant observation has been discussed in the literature. Schwartz and Schwartz (1955) were among the first authors to describe how participant observers should act and present themselves. Following from this literature, Gold (1958) outlines four modes through which observers may gather data: the complete observer, the observer as participant, the participant as observer and the complete participant.

(A) 'Complete Observer'

In the role of complete observer, the researcher takes no deliberate part in events and tries to record the event as objectively as possible. A classic research study set out to examine the effect of illumination levels on productivity at the Hawthorne plant of Western electric in Chicago (Roethlisberger and Dickson 1939). The experiment involved altering the levels of light over a period of 2.5 years and found that no matter what the levels were set at, productivity continued to increase. The authors concluded that the workers produced more mainly because they were being observed rather than as a result of different lighting. This type of observer effect is now known as the 'Hawthorne effect' (Parahoo 1997). Johnson (1997a) felt that from personal experience of being observed in this way, people changed their work routine because they were being observed. Schatzman and Strauss (1973) argue that whilst the researcher is visible to the participants, it is impossible for the researcher to have no effect on their behaviour.

I felt that as a nurse I could not observe events going on in the ward areas without feeling perhaps a legal and/or moral obligation to intervene, especially if a mistake was about to be made which would have endangered the patient. This has been identified as a problem with observation (Dingwall 1980; Johnson 1997a). Dingwall (1980) stresses that if the researcher allows poor practice to continue, then the informant might even think that their behaviour is acceptable.

Johnson (1997a) gives an example of an elderly debilitated patient having to undergo uncomfortable investigations, which if his own clear wishes had been noted, he would not have been subjected to. He felt that intervention by the researcher would have assumed a direct patient advocate role in opposition to medical staff and the patient's family. Johnson (1997b) argues that as an observer he has "invited status" and "the fragility of the researcher-respondent relationship must not be challenged too seriously by interventions of an unacceptable nature." However, Harris (1985) argues persuasively that people have the same responsibility to right and wrongs no matter what their contractual position. Johnson (1997a) advises the researcher to discuss these problems with supervisors and colleagues and then offer reasoned opinion upon researcher conduct. Johnson (1997a) uses a general unwritten policy that if he witnessed

anything resembling negligent or unsafe conduct, he would compromise his position as a researcher in the interests of the patient. For the purposes of this research, I also made this general policy with close links with my supervisor being maintained.

(B) 'Observer as Participant'

Gold (1958) argues that next along the continuum of observer roles is the 'observer as participant'. Here the observer accepts limited impact on the research setting. This has been used in classic studies of socialization into the medical and nursing profession (Olsen and Whittaker 1968, Becker, Geer, Hughes and Strauss 1961). The researchers generally tried to follow the participants during the day-to-day experiences of the students but did not take part in specific work treatments such as wound treatments. This perhaps was due to the fact that they were sociologists and not members of the profession being studied (Johnson 1997a).

(C) 'Participant as observer'

A more involved participation role, Gold (1958) calls 'participant as observer', and there has been limited use of this role as evident in the literature (Johnson 1997a). Schatzman and Strauss (1973) suggest that in the participative role, the researcher has a more 'active control' of data collection.

However, Gold (1969) also noted that there might be problems with this type of participant observation: it may take some time before the informant(s) begins to feel at ease with the observer or the informant-observer relationship may become too friendly. The observer may over-identify with the informant and start to lose his research perspective by 'going native'.

(D) 'Complete Participant'

The final category of observer role is that of 'complete participant' (Gold 1958; 1969). The informants are not told of the role of the researcher and is also known as covert observation (Bulmer 1982a). This role has been keenly followed in various branches of social science because it minimizes the risk of hosts

these situations and discovers their interpretations of the events he has observed.”

Kite (1999) stated that as a research student and a nurse she explained a potential for role conflict. In a clinical area which was understaffed it would be easy to help with the work at the expense of getting the research done. She also felt that there may be a professional responsibility to help the clinical staff. As a researcher she also felt that she would disrupt the normal goings on and owed it to the staff to be helpful. Following the participant observation I aimed to discuss this possible role conflict within the discussion section if and when it occurred.

For the purposes of this research I would like access to the clinical areas in which these students will be working. To carry out the participant as observer role I would be involved with the student in carrying out direct patient care while observing them. I would only intervene in the care of a patient if I felt that the safety of the patient was at risk.

If you would like to discuss this further please do not hesitate to contact me.

