ANGLIA RUSKIN UNIVERSITY

FACULTY OF HEALTH, SOCIAL CARE AND EDUCATION

BEING A STUDENT NURSE: ROLE DUALITY ISSUES FOR HEALTHCARE ASSISTANTS UNDERTAKING A WORK-BASED LEARNING PRE-REGISTRATION NURSING PROGRAMME

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A thesis in partial fulfilment of the requirements of Anglia Ruskin University for the degree of Professional Doctorate, Health and Social Care

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ABSTRACT

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Introduction and background: Nursing shortages have resulted in an increased interest in work-based learning programmes supporting employed healthcare assistants (HCAs) to train simultaneously as student nurses. This requires them to fulfil concurrent roles of both HCA and student. Successful transition generally results from exiting one role and accepting another, therefore these HCA/students risk remaining in a no-mans-land between the two roles. This study explored the practice experiences of one cohort of students and mentors in relation to the students' dual roles.

Methodology: The research was carried out using an exploratory sequential mixed methods approach, with a thematic literature review, qualitative interviews and a quantitative pilot evaluation of one intervention arising from the qualitative phase.

Findings: The dual roles of HCA and student nurse created a potential barrier to students' professional socialisation. Their ability to transition to the student nurse role was impacted by the primacy of the HCA role, lack of role clarity and the perceptions of other team members which resulted in them being perceived as '*HCAs doing extra'* rather than as student nurses. However, visual reinforcement, through artefacts such as uniform and by avoiding placing the students in their employed areas, was perceived as beneficial. Mentors did not identify such role duality issues for themselves. The introduction of a booklet was intended to reinforce the student role when appropriately applied.

Conclusions: This exploratory sequential mixed methods research supported the development of new knowledge through identification of the experiences of this student cohort. New theory was derived from the development of a revised professional socialisation transition process for this group of students, but further research is needed to identify the generalisability of this theory. Whilst the pilot evaluation of the booklet was impeded by a poor response rate, service colleagues still believe this to be beneficial and have continued to use it in practice. Further work is needed to embed the booklet in practice and further explore its efficacy.

Key Words: role duality, role transition, professional socialisation, work-based learning, pre-registration nursing programme, sponsorship.

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LIST OF ABBREVIATIONS

Abbreviation	Term, Title, Organisation or Word in full	Page
HEE	Health Education England	1
WBL	Work-based learning (learning from, through and at work)	1
DProf	Professional Doctorate	1
PhD	Doctor of Philosophy	1
RN	Registered Nurse	3
PRNP	Pre-registration nursing programme (a programme of education that leads to nurse registration)	3
HEI	Higher Education Institute	10
NHS	National Health Service	10
RCN	Royal College of Nursing	15
TDA	Trust Development Authority	15
NHSI	NHS Improvement	15
RePAIR	Reducing Pre-registration Attrition and Increasing Retention project	15
NHSE	NHS England	15
DOH	Department of Health	15
HCA	Health Care Assistant (a pre-professional nurse)	15
SHA	Strategic Health Authority	16
NMC	Nursing and Midwifery Council	18
GYOOG	Grow Your Own Operational Group (local group which operationalises delivery of the programme. Consists of HEI, HEE and employers link representatives. The Annual Open GYOOG is expanded to include students and mentors).	19
PHE	Public Health England	22
LETB	Local Education and Training Board	22
LWAB	Local Workforce Action Board	22
STP	Sustainability Transformation Plan	22
GP	General Practitioner	24
PEF	Practice Education Facilitator (employed by Health Education England, and former Strategic Health Authority, to support the quality of the clinical learning environment)	25
UK	United Kingdom	36
UKCC	United Kingdom Central Council	37

Zetoc	Research database and journal alert system	37
MEDLINE	Biomedical research database	37
EMBASE	Biomedical research database	37
Cinahl	Cumulative index to nursing and allied health literature	38
MESH	Medical Subject Headings (database)	38
BNI	British Nursing Index	38
AMED	Allied and Complementary Medicine Database	38
EBSCO	Online library search engine directory (largely health, social care, education, military and government)	38
OU	The Open University	38
ARU	Anglia Ruskin University	38
ETHOS	Electronic theses online access service	38
COP	Community of Practice	40
PIN	Personal Identification Number	64
ID	Identification	64
MMR	Mixed Methods Research	87
QUAN	Quantitative	97
QUAL	Qualitative	97
SRPP	Student Research Project Panel (programme provider's internal review to ensure students are not over-researched)	108
IRAS	Integrated Research Application System (the national integrated on-line application system designed to allow a "one" approach to multiple NHS ethical approval applications)	127
R&D	Research and Development (service providers' internal review of research governance and ethics)	127
FREP	Faculty Research Ethics Panel (DProf programme provider's full ethical review panel)	128
ITU	Intensive Therapy Unit	183
6Cs	The Chief Nurse's perceived 6 components which constitute compassionate practice; Care, Compassion, Courage, Communication, Commitment and Competence	201
FNP	Flexible Nursing Pathway	288

BEING A STUDENT NURSE: ROLE DUALITY ISSUES FOR HEALTHCARE ASSISTANTS UNDERTAKING A WORK-BASED LEARNING PRE-REGISTRATION NURSING PROGRAMME

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Prologue

This thesis has been developed in conjunction with my professional role in workforce development, education and training for Health Education England (HEE). In 2011, the programme being explored was commissioned locally as a pilot. It was primarily to be tested out as a grow your own programme for local employers, offering existing pre-professional nursing staff the opportunity to train as student nurses whilst retaining their employed roles three days per week. This type of programme, with nursing students continuing in their employed roles, had not been explored previously in the region. Therefore, I was curious as to the impact of this type of programme on the quality of the students' clinical learning experience and what their particular support needs might be. Hence the original remit for this study was very broad. Subsequently, with the publication of *Raising the Bar: Shape of Caring Review* (HEE, 2015), other work-based learning (WBL) programmes such as nursing apprenticeships and Trainee Nursing Associate programmes have become more prevalent.

From a developmental perspective, the preference for a Professional Doctorate (DProf), as opposed to Doctor of Philosophy (PhD), was based on the ability of this doctoral study to provide a springboard to further my professional, as well as researcher, development. This related not only to research skills, but also leadership and project management - all beneficial both professionally and academically. It also aligned this study to an area of professional interest and importance, enabling a meaningful research study to be built around my professional role and the application of the research to practice.

The main driving forces behind undertaking this doctoral study were the ability to develop myself into a reflexive practitioner and demonstrate through this research my scholarship of practice. This will be further explored through the Introduction (Chapter One) and I will reflect on whether this has been achieved in the Epilogue.

Notes on style:

As a professional doctorate essentially interlinks research and practice, my role as a researcher cannot be detached from my professional role. Therefore, rather than refer to myself as either 'researcher' or 'practitioner,' I am writing this thesis in the first person where appropriate. This also fits more with my natural style of writing and allows greater reflexivity through the research, which is defined by my ability to look inwards towards my influence and input on this research (Fook, 2019), particularly in relation to my professional role and background. However, in order to provide a writing stance which allows for objectivity when necessary, for example when discussing the wider literature in relation to my research, it is necessary to distance myself in the first person. Therefore, in order to differentiate between my research and other studies under review and discussion, I have termed my research 'this doctoral study' or 'this research' wherever possible in these circumstances.

The definition of role duality applied to this thesis denotes the simultaneous undertaking of both the employed HCA role and supernumerary student nurse role. The nature of the programme under investigation requires both roles to be fulfilled for the duration of the four-year programme. Whilst the thesis refers in places to the HCA/student, there is no suggestion that there is a distinctly combined HCA/student role. This is generally used where both HCA and student roles are referred to.

CHAPTER ONE

Introduction, Background and Context for the Study

1.1 Introduction

This thesis explores the practice experiences of HCAs/students undertaking a four-year work-based learning (WBL), open learning, pre-registration nursing programme (PRNP) and their registered nurse (RN)/mentors. Through this exploration, the intention was to develop an understanding of any issues and why they occurred, design an intervention strategy to resolve potential issues and to pilot the implementation and evaluation of the intervention.

The study has been carried out using a sequential cycle of data collection and analysis to drive each further phase of the research:

- The thematic analytic literature review focuses the research on the potential impact of role duality on the HCA/students and their RN mentors.
- The qualitative interviews explore the role duality experiences of participants which impact on their role identity, identifying potential barriers and enablers to the professional socialisation process necessary for the HCAs to be student nurses.
- Arising from the qualitative interviews is the design and development of a booklet, introduced as an intervention to better support the professional socialisation process and minimise the adverse effects of role duality.

- The quantitative phase provides a pilot evaluation to test the effectiveness of both the intervention and evaluation processes. It allows reflection on what went well and what can be improved ahead of any further research activity, with recommendations for future research and practice.

This introductory chapter explores the intention for undertaking a professional doctorate study and gives an overview of the thesis structure. It then goes on to determine the background to the study and differing contexts which impact on it. In order to set the scene for this, identifying the scope of the study is critical.

A robust approach is required to ensure that researchers maintain focus and avoid getting distracted by exciting, unexpected findings that are unrelated to the stated aims and objectives. This therefore necessitates clear parameters for the scope of the research - what is and is not to be covered. This study sought to address a gap in knowledge around the practice experiences of these non-traditional students. The existing literature, identified through the literature review, was limited and often related to similar student groups rather than these specific non-traditional HCA/students. Whilst much of the available literature tended to focus on student issues from an academic perspective, few studies focused on issues from a practice perspective. Hence the scope of this study was to explore issues from a practice perspective, with considerable data relating to academic experiences excluded from this study as a result.

There are four other key areas which were outside the scope of this study:

1. There was a wealth of evidence, both in the literature review and the exploratory phase of research, which highlighted the detrimental impact of the combined workload of work, study and family life. These work/life harmonisation issues have been excluded from this study since the practice-based elements are only one part of this issue and therefore the issue itself was unlikely to be resolved through this doctoral study alone.

2. The study relates to a specific four-year, non-traditional, work-based learning programme and whilst students' perceptions of traditional students is explored as part of this study, it is not intended as a comparative study between traditional and non-traditional students. The exploratory phase covers one specific local cohort of students, since this was a new programme at the time of the study. However, the implementation phase, which was undertaken two years later, includes participants from years two, three and four of the programme.

3. In the same way that each phase of research drove the subsequent phase, it also dictated the scope of the research. Whilst there were a number of issues identified as a result of the literature review, the focus of the exploratory phase was limited in scope to the role duality issues experienced by the student participants.

4. The implementation phase concentrated on the impact of the specific intervention that was introduced (the booklet) rather than the implementation of other recommendations adopted in practice.

As with all DProf studies, the research is inextricably linked to the work context of the researcher and the research focus was necessarily aligned to this. The lens through which this study has been carried out is one of workforce development, thus a research lens of, for example, academia or clinical practice may have derived differing conclusions. Whilst personal subjectivity can be controlled, the professional subjectivity cannot since the expectation of a DProf is that it aligns to the work context.

Having identified the scope of this research, Section 1.2 will identify the key drivers for this professional doctorate. This will be followed by an overview of thesis structure - the architecture of the thesis which underpins the main arguments and challenges that will ultimately give rise to the new knowledge and consequent improvements to practice.

1.2 Nursing scholarship and the professional doctorate

The journey towards my professional doctorate started with the aim to extend my practice beyond that of Benner's (2001) 'Expert Practitioner' towards Rolfe's (1997) 'Reflexive Practitioner'. This has entailed developing myself as a practitioner able to develop theory and practice as one entity and able to act as both researcher and theory builder. However, I would argue that the DProf has also added an additional element - that of an agent for change.

My choice of DProf, as opposed to a PhD, was clear in terms of career focus, since Bourner, Bowden and Laing (2001) state that the PhD develops a professional researcher, whereas a DProf develops researching professionals. There are a number of distinct differences between the two doctorates; the main difference for the DProf being the involvement of an interventionist approach, either problem-focused or action-based, with the research candidate involved in implementing change in, and on behalf of, their organisations (Anglia

Ruskin University, 2011). This reflects Bourner, Bowden and Laing's (2001) study, which analysed doctoral programmes from seventy English universities and found that the DProf leads to development of the candidate not only through increasing academic knowledge and research skills, but also through professional development. This is not to say that PhD research cannot also provide these aspects of personal and professional development, but that they are explicit requirements of the DProf. Conceptually, Trafford and Woollams (2002) recognise the sequence of development through a PhD as deriving from a theoretical stance applied to practice and returning to develop new or refined theory. By contrast, a DProf is driven by a practice issue or problem, linked to related theory and returned to practice to drive service improvement. The DProf candidate needs to demonstrate not only new knowledge, but also improvements to practice or, where this is not the case, to justify a rationale for this.

Whilst scholarship itself can be difficult to define, for many years notions of scholarship focused on academic aspirations, citing the need for academic study, research and teaching. Gortner (1975) identified the ways in which research, practice and education worked in harmony, recognising the important role of professional practice in scholarship development. However, it was the publication of a seminal paper by Boyer (1990) which really introduced the key component of practice to scholarship in nursing (Starck, 1996; Burgener, 2001; Happell, Edward and Welch, 2008).

Boyer (1990) recognised four dimensions of scholarship:

- Discovery of new knowledge;
- Integration of the new knowledge with existing theory;
- Application of the new knowledge to practice;
- Dissemination of the new knowledge, for example by teaching others or by publication of findings.

Thompson and Watson (2006) support these four elements, suggesting that all carry equal weight in the development of nursing scholarship. They argue that unlike other disciplines, such as science or mathematics, the purpose of nursing scholarship is not to be able to do nursing, but to be able to advance nursing practice. As a result, nursing scholarship needs to relate not only to theory, but also to practice. Burgener (2001) differentiates research leading to scholarship of practice from traditional approaches in a number of ways. Table 1.1 identifies these through a comparison of researcher attributes necessary to developing scholarship and scholarship of practice. Furthermore, she advocates that the researcher is key to the development of scholarship, needing to be:

> *"*...professionally prepared with the necessary experience, knowledge and skills to solve the problems at hand*."* (Burgener, 2001, p.49).

She claims that too often academic researchers lack the necessary clinical background to enable them to have a full understanding of the problems at hand or the ability to apply the research findings to practice. Rolfe (2009) agrees, likening the development of nursing scholarship to building a house, with researchers as brick makers and theorists as builders. He claims that too many random bricks (research) have been produced rather than the

specific bricks needed to allow the builders (theorists) to construct meaningful buildings. In short, it seems that brick makers and builders pay little attention to the architects of nursing practice resulting in research that is not applicable to practice and furthers the theory practice divide.

Table 1.1: Comparison of researcher attributes (adapted from Burgener, 2001)

Attribute	Traditional approaches to developing scholarship	Developing Scholarship of Practice
Role of Investigator	Expert	Collaborative model or Change Agent
Communication Patterns	Use of academic language	Avoidance of academic language
		Use of active listening
		Recognition of need for cultural appropriateness
Research Focus	Researcher determines the focus	Often formulated by the participants rather than the researcher
	Researcher not always a clinician and thus often lacks the ability to apply research findings	
Accountability	Less expectation and need for accountability of outcomes	Expectation that problem will be solved
		Risk that research will produce more questions than resolutions
Flexibility	Often have a rigid approach	Often need to be pragmatic and 'go with the flow' (p.51)
Context	Often have a single focus	Multi-faceted in many cases
Significance of results	Often need to demonstrate statistical significance	Demonstrated through recognisable changes in the health of individuals, populations or communities.
Dissemination of findings	Usually through peer reviewed journals to support credibility of findings	Whilst peer reviewed journals are desirable, the aim is to reach as wide an audience as possible to share best practice.

Burrage, Shattell and Habermann (2005) identify a practice focused model of nursing scholarship, termed the Scholarship of Engagement, which promotes a collaborative model of scholarship characterised by three phases:

- Engaged pedagogy – students gain active learning experiences within a social community context.
- Community-based research – ensuring the aims of the project seek to benefit the local community and values the community members as experts. Focuses on local problems and uses the researcher to help them solve the problems they have prioritised, fitting with the intention of doctoral study.
- Collaborative practice – combined tripartite working between student, faculty and community. This mirrors my professional role in linking between the Higher Education Institute (HEI), HEE and National Health Service (NHS) organisations, with students and mentors at the heart of this tripartite approach.

Hence for the true development of nursing scholarship, a doctorate involving a practice-based element is essential. Yam (2005) recognises the professional value of a DProf not only in promoting the academic study of contemporary issues, but by combining this with challenging the candidates thinking beyond the boundaries of existing knowledge. Testing and refining those theories in practice will support them to develop innovative and creative solutions to real-world problems, underpinned by the intellectual scaffolding of robust theory. Only by combining theory, research and practice will nursing scholarship in practice be achieved.

Furthermore, developing nursing scholarship can only enhance my professional role, and support the further advancement of both knowledge of, and practice in, healthcare and education.

1.3 The thesis structure

The structure of this thesis was largely driven by two main factors:

- my professional role and the contexts within which the study exists;
- the overarching methodological perspective which sees three distinct research phases underpinned by the literature review:
    - an initial exploratory phase;
    - implementation of an intervention arising from one of the recommendations;
    - a pilot evaluation of the intervention implemented.

The distinct phases of research which made up the overarching methodology necessitated consideration to the methods applied to each distinct phase. This required exploration of data collection and analysis, discussion of findings and recommendations which influenced the subsequent phases of research. The overall thesis has been set out in alignment with this, supported by the introduction and concluding chapters.

This methodological approach has acted as a funnel, with initial broad research aims and questions refined and adapted through each phase of research. This provides a transparent, auditable trail demonstrating how each phase has driven the subsequent phase of research,

contributing to a cohesive thesis as a result. The following section will set out the thesis structure more clearly, identifying the main defining landmarks contained within it and helping the reader to navigate this thesis.

Thesis structure

This thesis has been divided into nine main chapters, supported by a Prologue and Epilogue which allow reflections of my overall intentions for the study and personal journey through this doctoral research. The chapters forming each part of this thesis are detailed below.

The *Prologue* set out my original personal and professional intentions in undertaking the study and reflected on its perceived potential importance to the quality of healthcare education. In *Chapter One*, an overall introduction to the study is provided with an exploration of the drivers for choosing a DProf study. It sets out the scope for the study, recognising what areas have been excluded and why. It also provides the background to the study and contextualisation of the research from education and workforce, organisational, practitioner-researcher and leadership perspectives.

Chapter Two provides an in-depth critical review of the current literature using a thematic approach. The analysis of these themes, and recommendations arising, allows the refinement of the research questions which support the initial phase of exploratory research. *Chapter Three* identifies the research design and explores the overarching methodological perspective. This acts as a driver for *Chapter Four* which focuses on the study design and methods for the exploratory phase of the research.

Chapters Five and *Six* focus on the findings from the exploratory phase and relate these to other relevant literature, culminating in two conceptual frameworks based on the new knowledge gained as a result. The conceptual frameworks, and consequent identification of barriers and enablers to minimise identified issues, lead to the intervention phase of this DProf research.

Chapter Seven explores the design, implementation and pilot evaluation of the intervention, which was identified by participants as being necessary to support improvements to their practice experiences. The quantitative pilot evaluation method, along with the descriptive findings and reflections on this intervention phase, are also contained in this chapter.

In *Chapter Eight*, the strengths and limitations of the research are explored alongside reflections on the methodology, while *Chapter Nine* builds on the earlier chapters by identifying how this research has contributed new knowledge and improvements to practice, linking back to the four dimensions of scholarly practice identified in the Introduction. It goes on to provide recommendations for further action (from both research and practice perspectives). The *Epilogue* provides opportunities for reflection on my development through this doctoral journey reflecting on the original intentions in undertaking the DProf and to what extent these have been met. An overview of the thesis structure is provided in Figure 1.1.

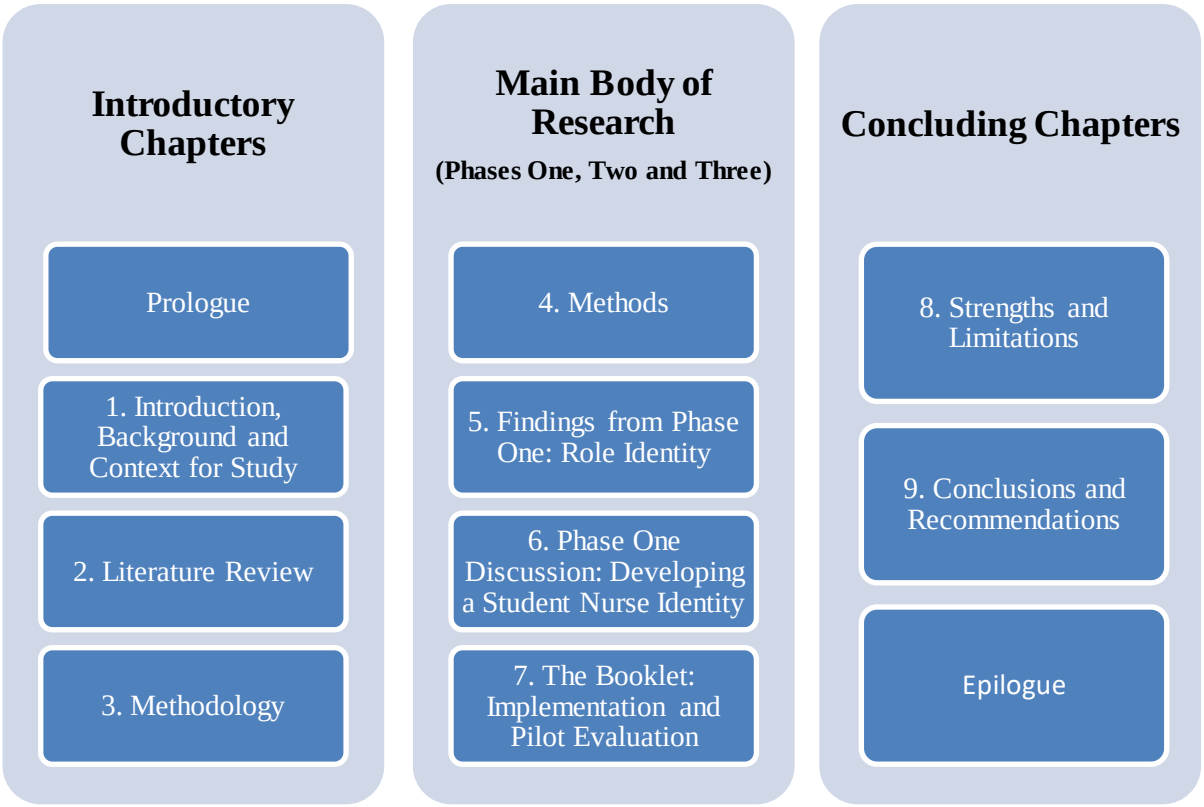

Figure 1.1: Overview of the thesis structure

The following section will explore the background to this research and sets out the context from a number of perspectives; a strategic nurse education and workforce perspective, an organisational perspective, a practitioner-researcher perspective and a leadership perspective. Setting the context for this study will support an understanding of the importance of this research and the wider issues which have resulted in a need for further investigation.

1.4 Education and workforce context

From a strategic viewpoint, a major driver for this study was the global issue regarding dwindling numbers of registered nurses (Wells and Norman, 2009; Royal College of Nursing (RCN) and Employment Research Limited, 2010). This necessitated employers locally, regionally and nationally becoming dependent on overseas recruitment and agency staffing to ensure their ability to provide safe staffing. Since the commencement of this study, the situation has worsened, with a 7% vacancy rate in acute nursing and 14% in mental health nursing locally (Norfolk and Suffolk Workforce Partnership, 2016) and the introduction of agency spending caps (NHS Trust Development Authority (TDA) and Monitor, 2015). This is set against a context where attrition from the nursing workforce is barely met by the numbers of new additions to the workforce through nurse training (Branson, 2016; HEE, 2016) and nursing supply cannot meet service demand (NHS Improvement (NHSI), 2016). Thus, in response to the nursing workforce crisis, it is insufficient to continue to train more nurses without addressing underlying issues of attrition from nurse training programmes and retention to our local workforce on qualification. This has been highlighted by the recent Reducing Pre-registration Attrition and Increasing Retention (RePAIR) project (HEE, 2018) which recognises the importance of assuring quality of education provision and student experience in reducing attrition, particularly in nursing. Furthermore, The *NHS Long Term Plan* (NHS England (NHSE), 2019) supports these concerns, recognising the need to expand current nursing numbers and to focus on reducing avoidable attrition and improving retention.