Reference list:

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Vidich, A.J. (1955) Participant observation and the collection and interpretation of data. *American Journal of Sociology*, 60(4); 354-360.



**South Glasgow
University Hospitals
NHS Trust**

Trust Headquarters

Southern General Hospital
1345 Govan Road, Glasgow G51 4TF

Telephone: 0141-201-1100

Fax: 0141-201-2999

Our Ref: IB\EM
Ext: 1289

7th June 2000

Mrs Jayne Donaldson
51 Barmore Avenue
Carluke
South Lanarkshire
ML8 4PE

Dear Jayne,

I have written to the appropriate Senior Nurses in the Southern General Hospital regarding your study and now enclose two copies of a Letter of Access which I would ask you to sign and return one copy to me.

I think I probably asked you to indicate the names of the students and the areas where they would be working and if you could do that it would be extremely helpful. I will then send it off to the Senior Nurses.

If there are any further questions please do not hesitate to contact me.

Yours sincerely,

Miss I Barr
Deputy Director of Nursing



**South Glasgow
University Hospitals
NHS Trust**

Trust Headquarters

Southern General Hospital
1345 Govan Road, Glasgow G51 4TF

Telephone: 0141-201-1100

Fax: 0141-201-2999

Our Ref: ib\em
Ext: 1289

7th June 2000

Mrs Jayne H Donaldson
51 Barmore Avenue
Carluke
South Lanarkshire
ML8 4PE

Dear Mrs Donaldson,

I am instructed to offer you Clinical Access to the South Glasgow University Hospitals NHS Trust from 26th June – 22nd July 2000.

1. Immediately on taking up this access facility, or as soon as possible thereafter, you should report to Miss I Barr's office bringing with you the following documents.
 - a) Registration documents
 - b) Signed copy of this letter
2. You will be required to maintain registration with the UKCc throughout the term of access.
3. You will be required to adhere to the Trust Board's and Hospital policies and procedures (see attached enclosures).
4. Access will be limited to the South Glasgow University Hospitals NHS Trust.
5. Providing you agree to accept these access facilities as outlined above, I should be grateful if you would sign both copies of the letter as detailed above and retain one for your own information.

Yours sincerely,

Miss I Barr
Deputy Director of Nursing

I agree to accept the above items of access as written.

Signature...*Jayne Donaldson*.....

Date...*19/06/00*.....

Appendix VI

**Response, consent and information sheets for
participants and interview checklist**

Group UG1: 0-2 months
Consent Form

Name: _____

Address: _____

Address: _____

Telephone: _____

I understand that the purpose of this research is to study the perceptions I have about nursing and the educational program I am currently undertaking. This will be carried out in the first two months of the course. This will involve focus group interviews containing 8-12 people.

I am assured that my identity will not be revealed to anyone other than the researcher. My name will be encoded so that I remain anonymous.

I have been informed of the nature of the research and I voluntarily agree to be a subject. I understand that I can withdraw from the research at any time, and that I can refuse to answer particular questions.

Signature: _____ **Date:** _____

Researcher Signature: _____ **Date:** _____

Group D1: 0-2 months
Consent Form

Name: _____

Address: _____

Address: _____

Telephone: _____

I understand that the purpose of this research is to study the perceptions I have about nursing and the educational program I am currently undertaking. This will be carried out in the first two months of the course. This will involve focus group interviews containing 8-12 people.

I am assured that my identity will not be revealed to anyone other than the researcher. My name will be encoded so that I remain anonymous.

I have been informed of the nature of the research and I voluntarily agree to be a subject. I understand that I can withdraw from the research at any time, and that I can refuse to answer particular questions.

Signature: _____ **Date:** _____

Researcher Signature: _____ **Date:** _____

Information Leaflet

Ph.D. Research

Researcher: Jayne Donaldson

I am currently a Nurse Lecturer at Bell College of Technology, Hamilton. For the purposes of a Ph.D. study, I have chosen diploma students at my own place of work, and the Bachelor of Nursing students at Glasgow University.

The aims of the study are:

1. What preconceptions do pre-registration undergraduate and diploma students have about their course and the nursing profession?
2. How do these preconceptions develop as the course progresses?
3. How do pre-registration undergraduate and diploma students perceive their preparation for the qualified role, and how does this match to their performance in the clinical area?

Participation in the study will involve being part of a focus group (8-12 people) interview with your classmates. At this stage of your education, I will want you to focus on the following two questions:

1. What is nursing?
2. Why did you choose this course to prepare you for registration?

There is no obligation for you to participate in the study, but your time would be greatly appreciated.

Please ask questions.

Jayne Donaldson

Response Form

Group UG1: 0-2 months

Having been introduced to the research today, I would like you to complete the following details and indicate if you would like to be part of the research. There is no obligation to take part, but your participation would be greatly appreciated.

Name: _____

Address: _____

Address: _____

Telephone: _____

Other : _____

**I would/ would not like to be considered for this research study.
(delete as appropriate).**

Thank you for your time today.

Yours sincerely

Jayne H. Donaldson

Response Form

Group D1: 0-2 months

Having been introduced to the research today, I would like you to complete the following details and indicate if you would like to be part of the research. There is no obligation to take part, but your participation would be greatly appreciated.

Name: _____

Address: _____

Address: _____

Telephone: _____

Other : _____

**I would/ would not like to be considered for this research study.
(delete as appropriate).**

Thank you for your time today.

Yours sincerely

Jayne H. Donaldson

Checklist for Focus Group Interviews
Jayne Donaldson

Tape recorder
Extension cable
Spare batteries for microphone and recorder
Tapes
Arrange room
Arrange time
Arrange seating in circle
Check tape recorder is placed in a way that it will pick up all the voices

Information for students:

- Confidentiality
- Anonymity
- Tape recording
- Coded names
- No obligation to take part
- No obligation to answer all the questions
- Can withdraw at any time
- Signing consent form

Opening questions:

I would like you to tell me about why you chose this diploma course to become a nurse....

Tell me what you think nursing is.....

Ending the interview.

Is there anything you would like to ask me?

Is there anything else I should have asked you?

Could I contact them again if needed?

Could I meet with them again so that they can read the findings of the study and gain their views?

Appendix VII

**Fitness for practice, purpose, award and
professional registration**

Fitness for practice: the UKCC is primarily concerned about fitness for practice – can the student register as a practitioner? The assessment of fitness for practice depends on the scope and nature of practice and how this evolves over time – on individual level, as careers progress, and on a societal level, as health care needs change. Registration, thus, represents an endorsement of the individual's fitness for practice – with the proviso that professional updating is an on-going process.

The U.K.C.C. and N.B.S. (2000) stated that within Scotland Fitness for Practice would entail:

1. Practice-Centred Learning

“The primary aim in pre-registration nursing programmes is to ensure that students are prepared to practice safely and effectively, to such an extent that the protection of the public is assured. On this basis, it is a fundamental principle that programmes of preparation are practice-centred and directed towards achievement of professional competence.”

(NBS 2000, p. 10)

2. Theory and Practice Integration

“Safe and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by that practice. Such knowledge must therefore be directly related to, and integrated with, practice in all programmes leading to registration as a nurse. The competencies, and preparation for such competencies, must therefore reflect a breadth of practice and learning.” (NBS 2000, p. 10)

1. Evidence-based Practice and Learning

“Within complex and rapidly changing healthcare situations it is essential that practice is informed by the best available evidence. This commitment is reflected in the competencies. It includes searching the evidence base, analysing, critiquing and using research and other forms of

evidence in practice, disseminating research findings, and adapting practice where necessary. This must be reflected throughout all programmes of preparation.”

(NBS 2000, p.10)

Fitness for purpose: prospective employers are primarily concerned about fitness for purpose – is the newly qualified nurse or midwife able to function competently in clinical practice? The speed of change in the context and content of health care makes it difficult to define fitness for purpose – its meaning cannot be fixed. Fitness for purpose depends on the commitment of employers and employees to constant professional updating. Given the pace of change, it seems unreasonable to expect fitness for purpose – other than in the broadest sense – to be a function of pre-registration education.

The U.K.C.C. and N.B.S. (2000) stated that nursing must relate to the changing in the needs of the health service and communities they serve, by responding to current and future needs. Fitness for Purpose would entail:

1. Provision of care

“Orientation must be towards practice that is responsible to the needs of various client groups across different care settings. This will be reflected in the capacity to assess needs, diagnose and plan, implement and evaluate care in such circumstances. Care practice must not only reflect collaborative working with other members of the care team but must also empower the patient/client and their carers to actively participate in the planning, delivery and evaluation of care. These principles must be reflected in all programmes of preparation leading to entry to the Register.”