In 2010a, The Department of Health (DOH) committed to supporting a qualifying Workforce '…more self-sufficient and less reliant on international recruitment' (p.7). The opportunity to *grow their own* nurses, from existing Healthcare Assistants (HCAs), was therefore an

attractive prospect for service provider organisations. Since studies suggest students, once qualified, are more likely to return to work in areas where they are more familiar (Andrews et al, 2005), this bodes well for employers supporting a home-grown workforce. One of the aims of the White Paper *Liberating the NHS: Developing the Healthcare Workforce* (DOH, 2010a) was to give employers greater responsibility for workforce development and improved autonomy in healthcare education and training. This has recently been further supported by changes in funding, with HEE no longer commissioning pre-registration nurse training places and responsibility for this sitting with HEIs and placement providers themselves (DOH, 2016). In addition, there was a recommendation that the potential of staff already employed within the NHS would be harnessed (Audit Commission, 2001; DOH, 2006, DOH, 2008). The Department of Health (DOH) (2006, 2010b) advocated the ability for nursing to *grow their own*, offering opportunities for mature students or those wanting a second career. This also fitted with the aims of higher education, through the *Dearing Report* (National Committee of Inquiry into Higher Education, 1997) to widen the access to higher education courses for students to whom higher education would normally be denied. This was supported by the later recommendations from *The Cavendish Review* (Cavendish, 2013) which advocated individuals gaining prior experience as HCAs prior to commencing nurse education and the *Raising the Bar: Shape of Caring Review* (HEE, 2015) where the value of work-based learning programmes was recognised.

In response, the regional office of HEE, formerly the Strategic Health Authority (SHA), piloted a number of places on a well-established, non-traditional PRNP. This curriculum is a four-year open learning, WBL programme for existing HCAs in current employment.

Individuals continue to work three days a week in their employing organisation as an HCA, with a further two days each week as a supernumerary student nurse undertaking placement experiences (Gallagher and Holland, 2004; Jones, 2008).

For the purposes of this study, the role of HCAs is defined as working under the direction of a registered nurse and providing largely task-focused, essential nursing care for patients (HEE, 2016). Assistant Practitioners are defined as providing competent health and social care with knowledge and skills beyond those of an HCA (Skills for Health, 2009). They may be able to undertake skills that were previously only the domain of the registered nurse (Skills for Health, 2009). In this research, the generic term HCA has been used for the study population although, in reality, some participants were employed as assistant practitioners.

WBL is an attractive option for employers, since it allows retention of skilled staff in the workplace, improved participation in education development and reduced training costs (East of England Development Agency, 2004). Given the current nursing workforce shortages, this is a key strategy to improving recruitment and retention of nursing students. This has since been further enhanced by the introduction of apprenticeship routes into nursing and trainee nursing associates with a *step on, step off* approach to training. The *NHS Long Term Plan* (NHSE, 2019, p.81) recognises the value of 'earn and learn' programmes, such as the one under investigation in this research, promoting these as a potential workforce solution.

1.4.1 Delivering an open learning, work-based learning curriculum

The introduction of an open learning/WBL curriculum was supported by the Nursing and Midwifery Council (NMC) (NMC, 2010) who encouraged the use of modern models of programme delivery. More recently, this has been further supported by the *Standards Framework for nursing and midwifery education* (NMC, 2018a) and *NHS Long Term Plan* (NHSE, 2019), where the value of alternative models of nurse training are identified. Open learning is derived from a combination of factors which define it by their presence or absence. Kember (2007) recommends four key elements; *open access* to programmes, flexibility in studying at a convenient *venue* and *time*, and greater freedom in the *choice of courses* towards the degree. Given these criteria, the commissioned programme was not open learning in the strictest sense, because it had to abide by NMC entry requirements (NMC, 2010). However, whilst students undertook an NMC validated programme, the course was individualised with the practice elements tailored to the student's needs and offered choice of time and place for study. Therefore, the programme achieved an appropriate level of openness to be considered open learning.

Rowntree (1992) recognises the link between open learning and the elements of self-study using materials provided, the learning *package*. The commissioned programme provided *packages* supplemented with face-to-face tutorials, online forums (Gallagher and Holland, 2004) and practice support through mentorship. WBL, comprising the practice element, is characterised by the ability to learn *for, at* and *through* work (Quality Support Centre, 1996). The key tripartite relationship in course development and delivery between HEI, employer and individual (Quality Support Centre, 1996; Clarke and Copeland, 2003; Presho, 2006) distinguishes it from other types of learning. This is an important element recognised by the NMC (Gallagher and Holland, 2004; Jones, 2008) and is supported

through the regional Growing Your Own Operational Group (GYOOG), with staff representation from HEE, employers and HEI, which supports this initiative. This programme constitutes WBL in a number of ways. It allows HCAs to remain in their employed areas whilst undertaking the programme, expanding their practice learning through alternate placement experiences (see 1.4.2). It also supports the use of practice learning experiences and ability for students to learn from them, through them and during them. The programme embraces their HCA experiences and tailors the clinical elements to the specific needs of each individual student – with more emphasis on areas of weakness and less emphasis on areas of strength.

Several authors recognise the important role of the mentor in enabling the success of WBL and that providing effective preparation for them is essential (Quality Support Centre, 1996; Williams, 2010). The definition of a mentor applied to this research study is that of a RN who has met the competencies and standards for mentorship set out in the *Standards to Support Learning and Assessment in Practice* (NMC, 2008) and is supporting learners in practice. The students undertaking this programme were allocated a mentor by their employing organisation who provided mentorship support to the student for the duration of the programme. This study was undertaken prior to the new NMC *Standards framework for nursing and midwifery education* (2018a) which came into effect in January 2019. Therefore, this required the mentor to also be a sign-off mentor (NMC, 2008), enabling them to formally assess and sign-off the student's proficiency against the programme requirements leading them to access registration as a nurse.

1.4.2 Benefits and challenges of a work-based learning approach to nurse education

Traditionally, students on a PRNP have a structured practice element, with rotation across placements based on differing practice experiences. As a result, students will regularly change placements, gaining a different mentor for each practice experience. This process is designed to ensure that the student gains exposure to as many different forms of nursing as possible, learning transferable skills that they have acquired across different settings. By contrast, this non-traditional programme argues that it is counter-productive for the student to have multiple placements, because learning opportunities are missed in the time it takes for the student to settle into each new area. The philosophy of the programme sees the student as central to the learning process and believes that in any given area many facets of nursing can be acquired. Thus, the students' employed work environment is audited as a learning environment at the commencement of their programme alongside the programme's practice requirements. Any learning outcomes that can be met there will allow the student to complete practice placements in that employed area (the home placement). Any learning outcomes that cannot be met there will necessitate negotiation of an alternate placement area (the external or alternate placement). Whilst day to day supervision and co-mentorship is provided by external mentors, the student's primary mentor remains in the home placement and there is a requirement for communication between home and external mentors in order to ensure robust mentorship is in place.

It was likely that individuals who work as students one day and HCAs in the same area another day would face different challenges than traditional pre-registration students, who only have to fulfil their student nurse role. Most were likely to be mature students, because they are already employed as HCAs, and may not have had the academic entry criteria that traditional students need to gain entry to university programmes. Therefore, these non-

traditional students were likely to have differing support needs which needed to be identified so that appropriate practice and academic support could be offered to them.

Despite the benefits of WBL, Boud (2001) warns of several potential issues such as conflict between priorities of work and learning, student identity issues, transition issues arising from conflicting roles of student and worker, lack of awareness amongst co-workers and supervisors around their differing roles in the workplace. The purpose of the early phase of this research was therefore to:

- critically explore the concept of an open learning, WBL curriculum;
- identify potential practice issues that might arise from this;
- provide an appropriate research focus and develop consequent research aims and questions.

Having explored the nurse education and workforce perspectives of the study, Section 1.5 will situate the study within an organisational context.

1.5 Organisational context

The NHS is a constantly evolving organisation, seeking to keep pace with population health changes, workforce demands and public expectation. Currently, it is undergoing an unprecedented era of reform – the most radical since the introduction of the NHS in 1948 (Warriner, 2009). Since the Department of Health's (2000) publication of the *NHS Plan*, the focus of health care has consistently progressed towards a more quality focused service with increased service user involvement (DOH, 2008). The new *NHS Long Term Plan* (NHSE, 2019) sets out new goals and ambitions which will require a workforce fit to deliver these. Whilst the corresponding Workforce Plan is yet to be published, the healthcare education

function of the NHS has not been exempted from change. The introduction of *Liberating the NHS: Developing the Healthcare Workforce* (DOH, 2010a) led to the creation of a number of arms-length bodies;

- NHSE - providing health care services;
- NHSI - formed from the previous organisations TDA and Monitor (and focusing on healthcare efficiencies and effectiveness);
- Public Health England (PHE) - dealing with health promotion and illness prevention;
- HEE - providing high quality workforce development and transformation.

With this came the abolition of SHAs in 2013, in favour of Local Education and Training Boards (LETBs) within one HEE organisation. This was subject to further reform in 2016, with the introduction of four HEE regional offices providing centralised core functions. These LETBs are supported by a series of Local Workforce Action Boards (LWABs), co-chaired by HEE and a representative of local NHS service providers, to support the developing needs of Sustainable Transformation Plan (STP) footprints. The STP/LWABs function being to provide the local planning and delivery of the *Five Year Forward View* intentions (NHSE, 2014) and consequent *NHS Long Term Plan* (NHSE, 2019), including workforce. More recently, NHSE and NHSI have formed a merged organisation, with HEE working increasingly collaboratively alongside them and PHE now having a direct reporting line to them (West, 2018). This is shortly to culminate in further restructuring within HEE to mirror the geographical footprints of NHSI/NHSE with the adoption of seven regional

offices in place of the current four. This ever-evolving organisational landscape provided a further challenge to this research, which is explored through this thesis, particularly regarding its impact on my professional role and the research itself.

Whilst HEE no longer has an education commissioning function for pre-registration nursing, it has retained its key functions in monitoring and supporting the quality of the clinical learning environment (DOH, 2016) as well as workforce supply. It remains, therefore, imperative that HEE identifies how best to prepare and develop these clinical environments. Key to this is the up-skilling and supporting of mentors, to provide the best possible practice experience for these students. In addition, due to the nursing workforce issues identified previously, there has been an expansion of local interest and uptake of similar WBL programmes across the region (Branson, 2014). There has not, however, been any local evaluation of the impact of this programme on student experience or the specific practice issues these students face. In my role within education and workforce, it is therefore essential to identify potential issues within the clinical learning environment that might impact on the success of this programme.

This study was therefore intended to support my ability to pre-empt any issues and identify what support might be needed to alleviate these, in order to:

- improve the quality of the clinical learning environment;
- improve the experiences of students and/or mentors;
- better retain students on the programme and at entry into our registered nursing workforce.

Within the study, the population of students and their respective mentors covered eight acute hospital trusts, one community trust, a small number of General Practitioner (GP) Practices and a mental health trust across three English counties, as well as the programme provider. During the evolution of this research, service providers experienced contractual changes resulting in movement of staff, including study participants, between organisations. In order to manage this research, it was necessary to link in with both the students' and mentors' employer, their programme provider and HEE local level management. The need for effective leadership in managing such a project was clear.

It was hoped that access to these organisations would be facilitated through the Education Link for each organisation who would act as a gatekeeper to the participants (Taylor and Bogdan, 1984). In addition, I had already developed a collaborative relationship with the HEI delivering the pre-registration nursing programme and local NHS organisations through my professional role. Having thus established the credibility and value of my role prior to commencement of the research, it was anticipated that this would enable me access to participants more readily, subject to ethical approval (McCormack and Slater, 2006).

From a contextual perspective, my role with HEE had no specific allegiance to either employing trusts or university, although at the outset of this study I acted as a critical friend and source of expert advice between university, Trusts, and HEE. Having no automatic right of entry to some of these organisations, it was identified that gaining entry into the research field required political diplomacy (Tomlinson, Swartz and Landman, 2006), since the researcher needs to be perceived as non-threatening and not intending harm to the organisation (Taylor and Bogdan, 1984). Given the historical regulatory function of the former SHAs, there has been a legacy perspective of HEE staff as primarily having a

monitoring and reporting function. This has historically led to a level of suspicion in some cases. Thus, in order to gain and retain a relationship of mutual trust and respect with participating organisations, there was a need to become adept at engaging, negotiating and collaborating with each of the key stakeholders. The following section will move the context for the study from an organisational perspective to a more individualised one, that of my practitioner-researcher role.

1.6 Practitioner-researcher context

As a practitioner-researcher in the field of this study I brought multiple perspectives with me. I am a qualified nurse (Registered General Nurse and District Nurse/Specialist Practitioner), mentor and Community Practice Teacher with twenty-six years of clinical and practice education experience. I am also a qualified lecturer/practitioner and have four years of experience as an associate lecturer. Therefore, I brought a background in both clinical practice and academia to this field of research. In addition, I have been employed in strategic workforce development since 2008, which also allowed me to bring a broader understanding of workforce and healthcare policy to this study. This was beneficial in supporting the wider context and implications of the research to be better understood.

On commencement of this research, I was employed as a Practice Education Facilitator (PEF) for the regional SHA. PEFs worked as part of a multi-professional regional team of healthcare professionals who, whilst allocated to a geographical area, were not employed or managed by those that they worked most closely with. The PEF role provided a strategic link between placement providers, key HEI personnel and SHA. The main aim of the PEF role was to support, improve and maintain quality within the clinical learning environment

– particularly with regard to supporting those who facilitate learning for healthcare students (Sykes, 2013). Although the role was discontinued in 2017, the broad remit of the role remained the same until then. Through the eight-year evolution of this thesis, I have changed role seven times – either through promotional opportunities or organisational restructuring. Whilst this has been a challenge, particularly in managing this concurrent doctoral study, these new roles have all retained a quality improvement education/workforce function. Therefore, while these roles have taken me further from the research field itself, they have enabled a greater leadership role and wider influence in implementing and supporting the findings of this research.

1.6.1 Situating my practitioner-researcher role in the practice setting

The role of the PEF was a particularly challenging role, having no positional power or authority within the employer organisations it served. This was the role I undertook in the early stages of this research and was a similar situation to that of my practitioner-researcher role. I have therefore drawn on the literature regarding the PEF role to support my approach to leading this study. There appeared to be very little written with regard to the role of the PEF with only one item identified through the original literature search (Carlisle, Calman and Ibbotson, 2009) and a further two identified through secondary sources (Cameron et al, 2006; McArthur and Burns, 2008). A literature review of broader educational facilitator roles was used to underpin this research and expanded to include my own addition to the available literature (Sykes, Urquhart and Foster, 2014). Furthermore, evidence supporting leadership in the context of Educational Facilitators within the literature was scarce.

Martin (1995), in his review of the role of Educational Facilitator, likens the role to that of a change agent (Rogers, 2003). He further asserts that:

> "… as the promoter of change and innovation the Educational Facilitator requires an appreciation of the principles and practices of change management." (Martin 1995, p.138).

However, Packwood et al (1991) warn that it is difficult to differentiate between change initiated as a result of the introduction of Educational Facilitator roles and those that would have happened anyway. Since I was not employed by any of the organisations where the participants worked, it was essential that I was able not only to gain entry into their employing organisations, but to gain their support and collaboration in adopting any recommendations arising from it. Therefore, a change agent role was likely to have been an ideal approach. Having explored my professional role, the following section critically explores the researcher stance and potential impact this has on access to, and relationships in, the research field.

1.6.2 Situating my practitioner-researcher role in the research field

Accessing the research field can be problematic for external researchers such as myself, who are not part of the organisation. However, although I was not employed in any of the participating organisations, I had an affinity with the participants by virtue of my professional background; as a registered nurse, ex-student and nurse educator. It might therefore have been assumed that it would be easier for me to gain access to participants and gain their engagement. However, the potential impact of an immature assumption can create a future barrier between researcher and participants which may adversely impact on access to participants and level of engagement. Le May and Lathlean (2001) identify two key models of researcher facilitation:

- Insider Model – combining the roles of actor (clinical leader with authority for initiating change) with change agent and researcher;
- Outsider Model – where the researcher is separate from the research setting, has no authority, and does not initiate or implement the change themselves.

Lofman, Pelkonen and Pietila (2004) believe that insiders have greater credibility than outsiders and are thus more likely to gain co-operation, while Taylor and Bogdan (1984) warn of lack of objectivity from insiders and their tendency to make assumptions about the data. There is considerable overlap between these models. For example, an outsider, someone separate from the research setting, may be viewed as an insider when they share the same profession as the participants (Lofman, Pelkonen and Pietila, 2004). Equally, an insider, through definition of being employed in the organisation, may be viewed as an outsider by participants if they lack credibility.

Merton (1972) concedes that in order to elicit a true picture, both insider and outsider perspectives are necessary, while Merriam et al (2001) acknowledge that researchers have more recently recognised the absence of clear boundaries between insider/outsider research. This blurring of boundaries can cause researchers to be:

> "…insiders and outsiders to a particular community of research participants at many different levels and at different times." (Villenas, 1996, p.722).

Whilst the researcher may be an insider by virtue of certain socio-cultural aspects of the community, a variety of social categories determine an individual's perspective and the social context of the research will itself decide which of these categories is prominent,

including age, gender and race (Merton, 1972). Thus, the position of the researcher within the community can change over time (Merriam et al, 2001). This can create challenges for researchers that need to be considered and managed during the research.

Banks (1998, p.8) identifies a typology of cross-cultural researchers (see Figure 1.2) which demonstrates the complexity of the insider/outsider stance of the researcher and accounts for this blurring of boundaries, ascribing this to the dominant influences of institutionalisation within communities which affect the socio-cultural characteristics of the individual. The typology recognises four types of insider/outsider:

- *indigenous-insider* who is perceived as a legitimate community member;
- *indigenous-outsider* who is perceived to be an outsider but has some socio-cultural links to the community (for example an ex-patriate);
- *external-insider* who has socio-cultural links to an external community but is perceived as an insider;
- *external-outsider* who has little understanding of the community and is perceived as an outsider.

The key component of the insider/outsider stance is that it is the perceived perspective of the community that determines the researcher's position, not the perceptions of the researcher. Thus, whilst I perceived my stance as an external-insider by virtue of our shared profession and endorsed beliefs and knowledge of the community, the community might have chosen to disagree.

The indigenous-insider: • Endorses unique values, perspectives,beliefs and knowledge of indigenous community. • Perceived by people within the community as a legitimate community member who can speak with authority about it.	**The indigenous-outsider:** • Socialised within their indigenous community but has experienced high levels of cultural assimilation to an outsider or oppositional culture. • Values, beliefs, perspectives and knowledge are identical to outside community. • Perceived by population of community as an outsider.
The external-insider: • Socialised within another culture and acquires its beliefs, values, behaviours attitudes and knowledge. • However, because of their unique experiences, they reject many of these values, beliefs, knowledge claims and endorses those of the studied community. • External-insider is viewed by the new community as an adopted insider.	**The external-outsider:** • External-outsider is socialised within a different community from the one under study. • They have a partial understanding of and little appreciation for the values, perspectives and knowledge of the community being studied. • Consequently they often misunderstand and misinterpret behaviours within the studied community.

Figure 1.2: A typology of cross-cultural researchers (adapted from Banks, 1998, p.8)

However, based on previous work carried out in identifying necessary leadership and change agent skills (Sykes, 2012a), I would propose a third authority in the setting. A partnership approach, with the researcher as neither insider nor outsider, but who acts as change agent and research facilitator in empowering the participants to plan and implement the necessary changes. In fact, a similar model, although not formally recognised, was successfully utilised by Lofman, Pelkonen and Pietila (2004) in their Action Research project. This partnership type approach is particularly recommended in research carried out by westerners in developing countries (Villenas, 1996; Costello and Zumla, 2000; Tomlinson, Swartz and Landman, 2006) in ensuring that communities studied gain benefits from the research rather than just the researchers themselves. Whilst this was not the case for this research, the concept fits with my own belief that research should be for the benefit of participants, not

just the means to achieving my doctorate. My ability to fulfil the role of change agent as a practitioner-researcher was ideally suited to this, since I had no authority or allegiance to any of the organisations involved and would need to adopt the stance of facilitation of others to deliver any change implementation. This will be further explored in the following section.

1.7 Leadership context

The change agent role required a leadership approach which promotes both collaboration and facilitation. The need to support and facilitate the development of others, through empowerment (Kotter and Cohen, 2002) or facilitation and collaboration (Kouzes and Posner, 2007), is a recognised leadership skill. A participatory style of leadership is useful for educational research roles as it fits with the facilitative, collaborative nature of the role, as Mason (2006) asserts:

> "… success is most likely when people are asked, informed and persuaded rather than told." (p.19).

Participative leaders delegate decisions to their followers and have minimal input other than setting boundaries and expectations, while *directive* leaders tend to make all decisions, dictate orders without any explanation and expect conformity from their followers. Tannenbaum and Schmidt (1958) identified a continuum of graduated perspectives from *directive* to *participative leadership,* with Bass and Bass (2008) suggesting empirical evidence indicates that most leaders demonstrate multiple perspectives of leadership from the continuum with varying degrees of frequency. Hord (1992) purports that leaders are:

> "… change makers and transformers, guiding the organisation to a new and more compelling vision." (p.30-31).

and further recognises the important role of the change agent / change facilitator in change leadership, particularly with regard to normative re-educative approaches (Chin and Benne, 1985).

There is a growing body of evidence to support the theory of *facilitative leadership* (Hood, 1982; Hord, 1992; Schwartz, 2003; Moore, 2004) which refers to a variety of leadership methods depending on the organisation (Moore, 2004). It often relates to a range of leadership skills along a continuum from persuasion, through collaboration, to facilitation (Rees, 1998). It takes the notion of participative leadership a stage further, with the belief that facilitative leaders should truly empower others by endeavouring never to undertake work that others can be supported to carry out themselves (Rees, 1998). Studies of PEF roles by both McArthur and Burns (2008) and Carlisle, Calman and Ibbotson (2009) support this belief, with stakeholders valuing a facilitative style as effective in empowering staff and giving them confidence in solving problems themselves, as opposed to PEFs taking over and solving the problems for them. This appears to mimic the ethos of healthcare in promoting independence, rather than dependence, for service users.

Hood (1982) studied major change agent projects and discovered that they demonstrated high interpersonal communications, promoted and disseminated innovative and evidence-based practice, aided needs analysis and problem solving, helped staff development and provided feedback from staff to key stakeholders. These are all functions identified in the literature as key aspects of the Educational Facilitator role (Martin, 1995; Wilkins and Ellis, 2004; Randle, Timmons and Park, 2005; Cameron et al, 2006; Carlisle, Calman and Ibbotson, 2009) and are all skills equally necessary for a successful change management project.

Hord (1992) suggests that facilitative leaders have the need and the ability to cope with very complex, ambiguous problems which they could not have foreseen. They are also willing to take a degree of risk in identifying potential solutions to problems (Hall and Hord, 1987). Whilst these studies may appear dated, the findings resonated in relation to the similarities between the leadership approach undertaken and my own preferred style in a way that other leadership models, such as transformational or transactional leadership, did not quite address. The findings of these studies in relation to their impact in change management initiatives further supported my belief that this was an approach which could be replicated through this doctoral research. My PEF background was ideally placed for such a change agent role, given recognised PEF skills in networking (Wilkins and Ellis, 2004; Randle, Timmons and Park, 2005), role modelling (Randle, Timmons and Park, 2005), collaborative working (Wilkins and Ellis, 2004; Randle, Timmons and Park, 2005), negotiation (Randle, Timmons and Park, 2005) and conflict management (Kelly and Simpson, 2001). These skills were all deemed necessary to manage a research study across multiple organisations and involving a variety of key stakeholders. This was particularly important for the change management phase, given my lack of any positional power or authority within these organisations to implement the change initiative.

In order to achieve success, it was unlikely that one leadership style could be applied in isolation. Bass and Bass (2008) found that participative leadership styles worked well where there was a need for increased acceptance, satisfaction and commitment from followers and where followers have the information needed. However, they also found that more directive approaches were required where structure was needed, the leader had the required

information and/or the quality of decisions was more important than follower commitment. With no position power or authority there was an increased need to be able to influence for more directive approaches to be successful.