(N.B.S. 2000 p. 11)

Management of Care

“The nursing role involves a capacity not only to participate actively in care provision but also to accept responsibility for the effective and efficient management of that care practiced within a safe environment. This involves the

capacity to accept accountability, to take responsibility for the delegation of aspects of care to others, and to effectively supervise and facilitate the work of such carers. It also involves the capacity to work effectively within the nursing and wider multidisciplinary team, to accept leadership roles within such teams, and to demonstrate overall competence in care and care management.”

(N.B.S. 2000, p. 11)

A Health for all Orientation

“In keeping with the orientation towards holistic care, the emphasis must be one that avoids a narrow disease-orientated perspective and instead adopts an orientation that encompasses a health promotion and health education perspective. It extends beyond a disease orientation to a commitment to health for all irrespective of class, creed, age, gender, sexual orientation, culture or ethnic background. On this basis, principles of equity and fairness are fundamental professional values that must be reflected in the competencies and addressed directly in all programmes of preparation.”

(N.B.S. 2000, p. 11)

Lifelong Learning

“The rapidly changing nature of healthcare reflects a need for career-wide continuing professional development and the capacity not only to adopt to change but to identify the need for change and initiate change. The provision of safe and effective healthcare and appropriate responsiveness to the changing needs of services and patients/clients cannot be achieved by adhering to narrow and/or rigid professional boundaries. The competencies must therefore include the capacity to extend the scope of practice and to address lifelong learning skills within all programmes of preparation.”

(N.B.S. 2000, p. 11)

Quality and Excellence

“The practice-centred competencies essential in nursing are not separate and insular professional aspirations. They are linked to wider goals of achieving clinical effectiveness within healthcare teams and agencies, with the ultimate aim of achieving high quality healthcare. In this respect, assuring the quality of nursing care is one of the fundamental underpinnings of clinical governance. It is therefore necessary that nursing competencies encompass the capacity to contribute to his wider healthcare agenda and must be addressed within all programmes of preparation.”

(N.B.S. 2000, p. 11)

Fitness for award: educational institutions are primarily concerned about fitness for award – has the student attained the appropriate level, breadth and depth of learning to be awarded a diploma or degree? Fitness for award does not mean fitness for purpose, but most employers acknowledge established academic awards as markers of achievement.

Fitness for Professional Standing: Nurse education needs to provide the profession with individuals who not only are competent, safe and carry out effective care, but also have the understanding of the responsibility for the highest standards of professional conduct and ethical practice.

- 1. Adherence to the Code of Professional Conduct**
- 2. Responsibility and accountability**

“It is the hall mark of all professions, one held by this Council, that the individual professional must have a willingness and capacity to take personal responsibility for actions and omissions, and fully recognise personal accountability in this regard. This requires that each individual practitioner has the capacity to make sound decisions in respect of such aspects

of their role as personal professional development; practising within the scope of personal professional competence and extending this scope as appropriate; delegating aspects of care to others and accepting responsibility and accountability for such delegation; and. Working harmoniously and effectively with colleagues, clients/patients and their significant others.”

(N.B.S. 2000, p. 13)

3. **Ethical and legal obligations**
4. **Respect for individuals and communities**

Following the report by the U.K.C.C.’s Commission for Education, *Fitness for Practice* (U.K.C.C. 1999) and *Requirements for Pre-registration Nursing Programmes* (2001), the N.M.C. (2002) updated the requirements for preregistration nursing programmes.

Appendix VIII

Abstract accepted for conference presentation

**Title: UNDERGRADUATE AND DIPLOMA NURSING STUDENTS: A
COMPARISON OF THEIR PERFORMANCE IN PRACTICE**

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Title: UNDERGRADUATE AND DIPLOMA NURSING STUDENTS: A COMPARISON OF THEIR PERFORMANCE IN PRACTICE

Very few research studies within the United Kingdom compare diploma and undergraduate nursing students (Bartlett, Simonite, Westcott, Taylor 2000; While, Fitzpatrick and Roberts 1998). With the promotion of graduate preparation within nursing (UKCC Commission for Nursing and Midwifery Education 1999) and as the debate over diploma versus degree level education continues, there is a need to research the similarities and differences in students produced by each programme. The research questions included: (1) How do pre-registration undergraduate and Higher Education Diploma students perceive their preparation for the qualified role? and (2) How do their perceptions of their preparation for the qualified role compare with their actual performance in the clinical area near to qualification?

The study used Grounded Theory methodology (Glaser and Strauss 1967). Undergraduate (n= 6) and diploma (n=8) nursing students were used. Volunteers for the study were sampled using the theoretical sampling technique (Glaser and Strauss 1967). The students were individually interviewed to find out how they felt the educational programme had prepared them for clinical practice. Participant observation was carried out with the students in acute areas of practice. The researcher role was that of 'participant as observer' (Gold 1958). All students were within two months of qualifying as a Registered Nurse (Adult).