Through this chapter the various, and often competing, contexts for this research have been identified. A preferred leadership model, facilitative leadership, was chosen to support my role as a change agent in leading not only the interventionist phase of research, but also the wider research. This promoted a cohesiveness between my professional role, my researcher stance and my leadership style that underpinned this research.

Chapter Two will further refine the parameters of this research through a critical review of the current body of evidence and subsequent identification of the gaps in knowledge in relation to these HCA/students.

CHAPTER TWO

Literature Review

This chapter presents a critical review of the literature and current evidence necessary to identify what is currently known about the topic under investigation and what gap in knowledge may exist. This will support the development of the research question and subsequent research design intended to fill the gap in knowledge. The chapter begins with a description of the review process followed by discussion of the three themes identified as a result.

2.1 Formulating the review question

While the research question is crucial to determining the research design, in the early stages an initial broad review question was developed to focus the literature review. The following question was deemed sufficiently broad to allow critical exploration of all relevant issues while supporting the development of more refined aims and questions for the research itself:

What are likely to be the main issues faced by healthcare assistants undertaking an open learning / work-based learning pre-registration nursing programme and their registered nurse mentors?

This broad review question was further refined by the review findings to provide a more focused question to underpin the research itself. The following section sets out the search strategy, identifying search criteria and data extraction processes, before going on to explore the review findings.

2.2 Search strategy

The intention of the search strategy is to identify the relevant key literature to support a review of the evidence whilst ensuring it is restricted to a manageable level. The first step is therefore to set the search criteria.

Primary research papers from peer reviewed journals were accessed initially to ensure that high quality findings were included. This was subsequently broadened out, given the low number of relevant papers, to include (for example) secondary references, books, bibliographies, conference papers, dissertations and reports. This enhanced the search and yielded a range of relevant material. All papers were reviewed for quality against the criteria of methodological rigour, credibility and relevance to the review. Only English language papers were included, given lack of access to, or funds for, translators. United Kingdom (UK) studies were considered most suitable, due to the specific nature of the pre-registration curriculum and HCA roles.

While some studies from America, Australia and Scandinavia were considered, none of these included studies of HCAs training to gain registration, but were largely Licensed Practice Nurses, equivalent to the former Enrolled Nurse role, training for registration. These papers may not be directly comparable to the UK context, but informed the overall review. Whilst it is possible that their issues could differ from those for HCAs, their inclusion enabled the studying of as many different groups as possible to test the parameters of the identified themes. As a result, not all the literature reviewed focused on HCAs training to be student nurses, although principles of work-based learning models and/or widening participation initiatives were demonstrated.

Papers published prior to 2000 were excluded from the initial literature review because:

- the Project 2000 curriculum in the 1990s was a very different programme to contemporary programmes (United Kingdom Central Council (UKCC), 1986);
- contemporary clinical and education contexts in healthcare post-2000 were likely to have impacted on the programme, particularly the introduction of Standards to Support Learning and Assessment in Practice (NMC, 2008).

The search was performed regularly through the duration of this research using the same criteria and the Zetoc alert system was also used to ensure that any recent publications were captured. This minimised the potential for missing new information.

Data search

Key search terms were identified that included the main components 'open learning' and 'work-based learning'. These were then refined to include a population of 'nursing', 'student', 'nurse' and 'healthcare assistant', with the ideal being inclusion of all four, to try and identify the specific issues these population groups might encounter. These broad search terms provided a wide range of papers, many of which were descriptive or pertained to groups of nurses outside the remit of this review, such as registered nurses rather than student nurses. The main search engine used was Library Search at the host university (and prior versions) which yielded a wide source of literature. In addition, other search engines were used, including the biomedical research databases MEDLINE and EMBASE. The most useful data were screened and either excluded, included, or used as a potential source of situational theory. Following the initial search, themes began to emerge which were then used for a second, refined search, which included 'mentor'.

In updating the review through the evolution of this thesis, new search terms became available for MEDLINE and Cumulative index to nursing and allied health literature (Cinahl), 'learning at home' or 'work based learning', which allowed a wider scope than 'work-based learning' alone. Medical Subject Headings (MeSH) were checked to test reliability of search terms. Similar terms were then applied to the other databases including:

- British Nursing Index (BNI);
- Allied and Complementary (AMED);
- EBSCOhost;
- Journal @ Ovid (full text).

More general searches were applied through the library database to reduce the likelihood that key papers were missed. The Open University (OU) and Anglia Ruskin University (ARU) repositories and the e-theses online service (ETHOS) were also searched. The robust search strategy reduced the potential for missing unpublished data.

2.3 Findings

The main findings of each paper were tabulated to allow comparison of emerging evidence and to clearly identify recurrent themes. These themes were then reviewed against the content and context of other papers to check for relevance, until no new themes emerged. A summary of the review process is set out in Figure 2.1.

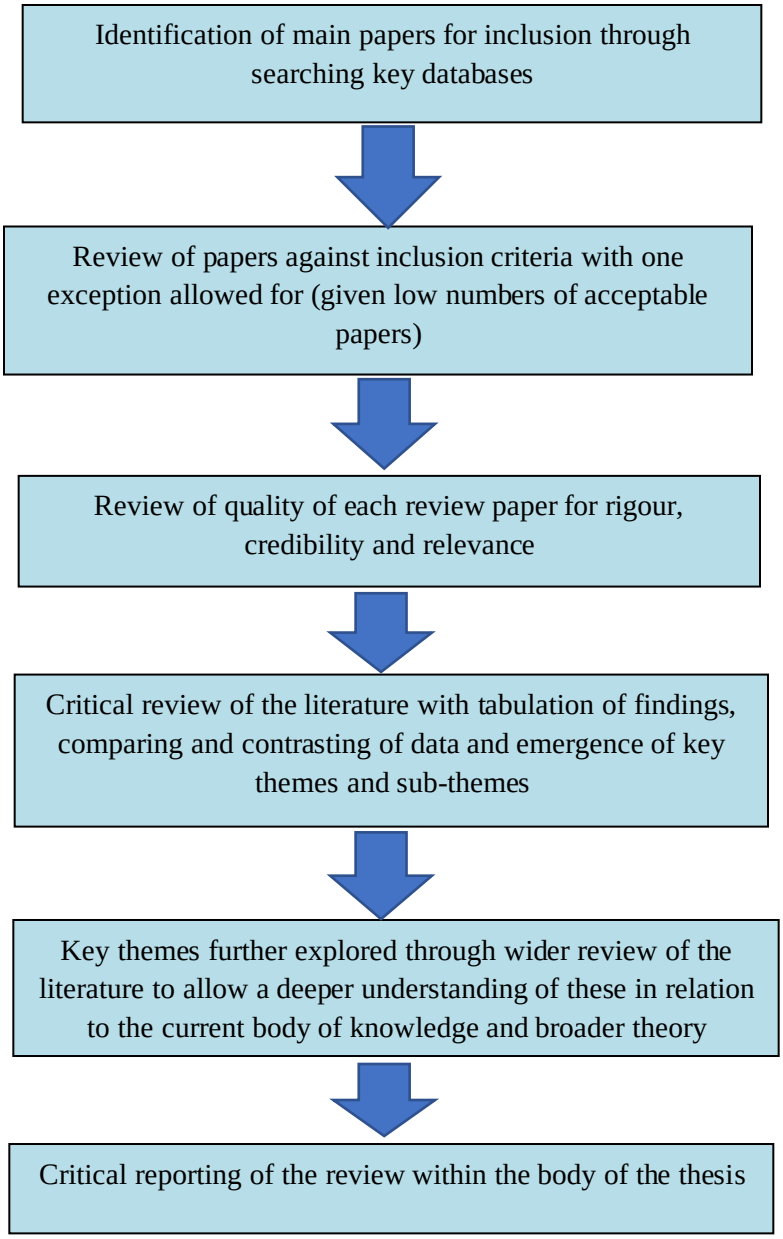

Figure 2.1: Summary of the review process

In total, twenty-two papers met the inclusion criteria which were largely UK studies, Australian or American. The findings of these papers were then exposed to a wider range of contextual literature, with the key emerging themes and sub-themes subjected to further data searches. The same process of rigorous review was applied to ensure the quality and relevance of the literature. The wider reading allowed a range of perspectives to be

considered in relation to the theme/sub-theme whilst remaining closely aligned, where possible, to the topics of HCAs and/or student nurses and/or mentors - with the ideal being the combination of all three. This wider literature provided a range of historical and contemporary context, whilst staying true to the findings of the original review papers. The main reason for inclusion were the relevance to the topic and strength of the link to the original review findings. Whilst this is not a comparative study, some contemporary literature relating to traditional students is also included (for example, Jack et al, 2017) which supported the recognition that some issues affecting these WBL nursing students may not be isolated to the WBL nature of the programme.

In exposing the findings to this wider literature, the theoretical concepts of Wenger's (1998) communities of practice and Van Gennep's (1960) transition theories were heavily drawn on. This eventually culminated in the identification of three overarching themes supported by a number of sub-themes (see Figure 2.2). The three themes identified were:

1. *Gaining entry into the community of practice (COP)* and the barriers and enablers for these learners entering the clinical placement area.
2. *Role transition,* including the three phases of the transition process as they relate to learners. This will help identify what the psychological impact of the transition to their student role might be and how this might be mitigated. It will also explore the importance of transition rites and how artefacts might support the legitimisation of learners.
3. *Mentorship* and its importance to supporting learners both in gaining entry into the community of practice and successfully transitioning into the student nurse role.

The following sections of this chapter critically explore these three themes.

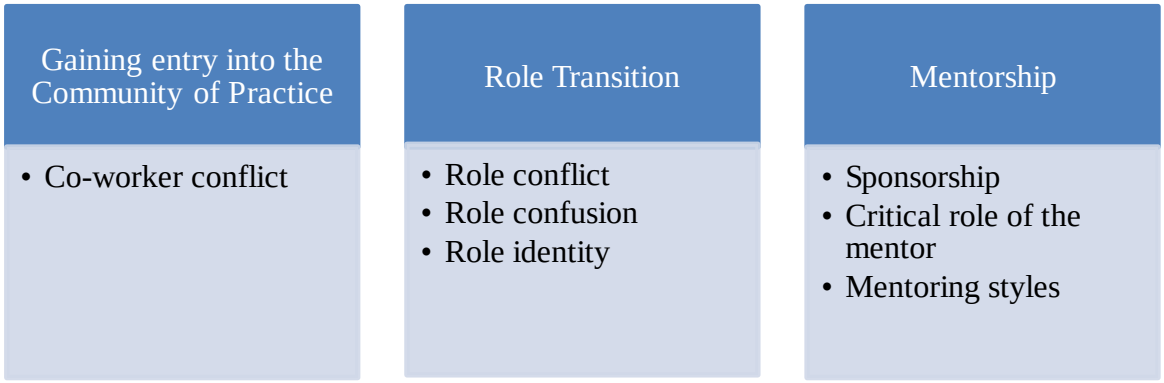

Figure 2.2: The main themes and sub-themes derived from the review findings

2.4 Gaining entry into the community of practice (COP)

In order to prepare for transition from the employed HCA to the student nurse role (discussed in Section 2.5), the literature describes how it was necessary for the student to successfully gain entry and acceptance into the clinical placement area. This clinical placement acts as a COP which is defined as:

> "Groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an on-going basis." (Wenger, McDermott and Snyder, 2002, p.4).

This entry and acceptance into the COP forms part of the early transition process, which Wenger (1998, p.152) describes as 'legitimate peripheral participation'. He suggests that practice defines a community in three ways; 'mutual engagement, a joint enterprise and a shared repertoire' (Wenger, 1998, p.152). Newcomers need to be granted legitimacy to gain entry to a COP, for example, through being useful or being sponsored by another member of the community (Wenger, 1998). Figure 2.3 demonstrates these dimensions of practice in relation to the COP.

Through the process of legitimate peripheral participation, newcomers to the COP begin to gain acceptance through undertaking simple tasks and activities which make them useful. They progress through their professional development to become useful community members and ultimately develop a mastery of skills as an old-timer of the COP, essential to its functionality (Lave and Wenger, 1991). This will be further explored later in this chapter. In the literature reviewed, students tried to make themselves useful in order to gain entry into the COP by reverting to their HCA role, where they had already established competency (Brennan and McSherry, 2007).

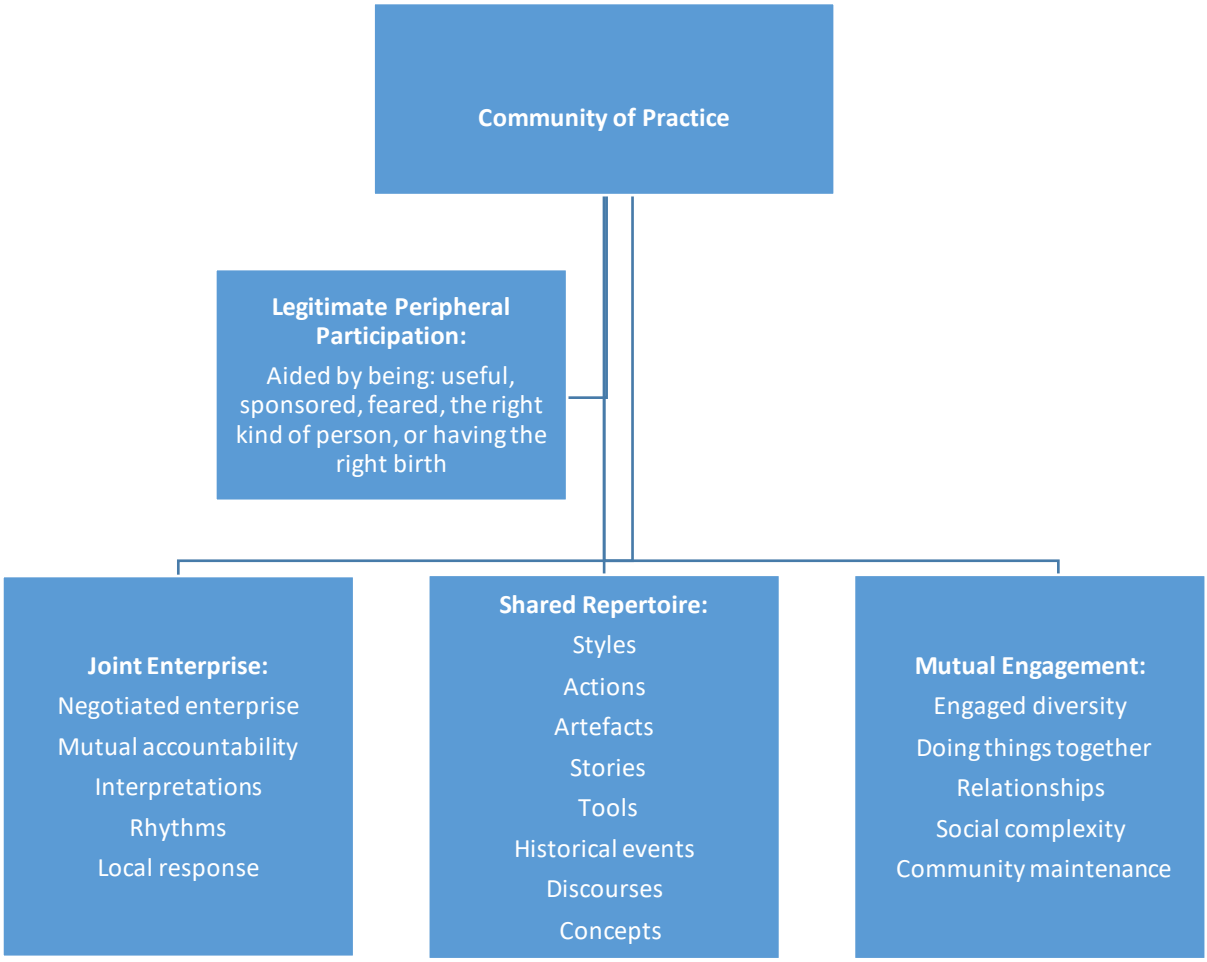

Figure 2.3: The community of practice (adapted from Wenger, 1998, p.73)

Gaining acceptance into the COP is essential to co-participation. Co-participation encompasses the notion of a mutual engagement between the learner and the service, with the role of the workplace being to regulate learning through managing access to learning activities, providing support and supervision, identifying work-related goals and undertaking assessments against these (Billett, 2004a). The role of the learner is to positively and proactively engage in these activities and not just become passive recipients of the learning (Billett, 2004a). Billett (2004a; 2004b) promotes the concept of co-participation as necessary to achieving work-based learning through 'the reciprocal basis for thinking, acting and learning' (Billett, 2004b, p.191). Students recognised the need to undertake reciprocal activities in return for the time mentors spend with them (Spouse, 2000). This is part of the larger impact of WBL where negotiation is needed between learner and mentor in order to align the needs of service and teaching/learning. Similarly, a systematic review of traditional student nurse experiences in acute hospital settings identified how students willing to engage in care giving were more likely to gain acceptance in practice and feel a sense of belonging (Thomas, Jack and Jinks, 2012).

Whilst belonging to a COP can provide positive benefits to individuals, such as supporting professional development and increasing job satisfaction, it also provides challenges (Wenger, McDermott and Snyder, 2002). COPs can afford a level of intimacy between members or can develop individual cliques with powerful individuals acting as gatekeepers, all of which can become a barrier to entry for new members (Wenger, McDermott, Snyder, 2002). These cliques can be formed when individuals band together either intentionally, or as a result of very close working relationships, and can be prohibitive to others attempting to join the COP (Wenger, McDermott and Snyder, 2002). This can result in access to a COP not being accorded equally. A study of previous nursing students and employers from a

similar WBL programme found that some mentors failed to recognise this gatekeeping role, resulting in difficulty for students accessing learning opportunities (Beretta et al, 2012). However, the study also found other examples where, due to the students' maturity and previous experience, wider learning opportunities were offered to them (Beretta et al, 2012). Billett (2004a, p.319) warns of the danger of 'old-timers' limiting access to learning for the student 'newcomers', identifying that individuals may be inhibited from accessing learning where 'old-timers' see the knowledge and skills as highly valued or where they feel they have ownership of that knowledge. This can be the case in a clique, particularly where existing staff have worked as a team for a long period of time and have become resistant to newcomers. With access perceived to be power driven and socially determined (Billett, 2004b), co-workers may perceive that providing access to learning for students seeking to enter the COP will alter that power balance.

The literature indicates that some students struggled in the COP and several studies report students experiencing conflict with co-workers (Gibb, Anderson and Forsyth, 2004; Kevern and Webb, 2004; Watts and Waraker, 2004; Swallow et al, 2007; Wareing, 2010a; 2010b). This often came as a shock to the students, particularly if these co-workers were former colleagues. For some, this was a result of resentment from colleagues who had not been accepted onto similar programmes, or simply lack of recognition or distancing arising from their new status (Kevern and Webb, 2004; Gibb, Anderson and Forsyth, 2004; Swallow et al, 2007; Wareing 2010a; 2010b). This conflict in the literature may have derived from old-timers in the practice setting resenting the revised social standing of the students in the COP, or of them perceiving the students as newcomers. This would suggest that whether the student is treated as a newcomer to the COP or treated as an existing HCA member but with adaptations to accommodate their new student role, support for their entry into the COP as

a student would be beneficial. Beretta et al (2012) found mixed experiences of co-worker support and conflict in their study and believe this conflict may simply be due to a lack of understanding of the programme. The gatekeeper role as a barrier or enabler is therefore key to supporting entry.

The evidence suggests that whilst not all learners experienced co-worker conflict, when it did arise it was emotive and unexpected, especially when the conflict came from a former HCA peer. However, co-worker conflict is not restricted to the HCA/students. Van de Vliert and Janssen (2001) assert that all work groups suffer some degree of conflict with McElhaney (1996) identifying that conflict is common amongst nurses and a part of their daily life. Students affected by co-worker conflict are likely to suffer loss of support, damaged confidence and reduced ability to cope with challenging situations which will affect their learning (Eraut, 2007). Conflict within a COP will undoubtedly have an impact on the learner's learning experience and their ability to successfully function within the new COP. Conversely, in a study of HCAs perceptions about their relationships with student nurses, they believed themselves to be more approachable and to have a closer working relationship with student nurses than qualified nurses do (Hasson, McKenna and Keeney, 2013a).

Students' confidence and competence cannot be adequately developed without gaining access to the COP. Once entry has been gained, participation in the COP enables good working relationships, involving mutual trust, support for the development of professional identity and mutual learning (Eraut, 2006). Mutual trust is necessary to the sharing of professional confidences, particularly relating to exploring challenging situations and, without this, the individual's confidence will be eroded (Eraut, 2006). High confidence,

combined with support from co-workers, enhances the ability for the individual to deal with work challenges and learn from the work environment (Eraut, 2007). These three factors (confidence, support and challenge) make up a triumvirate that affects WBL. Therefore, where this support from co-workers is missing, it can have a detrimental effect on the student's ability to successfully access learning in the COP. By contrast, existing team members may perceive employed nursing students as work colleagues, rather than students, therefore affording them more support than traditional students (Gamroth, Budgen and Lougheed, 2004). This is likely to be in recognition of their contribution to, and potential retention in the workforce, rather than being perceived as transient workers, such as traditional nursing students. In addition, where learners were placed as students in areas they were employed, additional time was not needed for induction and/or orientation to the area (Beretta et al, 2012). Thus, the familiarity of the workplace was beneficial to their ability to integrate into the team.

Whilst the new *Standards framework for nursing and midwifery education* (NMC, 2018a) does not specifically identify clinical placements as a COP, or highlight the need for students to gain entry to it, it does recognise the need for a good educational culture for student support offering:

> "… protection from discrimination, harassment and other behaviour that undermines their performance or confidence." (NMC, 2018a, 3.1.2).

Hence it implicitly recognises the need for those supporting learners to have an advocacy role in protecting students from adverse cultures. The key enablers and barriers to gaining entry into the COP which have been identified through the literature are summarised in

Table 2.1. These include the cultural elements of existing COP members, the importance of support and sponsorship and the activities students can undertake to facilitate entry.

Table 2.1: Perceived barriers and enablers to gaining entry to the COP

Gaining entry into the Community of Practice	
Barriers	**Enablers**
Adverse culture (cliques)	Sponsorship
Co-worker conflict	Gaining legitimacy
Old-timers limiting access to learning	Making themselves useful
Gatekeepers	Ultimately gaining mastery (of some skills)
	Co-worker support
	Gatekeepers

Having identified the importance of the COP in relation to both the students' access to learning and acceptance in practice, the following section explores the literature informed by theoretical concepts of transition and rites of passage.

2.5 Role transition

Role transition is one of the key factors impacting upon the socialisation process that the learners experience in progressing from being an employed worker to a student. Whilst there are a number of transition theories, this section focusses largely on the seminal work of Van Gennep (1960) and more recent publications from Barton (2007), Bridges (2009) and

Bridges and Bridges (2009). Van Gennep's (1960) work provided early insight into transitions across the life-course from which further theory has evolved. It is therefore important from an historical perspective to seek a robust understanding of transition theory.

Van Gennep (1960) proposed that throughout the individual's life a series of transitions, or rites of passage, will take place which mark their progress through, for example, childhood to adulthood, single status to married, adulthood to old age. These rites of passage are characterised by the individual's progression from one role to another, both socially and occupationally:

> "… the life of an individual in any society is a series of passages from one age to another and from one occupation to another." (Van Gennep, 1960, p2).

Van Gennep's (1960) social theory identified the three phases which marked an individual's progression through these Rites of Passage as:

1. *Rites of Separation* - rituals associated with separating from and leaving behind their old identity.
2. *Transition Rites* - rituals associated with undergoing the transition to the new status.
3. *Rites of Incorporation* - rituals associated with incorporating and accepting their new identity.

Each of these transitions is accompanied by a psychological process which is required for the change to be assimilated and the new status accepted. One of the areas associated with rites of passage for learners was their entry into the placement COP. Nursing students, in an American study, identified bullying behaviours by other nurses which they attributed to a

rite of passage they were expected to undertake as part of their transition into the placement area (Smith, Gillespie and Brown, 2016). This led to a potential normalisation of these behaviours into the culture of nurse training, possibly to support development of resilience, or to the excusing of behaviours as deriving from stressors such as high workloads (Smith, Gillespie and Brown, 2016). Furthermore, traditional student nurses in a UK study voiced concerns about the negative attitudes and behaviours of co-workers (HCAs and RNs) towards them and the consequent impact this had on their desire to remain in the profession (Jack et al, 2017). This suggests the type of co-worker conflict identified in Section 2.5.2 could be a common part of a student nurse's rite of passage when entering a new COP.

Two of the more recent transition theories which appear particularly relevant to the review literature, drawing on Van Gennep's three stages of transition, are the focus of this next section. Bridges and Bridges (2009) focuses largely on organisational change and how to successfully manage transition, while Barton (2007) provides a more focused view of transition as it relates to his study of transition in post-registration student nurse practitioners.

Bridges (2009) describes transition as:

> "… a three-phase process that people go through as they internalise and come to terms with the details of a new situation that the change brings about." (p.3).

This transition is a psychological process defined by its three distinct phases, which Bridges and Bridges (2009) liken to three of the stages of bereavement (denial, anger and ultimate acceptance). Bridges and Bridges (2009) transition process is set out in Figure 2.4.

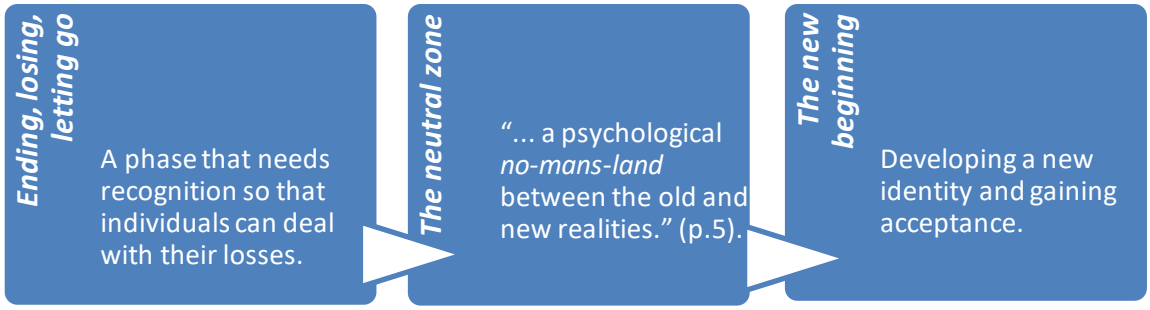

Figure 2.4: The transition process of Bridges and Bridges (2009)

Barton (2007) found distinct parallels between the experiences of his study participants and Van Gennep's (1960) transition theories. The three phases he identified were aligned to specific periods of their programme, with the first stage (Identity Loss) typically taking place in the first year, the second stage (Transitional Role Evolution) spanning years one and two and the third stage (Re-socialisation) taking place towards the end of year two. These are depicted in Figure 2.5.

Figure 2.5: The transition process for student nurse practitioners (based on Barton, 2007)

In summary, each of these three-phase models focus on a process of letting go of the previous role, a period of no-mans-land between the old and the new and then acceptance, or incorporation, of the new role. The middle phase of the transition, where the individual is caught up in a no-mans-land between the two different roles, can often be the most challenging phase. There is a sense of chaos and of being overwhelmed by trying to cope with a push from the old reality and a pull towards the new (Bridges, 2009). Once this phase is complete, the final phase of transition moves towards an acceptance of the new reality and recognition of the new identity. Whilst depicted in these diagrams as a linear process, it is recognised that transition is not necessarily a linear, sequential process, but is likely to be experienced as a series of overlapping phases which lack clear boundaries (Bridges, 2009).

The remainder of this section will focus on these three phases of transition in turn, using the descriptors of Bridges and Bridges (2009). The importance of gaining legitimacy in supporting this transition process, and factors underpinning this, will also be explored, thereby drawing together the two theoretical concepts of transition and entry into the COP. It will also explore the concept of symbolism in relation to supporting entry into the COP and the transition process itself (Section 2.5.4).

2.5.1 Ending, losing, letting go

This section explores the degree of shock felt by these learners, despite previous healthcare experience, largely due to the role conflict students face between their student roles and other roles they might undertake. This included roles as a worker, as a parent, as a spouse.

It looks at the action learners take to mitigate this shock and goes on to explore the benefits and disadvantages of previous healthcare experience in supporting their transition to the student role.

Competing time demands of work intensity, study and placements, with associated travel and unsocial hours, all had a negative impact on students' abilities to cope with the demands of work (Kevern and Webb, 2004). Kevern and Webb (2004, p.300) identified the initial 'reality shock' experienced by mature female students on a traditional nursing programme, of trying to work and learn simultaneously in addition to managing their out of work lives. This was perceived as a 'short, sharp shock' for HCAs undertaking a PRNP (Swallow et al, 2007, p.144). Nursing students were not alone in struggling with role conflict, which was also an issue Ryan (2001) identified amongst Occupational Therapy students.

This role conflict was felt to be 'extremely difficult to manage' with work-life tensions particularly high when on placement (O'Driscoll, Smith and Magnusson, 2009, p.211). To manage role conflict, students learned to 'compartmentalise their minds' (Wareing, 2008, p.535) and developed practical solutions such as giving up leisure activities and reading whilst travelling, rather than in leisure time (Watts and Waraker, 2008). However, they were not prepared to compromise their personal relationships (Watts and Waraker, 2008). It was apparent that whilst in the process of *ending*, *losing* and *letting go*, students were only prepared to sacrifice so much and worked hard to retain those elements that were most important to them, such as their relationships with partners/spouses.

The literature reports the sense of shock associated with the transition from worker to learner and the expectation that transition would be minimised due to their previous experiences in healthcare roles. Part of this reality shock was due to students' growing understanding of accountability and professional responsibility in their student role that was different to their role as HCAs (Brennan and McSherry, 2007). Whilst this was a shock to the students, it also helped distinguish between their student and HCA roles (Brennan and McSherry, 2007).

Students had anticipated that the prior clinical knowledge they brought with them as HCAs would make the transition easier. By contrast, they found their lack of theoretical underpinning left them questioning the clinical competency they had acquired as HCAs (Brennan and McSherry, 2007). HCAs with no prior acute hospital experience found transition to the programme challenging, since the pace and routine of acute placements was very different from their previous clinical experiences (Brennan and McSherry, 2007). Meanwhile, seconded HCAs on a traditional nursing programme believed previous HCA skills supported their transition to the programme at least as well as, if not better than, students without such experience (Gould et al, 2004; Gould, Carr and Kelly, 2006). Furthermore, it was found that pre-registration nursing students with prior HCA experience acted as role models to students without such experience in the early stages of the programme (Brennan and McSherry, 2006). Previous HCA experience may, therefore, be beneficial where that experience was gained in a similar setting to their student placements.

Some studies found that co-workers and mentors had a much greater expectation of the students' abilities than they did traditional students, because of their prior HCA knowledge and skills (Wood, 2006; Beretta et al, 2012). This resulted in the students' delayed development of appropriate autonomy and transition to the student nurse role (Wood, 2006) and the need for more support than was originally anticipated (Beretta et al, 2012). Varying accounts of theory/practice integration were identified in the literature. Kevern and Webb (2004) in their study of mature, female, nursing students on a traditional programme, found that students compartmentalised the academic and clinical placement elements of the programme, rather than seeing them as integrated. In contrast, HCAs studying to be nurses appear to more successfully integrate the two (Gould et al, 2004; Watts and Waraker, 2008). This was perceived to be because students better understood

the academic components when they could directly relate this to their previous practice experiences (Gould et al, 2004). Students, when not in clinical placement, found the inability to reflect on learning and share ideas in practice was an inhibiting factor to the transition process (Watts and Waraker, 2008). This may simply be because of lack of opportunity but suggests that previous healthcare experience may better support the integration of theory and practice.

The literature recognises the risk of employed students compartmentalising the roles of learner and worker. Wareing (2008) identified that foundation degree students switched on and off between the roles of worker and learner, rather than transitioning from one to the other. This may have been necessary to protecting the different roles they had to enact as employed students. It was also recognised that WBL students need to permit themselves to become students in order to embrace the learning culture (Watts and Waraker, 2008). This requires a level of vulnerability for the student, who may need to regress their clinical skills initially, while building underpinning knowledge and holistic care, particularly when work colleagues fail to recognise their student status (Watts and Waraker, 2008). However, it should be noted that the students in Watts and Waraker's (2008) study were in their first theoretical module and thus had limited practice experience as a student nurse to draw on.

To support transition to the student nurse role, the literature indicates that students devised a range of coping strategies. Withdrawing to the 'comfort zone' was noted by Brennan and McSherry (2007, p.211) as a way of dealing with the degree of shock associated with this transition. Students deliberately reverted to the HCA role as a means of either gaining acceptance into the COP of clinical areas (by demonstrating their abilities) or when they were unsure of, or insecure in, their student role (Brennan and McSherry, 2007). The

'comfort zone' was used as a shelter, which allowed them professional acceptance and renewed socialisation with their familiar peer group including other HCAs (Brennan and McSherry, 2007). This delayed the need to let go of their employed worker roles and is characteristic of the *ending, losing, letting go* phase of transition. Whilst students recognised the need to relinquish the 'comfort zone' in order to progress to the student role, they also saw it as essential to their survival (Brennan and McSherry, 2007). This could therefore be perceived as a ritual associated with their rites of transition, although for some students reverting to the HCA role was a mechanism for escaping the more challenging aspects of the student nurse role. It is therefore important to recognise that the 'comfort zone' can act as both a barrier, in being used to escape the reality of transition, and as an enabler, in supporting their ability to cope. The barriers and enablers which act as rites of separation for this phase of transition are summarised in Table 2.2.

Table 2.2: Perceived rites of separation to ending, losing and letting go

Ending, losing and letting go – Rites of Separation	
Barriers	**Enablers**
Comfort zone	Comfort zone
Role conflict	Relevant previous clinical experience
Concerns about accountability and responsibility	Recognition of changing accountability and responsibility as part of transition
Lack of theoretical underpinning	Familiarity of the workplace
Compartmentalisation of roles	

2.5.2 The neutral zone and role confusion

Bridges and Bridges (2009) describes the second phase of transition (the neutral zone) as being accompanied by a sense of feeling overwhelmed and of chaos as the individual occupies a no-mans-land between their old and new states. There is a clear sense of this in the literature with many students feeling overwhelmed by the lack of role identity and the conflict arising between the roles of HCA and student nurse (Watts and Waraker, 2008; Beretta et al, 2012). These issues are compounded by the lack of a clearly defined role for the student nurse, and ambiguous boundaries between that of HCA and student nurse.

Whilst the HCA may be defined by the task-oriented nature of their role (Ahmed and Kitson, 1997; Poole, 1998) there are several skills, particularly for those in assistant practitioner roles, in which they have demonstrated competence and can undertake independently. As a student nurse, these same individuals would need to be re-assessed as competent at the level of their training (Beretta et al, 2012). This would include demonstrating the underpinning knowledge and awareness of the wider implications relating to the task. Therefore, they may both carry out the same task, but the expected level and understanding with which the task is carried out varies between the two roles.

To further complicate the issue, some employers will allow the HCA to extend their employed HCA role to incorporate those tasks they are able to undertake as a student, whereas other employers will not. As a result, there is no clear role definition between the function of the HCA and the student nurse beyond the obvious supernumerary student status and need for demonstration of competence against the student's learning objectives leading to registration.

The literature indicates that role confusion issues can emerge from the learner's difficulty in establishing a clear understanding between their employed worker and learner roles (Kevern and Webb, 2004; Watts and Waraker, 2008). This confusion was compounded by the challenge students encountered in moving away from their previous HCA role, particularly where they were employed or seconded students (Wareing, 2008, Watts and Waraker, 2008). Students with previous HCA experience were often relied upon to support service needs in clinical areas (Kevern and Webb, 2004) or 'utilised as a HCA' rather than as a student (Brennan and McSherry, 2007, p.211). Some students found the emphasis on their worker identity to be overwhelming, based on their sense of obligation to the employer (Watts and Waraker, 2008). Worker/learners appear to suffer a culture shock of competing expectations and conflicting demands (Kevern and Webb, 2004; Watts and Waraker, 2008), where work sets the direction for learning, rather than work being focused on meeting the defined learning needs of the student (Wareing, 2008).

Confusion concerning role boundaries and role definition was not confined to the students themselves. Swallow et al (2007) identified confusion amongst other clinical staff regarding the identity of HCA/students. This resulted in a lack of recognition of their student status and students not getting protected time. In a study of foundation degree students, staff not only forgot the former HCA was a learner, but also expressed uncertainty around what they could do in their learner role (Wareing, 2010a). In addition, lack of clarity around the dual roles of student and employed worker can cause confusion around who is responsible for them, particularly regarding performance issues (Kenny et al, 2012). This can have an impact in relation to support for, or management of, the HCA/student.

The literature identified strategies students developed to help avoid being used as an HCA, including not disclosing their HCA background while on placement (Gould, Carr and Kelly, 2006; Brennan and McSherry, 2007). However, whilst students did not want to be used as a pair of (HCA) hands, they often wanted to be recognised and valued for their prior knowledge and experience (Ryan, 2001; Melrose and Gordon, 2008). Some felt frustrated by having to be supervised as students in skills they had undertaken independently in their previous employed roles (Brennan and McSherry, 2007). This did not just relate to HCA roles, but also to transferable skills from other related occupations such as management, cancer screening and elderly care (Melrose and Gordon, 2008).

In contrast, Gould et al (2004), in a longitudinal study of two consecutive cohorts of HCA secondees to a pre-registration nursing programme, found that participants did not feel undervalued in terms of their previous experience, nor did they express concerns about being used as HCAs. This might be due to a greater sense of obligation to their employers as funded secondees. Furthermore, employers valued the additional skills and knowledge that these HCA/students brought to the programme with them (Beretta et al, 2012), whilst recognising that the dual roles of worker and learner could lead to exploitation of this where the programme itself was poorly understood. Whilst students found it hard to differentiate between the roles, Brennan and McSherry (2007) found that the students associated their increased recognition of responsibility and accountability in nursing as a key signifier of change from their previous HCA perceptions.

From the literature it is clear there are issues of confusion around the student identity, both for the students and for those supporting them in practice. This is compounded by a recognition that student nurses are often used to underpin service needs, rather than having

service provision support their learning in practice. The introduction of supernumerary status as part of the Project 2000 initiative (UKCC, 1986) was intended to protect students from being used to supplement the nursing workforce. The issue of students being used 'as a pair of hands' is compounded by confusion about what is meant by supernumerary status, leading to difficulties for both students and mentors which can further challenge student identity. Therefore, protecting supernumerary status in WBL programmes, with an ethos of learning *from*, *through* and *at* work (Quality Support Centre, 1996), appears to have been particularly challenging.

Confusion over what is meant by 'supernumerary,' combined with competing service pressures, challenges the ability to protect student identity in the workplace. In a mixed methods (MM) study of traditional pre-registration nursing students, 59% (n=1425) of students reported being 'used as an extra pair of hands' (Jack et al, 2017, p.4). This was characterised by lack of respect for their supernumerary status, resulting in allocation of what were perceived by the students to be non-learning related menial tasks and being used as workers rather than learners (Jack et al, 2017).

Similarly, in a study of sixty traditional second year student nurses, students understood that supernumerary status prevented them from being counted as part of the ward staffing numbers, but this was not the reality they experienced when on placement (McGowan, 2005). Students identified that the Ward Sister's (or Charge Nurse's) stance in protecting supernumerary status was crucial to influencing the team and that where supernumerary status was protected, learning was felt to be enhanced (McGowan, 2005). Furthermore, where it was not protected, students found that their learning needs were compromised in order to meet service needs and they felt used (McGowan, 2005). Protecting supernumerary

status can also be an issue in the immediate pre-qualifying period. Six out of eight final placement traditional nursing students perceived that they were still being used as an 'extra pair of hands' which led to feelings of anger and frustration about being used to fill service gaps and a craving for the learning they felt they were missing out on (Morrell and Ridgway, 2014, p.519). Students felt that being used as a pair of hands had a negative impact on their ability to learn and to achieve their competencies in practice (Morrell and Ridgeway, 2014; Jack et al, 2017). Hence this issue is not isolated to HCAs undertaking these WBL nursing programmes.

The ability to maintain a student's supernumerary status, given the need to deliver a healthcare service, is an on-going challenge. This confusion was recognised by stakeholders responding to the NMC's consultation around the new *Education Standards for pre-registration nursing programmes* (NMC, 2018c) and resulted in further clarification through the new *Standards framework for nursing and midwifery education* (NMC, 2018a):

> 'Supernumerary status applies to pre-registration students; students in practice or work placed learning must be supported to learn without being counted as part of the staffing required for safe and effective care in that setting.' (NMC, 2018a, Glossary).

However, the NMC (2018b) acknowledges that this definition is deliberately broad to allow some flexibility for decreasing supervision in response to students' increasing level of proficiency during their training. This may, as a result, provide a continued challenge in protecting supernumerary status and student role reinforcement.

Billett (2004b) recognises that workplaces provide access to learning providing doing so supports the workplace needs and interests. Whilst supporting supernumerary status does not guarantee greater learning in the workplace, it has the potential to facilitate a better learner experience. Experiential learning has a risk of being ad-hoc, failing to focus on the specific learning needs of the student, and therefore an inability for them to develop the required competencies. This is further compounded by student reports of the primacy of the worker role over the learner role in practice (Watts and Waraker, 2008).

Whilst it was recognised in Section 2.4 that students needed to make themselves useful in order to gain entry and acceptance into the COP (Brennan and McSherry, 2007), this should not be at the expense of meeting their learning needs. Although patient care quality is paramount, staffing levels and ability to provide adequate support and supervision to student nurses (including WBL programmes) is a key consideration before approving clinical placements.

While HCAs undertaking WBL nursing programmes are not alone in experiencing difficulty protecting supernumerary status, these issues are compounded by confusion and lack of boundaries between the roles of student and HCA and the primacy of their employed worker roles. A summary of the key barriers and enablers which act as transition rites through the neutral zone are set out in Table 2.3.

Table 2.3: Key transition rites through the neutral zone

The Neutral Zone – Transition Rites	
Barriers	**Enablers**
Primacy of worker role	Relevant pre-existing skills and knowledge
Role confusion	Role identification and reinforcement
Competing expectations	Protecting supernumerary status

The following section will explore the transition to the new beginning, the students' progression towards adoption of the student role and acceptance of the student identity.

2.5.3 The new beginning

Whilst there is limited evidence in the literature that students have progressed to the third phase of transition and fully adopted their student status, this may be because many of the studies took place too early in the transition process, before the students reached the end of their programmes. Wareing (2010a; 2010b) identified that towards completion of a foundation degree, students had adopted their health professional identity and their teams better understood the potential of their role. In addition, Gould et al (2004) identified that final placement students could clearly articulate the differences between their student role and previous HCA roles. Transition into the student role was perceived to be linked to being more knowledgeable, more reflective, more professional and more holistic than when in the HCA role (Gould et al 2004). This would suggest that students will eventually complete their transition and will embrace their new beginning. Furthermore, Beretta et al (2012), in their

study of former HCA/students and employers, found that despite the challenges in negotiating the neutral zone, students did eventually exit this stage of transition and successfully re-socialise into newly qualified nurses.

Draper (2018), in a study of newly qualified nurses who had undertaken a WBL PRNP, found that whilst they recognised the tensions between the roles of HCA and student during their training, they had reconciled the need to pivot between the two. They also found that whilst they had needed to revert back to their HCA roles on occasion to manage these tensions, they had accepted the need to step away from their HCA role and for other HCAs to recognise their new status. Their previous experiences, however, had left them with a deeper appreciation for HCAs in their teams which had stayed with them on qualifying (Draper, 2018).

Thus, key rites of incorporation for this final stage of transition focus on developing an understanding of their roles and responsibilities which they are able to articulate, and which is accepted by their co-workers. This is enhanced by their ability to demonstrate differences in the way that they undertake their role in relation to professionalism, holism and reflective practice.

2.5.4 Symbolism in support of transition

The rites of passage described in 2.5 (Van Gennep, 1960) are closely associated with items of symbolism. Symbolism is a cultural feature, denoting status in society. Artefacts, particularly in organisations such as the NHS, can act as cultural symbols, denoting the natural order within the organisation (Barton, 2007) and underpinning the role of transition rites in supporting the transition process (Bridges, 2009). For example, a nurse on

qualification will have a number of symbols associated with this rite of passage which may include; letter of confirmation, allocation of NMC personal identification number (PIN), new uniform, new job, new title. This section focuses on the role of artefacts, such as the uniform, in legitimising the student role, which in turn helps protect against the primacy of the worker role.

The literature suggests that one of the issues students faced was the difficulty gaining legitimacy of their student role at the same time as being employed workers. Two key issues appeared to inhibit the HCA's adoption of the student role – the absence of legitimising activities such as library attendance (Watts and Waraker, 2008) and the primacy of their role as a worker (Swallow et al, 2007; Watts and Waraker, 2008; Wareing, 2008; 2010a and 2010b). Symbolism can be beneficial in reinforcing the new identity (Bridges, 2009), with a number of studies in the literature recognising the benefits of artefacts in conferring student role status (Swallow et al, 2007; Wareing, 2008; 2010a and 2010b).

Artefacts included student identity (ID) cards, name badges, separate HCA and student uniforms, and library cards. Swallow et al (2007) found that despite having student ID badges, some students still suffered from confusion over their HCA and student roles although this was perceived to be largely because they still wore HCA uniforms. Student cards were considered to be the 'artefacts of studentship' (Watts and Waraker, 2008, p.109) and were significant in legitimising student identity. Artefacts appeared to act as a visual reinforcement of the student role, reminding other nursing staff of the need for supernumerary status, protecting to some extent against the dominance of the worker role. These artefacts could be regarded as symbols associated with rites of passage, with uniforms

and name badges key signifiers of legitimacy for entry into the COP. The value of artefacts or symbols in helping cross over boundaries from one community to another is well recognised in transition theory (Wenger, 1998; Bridges, 2009).

Having explored the significance of these artefacts as symbols of transition, the following section discusses the final theme identified in the literature, mentorship, and its impact on supporting students' transition. This includes the functional, personal and relational elements of mentorship, relating these to the support needs of WBL students.

2.6 Mentorship

The *NMC Standards for Learning and Assessment in Practice* (NMC, 2008), which were in operation at the time of the study, define the role of the mentor as being responsible for supporting the learning and assessment of pre-registration nursing students in practice. Other countries (including the United States of America) describe this as the preceptor role. Morton-Cooper and Palmer (2000, p.189) distinguish between the role of mentor as a guide to the student through 'the organisational, social and political networks' of the workplace and the preceptor as providing 'transitional role support' for the newly qualified practitioner. Hence in the UK, the preceptor role is a support role for the newly qualified practitioner during a defined period of preceptorship.

There was limited acknowledgment of the role of the mentor in the literature specifically relating to these types of work-based learning programmes, although this was found to be a crucial role in those studies where the role was explored (Spouse, 2001; Gibb, Anderson and Forsyth, 2004; Swallow et al, 2007). This may be due to the academic focus of support roles

in many of the studies. The role of the mentor is multi-faceted comprising functional, personal and relational elements (Morton-Cooper and Palmer, 2000). These elements are interlinked with no clear demarcation between them, providing instead a complex relational role which is critical to the successful transition and development of the student. The remainder of this section explores these three inter-related aspects.

2.6.1 Functional elements of mentorship

Morton-Cooper and Palmer (2000) identify numerous functional elements, including coaching, role modelling, counselling, supporting, advising, guiding and sponsorship.

Supporting, advising and guiding work-based learning

WBL in nursing is different to other forms of learning as it is influenced by actual events in practice and therefore difficult to plan. The work environment forms the curriculum for learning and support is provided by co-workers who often have no additional resources allocated for this role. One of the main challenges in WBL is the application of the principles of learning from, through and at work in practice (Green and Holloway, 1997; Dewar and Walker, 1999). Service pressures, lack of access to appropriate learning opportunities and lack of availability of appropriate support all contribute to potential limiting factors (Billett, 2004a). Dewar and Walker (1999) recognise the importance of time spent in debating practice with the mentor, which facilitates learning and is an element that the literature suggests is often lacking. Although some learning can occur simply through observing and participating in activities, developing 'tricks of the trade' and/or conceptual knowledge require active engagement with more experienced co-workers (Billett, 2004b, p.198). The work environment is the ideal forum for developing thoughts, actions and associated reflections to support learning (Birchenhall, 1999), with the reinforcement of what is already

known through repetition and refinement of activities (Billett, 2004a). However, without a knowledgeable mentor providing critical challenge and opportunities for reflection and debate, learning may be limited.