Data analysis was carried out using the constant comparative analysis where data coding and collection took place simultaneously (Glaser and Strauss 1967). Data was coded and analysed using substantive (Strauss and Corbin 1990) and theoretical coding (Hutchinson 1993, Stern 1980), with the formation of core categories (Gray 1997). Subsequently a grounded theory was developed (Glaser and Strauss 1967).

Reliability and validity of the qualitative data produced was facilitated with the use of member validation (Guba and Lincoln 1981), outsider validation (Sandelowski 1986), the provision of an 'audit trail' (Leininger 1994), reflexivity of the researcher (Abbott and Sapsford 1998), and data saturation (Glaser and Strauss 1967).

During the individual interviews, both groups stated they felt that diploma students were more skilled in practice while undergraduate students had a better understanding and a deeper knowledge of certain areas of practice especially when arguing the rationale for interventions (e.g. understanding drug actions and side effects). Undergraduate students expressed that they were looking forward to the new challenge of being a newly qualified staff nurse. However diploma students expressed concern and fear over the prospect of the added responsibility and accountability associated with the staff nurse's role.

During the participant observation, the undergraduate students demonstrated an understanding of patients' social, psychological and physical backgrounds. However, the diploma students had difficulty demonstrating the same understanding of patients' problems and with problem solving skills within the clinical area.

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While, A.E., Fitzpatrick, J.M., Roberts, J.D. (1998) An exploratory study of similarities and differences between senior students from different pre-registration nurse education courses, *Nurse Education Today*, 18; 190-198.

Appendix IX

Outsider validation: summary and questionnaire

18th July 2001

Dear

I am currently a Ph.D. student within the Department of Nursing and Midwifery at Glasgow University, studying undergraduate (Bachelor of Nursing, Glasgow University) and diploma (Diploma in Higher Education, Bell College) nursing students. I have recently completed a qualitative study investigating how students viewed their preparation for the qualified role. I also carried out participant observation of each student within the clinical area.

I would like your input with regards to some of the issues the research has raised. Firstly, I have included a very short abstract of the research methodology and background to the study. Secondly, I have included a short description of the findings of the study.

Please read the following document, complete the questions, and return in the prepaid envelope (It should only take 10-15 minutes!).

I look forward to your reply.

Thank you for your time and effort. I wish you every success with your future career in nursing.

Regards,

Jayne Donaldson M.N., B.N., R.G.N., P.G.C.E.

Title: A comparison of the perceptions and performance of undergraduate and diploma nursing students

Very few research studies within the United Kingdom compare diploma and undergraduate nursing students (Bartlett, Simonite, Westcott, and Taylor 2000; While, Fitzpatrick and Roberts 1998). With the promotion of graduate preparation within nursing (UKCC Commission for Nursing and Midwifery Education 1999) and as the debate over diploma versus degree education continues, there is a need to research the similarities and differences in students produced by each programme. The research aims were to explore:

- the preconceptions of pre-registration undergraduate and HE diploma (Adult) students have about their course and the nursing profession;
- how these preconceptions develop as their programmes progress;
- how pre-registration undergraduate and HE diploma (Adult) students perceive their preparation for the qualified role;
- how their perceptions of their preparation for the qualified role compare with their actual performance in the clinical area near to qualification?

The study used a Grounded Theory methodology (Glaser and Strauss 1967). Undergraduate and diploma nursing students were used. Volunteers for the study were sampled using a theoretical sampling technique (Glaser and Strauss 1967). Table One illustrates the groups of students used and the method(s) of data collection used.

Focus group and individual interviews were carried out. Participant observation was carried out within acute areas of practice. The researcher role was that of 'participant as observer' (Gold 1958). All students within the final year were within two months of qualification as a Registered Nurse (Adult).

Data analysis was carried out using the constant comparative analysis where data coding and collection took place simultaneously (Glaser and Strauss 1967). Data was coded and analysed using substantive (Strauss and Corbin 1990) and theoretical coding (Huchinson 1993; Stern 1980), with the formation of core categories (Gray 1997). Subsequently a grounded theory was developed.