Spouse (2001) criticises the lack of understanding that some mentors had of their role and who resorted instead to apprenticeship styles of mentoring. This fails to challenge the students' understanding of underpinning theory or consequences of practice (Morton-Cooper and Palmer, 2000). Spouse (2001) acknowledges that for workplace learning to be successful, it should incorporate opportunities for students to challenge practice and achieve resolution through discussion with their mentor. Jack et al (2017) recommends that to combat issues such as role confusion and co-worker conflict, there are four central elements for the mentor role as a:

- role model – offering an enthusiastic and caring approach;
- legitimiser – legitimising the student role and promoting the mentor role as integral to the RN role;
- advocate – legitimising student concerns and supporting access to learning;
- respecter – respecting the student's views and status, conferring a sense of belongingness and value on the student.

Hence the mentor's role in supporting, advising and guiding WBL students is crucial.

Coaching: The benefits of coaching style models of mentorship are highlighted in several publications (Branson, 2014; Lobo, Arthur and Lattimer, 2014; HEE, 2015). It is an approach endorsed by both the RCN (2015) and NMC (2018b) as an appropriate model of

mentorship for facilitating learning in nursing practice. This reinforces the findings of Morton-Cooper and Palmer (2000) who recognised the need to critically challenge the student in order for the student to access professional knowledge.

In a mentorship context, coaching models are described as being less taught and more enquiry based, with students taking a lead role supported and prompted by the coach/mentor (HEE and University of East Anglia, 2014). This tends to produce students who are more solution focused and who have a collaborative learning experience with their mentor (HEE and University of East Anglia, 2014). The coaching approach supports WBL through encouraging the learner to take the lead in care giving, offering a more hands-on approach and better preparing the learner for the realities of practice (HEE, 2015). This supports the mentor in challenging the student's knowledge and understanding of the patients, whose holistic care they are leading, and promotes successful WBL. Through this model, the coach acts as an old-timer in supporting the legitimacy of the learner and, through taking the lead in care giving, the learner proves their usefulness in the COP. Wareing (2008; 2011) recognises the value of a coaching based model of mentorship for HCAs undertaking a WBL foundation degree. He argues that WBL students offer different mentorship challenges than traditional learners and that their existing familiarity and assimilation into the clinical environment requires a different approach. Coaching models are believed to be less hierarchical and more collaborative than other mentoring models and as such are supported by Spouse (2001) and Wareing (2008) as the model of choice for clinical practice.

Sponsorship: The role of the sponsor is a functional element of the mentor's role in legitimising entry into a COP through sponsorship of the individual (Wenger, 1998) – see Figure 2.2. Spouse (2000, p737) identified that the newcomer needs an 'old-timer' to

sponsor her admission to a COP, who can act as a guide to the language, culture and jargon used within. This is especially important in nursing where a number of healthcare abbreviations prevail. Furthermore, sponsorship denotes the role of an influential staff member (such as the mentor) who sponsors the student through befriending them, promoting a nurturing clinical learning environment and encouraging openness (Spouse, 2001). While this role can be undertaken by any member of the nursing team, it is ideally suited to the mentor, who will have demonstrated the necessary proficiency in these skills. This sponsorship leads to confident students who are more likely to interact with others in the team and report a good experience of practice (Spouse, 2001). Conversely, students without sponsors often cling to individual staff, tending to hide or absent themselves from practice, and may become alienated resulting in a failure to develop (Spouse, 2001). Such students may then be perceived as failing students when it could be an issue of failed sponsorship.

Findings indicate that mentors are seen by learners as crucial to supporting confidence and development, protecting supernumerary status and negating a hostile clinical learning environment (Jack et al, 2017). Hence this suggests that mentors have a crucial sponsorship function in clinical placements. Students also felt that where mentors were enthusiastic and committed to this role, they were more likely to feel they belonged and were valued (Jack et al, 2007). It is generally agreed that sponsoring students and fostering this sense of belongingness is key for the students' socialisation into placement areas (Myall, Levett-Jones and Lathlean, 2007; Levett-Jones and Lathean, 2008; Levett-Jones, Lathlean, Higgins, and McMillan, 2009; Levett-Jones and Lathean, 2009a; Epstein and Carlin, 2012). Whilst some may assume that existing HCAs will have a sense of belongingness and value in their

COP already, earlier identification of co-worker conflict would suggest this is not necessarily the case. Hence the role of the mentor in sponsoring the successful entry of the student into the COP is a critical one.

2.6.2 Personal elements of mentorship

There are a number of personal elements of mentorship which support the development of students. Those which are particularly relevant to the literature in relation to these WBL nursing students include: *self-development, confidence building, creativity, fulfilment of potential* and *risk taking* and are explored in this section. Spouse (2001) found that effective mentorship was the most significant influence on a student's professional development. She found that with good mentorship, students settled in more quickly, developed confidence and were able to better relate theory to practice (Spouse, 2001).

The mentor was able to support the HCAs' transition to the student role by identifying the differences between old and new roles, both of which were familiar to the mentor, and this support was enhanced by pre-existing knowledge of the student's strengths and weaknesses (Swallow et al, 2007). This is particularly important since Bridges and Bridges (2009) warn that failure to identify and prepare for letting go is the main difficulty for staff in transition. They state that in the first stage individuals need to be supported to deal with their losses, in the second stage there needs to be a period of psychological adjustment and redefining and in the third phase there needs to be a new sense of purpose and energy (Bridges, 2009). Having this pre-existing knowledge of the student, and being able to prepare for and support them, is likely to be beneficial to the transition process. The mentor acts both as an advocate

to the nursing student and a legitimiser for the student role (Jack et al, 2017). This supports transition from HCA to student through retention of student status and facilitation of learning (Draper, 2018).

In Section 2.4 the importance of participation in the COP, in facilitating students' access to support and exposure to challenge, was identified as crucial to developing their confidence (Eraut, 2006). Therefore, identifying an appropriate mentor for WBL students, particularly those working and learning in their existing workplace for long periods of time, is essential. Wareing (2010a; 2010b) acknowledged the need to deter mentors with existing social relationships with students and those who may lack confidence to challenge practice, recognising the challenges this may bring to providing objective assessment decisions. However, other literature suggests students themselves found existing familiarity with their mentor beneficial in establishing a good rapport (Swallow et al, 2007).

This dichotomy suggests that mentors need to be more aware of the challenges of mentoring WBL students and the particular support needs they might have. In an Australian study, increasing awareness of WBL and allowing staff to choose their own mentoring models led to an improved understanding of mentorship in WBL for mentors and students (Gibb, Anderson and Forsyth, 2004). This resulted in more effective mentoring partnerships and led to the realisation the deeper the mentor relationship, the greater the level of student competency (Gibb, Anderson and Forsyth, 2004).

Furthermore, coaching models allow mentors to take safe risks, allowing learners to practice their skills within agreed parameters, acknowledging the potential for learning from mistakes whilst protecting patients from the risk of harm. Failure to do so may result in over-supervising, which can stifle the student's development by blocking their progress (Darling, 1984).

2.6.3 Relational elements of mentorship

This section focuses on the relationship elements pertaining to *interpersonal relations, social relations, networking, sharing* and *trust* (Morton-Cooper and Palmer, 2000). The quality of the professional relationship between student and mentor is essential to the student's ability to feel connected to the COP and in making them feel part of the team (Myall, Levett-Jones and Lathlean, 2007). Where this relationship fails, students can feel both excluded and isolated. There are a number of ways in which mentors can support students through sponsorship to feel connected to the COP:

- providing a welcome to the area (Myall, Levett-Jones and Lathlean, 2007) including recognising them by name and treating them with respect (Bradbury-Jones, Sambrook and Irvine, 2011);
- including and valuing them in the team (Myall, Levett-Jones and Lathlean, 2007), particularly through supporting their contribution to care within a team environment (Bradbury-Jones, Sambrook and Irvine, 2011);
- treating them as valid and legitimate students, as opposed to employed workers (Myall, Levett-Jones and Lathlean, 2007) including recognising their learning needs and supporting their achievement (Bradbury-Jones, Sambrook and Irvine, 2011).

One of the biggest mentorship concerns over the past decade has been the issue of failing to fail students who lacked the appropriate clinical competence which was identified by Kathleen Duffy (NMC, 2003). This may be particularly difficult for mentors who may have long-standing relationships with the student/HCAs and as a result have a more in-depth relationship than traditional students and mentors.

There are many compounding factors that prevent mentors from failing students who have not evidenced their competence in practice, particularly those who were on the border of passing/failing in practice (NMC, 2003). One such issue is that of mentors wanting to be kind to their students and not fail them, especially where such failure may result in an inability to complete their training (Luhanga, Myrick and Yonge, 2010; Earle-Foley et al, 2012, Hunt, 2012). Hursthouse (1999) refers to the ethical dilemma for mentors between being kind and doing the right thing. However, Earle-Foley et al (2012) reports that where students feel respected and well supported by their mentors, they are more likely to find their evaluations credible and thus more accepting of pass/fail decisions. This ethical dilemma has led to the NMC separating out the roles of supervisor and assessor in the new *Standards for student supervision and assessment* (NMC, 2018b).

The trusting relationship between mentor and student to support the challenge necessary to facilitate effective learning may be enhanced by the pre-existing relationship between RN and HCA. As identified in 2.6.2, it is unclear, therefore, whether being supported by familiar mentors with a pre-existing relationship to the HCA/student will support or inhibit pass/fail decisions. These functional, personal and relational elements of mentorship are summarised in Table 2.4.

Table 2.4: Functional, personal and relational elements of mentorship

Mentorship		
Functional elements	**Personal elements**	**Relational elements**
Supporting, advising and guiding WBL	Self-development	Interpersonal relations
Coaching	Confidence building	Social relations
Sponsorship	Creativity	Networking
	Fulfilment of potential	Sharing
	Risk taking	Trust

The remainder of this chapter will summarise the key themes, identify gaps in current knowledge and the need for further research.

2.7 Summary of key themes

This literature review has identified a number of key issues relating to the successful entry of students, who are also HCAs, into the COP and their transition to the student nurse role. It is clear from the literature that the dual roles of learner and worker have the potential to adversely impact on their transition to the student nurse role. The inability to leave behind their previous worker identity and fully embrace their student identity may result in them remaining in limbo, or a no-mans-land, where they are neither learner nor worker. This is further impacted by the temptation to stay in the 'comfort zone' of their HCA role to help them gain acceptance into the COP, which may hinder their ability to fully complete the transition process and reach their *new beginning.* One of the main barriers to the successful transition is the role confusion surrounding the HCA/students and those supporting them,

particularly in legitimising the role and protecting supernumerary status. These issues may be supported by good mentorship and artefacts such as uniforms and name badges, but can be impeded by poor mentorship, service demands and lack of understanding of their roles.

For their mentors, the main issues are likely to be understanding the support needs of these WBL students and providing the key elements of mentorship necessary to sponsor their successful transition to the student role. Familiarity with HCA colleagues may lead mentors to perpetuate failure to fail issues or may lead to mentor/student relationships which are deeper and more meaningful, resulting in a greater sense of trust and mutual respect for pass/fail decisions.

Therefore, the three identified themes of *gaining entry into the COP*, *transition* and *mentorship* are inter-linked, necessitating successful entry into the COP as the first step to the transition process and good mentorship to underpin both entry to the COP and successful transition. This transition is further supported by a number of transition rites and student nurse artefacts.

2.8 Gaps in knowledge and recommendations for further research

In addition to providing evidence to support the understanding of the clinical experiences of WBL students undertaking healthcare programmes, this literature review has also identified gaps in knowledge, particularly in relation to the dual roles of being both an HCA and student nurse.

Role duality issues:

1. It was unclear exactly how student nurses were affected by the constantly pivoting roles of HCA and student over the duration of the programme. There remained a potential for them to be caught up in a *neutral zone*, unable to fully accept and integrate their *new beginning*, since they were unable to truly *end, lose* and *let go* of their employed HCA roles. It was recognised that it would therefore be helpful to improve our understanding of the impact of barriers and enablers and how we might use these to better support the transition process.

2. Nowhere in the identified literature was there exploration of any similar role confusion issues experienced by their registered nurse/mentors, who will act as registered nurse (RN) colleagues to the HCAs (often over many years) but as mentor/assessors to them when they are in their student role. It was possible that they might suffer similar transition issues.

This role duality for students and mentors was worthy of further investigation, particularly given the recognition of the potential dichotomy between the benefits of having prior knowledge of the learner and the risks of this leading to subjectivity in assessing practice. It was necessary to identify what impact this programme might have on the RN/mentors' ability to support long-term colleagues through potential new roles as assessors and crucial to determine whether this familiarity will be a barrier or enabler to making pass/fail decisions in practice. Whilst the new *Standards for student supervision and assessment* (NMC, 2018b) have recognised the potential opposing roles of supervisor and assessor, separating the two

out in order to better manage this, these standards were not in place at the time of this research. These identified gaps in knowledge provided the focus for this study which is set out in Section 2.9.

2.9 Study aim, focus and research questions

This section sets out the aims and focus for this DProf study with the overarching research question and sub-questions for the initial, exploratory phase of research.

2.9.1 Aim and focus of the study

The purpose of this research was to explore the role duality experiences of HCAs undertaking a WBL PRNP, and their registered nurse mentors, to gain a better understanding of the participants' experiences in practice and any potential barriers and enablers to this. The analysis of the data from this phase would then inform the second phase, the purpose of which was to improve the practice experiences of these HCA/students and/or their RN mentors.

2.9.2 Research questions

An overarching research question was adopted which integrated both elements of the research; the descriptive, exploratory *what* and the interventionist *how* which seek to identify causes or explain relationships between phenomena (Blaikie, 2007).

"What are the role duality issues facing healthcare assistants undertaking a work-based learning, pre-registration nursing programme and their RN/mentors and how can these be mitigated by an intervention derived from exploratory findings?"

The *why* questions were used through the data collection process in helping make sense of responses and are associated with interventions and outcomes (Blaikie, 2007). This overarching research question was underpinned by separate sub-questions for the initial, exploratory phase of research and reviewed for its continued relevance ahead of the subsequent evaluation phase of research.

For the exploratory phase of research, the underpinning sub-questions set were:

- *What are the experiences of both HCA/students and their RN/mentors regarding the duality of their roles?*
- *Is the mentor role in relation to mentoring these non-traditional students different to that of mentoring traditional students and, if so, how?*
- *Does the relationship between the HCA/students and their RN/mentors differ when they are working as HCA and RN from when they are working as student and mentor? If so, how?*

The following chapter (Chapter Three) provides an overview of the research design setting out the various methodological considerations.

CHAPTER THREE

Methodology

3.1 Introduction

This chapter explores the research paradigm, ontology, epistemology, the methodology and the researcher stance underpinning this research (Figure 3.1). These will inform the research methods described in Chapter Four.

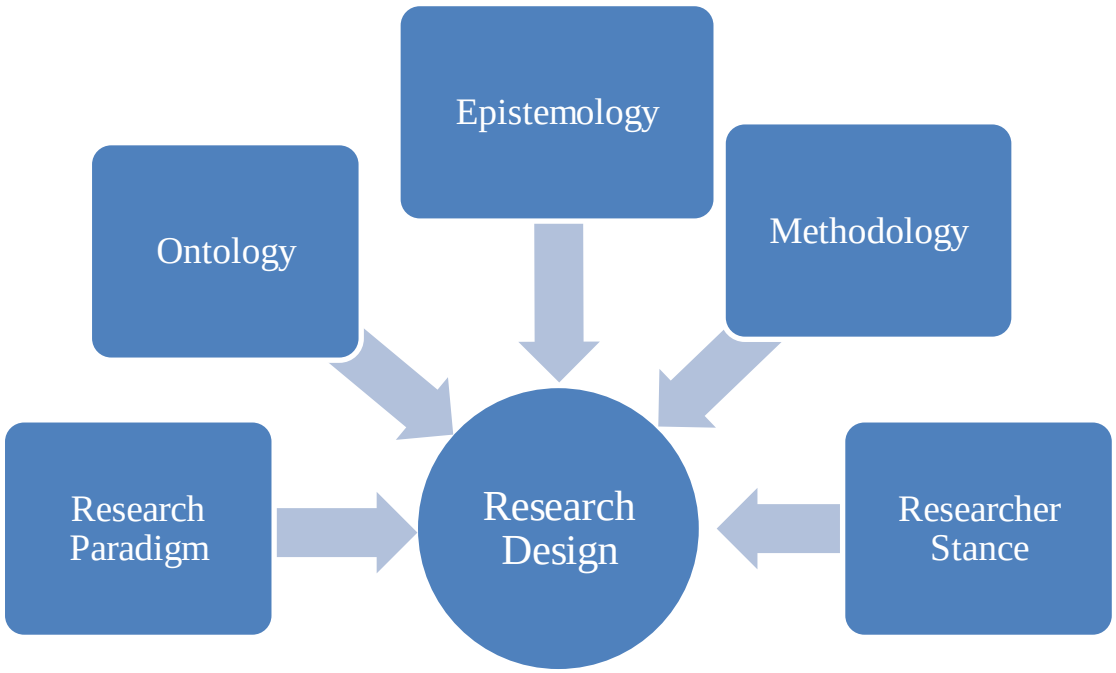

Figure 3.1: The theoretical underpinnings of the research design

The research design includes the crossover between the research paradigm, strategies of inquiry and the chosen method (Cresswell, 2009), providing a cohesive link between data collection, consequent conclusions and the original research question(s) (Yin, 2009). The

first step in this research design was to determine the overarching paradigm or philosophical worldview.

3.2 Research paradigms

Regardless of the methodological approach being adopted, it is important to consider the paradigm underpinning the research. The research paradigm is defined by Guba (1990, p.17) as 'a basic set of beliefs that guide action'. Setting out the research paradigm should include not only the characteristics of the worldview, but also how it shaped the researcher's approach to the research (Cresswell, 2009). There are two main dichotomous social theories, objectivist and subjectivist, which form the basis for research paradigms (Durham et al, 2015). Objectivist paradigms rely on objective, sense data and believe that there is only one version of the truth (positivism) or that whilst reality exists, a single version of the truth is not certain and therefore needs to be tested or challenged for confirmation (post-positivism) (Durham et al, 2015). Subjectivist paradigms are naturalistic and rely on personal perspectives (Durham et al, 2015). Hence the two approaches support contrasting views.

A positivist paradigm proposes one true reality, determined through hypothesis testing and quantitative approaches to identify 'how much' or 'how strong' (Dures et al, 2010, p.333). It does not fit with my identified personal worldview or research aims, which are more exploratory, focusing on 'why' questions and intending to support improvements to practice (Dures et al, 2010, p.333). Therefore, given my research aims fit more within an objectivist/subjectivist continuum, Cresswell (2009) identifies four paradigms within this continuum which will be used to frame this section. These four paradigms are *Post-Positivism, Social Constructivism, Advocacy/Participatory* and *Pragmatic*.

A *post-positivist* paradigm challenges the positivist view that there is only one version of the truth but supports the belief that:

- causes can determine effects (deterministic philosophy);
- ideas can be reduced into a number of small variables that can be tested (reductionist philosophy);
- tools can be used to measure the observed objective reality;
- development of a hypothesis or theory can allow testing for confirmation or refuting (Cresswell, 2009).

Post-positivist paradigms seek to quantify or measure the degree of variations in the phenomena under investigation (Kumar, 2014) and are therefore useful in confirmatory or explanatory research. However, from a paradigm perspective, a *post-positivist* view does not necessarily allow the deep exploration that I had intended for this research.

In a *Social Constructivist Worldview,* individuals seek to understand their experiences of the world in which they live or work (Cresswell, 2009). The participants' experiences can be explored, searching for a complexity of views. These can be analysed and fed back to participants in order to interpret the meanings they attribute to their experiences, with the aim of 'generating or inductively developing a theory or pattern of meaning as a result' (Cresswell, 1998, p. 8). As such, this approach is beneficial in exploratory research.

An *Advocacy/Participatory Worldview* supports actions intended to result in improvements to the lives of participants and necessitates a collaborative approach to avoid further marginalisation of participants (Cresswell, 2009). It has the potential not only to improve the experiences of participants, but to empower them through inclusion in the research (Cresswell, 2009). Kemmis and Wilkinson (1998) suggest that advocacy/participatory studies result in the development of a change agenda, thus it is ideally suited to interventionist or action research approaches. Whilst an *Advocacy/Participatory* approach would have met my research intention to improve the practice experiences of participants, it is a collaborative approach which was impossible to fully adopt since the initial research planning and literature review had been carried out without the inclusion of participants.

The *Pragmatic Worldview* offers a more flexible and agile approach, emphasising the research problem and promoting any option to support an understanding of it, rather than restricting choice of method (Cresswell, 2009). In this way, a pragmatic paradigm is not only unaffiliated to any one view of reality, it also offers a flexibility in the choice of methods that is not necessarily available with other philosophical worldviews (Cresswell, 2009). This may be a better fit, particularly for multi-phase research, or where solution focused outcomes are required (Doyle, Brady and Byrne, 2009).

Both *pragmatic* and *social constructivist* approaches would have allowed the participants' practice experiences to be explored, whilst searching for a complexity of views. However, given the need for multi-phase research, with both exploratory and interventionist components, a pragmatic approach could provide additional benefits through its diversity.

Therefore, a pragmatic paradigm was deemed most suited to this research. Having identified the chosen research paradigms, the following section will explore the associated ontological approach.

3.3 Ontology (the nature of reality)

The ontological perspective of each of the paradigms identifies the researcher's belief about the nature of reality and the way in which the existence of the phenomena under investigation can be determined (Campbell, 2015).

While *Post-positivists* believe in confirming or refuting their one true reality against a hypothesis or a priori theory (Cresswell, 2009; Durham et al, 2015), *Social Constructivists* believe that truth is determined by individuals in groups and is socially constructed through interaction with others (Cresswell, 2009; Durham et al, 2015). It is therefore a much more individualised perspective of reality. By contrast, both *Social Constructivist* and *Advocacy/participatory* approaches aim to describe events or phenomena, identifying parameters of the event through analysis but without seeking to quantify it (Kumar, 2014). However, *Advocacy/participatory* approaches recognise the value of collaboration involving the research participants themselves (Cresswell, 2009).

Pragmatic approaches reject the notion that there is one truth and believe that we constantly reassess our perception of reality from the circumstances surrounding us. The ontological approach aligned to this recognises that the nature of reality may be derived from the real-life experiences of individuals, but also from identifying the relationship between variables

(Robson, 2016). Integration of both sources of data, quantitative and qualitative, is intended to enhance the understanding of the phenomena and lead to a greater depth and breadth of knowledge than either one alone (Cresswell, 2015). Therefore, the pragmatic ontology adopted recognises benefits of both quantitative and qualitative data sources in determining the nature of reality. This ontology is intended to support transferability of knowledge rather than context-generality (Morgan, 2007) and was ideally suited to this DProf research, where the focus will be on improving the practice experiences of these students and their mentors.

This belief about the nature of reality is further supported through determining the epistemology, which identifies not only the nature of knowledge, but how it informs our reality.

3.4 Epistemology

Epistemology seeks to explore the meaning given to certain situations by individuals, allowing a deeper understanding, whilst recognising that there is no one method which is superior to another (Dures et al, 2010). *Pragmatic* approaches tend to be solution-focused, seeking to identify the meaning behind phenomena. This makes it an ideal approach for DProf research where the intention is to drive improvements to practice.

Interpreting research findings is key to this, recognising that evidence gathered needs to be interpreted alongside other, equally valid claims in order to understand it (White, 1997). The two main interpretive approaches from which theory is derived are deductive and inductive. Objective paradigms use a knowledge source that is value free, quantitative and

deductive, with phenomena which is able to be observed (Durham et al, 2015). This deductive epistemology values theory derived from the rejection of a hypothesis, or a priori theory, with post-positivists seeking causal relationships in the data (Scotland, 2012).

For subjective approaches, these knowledge sources tend to be relativistic, qualitative and inductive and are aligned to phenomena that we cannot observe (Durham et al, 2015), thus we would need to explore these phenomena in other ways. This subjective epistemology, values theory developed inductively, driven by 'findings, data and phenomena that are revealed during the research process' (Levin-Rozalis, 2004, p.6). Ideally, for inductive approaches, any data collection should be carried out with no preconceptions or a priori theory (White, 1997). Deductive reasoning tends to be a top down approach, with the researcher providing a hypothesis for refuting, whilst inductive reasoning offers a bottom up approach, with the researcher deriving the theory from the situation (Blaikie, 2007).

There is, however, a third, abductive interpretive framework, recognising theory which is field-dependent. It is a production of two unknowns ('a rule and a case') from a known result (the data collected), and as such generates new knowledge (Reichertz, 2010, p.5). Whilst inductive and deductive approaches are linear, abductive reasoning forms a spiral of iterative processes (Blaikie, 2007). Explanations are sought through a cycle of analysis and review of evidence against observations, which broaden and modify the explanation (Levin-Rozalis, 2004). It offers an interface between the deductive approach of those with a conceptual/philosophical orientation and the inductive approach which is driven by issues of methods and/or research questions. Hence it offers a valuable epistemology for pragmatic approaches.

From an epistemological perspective a solution focused, problem solving epistemology was required for this study, where there is a need to not only develop new theory, but also to demonstrate improvements to practice. In order to interpret and make sense of the findings, this research design adopted an abductive interpretive paradigm. Abductive reasoning is an interpretive paradigm which lends itself to the generation of new knowledge, encouraging the researcher to explore all phenomena deriving from the research, not just those arising from a priori theories (Levin-Rozalis, 2004) or researcher preconceptions.

Having identified the chosen pragmatic paradigm, ontological approach and abductive epistemology, the following section explores an appropriate methodology which aligns to this approach.

3.5 Methodology

The choice of methodology (the philosophical approach by which the knowledge is gained) is crucial to the success of the research and should be driven by the overall research paradigm and purpose. The methodology provides the framework for the research and is the 'strategy or plan of action' underpinning the rationale for the choice of method (Scotland, 2012, p.9). The chosen methods (Chapter Four) provide the process and techniques by which the methodology is implemented (Scotland, 2012). Cresswell (1998) suggests that qualitative (subjective) studies address questions of *What* or *How*, whilst quantitative (objective) studies address issues of *Why*. Qualitative research supports the exploration of phenomena to better understand underlying issues while quantitative studies focus on measurements, predictions and/or correlations (Dures et al, 2010). Whilst qualitative studies provide a mechanism for developing an understanding of the perceptions and experiences of others through

exploratory inquiry (Cresswell, 2009), they are not necessarily generalisable outside the study setting. By contrast, quantitative research might allow greater generalisability by focusing on the relationships between variables through numeric data collection and analysis, but this may be at the expense of an in-depth understanding of the phenomena itself (Plano Clerk and Ivanova, 2016). Therefore, these two approaches can be positioned as dichotomous. Many researchers, however, suggest there is an alternative to adopting an either quantitative or qualitative research stance and that Mixed Methods Research (MMR) can be used as a bridge to combine qualitative and quantitative approaches (Cresswell, 2015).

The intention of MMR is to explore relationships and interconnections between the various phenomena under investigation and to do so by combining quantitative and qualitative approaches (Dures et al, 2010). MMR is a methodology which is distinctly different from either qualitative or quantitative approaches alone. It is defined as:

> "… the broad enquiry logic that guides the selection of specific methods and that is informed by conceptual positions common to mixed methods practitioners (eg the rejection of "either-or" choices at all levels of the research process)." (Tashakkori and Teddlie, 2010, p5).

The following section will focus on the methodology of MMR as a philosophical approach to gaining the necessary knowledge.

3.5.1 Benefits of Mixed Methods Research (MMR)

Several multi-method and mixed method designs exist which researchers have tried to encapsulate within MMR (Teddlie and Tashakkori, 2009). These include research studies which comprise multiple phases of either quantitative or qualitative research, or qualitative

and quantitative research as separate phases of the same research (Teddlie and Tashakkori, 2009). Researchers are often unable to agree the need for complete integration of the approach over separate phases of qualitative and quantitative data collection and analysis (Doyle, Brady and Byrne, 2009). Cresswell (2015) recognises both approaches, acknowledging that MMR responds to research questions using both qualitative and quantitative methods and integrates two or more data sources by:

> "… combining or merging them, connecting them (e.g., qualitative follows quantitative), or embedding them (e.g., qualitative data flows into an experimental trial)…" (p18).

Historically, it was the belief of MM researchers that integrating the two data sources would give a more complete view of the phenomena under investigation. However, it is increasingly apparent that whilst MMR was originally associated with triangulation and convergence of results, divergence is just as likely to result. This divergence may give greater insight into previously unrecognised or complex phenomena resulting in further exploration (Tashakkori and Teddlie, 2010).

The literature identifies a number of further benefits for choosing a MMR approach over a singular qualitative or quantitative approach which include:

- improving the accuracy of data (Denscombe, 2008; Murphy et al, 2014), often through triangulation of different qualitative and quantitative data sets;
- producing a more complete, comprehensive overview of the phenomena under research by combining complementary data sources (Denscombe, 2008; Murphy et al, 2014, Plano Clark and Ivankova, 2016);

- reducing the biases inherent in single method approaches by reducing weaknesses and maximising strengths of both approaches (Denscombe, 2008; Murphy et al, 2014, Plano Clark and Ivankova, 2016);
- supporting more powerful data analysis through the ability to compare and explain findings through a single, integrated dataset (Murphy et al, 2014);
- developing and testing hypotheses – for example a qualitative phase may generate an hypothesis to be tested out in quantitative phase (Doyle, Brady and Byrne, 2009);
- developing and testing research instruments (Doyle, Brady and Byrne, 2009) or interventions (Cresswell, 2015);
- building research expertise, through exposing qualitative researchers to quantitative methods and vice versa (Cresswell, 2015).

However, there are also a number of challenges to the approach, which are explored below.

3.5.2 Challenges of MMR

The main challenges in MMR include difficulty in integrating objective and subjective data in a meaningful way, having proficiency to undertake both approaches in the same research study and identifying sufficient added value to warrant the resources needed to undertake multi-phase MMR (Murphy et al, 2014). These will each be explored in turn through this section.

Meaningful integration of data: as identified in 3.5.1, there are multiple interpretations of how or whether qualitative and quantitative data can be mixed in MMR. Onwuegbuzie and Leech (2005) identify three key researcher standpoints sitting along a continuum of approaches, with purists and pragmatists at opposite ends and situationalists taking up a position between the two. Purists believe that objective and subjective approaches have

distinctly opposing epistemological and ontological positions, focusing on the differences between the two (Onwuegbuzie and Leech, 2005) and supporting their position that combining the two approaches is therefore not possible (Sandelowski, 2001; Denzin, 2012). This is otherwise known as the incompatibility thesis. Others, however, contend that this incompatibility has largely been discredited by the number of successful examples of MMR (Teddlie and Tashakkori, 2009; Denzin, 2012).

Pragmatists recognise the differences between qualitative and quantitative approaches as a false dichotomy and advocate the integration of the two (Onwuegbuzie and Leech, 2005). They support perceived commonalities between the two approaches (rather than differences) advocating this as a reason to combine them (Onwuegbuzie and Leech, 2005; Denscombe, 2008). This is recognised as the compatibility thesis. The compatibility thesis supporters argue that combining qualitative and quantitative approaches is a positive move and that there is no incompatibility at a practical or epistemological level (Denzin, 2012). Pragmatists support the notion that pragmatism is the natural partner for mixed methods approaches, with the suggestion that pragmatism underpins MMR by:

- providing a 'fusion of approaches' allowing common ground to be sought between qualitative and quantitative philosophies of research;
- providing the basis for a 'third alternative', where the researcher perceives that no single approach (qualitative or quantitative) can provide adequate findings for the research;
- providing a 'new orthodoxy' for those who believe all good social research will inevitably require both qualitative and quantitative elements (Denscombe, 2008, p.274).

As a result, pragmatists support MMR as a third, alternative paradigm to either quantitative (objective) or qualitative (subjective) approaches. This is not, however, a universally held belief.

Situationalists support the adoption of either qualitative or quantitative approaches, but also recognise the merits of both approaches, believing that whilst some research questions require subjective (qualitative) approaches, others are better addressed by objective (quantitative) approaches (Onwuegbuzie and Leech, 2005). It has been argued that the key intent for MMR, in relation to the mixing of quantitative and qualitative methods, is neither compatibility nor incompatibility but rather complementarity (Brannen, 2004). This is as a result of the ability for qualitative and quantitative components of a study to complement one another – with the usefulness of qualitative and quantitative approaches enhanced through their application in parallel, working to the strengths of each approach (Morse, 2010).

Building on this complementarity, Morgan (2007) proposes a model conceptualising points of connection between qualitative and quantitative approaches, as opposed to incompatibility, highlighting three key areas of difference and offering alternatives to span the respective divides.

1. *Abductive epistemology* – Morgan (2007) recognises that the adoption of an abductive approach supports movement between induction and deduction through an inquiry-based process. This supports the ability in multi-phase research to both explore and potentially explain phenomena in the same research.

2. *Inter-subjectivity* – Supports the progression from dichotomous positions of subjectivity or objectivity to inter-subjectivity. This inter-subjectivity places the emphasis on shared meanings and recognises total subjectivity or objectivity are impossible to achieve.

3. *Transferability of findings* – Morgan (2007) proposes that findings need not be so unique that they are meaningless beyond their research context, nor should they be so generalised that they can be applied everywhere in any situation. This minimises the impact of context-generality through recognising the value of transferability of findings. Hence MMR can produce transferable findings to maximise the benefits from the research.

As a result, the ability to blend both subjective and objective elements in one methodology through these points of connectivity, may be beneficial, particularly in multiple phases of a research study. Whilst concepts of MMR have progressed over the past decade, with an increased acceptance of MMR as a methodology, these varied perspectives of how, and at what point, mixing of methods occurs appear to continue (Cresswell, 2015). These perspectives will be further explored in Section 3.6.

Having proficiency in both qualitative and quantitative methods: It is a challenge for researchers to become proficient in a variety of methods and methodologies, whether quantitative or qualitative, however this is one of the goals of DProf research. Whilst this is a challenge of MMR, it can also be beneficial. The opportunity exists to not only learn about both quantitative and qualitative methods, but also to learn the additional skills of MMR which are distinctly different from either qualitative or quantitative research (such as the

complementarity of data and points of connection). In overcoming issues of researcher expertise, Murphy et al (2014) suggest undertaking MMR as a team, with individual team members having strengths in either qualitative, quantitative or MMR methodologies. Hence the team has a collective expertise across all three methodologies. In lone academic research, such as this DProf, this is not possible. However, this challenge can be overcome through the support and advice of the combined skills and knowledge from the supervisory team.

Demonstrating value for money in the approach: Given the interventionist nature of the DProf research, it was always intended to undertake a three-phase approach: the exploratory phase, design and implementation of an intervention arising from phase one and the pilot evaluation of the intervention. Thus, regardless of the methodology chosen to deliver this, the likely resources required to implement it will be the same.

Despite the challenges inherent in the MMR methodology, this methodology was chosen as most suited to underpinning this research design, which allows for multiple phases of research that can be either qualitative or quantitative. It was felt that the benefits outweighed potential challenges and the opportunity for a pilot evaluation of the intervention allowed further opportunities to extend the MMR design.

Having identified the various elements in relation to research design, a summary of the theoretical philosophies which underpinned this DProf research is provided in Table 3.1 (below). The overarching paradigm was pragmatic, influencing the choice of ontology, epistemology, interpretive paradigm and methodology accordingly. The ontology was driven by the experiences of participants with a solution focused epistemology appropriate

to interventionist research. The interpretive paradigm was an abductive one, moving between inductive and deductive approaches, while the methodology aligned to these underpinning philosophies was MMR.

Table 3.1: Summary of underpinning research design

Overarching pragmatic paradigm: offering flexibility of approach and outcome focus.			
Ontology	**Epistemology**	**Interpretive paradigm**	**Methodology**
Truth is context dependent and variable – driven by experiences of individuals.	Solution focused in line with research purpose to improve practice.	Abductive: based on a *rule* and a *case* and moving between inductive and deductive approaches.	Mixed Methods Research - supporting inter-subjectivity as opposed to either objectivity or subjectivity (Morgan, 2007).

The following section provides an overview of some of the key characteristics of MMR including definition, the importance of the research question, MMR language and design strategies.

3.6 Mixed methods design

In this thesis the definition of MMR adopted was research which contains both qualitative and quantitative elements in the same study, with points of connection (or integration) clearly identified between the two. Whilst multi-method research (defined here as having multiple phases of either quantitative or qualitative research) may support the two phases of exploratory and interventionist research, it limits the choice of method to either qualitative or quantitative and is therefore more restrictive. Figure 3.2 sets out an overview of MMR and its application. The following sections focus on some key characteristics of MMR identified in the literature. These include the importance of the research question, the language and research design strategies in MMR.

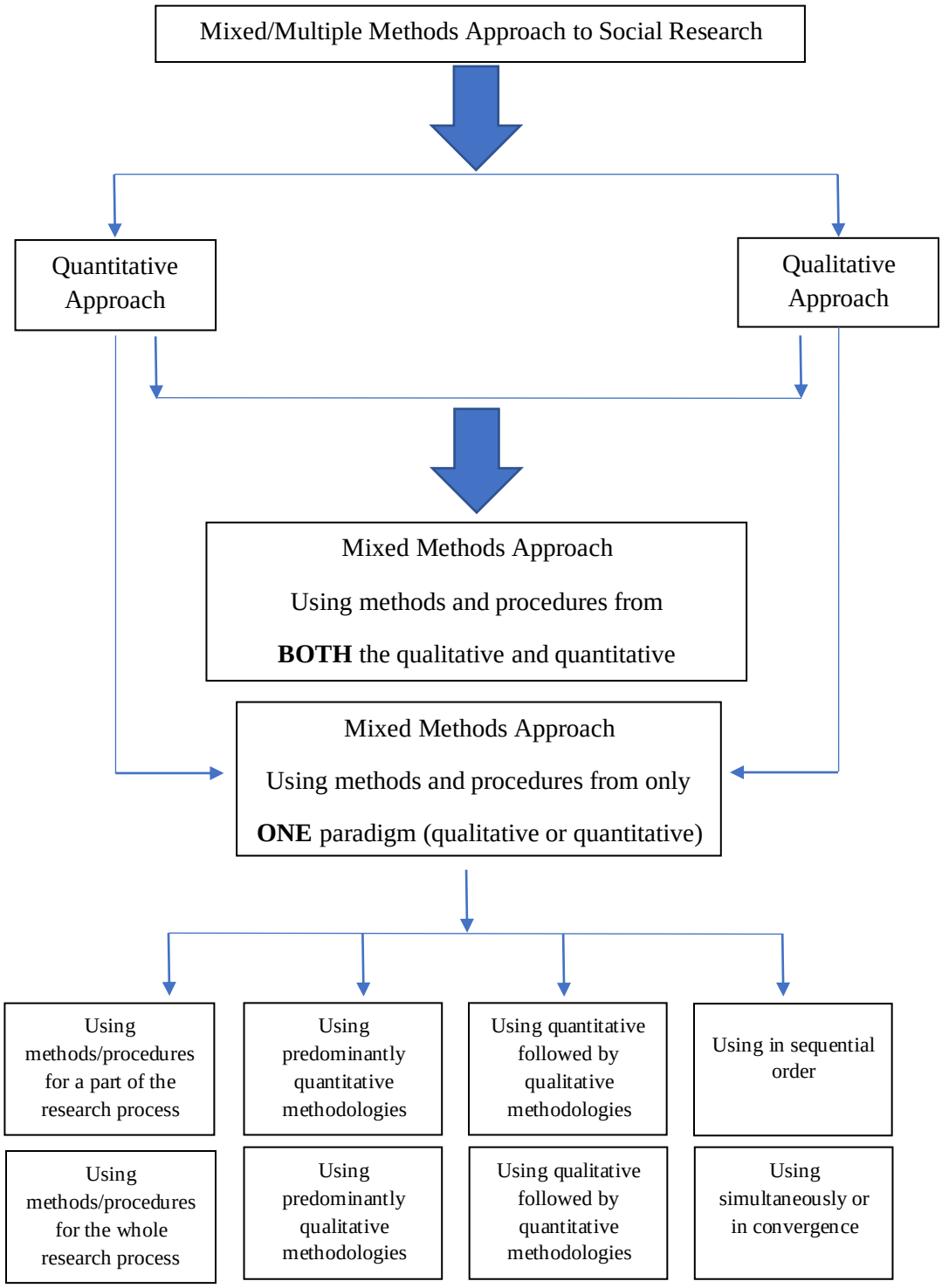

Figure 3.2: Mixed/multiple methods, quantitative and qualitative approaches in social science (based on Kumar, 2014, p.21)

3.6.1 The research question in MMR

Plano Clark and Ivankova (2016) propose that there are two approaches to the research question in MMR:

1. Development of separate questions which guide each of the qualitative and quantitative research phases, with a final question (pre-empting the mixing of methods) addressing the integration of qualitative and quantitative components.

2. A single, integrated question which encompasses the whole study, with a number of sub-questions for each qualitative and quantitative phase of the study.

Hence decisions about whether to use a concurrent or sequential model, and at what point integration occurs, are essential to the development of the research questions. Tashakkori and Teddlie (2010) recognise that in emergent sequential studies the later phase is driven by the inferences of the initial phase.

3.6.2 The language of MMR

The complexity of MMR, combined with the different philosophical perspectives and understandings of qualitative and quantitative researchers, can inadvertently create a language barrier. MM researchers have debated the need for a common language that is specific to MMR, or is common across all methodological approaches, or is a combination of both (Tashakkori and Teddlie, 2010). Tashakkori and Teddlie (2010) recognise three potential sources of mixed methods vocabulary – language derived through common usage, from amalgamated quantitative/qualitative terminology and/or specific terms unique

to MMR. In addition, diagrams are used throughout MMR as another form of shorthand, with the commonly accepted rules identified in Table 3.2. These will be helpful later in this chapter when the research design is set out.

Table 3.2 Commonly accepted notations and elements of diagrams in MMR design (based on Cresswell, 2015, p.53-54)

Essential Elements and notations	Indications
Boxes	Indicate data collection and analysis
Circles	Indicate integration and interpretation
Text	Summarise products and procedures
Arrows	Indicate sequence of procedures
Uppercase letters	Indicates prioritised methods (eg QUAN, QUAL)
Lowercase letters	Indicates auxiliary role (eg quan, qual)
+	Indicates convergent methods (eg QUAN+qual)
>	Indicates sequential methods (eg QUAN>qual)

The long-term goal amongst researchers for a common language across the methodological continuum is an iterative process, with further testing of research designs requiring the language to expand to ensure a common understanding amongst the MMR community.

The following section will explore MMR design and potential issues arising, which are important for any researcher to consider.

3.6.3 MMR design and analysis

MMR design strategies are distinctly different from qualitative or quantitative approaches, support the establishment of an agreed common research language for mixed methods researchers and provide an audit trail for future MMR practitioners (Tashakkori and Teddlie, 2010). Cresswell and Plano Clark (2011) identified three major decisions to be taken when planning MMR: sequencing, prioritisation and integration. This helps provide transparency of approach (Denscombe, 2008).

Sequencing of the study: The timing or pacing of the study is an area for key consideration (Plano Clark and Ivankova, 2016). This should identify whether the qualitative and quantitative phases should be undertaken simultaneously (concurrent) or separately, with one following the other (sequential).

Prioritisation in design: This relates to the relative levels of priority applied to each phase of the research. As identified in Table 3.2, recognition of the priority of method is widely acknowledged to be denoted by capital letters, with lower case denoting the auxiliary role. For example, QUAN>qual denotes the prioritisation of the quantitative phase over the auxiliary role of the qualitative method. The directional arrow indicates that the data collection and analysis of the two phases is sequential. A convergent approach, with simultaneous qualitative and quantitative phases, is denoted through the + sign which indicates the addition of the two data sets (Cresswell, 2015).

The mixed methods model has evolved to provide a variety of approaches in which either method can take the lead role, with the other playing an auxiliary part, or where both can hold equal weighting and priority. While Morse (2010) highlights that the predetermination

of one method's priority over another needs to be undertaken prior to the data collection phase, Tashakkori and Teddlie (2010) believe each of the elements (whether quantitative or qualitative) form part of a continuum. They advise that identification of priority should not be used to influence research design unless there is clear justification through the research question (Tashakkori and Teddlie, 2010).

Integration of methods: Integration is recognised as the point at which the quantitative and qualitative elements of the study combine, which is commonly called the *point of connection* (Morgan, 2007).

> "…integration refers to how one brings together the qualitative and quantitative results in a Mixed Methods study. The way the researcher combines the data needs to relate to the type of Mixed Method design used." (Cresswell, 2015, p.75).

It is crucial to the integrity of the research that these points of connection are clearly identified, for example through use of both open (qualitative) and closed (quantitative) questions in a questionnaire (Denscombe, 2008). Tashakkori and Teddlie (2010) distinguish between the concepts of quasi mixed studies (those in which at least two types of data are collected and analysed but where there is little, if any, integration of findings or inferences) and mixed studies (where integration takes place). They also recognise that integration can take place either at a single point within the study or throughout the study.

Furthermore, Cresswell and Plano Clark (2011) and Cresswell (2015) recognise that for researchers to claim a mixed methods approach, there needs to be integration of findings from datasets. Cresswell (2015) perceives the most common problem with MMR is where this data integration is not included. However, this is not always possible where, for example, the differing research phases necessitate separate research questions and focus. In these

instances, there needs to be complementarity of findings, with separate qualitative and quantitative data which complement one another or may be used for triangulation, as opposed to true integration (Brannen, 2004). This may be demonstrated through use of an overarching research question to align the two phases of MMR. Thus, even within MMR itself, there are multiple approaches to the issue of integration.

Having identified the three critical elements of design – sequencing, prioritisation and integration – the remainder of this section provides an overview of MMR designs.

3.6.4 MMR design typologies

The detail of the MM design within the methodological approach is crucial to the success of the project and, as explored in 3.6.1, inextricably linked to the research question and aims. While some researchers have suggested that a predefined menu of typologies should be available (Cresswell, 2015), Tashakkori and Teddlie (2010) recognise that the iterative nature of MMR design may be restricted by this approach. Cresswell (2015) identifies three basic Mixed Methods designs; convergent, explanatory sequential and exploratory sequential, which will be explored here in more detail. In choosing the design, Cresswell (2015) recommends firstly determining the need for merging (convergent) or connecting (sequential) the data.

Convergent – this involves separate data collection and analysis for the qualitative and quantitative phases with the intention of merging the results of both analyses. The quantitative phase provides generalised trends or themes which are then explored through gathering participant's perspectives of the observed trends. This may be particularly helpful

for studies where the same research question is used for both phases of research with the intention to combine the qualitative and quantitative data (see Figure 3.3).