Table One: Outline of the cross-sectional study design employed in this study

Time-frame within programme	Diploma (36 month duration)	Undergraduate (48 month duration)
0-2 months	Focussed focus group (D1) n= 6	Focussed focus group (UG2) n=6
18-20 months	Focussed interviews (D2) (midway) n=8	Nil
24-26 months	Nil	Focussed interviews (UG2) (midway) n=8
34-36 months	Focussed interviews + Focussed participant observation (D3) n=8 (within 2 months of completion)	Nil
46-48 months	Nil	Focussed interviews + Focussed participant observation (UG3) n=6 (within 2 months of completion)

Findings

Professional self-concept

Professional self-concept is constructed through self-evaluation about professional knowledge, values and skills (Kelly 1992). The students within this study developed their own professional self-concept as the programmes progressed. The students' perceptions of their knowledge, values and skills changed as the programmes progressed. The participant observation revealed some interesting findings regarding students' knowledge, values and skills.

However, the students identified many factors which greatly influenced their knowledge, values and skills:

1. **“Confidence to go out and do” (Anne, D1):** Having the confidence to go out and work as a nursing student was a concern for all neophyte students (D1 and UG1), although undergraduates expressed much more stress and apprehension about their first placement than diploma students. All of the students at the mid-point of each programme felt that each programme had helped to develop their confidence. However, diploma students (D2) were more confident in their practical ability, while undergraduate students (UG2) were more confident in their theoretical ability.

Near to qualification, diploma students (D3) experienced high levels of anticipation and stress at the thought of being newly qualified. They identified deficits in their knowledge (e.g. drugs, documentation, managerial), in their skills (e.g. managerial, drug administration and calculations, recording and evaluation of nursing care), and in their values (e.g. ability and assertiveness to question ethical decisions). However they did feel confident with some knowledge and skills (e.g. wound dressings, aseptic technique, IV fluids).

Near to qualification, undergraduate students (UG3) stated that they were eager to start as a qualified nurse. Although they stated it was inevitable to feel slightly apprehensive when doing tasks unsupervised when newly qualified, they all stated that they felt confident in their theoretical and practical knowledge

2. **Clinical learning environment:** This was a major source of stress and apprehension for all neophyte students. It was anticipated that this area would be a major source of data due to the practical nature of the programmes. Both groups (D2 and UG2) stated that the clinical learning environment had had a major impact on their level of practical competence.

Professional self-concept is linked to the clinical learning environment since this was seen by students as having a significant effect on the level of competence the student had.

All students, once they had experienced practice, stated episodes of uncaring/caring practice, unfriendly/friendly, unsupportive/supportive staff, opportunities for learning (or not), and the inconsistent use of supernumerary status. The link between theory

and practice was inconsistent – students often knowingly practiced using out-of-date research for the sake of ‘fitting in’ to the nursing team.

3. **“Good nurse” (Lorna, D1):** Both groups (D1 and UG1) wanted to have the qualities of a “good nurse”. They identified various areas that they felt would be important qualities. Both groups (D2 and UG2) of students had stated that they had learned from examples of a “good nurse”.

Professional self-concept is related to the qualities of a “good nurse” as this provided students with a good role model on which to base practice attitudes, behaviours, knowledge and skills (Kelly 1992).

4. **Level of theoretical knowledge:** Students identified positive and negative aspects which they felt each programme had.

Course content provided some controversial views from both sets of neophyte students. Undergraduate students (UG2) stated that they had begun to see the integration of subjects and commented on the benefits of having a better level of theoretical knowledge than diploma students.

It has been argued that the level of theoretical knowledge has been linked to the students’ professional self-concept. If the students’ knowledge is poor, they will be incompetent and lack in confidence (Davidhizar 1991).

Diploma students (D3) near to qualification felt that their theoretical knowledge was not as good as undergraduate students, but their practical skills were of a better standard. Undergraduates (UG3) were also of the opinion that diploma students had better practical skills, but did not have as good a level of theoretical knowledge.

5. **Previous practice experience:** Students felt that the quality of previous experience was dependent on the ‘luck’ of the allocation of placements. They felt that a series of ‘bad’ placements meant they had fallen behind with practical skills, and had limited exposure to good role models on which to base their practice. Availability, interest and motivation of trained staff were identified as being a huge influence on the quality of the learning experience. Some students found that they had to compete with other students within the same clinical area for practice of skills.

Roistered service for diploma students appeared disappointing in the sense that they had not developed management skills as they had expected, and again the experience was very dependent on the attitude, interest and motivation of practice staff. However the undergraduates appeared much more satisfied with their experience within their ‘management module’.