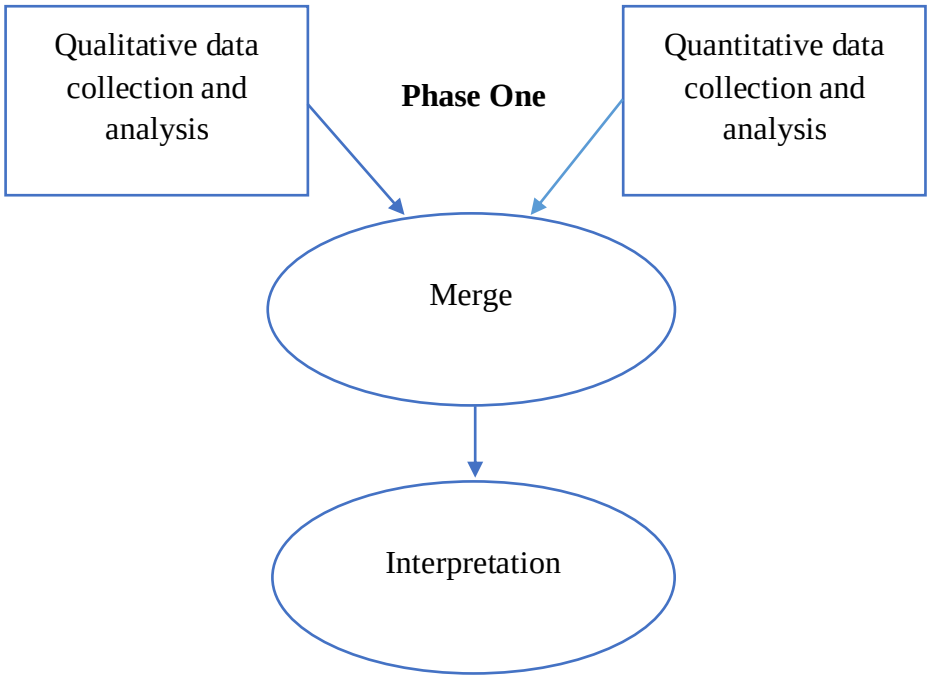

Figure 3.3: The convergent MMR design (based on Cresswell, 2015, p.37)

Explanatory Sequential – this involves a quantitative strand of data collection and then analysis of an issue (the *What*), followed by a qualitative strand to explain the quantitative results (the *Why* or *How*). This is helpful where an explanation is sought to qualify and help drive any hypotheses derived from the quantitative data (see Figure 3.4).

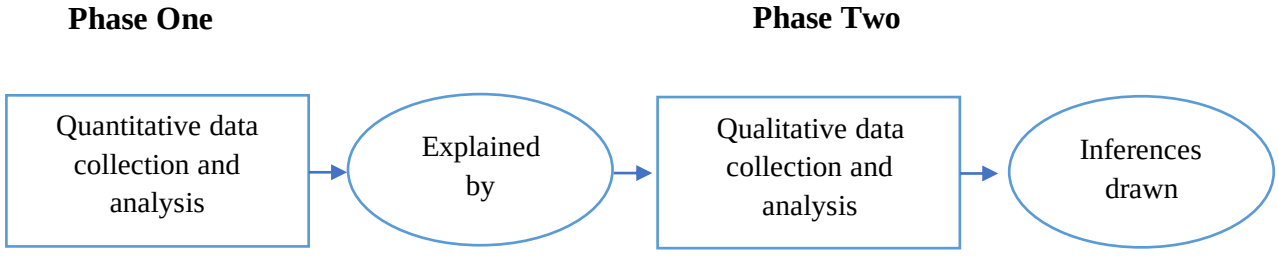

Figure 3.4: The explanatory sequential MMR design (based on Cresswell, 2015, p.39)

Exploratory Sequential – this involves exploration of the problem through data collection and analysis, development of an instrument or intervention, followed by a further quantitative phase to test any a priori theory or hypothesis around the intervention. It can therefore offer the opportunity to test out tools for measuring the intervention, as well as the intervention itself. This is beneficial when seeking to resolve an issue identified through exploration of the problem and introduction/evaluation of an intervention. It is intended to be beneficial since it will be 'grounded in the actual experiences of the participants' derived from the first strand of research (Cresswell, 2015). The exploratory sequential design usually consists of three components:

1. A qualitative phase (collect and analyse qualitative data);
2. An intervention design phase (based on examination of qualitative themes);
3. An experimental trial of the intervention, with a report on how the new intervention provides a better understanding (Cresswell, 2015, p.40). This is demonstrated diagrammatically through Figure 3.5.

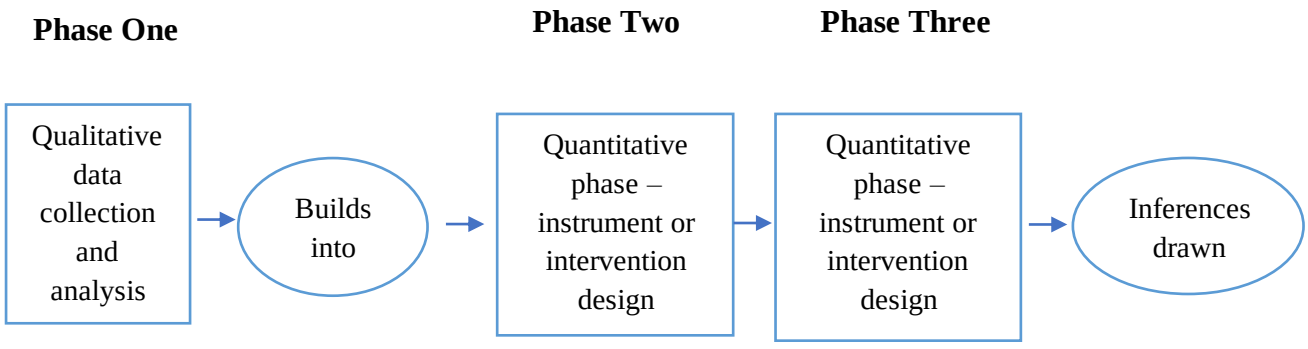

Figure 3.5: The exploratory sequential MMR design (based on Cresswell, 2015, p.41)

The purpose of this research was to explore practice issues experienced by the study participants and then, if necessary, to provide an intervention to improve practice. The research was therefore ideally suited to an exploratory sequential MMR design, which will allow the intervention phase to be driven by findings from the exploratory phase.

3.7 Combining data in MMR

Drawing on the information from Sections 3.5 and 3.6, it would appear that there is a continuum of mixing of methods within MMR. One end sees qualitative and quantitative components of the same study undertaken independently, but combined through the final analysis, the other a fully integrated approach with total fusion of qualitative and quantitative data. In between lie approaches with varying elements of integration where there is mixing of methods (points of connection). My chosen position is within the mid-range of this continuum, a situationalist approach. This also recognises that total data fusion is not necessary for this research, given it has multiple phases which may each be suited to either qualitative or quantitative approaches and, therefore, separate research sub-questions. The method for phase two will be determined by the phase one findings and participants themselves. Hence an MMR approach with appropriate points of connection, offering complementarity of qualitative and quantitative data, has been chosen.

3.8 Adopting an exploratory sequential mixed methods design

This section sets out the specific design for this MMR research, identifying each of the key components. A single, integrated question was identified to encompass the whole study, underpinned by sub-questions for the qualitative and quantitative phases. The qualitative exploration of student and mentor issues in practice informed the development of an

intervention intended to resolve these issues, whilst the quantitative phase evaluated the intervention. Combining the two, using a MM approach, was intended to allow a more comprehensive view, and more information about both the problem and possible solution, than either approach alone (Cresswell, 2015).

The study adopted an exploratory sequential MMR design with priority given to the qualitative phase and the quantitative phase as auxiliary. This comprised:

- a literature review to support the initial exploratory research question;
- the first, priority strand (QUAL) to explore the experiences of HCA/students and their registered nurse mentors;
- the second, auxiliary strand (quan) to design and implement an intervention, driven by the qualitative phase;
- the third, auxiliary strand (quan) to undertake the pilot evaluation of the efficacy and impact of the intervention through application of an on-line survey with open and closed questions.

This can be explained in MMR shorthand as: QUAL > quan > quan and is diagrammatically represented in Figure 3.6. In relation to the concept of integration, there were four points of connection in the research design at which the quantitative and qualitative elements of the study were mixed:

- *Iterative approach* – the qualitative phase of research driving the quantitative (intervention) phase through the involvement of the research participants themselves;

- *Abductive reasoning* – the inductive phase of the qualitative research leading to a deductive research assumption for testing in the quantitative intervention and pilot evaluation;
- *Data collection* – the inclusion of both open and closed questions in the quantitative data collection tool;
- *Research questions* – an overarching research question to support the integration of findings, underpinned by separate sub-questions for each qualitative and quantitative phase.

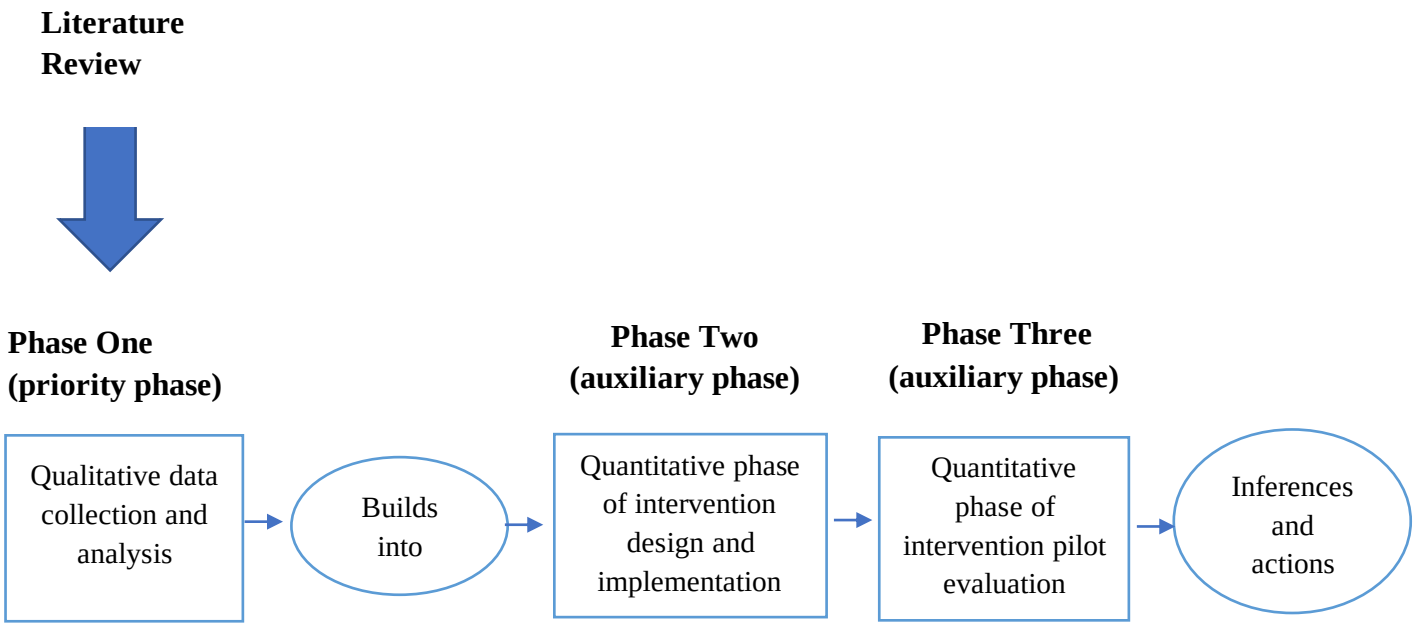

Figure 3.6: The exploratory sequential MMR design applied to this research (based on Cresswell, 2015, p.41)

The following section summarises the research design, detailing the underpinning philosophical approach which has informed it.

3.9 Summary

This chapter has considered four aspects of the research. The research design was informed by an overarching pragmatic paradigm to support an understanding of the research problem. The ontological perspective was that of a world where both socially constructed meaning and positivist approaches can be combined to provide a more holistic view than either one alone. The intention of the research was to improve the practice experiences of these HCA/students and their mentors, with the abductive epistemology therefore grounded in the real world of practice. The methodology, which provided the framework underpinning this research, was MMR using an exploratory sequential approach supported by both prioritised qualitative and auxiliary quantitative phases. This ensured an iterative approach to driving the intervention implementation and pilot evaluation phases through the qualitative exploratory findings. The quantitative pilot evaluation was intended to test out of the efficacy of the intervention and the approach, leading to a greater understanding and theory testing than a qualitative study alone.

Chapter Four sets out the methods adopted within the prioritised qualitative phase of this exploratory sequential MMR approach. This includes the sampling and recruitment, data collection and data analysis processes, ethical considerations and scientific rigour.

CHAPTER FOUR

Methods

4.1 Overview of the study

The intention of this phase of research was to explore the role duality experiences of HCAs undertaking a WBL PRNP, and their RN mentors, to gain a better understanding of the participants' experiences in practice and any potential barriers and enablers to this. The chosen methodology was an exploratory sequential mixed methods approach, with the exploratory, qualitative phase as the priority phase of research.

This chapter explores the chosen methods for the qualitative phase. It will provide the rationale for the sampling and recruitment strategy, the data collection, analysis and display choices and ethical considerations. It will also explore the research ethics and governance surrounding this research and provide assurances regarding the scientific rigour of the approach. The method for the auxiliary, quantitative phase of this research (the intervention design, implementation and pilot evaluation) was driven by the findings of this qualitative phase and is discussed in Chapter Seven.

4.2 Sampling and recruitment

The sampling and recruitment strategy has been supported by the literature review findings and subsequent research aims and questions arising. The exploratory, qualitative phase involved a target population of one cohort of students undertaking an open learning/WBL PRNP employed across six NHS organisations (within one English county) and their

respective mentors. The students were a combination of Mental Health (n=6) and Adult (n=8) fields with an equal number of mentors. Whilst data saturation cannot be predicted in this type of research, these numbers were predicted large enough to produce sufficient data, but small enough to allow a rich, deep exploration of the research questions (Kitzinger, 1995; Krueger and Casey, 2000). While other cohorts were available, they were either on a slightly different programme or would have had insufficient practice experience to reflect on at the proposed time of data collection.

The total population of students and mentors (above), which excluded those who joined the programme directly at Stage Two and those who left within the first twelve months, were invited to participate since the overall cohort number was relatively small. The exclusion criteria were based on the assumption that those individuals excluded would have had limited exposure to practice placements. In addition, the host university's Student Research Project Panel (SRPP) refused permission for two adult students to be included (see ethical considerations in Section 4.5 for further details). A further student and mentor were excluded from one Trust due to excessive research governance demands. This left a total of five adult and six mental health students, with their respective mentors, available to be recruited. These issues will also be considered later in this thesis.

The chosen data collection method for this research was focus groups which can be notoriously difficult to recruit to. Whilst the opportunity existed to access support from the employer leads, within the employing organisations, who could facilitate access to participants (Morgan, 1997; Clarke, 1999) and act as gatekeepers, this made little, if any, difference to those agreeing to participate. Four homogenous (student-only or mentor-only) focus groups were planned, two each of students (adult and mental health) and mentors (adult

and mental health). These numbers are supported by Litosseliti (2003) and Krueger and Casey (2000) who recommend 4-6 focus groups before determining if saturation has been achieved. Each group would then have consisted of the 4-10 participants consistent with recommended focus group size (Kitzinger, 1995, Krueger and Casey, 2000).

Given the small numbers involved, it would have required a minimum of:

- four adult students and four mental health students plus allocated mentors to achieve four focus groups as originally planned;
- four students and four mentors (mixed fields) for two focus groups, one each of students and mentors.

Recruitment took place through electronic sending of recruitment letters (Appendix G), participation information sheets (Appendix F) and consent forms (Appendix E) in advance of the interviews. Further copies were provided at the interviews with informed consent being gained on the day. This allowed an informed conversation with individual participants about the research and the ability to respond to any questions that they might have had prior to gaining consent.

Initially, only two adult students and one mentor were recruited due to delays in the approval process for the mental health cohort (detailed under ethical considerations in Section 4.5). The possibility of achieving insufficient numbers for focus groups was allowed for in the approval process, with individual interviews identified as a contingency plan. Thus, given the time constraints of the research, individual interviews were carried out for the recruited participants. Once further approval was gained, an additional three mental health students

and one mental health mentor were eventually recruited. Whilst numbers for the individual interviews were lower than anticipated, the approval for the study had only allowed authorisation for a maximum of 50% of the total population to be interviewed individually.

On discussion, it appeared that participants were reluctant to commit to focus groups since the venue was likely to be anywhere within the county. The individual interviews, held at a time and location convenient to the participant, were much more attractive and aided recruitment. Having allowed for the potential of follow up individual interviews we were able to proceed directly to these.

4.3 Data collection

In a systematic review of published action research papers, Munn-Giddings, McVicar and Smith (2008) found that 63% utilised just four types of data collection methods: focus groups (n = 30), interviews (n = 30), questionnaires (n = 27) and observations (n = 15). Drawing on the approaches used for the papers reviewed in the integrative review, it was found that the data collection methods used closely mirror the findings of Munn-Giddings, McVicar and Smith (2008), with the majority using interviews, either individual or focus groups, sometimes combined with other methods. Hence, for the qualitative phase of this research, focus group interviews were initially chosen as these were perceived to produce the richest data in comparison with other interview methods.

With the intended focus group approach in mind, topic guides for students and mentors (Appendix H and Appendix I) were produced based on Morgan's (1995; 1997) suggested flexible approach to focus group moderation providing:

- an introductory ice-breaker question;
- introductory or starter question to introduce the topic in a broad sense;
- transition questions to prompt discussion, move conversation from one topic to another and explore areas of interest more deeply;
- key questions which cover range, specificity, depth and personal context for the research focus (Morgan, 1997). These are often driven during the interview by earlier participant responses and are thus added to beyond the topic guide itself;
- ending questions which allowed a natural conclusion to the interview whilst providing an opportunity for participants to cover anything they perceived to have been missed previously.

The ethically approved topic guide was still deemed appropriate to support semi-structured individual interviews. The topic guide offered sufficiently broad questions to focus the interviews whilst providing opportunities for individualised responses. Duffy, Ferguson and Watson (2004) state that both unstructured and semi-structured interviews offer sufficient flexibility to allow the adaptation of subsequent interviews based on the need to further explore emerging themes. Therefore, this was an appropriate data collection method for this approach. Interview questions were adapted according to responses to topic questions and to test out boundaries of codes and categories from previous respondents. The interviews provided an opportunity for in depth exploration of topics at an individual level. The ability to observe body language, nuances, tone of voice and so forth to support the language transcribed was still apparent. At times, participants' emotional responses were recorded including; banging their fists on the desk, laughing, demonstrating their thoughts through hand gestures. These were included, wherever possible, in the transcriptions. Interviews

largely took place outside the practice area, not around service users or their families which was precluded by employer approval agreements, but usually on NHS premises. This was for convenience of access for participants. Whilst some of the themes arising from the literature review were raised explicitly at times, in order to explore the topic fully, participant responses did not appear to be affected by this with mixed responses to the majority of questions.

All interviews support exploratory research, enabling the exploration of views, attitudes and perceptions. However, focus groups also support participants to build on the views of others and enable the researcher to examine shared understandings within the group (Litosseliti, 2003). Lambert and Loiselle (2008) criticise researchers for using focus group interviews as a less expensive method of gaining individual responses, rather than as an opportunity to explore group interactions and to examine the group's perspective on a particular phenomenon. Whilst the individual interviews allowed themes which emerged in early interviews to be explored further through subsequent interviews, it did not allow for retrospective follow up of those interviewees who had gone before. Nor did it allow for group interactions to be observed and explored. However, it did provide very rich data, with participants potentially less inhibited in a one-to-one environment than they might have been in a group setting, allowing greater freedom of speech. It also allowed personal experiences to be explored which was the real intention of the research and is the main outcome of individual interviews (Lambert and Loiselle, 2008). Thus, in hindsight, individual interviews may have been a more appropriate method, since garnering collective understandings was not the main intention.

4.4 Data analysis

The data was analysed using a thematic analysis, since it is useful in understanding the underlying themes and relationships inherent in the impact of a programme (Krueger and Casey, 2000), with application of a constant comparative approach to identifying themes. The analysis of data from interviews was simultaneous to undertaking further interviews, with the topic guide being refined to reflect additional emerging topics. Similarly, refinement of the interview questions may occur as a result of emerging data during the interview itself. A co-researcher was identified at the start of the study to undertake the role of observer in the focus group interviews, recording observations of body language and behaviours to supplement the verbal data. It was also intended to involve them as a source of verification for the development of codes and categories arising. Given the focus groups were replaced by individual interviews, the co-researcher input to these was not required. However, their role in the early verification of categories and codes arising from the transcripted data was retained.

To further support the constant comparative approach, the principles of Miles and Huberman's (1994) three tier approach to analysis of *Data Reduction, Data Display* and *Conclusion Drawing and Verification* have been applied.

4.4.1 Data reduction

Conceptual categories, with their particular properties and boundaries, were identified from the data. These categories were then analysed for inter-relationships in order to identify common themes. The initial phase of data reduction necessitates transcribing the text, affixing codes to the text and identifying themes or trends in the data (Miles and Huberman, 1994). This required immersion in the data in order to identify these codes, concepts or

themes and crystallize the data into a meaningful form Borkan (1999). In order for this to take place, researchers need to be open to 'uncertainty, reflection and experience', using accurate data, listening deeply to what participants say, and reflecting on how their own role can influence the data and its analysis (Borkan, 1999, p181). In order to achieve this immersion, the digitally recorded interviews were transcribed directly onto the laptop manually. Whilst this is time consuming (each hour of recording took approximately ten hours to transcribe) it allowed deeper listening, including the emotional tones of voice and language, and a greater understanding of the participants' perspectives to be achieved than computerised or third-party transcription would have allowed. The data analysis process is depicted in Figure 4.1. Assigning codes to the data provided an efficient method of analysis (Miles and Huberman, 1994), whilst the use of *in vivo* coding ensured adherence to the participant voice and is believed to be particularly beneficial to novice coders (Saldana, 2013).

The most important factor in data analysis is visiting and revisiting the data after initial coding to ensure that all themes have been identified (Miles and Huberman, 1994; Charmaz, 2008; Hewitt-Taylor, 2001). In this case, the constant comparison of data allows concepts to be identified through coding and testing against further coded data to determine boundaries and properties of the concepts identified. This was achieved through constant refinement of the topic guide between interviews.

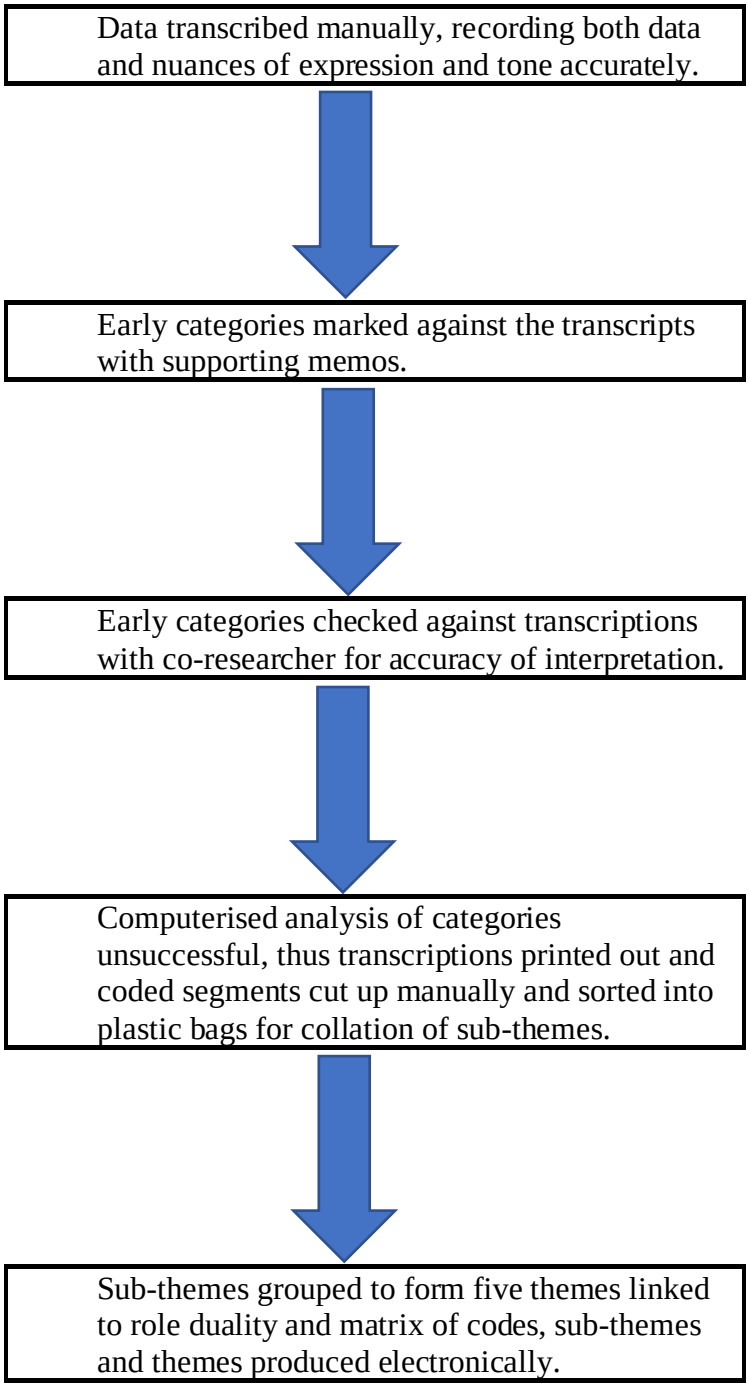

Figure 4.1: Flowchart of data analysis process

For the first interview, line-by-line coding was attempted which to some extent lost the context and meaning from which the data derived. Charmaz (2006) warns of the danger of this immature coding, advocating instead use of incident-by-incident coding. Having adopted the latter approach, it allowed easier comparison of previously identified concepts (Charmaz, 2006) and was easier to ascribe meaning to. The criteria for the analysis which was adopted was to identify both 'fit' (ability to meaningfully apply the constructed categories to the participant's experiences) and 'relevance' (the ability to develop an analytical interpretation of the experience demonstrating relationships between processes and structures) (Charmaz, 2006, p.54).