6. **Mentorship:** All students had had experience of good and bad mentors. They explained how this had affected the integration of theory to practice, had ‘shaped’ their learning experience, and had resulted in different degrees of supervision and feedback. Positive constructive feedback has been shown to improve performance (Wood and Bandura 1989), but too much can result in overconfidence (Kissinger 1998).

All students explained that they had had feelings of fear, pressure and stress of work, worry, lack of confidence, and were 'used as a pair of hands'. They had experienced negative and positive attitudes (e.g. enthusiasm and motivation to teach) from mentors. Poor mentorship, it has been argued reduces self-beliefs, thereby reducing the students' confidence and willingness to carry out that skill (Appelbaum and Hare 1996).

They felt that role modeling was a good way to learn, but it was not always their mentor who had those special qualities. They were often disappointed by the lack of availability of mentors within acute areas due to shift work, holidays and internal rotation. None of the students mentioned the role of the lecturer within practice.

- 7. Development of competence:** All students at the mid-point of their programme explained their anxiety as to their lack of practical skills, and the lack of opportunity to link theory to practice. However, undergraduate students felt that they were much more able to understand what, why and how they were doing practical skills than diploma students. However, diploma students felt that they were much more able to carry out a wider variety of skills and were more competent at carrying out that skill than undergraduate students.

Near to qualification, undergraduates were much more confident in their theoretical and practical knowledge and skills. However, they still thought that diploma students had a better level of practical skills than undergraduates.

During participant observation, I noted some similarities and differences in the theoretical knowledge and practical ability of diploma and undergraduate students.

Undergraduates demonstrated a detailed knowledge of their patients' current health status, social and medical/nursing problems. There was evidence of good communication skills, including explanation of health and medical details to the patient. They demonstrated knowledge of the holistic, multidisciplinary care of the patient. Skills were demonstrated to an acceptable level of motor ability, while the theoretical knowledge supporting that skill was very good. Nursing problems identified were dealt with efficiently and effectively.

Diploma students had much more difficulty in demonstrating the same level of knowledge of the skill, the holistic/multidisciplinary care of the patient, and the social/medical/nursing problems patients had. The confidence they had in their own ability was definitely much less than undergraduates. The level of motor skill was very efficient, but there was evidence that they had poorer knowledge in the reasoning why and how. Patients who presented with clinical problems were either undiagnosed or the student was unable to solve the problem independently. However, communication skills were very good, but the students often lacked confidence to give health/medical explanations which the undergraduates had dealt with confidently and effectively.

Outside validation/ Diploma
The links between these concepts are illustrated in Figure One.

Professional self-concept(Kelly 1992):

core category

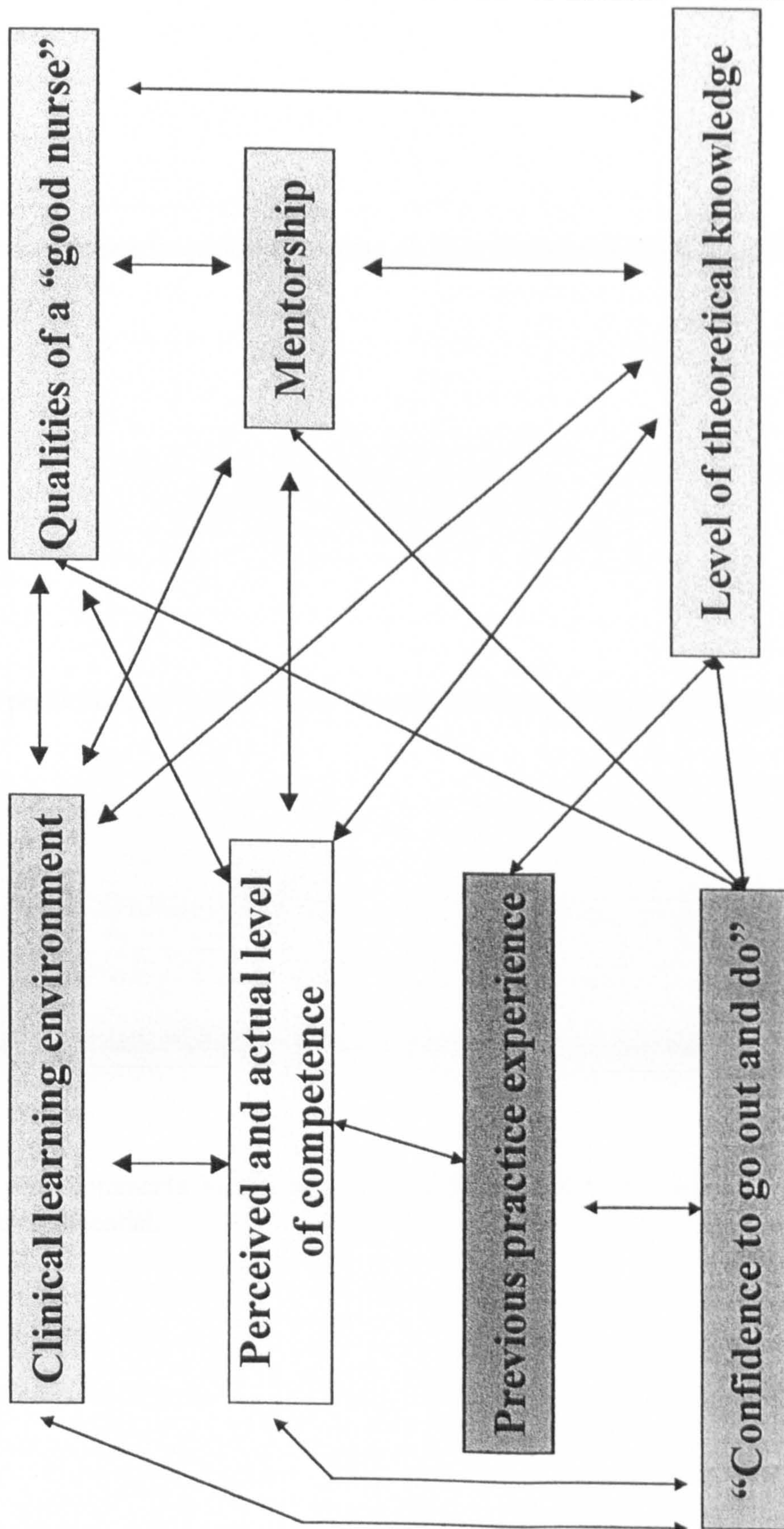


Figure 1

Please comment on the following:

1. The preconceptions of both groups of nursing students at the beginning of the programme
2. The perceptions of nearly-qualified students on their preparation for the qualified role
3. The actual performance of nearly-qualified students during participant observation

Please return your comments in the prepaid envelope. Your response is completely anonymous and confidential.

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Outside validation/ Diploma

Wood, R., Bandura, A. (1989) Social cognitive theory of organizational management. *Academy of Management Review*, 14(3); 361-384.

Appendix X

Conference presentations and published papers

Conference presentations between 2001-2003:

Donaldson, J.H., Carter, D. (2001) *Undergraduate and Diploma Nursing Students: A Comparison of their Performance in Practice.* Conference Presentation/Paper, Trinity College, Dublin.

Donaldson, J.H., Carter, D. (2002) *Undergraduate and Diploma Nursing Students: A Comparison of their Performance in Practice.* Conference Presentation/Paper, Staff Seminar, Bell College, Hamilton.

Donaldson, J.H., Carter, D. (2003a) *Undergraduate and Diploma Nursing Students: A Comparison of their Performance in Practice.* Conference Presentation/Paper, Research Speaker, Research Degree Module, Dumfries Campus, Bell College.

Donaldson, J.H., Carter, D. (2003b) *Using Qualitative Research: Some Practical and Theoretical Issues.* Conference Presentation/Paper, Research Speaker, Research Degree Module, Dumfries Campus, Bell College.

Conference presentations arranged for 2003:

Donaldson, J.H., Carter, D. (Sept-Dec 2003 to be arranged) *Undergraduate and Diploma Nursing Students: A Comparison the Similarities and Differences of Diploma and Undergraduate Nursing Students.* Staff and Postgraduate Research Seminar, University of Glasgow.

Titles of articles written for consideration by professional journals by Donaldson, J.H., and Carter, D.:

The Value of Clinical Role Modelling: The Perceptions of Undergraduate and Diploma Nursing (Adult) Students. Presented to Nurse Education Today for consideration.

The Development and Significance of Professional Self-concept in Nursing Students. For presentation to the Journal of Advanced Nursing or Nurse Education Today.

The Role of the Mentor in Promoting Professional Self-concept in Nursing Students. For presentation to the Journal of Advanced Nursing or Nurse Education Today.

The Theoretical and Practical Aspects of Carrying Out 'Participant-As-Observer' Roles within Participant Observation. For presentation to the Nurse Researcher or NT Research.