Whilst initially the early transcriptions were coded electronically onto the laptop, this proved unmanageable due to difficulties making comparisons across and between transcriptions and I rapidly became lost in the plethora of data. Miles and Huberman (1994) warn of this excess of data produced and advise that the best strategy to protect against this is being selective in the coding by adhering to the research aim and questions. Ultimately a more traditional approach was adopted which saw the cutting up and coding of chunks of hard copy transcriptions. These segments of text were then assigned early codes and allocated to labelled bags. As codes, categories and sub-themes emerged, these bags of labelled data were added to and aggregated to the appropriate code/category/sub-theme. Once this was complete the codes, categories and sub-themes were then recorded electronically to allow a strategic view of the emerging theory and ensure the appropriateness of the data included.

4.4.2 Data display

Memo writing supported the organisation of my thoughts and is a well-recognised method of organising and displaying early categories and concepts (Glaser and Strauss, 1967; Miles and Huberman, 1994; Charmaz, 2006). Applying these early memos to develop a diagram or framework supported the development of early theory through sorting, diagramming and integration (Miles and Huberman, 1994; Charmaz, 2006). Displaying this data in the form of tables or matrices then made it easier to identify themes and recognise patterns, supporting the justification of conclusions (Miles and Huberman, 1994). Table 4.1 demonstrates the development of themes and sub-themes from categories derived from the data.

Providing direct quotations from transcripts is an engaging method of data display allowing authenticity and derived themes to be clearly demonstrated (Miles and Huberman, 1994). Providing quotes in the form of anonymised narratives may help readers engage with the data and help provide a practice-based realism to the data, allowing a deeper understanding to be achieved (Charmaz, 2006). It also contributes to demonstrating the trustworthiness of the data.

Table 4.1: Summary of themes, sub-themes and categories

Theme	Sub-themes	Categories
Being out of their depth	Being Useful	HCA Pull
		Being used as an HCA
		Comfort zone
	Role Identity	Role boundaries
		Strategies to support role identity
		Fighting to be a student
		Role differentiation
		Role preparation
	Artefacts	Artefacts
	Role Perceptions	Lack of recognition
		Role perceptions
	Expectations	Expectations
	Feeling valued	Pride
		Feeling valued
		Belonging
	Service-user Impact	Service-user impact
	Impact on HCA Role	Confidence
		Accountability
		Impact on HCA role
Battling to be a student	Knowing the programme	Knowing the programme
		Mentor preparation
	Battle fatigue	Battle fatigue
		Fighting to be a student
Being on the fringes	Demonstrating values	HCA pull
		Being used as an HCA
		Sacrificing learning
		Relationships with traditional students
		NHS Values
	Building a house with foundations	Book knowledge versus practice knowledge
		Becoming well rounded
		Transferable skills
		HCA specialist knowledge
		HCA life skills
		Comfort zone
		Traditional versus non-traditional students
		Building a house without foundations
	Being a student	Being a student
		Student behaviour
		Acting as a student (on HCA days)
		2 day challenge
	Expectations	Expectations
	Role transition	Role transition
Understanding the realities of practice	Mentorship	Good mentorship
		Poor mentorship
		Mentor/student relationships
		Mentor challenges
		Belonging
		Support
		Mentor preparation
	Self-directed practice	Self-directed practice
		Leadership
Developing Professionalism	Relationships with traditional students	Competing for placements
		Sacrificing learning
		Relationships with traditional students
		Traditional versus non-traditional students
	Co-worker relationships	Co-worker relationships
		Stepping on toes
	Service-user impact	Service-user impact

In presenting data which was both trustworthy and relevant to practice to underpin this study, memo writing was used to support development of a framework of early theory (with supporting tabulated codes and categories) and multiple conceptual frameworks which help evolve the findings from factual to conceptual. These were refined as the research progressed and more evidence became available. Data were supported by direct quotes from participants and the matrix in Table 4.2 demonstrates the link between direct quotes, early codes and emerging categories.

Table 4.2: Matrix of emerging categories

Category	Code
Comfort zone	**Comfort zone:** Jo (Student): *I've got my maternity placement in a few weeks' time* ((laughing nervously)) *which I'm* ***absolutely*** ((emphasised)) *terrified about*. Chris (Researcher): *That's it, because you don't really have children at all here. Well, not very often.* Jo (Student): *No, that's it ... when I emailed the lady at* ((placement)) … *I said "I'm coming to placement here, I'm just letting you know this is completely out of my comfort zone. I have absolutely no interest in children, I have no interest in pregnant women, and I'm really looking forward to it. Because ... you're not caring necessarily for the person in the bed …. And then that person turns into two people ….*
	Out of my depth: Sam **(**Student): *But when I went onto the children's bit recently, I felt a little bit out of my depth, you see, because it was "Oh my God, Children!"* ((laughs)). *But I got over it, but it was, it was a bit tough at first. A bit of a challenge, cos you have to change the way you talk and all that.*
	Different outside the home placement: Jo (Student): … *And then recently went to* ((name of hospital)) *and I was like "Yep, I've never been to this hospital. I don't know my way around it. I don't know how to get in touch with someone. I don't know how if someone's got a problem, like, all the different resus guidelines – it's different to here"*
	Wow I know nothing: Jo (Student): *The first placements were in* ((home placement)) *and it was ... I already know how to do it cos I already work here. So then, that sort of transition was quite easy, but then I went to my first placement it was Community and I was like "Wow, I know nothing about community nursing" and was really surprised. And then, come back* ((here)*) I was very comfortable, very safe, I'm like "I know where I am, I know how to get this done…"*
	Leaving the Comfort Zone: Danny (Student): *I've liked, I've definitely liked the placements away from, sort of, the core team. They are really good experiences. Um, because they get you thinking. I've found that they really ... they take you out of your comfort zone. And sort of help you to develop much more. And for me, things like medications management and things like that, which I wouldn't do, in my core placement. Have been really valuable for me.*

4.4.3 Conclusion drawing and verification

Three levels of data analysis are described (Massey, 2011, p.23); 'articulated' (data arising directly from questions or prompts), 'attributional' (derived from a priori theories or research questions of researcher) and 'emergent' (data derived from individual comments or group discourse which 'contributes to new insights'). The latter is seen as the richest form of qualitative data analysis. A mix of all three types of data was used to form the conceptual categories. Articulated and a priori data were further explored in subsequent interviews to justify emergent data through refinement of the research guide. Each individual interview was followed by analysis, reflection and refinement of the topic guide ahead of the next interview.

Whilst researchers need to understand their perspective and how this might influence their interpretation of the research, Rolfe (1996) argues that subjectivity is necessary to successfully analyse, interpret and produce meaning from the data, which in turn allows practical use of the findings. Rolfe asserts that:

> "…the question is therefore not whether social and nursing research is subjective or objective, but at what point, and by whom, a subjective interpretation is introduced." (1996, p.1319).

This is particularly important where the goal is concerned with driving improvements to practice, as opposed to only driving new theory. This fits with the MMR stance around inter-subjectivity, placing emphasis on shared meanings and recognising difficulty in achieving either total subjectivity or objectivity. Hence intersubjectivity supports Rolfe's (1996) position, allowing movement across the two. Glaser and Strauss (1967) recognise that not all research categories are equal in terms of importance and that priority needs to be given to core theoretical categories, with less important categories being dropped. My subjectivity

as a nurse, an educator and a potential expert in this topic has enabled me to prioritise these categories and themes in relation to the research focus. Inter-subjectivity was applied in particular to memo writing, particularly as conceptual categories began to develop and inter-relationships emerge. Objectivity ensured any preconceptions were minimised, whilst subjectivity ensured an understanding and prioritisation of emergent themes. Memos form the early developmental theory (Glaser and Strauss, 1967) and the first stage in writing up findings (Charmaz, 2006). They help link categories conceptually and are a useful aid to organising thoughts and ideas. The application of inter-subjectivity to the research will be further reviewed in Chapter Eight.

One challenge of this method was that when analysing the early data premature assumptions could be made, given the insufficiency of information to allow identification of the whole picture. Subsequent interview data provided further snapshots which, whilst rarely disproving early assumptions, often provided different perceptions of the same story. This therefore allowed a slightly different picture to emerge. Hence it was a very time-consuming method and often early memos were subsequently abandoned in favour of more developed themes. The positive aspect of this, however, was the ability to focus future interviews towards the key emergent areas – thus allowing further, more detailed exploration of these. Therefore, what was a resource intensive exercise ultimately yielded better quality results – although a final categorisation and coding exercise was carried out on all the data to ensure nothing had been missed in the earlier data analysis.

The following section explores the ethical considerations necessary for this qualitative phase of the exploratory sequential mixed methods approach.

4.5 Ethical considerations

All research needs to consider the impact it might have on participants and account for ethical considerations relating to key principles. The qualitative and quantitative research phases each have ethical implications for participants and approval was sought separately for each phase. The main principles relating to this study and actions taken to mitigate these for the qualitative phase are detailed below. These ethical principles are largely drawn from the work of Fulton and Costley (2019) who recognise four main ethical principles in relation to practice-based research:

- Beneficence – for the research to be of benefit to others, demonstrated through good study design and researcher competence;
- Non-maleficence – for the research to do no harm to anybody involved, with any risks mitigated to avoid harmful impact;
- Justice – care of vulnerable individuals and ensuring equity for all;
- Respect for autonomy – ensuring respect for people's right to participate (or not), including the ability to withdraw from the programme without fear of reprisals.

While Fulton and Costley (2019) address issues of anonymity and confidentiality of data within the principle of non-maleficence, this has been explored separately here. A further principle, that of veracity and fidelity, has also been added and relates to the truthfulness and credibility of the research.

Beneficence – The study intention was to identify any practice-related issues relating to role duality experienced by students and/or mentors and to seek to resolve the most important of those issues. It was anticipated that there would be some benefit from this, although this was not guaranteed, and that this would potentially affect subsequent cohorts of students and mentors, rather than participants. This was explicitly set out in consent forms (Appendix E) and participant information sheets (Appendix F). However, even if identified issues from the research were not able to be resolved, developing a better understanding of them should still be beneficial.

Non-maleficence – To avoid any unintended impact to students from being over-researched, it was important to ensure that students were not already involved in multiple research studies. In these cases, students were excluded by the host university from participation. In the event that a participant became upset during the interview, there existed the ability to stop the interview and support them as necessary.

Justice – All potential participants (the whole population meeting the inclusion criteria) had a fair opportunity to be involved in the research with equal access to support and information. Whilst my professional role is neutral, since it has no allegiance to any organisation involved in the study, students may perceive me to be in a position of authority by virtue of my status within the NHS or of my collaboration with Trust employer leads and HEI academics (Taylor and Bogdan, 1984). In addition, I had previously been a line manager to one of the participants which could have resulted in their maintaining an historical perception of a hierarchical relationship between us. My role within the context of the study was therefore clearly set out to participants at the outset to allay any concerns and reinforced at the interview itself. All research participants have a degree of vulnerability, since the researcher

is ultimately in control of the research, and a certain power exists in the ability to control outcomes and decisions arising from it. There was also a mismatch in levels of vulnerability because, hierarchically, the mentors are in a more powerful position than the HCA/students. However, the effects of this were minimised by the fidelity and veracity of data analysis and reporting, the collaborative, participative approach taken towards identifying what the main issues were and decision making around necessary actions to address these. This better empowered the participants.

Meyer (1993) argues that while collaborative approaches to intervention based research suggest equality in the researcher:participant relationship, this is only superficial, since the researcher will always maintain dominance due to greater knowledge of the research process and data itself. Lindsey et al (1999) disagree however, suggesting that power inequities are explored collaboratively between researcher and participants, resulting in participants discovering their *voice* and becoming fully engaged with, and empowered by, the research process. It is well recognised that increased ownership is more likely to lead to successful change implementation (East and Robinson, 1994), thus seeking clarification and verification of data with participants and including them in the decision-making process for the action phase of research supported feelings of ownership.

Respect for autonomy – In gaining freely given informed consent it is important that there is adequacy and comprehension of information provided and voluntariness with which consent is obtained. Gaining informed consent, or indeed ethical approval, at the outset for interventionist approaches can be challenging due to the inability to provide specific information regarding the nature of the intervention needed. Freedom of choice to take part is impeded when this information is not available (Lofman, Pelkonen and Pietila, 2004;

Gelling and Munn-Giddings, 2011). Whilst Meyer (1993) acknowledges that consent may be given with the specification of uncertainty around such actions, approval and consent were sought separately for the qualitative and quantitative phases of the research to mitigate this. Detail was therefore able to be provided as the focus of the different phases evolved and clarity around the future direction of the study emerged. Emails were sent to potential participants including consent forms (Appendix E), participant information sheets (Appendix F) and invitation letters (Appendix G) to support informed participation. Intention to participate was gained via email contact with further explanation and opportunities for clarification provided at the start of each interview and written consent or potential for withdrawal provided at that time. The original intention was for face-to-face delivery as it was perceived that this engagement might better promote participation than a less personal electronic approach. However, the ethical approval panel asked for this to be changed to an email contact as part of the approval conditions.

Privacy and confidentiality – A further ethical challenge was presented in maintaining confidentiality and anonymity, given the small numbers of participants. Whilst I knew who the participants were, thus total anonymity was not possible or desirable, they were not known to anyone else. Whilst others might know which cohort was involved and who was in that cohort, they would not know specifically who had/had not participated. This was achieved through the following actions:

- No personal details were requested as divulging age/sex/employer within responses would further compromise any chance of anonymity in such a small group. Even the anonymised names applied to the participant quotes are gender neutral as far as possible to further support anonymity;

- All interviews were anonymised on transcription and only these anonymised transcripts were reported;
- Adhering to ethical approval and organisation research governance approved information governance processes. These included storage of data on password encrypted laptops with central backup in place, anonymisation of data on transcription and destruction of digital recordings immediately after transcription.

Specific organisational governance processes varied, for example some only allowed email contact through the nhs.net system and some refused access to contact details through the organisation, but each requirement was adhered to in the conduct of the research. It was also possible that individuals might use a particular turn of phrase or colloquialism from which they could be identified, or they might relate to a particular experience that others might recognise. There is little that can be done to protect against this, since I would not have been able to recognise if and when this occurred. However, participants were aware of the very small sample size they were part of and the associated risks resulting.

Fidelity and veracity – Endeavours have been made to ensure that an open and honest approach has been taken to the implementation and reporting of this research. Participant information provided has been clear and allowed participants to be informed about the study. The interviews were digitally recorded and transcribed verbatim by myself, thus I am confident of the fidelity and veracity of transcriptions. Verification was provided by the co-researcher who independently verified codes, categories and themes arising from the early interviews and by participants themselves through repeatedly checking the meanings ascribed to what participants were saying at interview. In addition, there was testing for agreement between participants on themes arising and by testing category boundaries

through the interview process. A group meeting was held with participants to feedback a summary of results, or through electronic feedback of results for those unable to attend, which provided verification of conclusions. Direct quotations from participants were designed to support the findings and demonstrate their truthfulness through the accuracy of the data reported. A clear and accurate audit trail has been provided throughout this research which enables others to recognise the fidelity and veracity of it whilst also enabling replication of the research if desired.

Full ethical approval was gained for the qualitative phase of research (Appendix B) plus a further amendment (Appendix C). Having explored how the ethical principles were applied in this sequential, exploratory MMR study, the following section will critically evaluate the research ethics and governance processes applied. This will include a review of challenges and benefits to the approval processes in place at the time this study was undertaken.

4.6 Research ethics and governance

It was of paramount importance that, having taken account of potential ethical issues, appropriate approval was sought from all organisations involved. This can be a complex and time-consuming process. Whilst the introduction of the Integrated Research Approval Service (IRAS) in 2009 had arguably achieved its stated intention of unifying and streamlining ethics application processes (Randall, 2014), gaining research and development (R&D) governance approval from organisations remained a challenge for researchers. This was particularly the case where multiple NHS organisations are involved (Jonker, Cox and Marshall, 2011; Watson and Gelling, 2012). In addition, gaining approval from areas where the researcher was an NHS employee, but not through the organisation(s) involved in the

study, compounded these challenges. By not meeting the requisite criteria for an NHS research passport, there was a need for separate access letters or honorary contracts with each organisation involved. Full ethical approval was gained from the Faculty Research Ethics Panel (FREP) ahead of the study, with separate R&D approval gained from each of the six NHS trusts. Each organisation required different processes, from in-house application forms to full IRAS submission. Decisions varied, with some organisations perceiving this to be a service evaluation, thus requiring no formal ethical / R&D processes, and others requiring more rigorous processes such as:

- honorary contracts or access letters for both researcher and co-researcher;
- changes to the protocol;
- changes to supporting documents;
- information governance restrictions – in one case this required transference of Intellectual Property Rights to the organisation and acknowledgement in any publications arising;
- restrictions around access to students – seeking additional approval for contact through line managers, not using organisations to access contact details for participants;
- submission of Curriculum Vitae from research team members and allocation of a Local Investigator employed by the Trust;
- additional approval from director of the organisational department.

SRPP approval was also gained from the programme provider and student participation was only approved once it was perceived that the sample was not already involved in multiple research studies. This was to prevent students being over researched (non-maleficence).

Access was denied to two students (adult) with no reason supplied, although presumably this was because they were already involved in other research studies. Whilst this potentially denied these students opportunities to participate and to tell their story, the approval process existed to protect participants, and this must therefore be respected even if we do not understand the reasons behind it. Every change initiated by an organisation required further application for approval of amendments to all organisations, thus in total ten months was spent in gaining full ethical approval.

The *NHS Research Governance Framework for Health and Social Care* (DOH, 2005) was introduced to prevent unethical practices such as those at Alder Hey Hospital (Watson and Gelling, 2012). However, its requirement for researchers to now seek separate R&D governance approval alongside ethical approval resulted in added complexity to the approval process. Processes simplified through the introduction of a single IRAS application have been lost again in further bureaucratic processes which can both delay and discourage researchers.

The previous Local Research Ethics processes were criticised for:

- duplication of information (from the central process) (MacPherson and Lattin-Rawstrone, 2005);
- volume of information required (MacPherson and Lattin-Rawstrone, 2005);
- inconsistency of approach and decision-making between organisations (MacPherson and Lattin-Rawstrone, 2005; McDonagh, Barbour and Williams, 2009);

- lack of flexibility and lack of timely response (Gelling, 2003; MacPherson and Lattin-Rawstrone, 2005; McDonagh, Barbour and Williams, 2009).

The issues arising in gaining full approval ensuing from this study would suggest that little appears to have changed in respect to the overall process, other than the exchange of local ethical approval for organisational R&D approval. This was confirmed by the experiences of other researchers (Jonker, Cox and Marshall, 2011; Watson and Gelling, 2012) and is a particular issue for short-term projects such as those associated with academic study (Watson and Gelling, 2012). Where organisations have clear definitions of what constitutes research and what constitutes service evaluation there is a more streamlined approach in recognition of the differing levels of ethical risk. In addition, where the level of risk was used as a measure of the level of R&D governance needed, the process can again be timely and less complex for low risk research projects. The real issue is where no flexibility exists, and organisations fail to consider levels of risk. In these cases, approval requires the same process of scrutiny to a service evaluation project involving fully consenting adults, who might not be deemed vulnerable participants, as they would a drug trial of vulnerable child patients.

Whilst changes have since been made to the national NHS ethical approval process, designed to further streamline the application, these were not in place in time to facilitate the complex approval processes necessary to support this study.

4.7 Scientific rigour

Whilst in quantitative research issues of reliability and validity are paramount, these same measures of rigour are not deemed appropriate for qualitative research. However, it remains of prime importance that scientific rigour is applied, through thorough planning and application of the methods, allowing confidence in the findings. There are a number of ways in which this can be determined in qualitative research, some of which are considered in this section. Streubert (1994) states that the validity of qualitative research can be assessed through:

- Credibility – the ability of participants and wider audience to identify with the experiences articulated in the research;
- Auditability – the transparency of the audit trail for the research that has been reported by the researcher;
- Fittingness of the data – the meaningfulness of the findings to others outside the research study.

Crabtree and Miller (2008) recognise the appropriateness of comparable assessment criteria, identifying the need for an account of the research which is both rhetorically and clinically credible. From a rhetorical perspective, there needs to be an assurance that the account of what has taken place is believable. This equates to Streubert's (1994) notion of an audit trail. From a clinical perspective, there needs to be an assurance that the findings add value. The clinical credibility is derived from three perspectives;

- the research question should be important to participants, and findings must address the research question;
- the findings should matter to the reader and wider audience;
- the reader and wider audience should be left in no doubt as to who the intended recipient of any benefits of the research will be.

These measures of clinical credibility align to Streubert's (1994) quest for credibility and fittingness of the data. McCaughan (1999) acknowledges these criteria more simply as a need for truthfulness and usefulness, do the findings resonate with participants and the wider audience (truthfulness) and are the findings useful to practice. Combined, these aspects provide the trustworthiness necessary to the scientific rigour of the research. Consideration will be given to both aspects and how they have been applied in this research.

Truthfulness: There has been a very clear audit trail for other researchers who may wish to replicate this research with transparency of reporting and accurate timelines which support the truthfulness of this research. This also supports the reader in judging the quality of the research. The research design has been stated explicitly throughout all phases with the methodology and methods critically analysed in detail. The scientific rigour has been further enhanced through the input of the co-researcher in checking assigned codes and categories for early interviews and through the verification of findings with participants. The findings were also shared with wider stakeholders who identified with the experiences of participants and believed the findings to be important and worthy of further research. The original research questions were answered by the findings as demonstrated in Section 5.6.

Usefulness: The research was believed by participants, both mentors and students, to be of importance and relevance. Despite a smaller number of participants than anticipated, there has still been a high level of interest and engagement in learning about the research more widely from others within the student and mentor population. There has been wide interest from other regional stakeholders in the qualitative findings, particularly because of the increased interest in WBL programmes. There has also been considerable interest from the programme provider, who was keen to learn from the findings in order to take any necessary steps themselves to better support these students and mentors. In addition, there has been a lot of interest nationally and internationally when presented at conferences.

Overall trustworthiness: The evidence to support the truthfulness and usefulness of this research would suggest that there is a high level of trustworthiness in the qualitative phase of this research study.

4.8 Summary of research methods

The data collection and analysis phases are key to the success of any research project and it is of paramount importance that these are undertaken according to a robust research design. Despite the challenges surrounding the ethical approval process, this exploratory phase of research was undertaken in line with the original research design and aligned to the proposed methodology. Whilst amendments were made to the data collection process, with individual interviews being carried out in isolation, as opposed to focus groups with follow up interviews, this nonetheless resulted in rich data incorporating the emotional responses

of students through inclusion of verbal and non-verbal data. Data saturation was reached through this process with no changes to the interview questions derived from the final participants or identification of new themes.

The next chapter discusses the core theme which emerged from the data and critically explores the five sub-themes from which it derived. Chapter Six then contextualises these findings within the wider literature, linking existing theory with the research.

CHAPTER FIVE

Findings from Phase One: Role Identity

This chapter explores the findings from the qualitative phase, identifying the core theme and associated supporting themes derived from the data. This leads to the development of early conclusions which are linked back to the original research questions posed for this phase of exploratory research. The findings were fed back to participants who helped provide recommendations for the quantitative intervention and pilot evaluation phases of research, which are used to summarise and close this chapter. This has contributed to the scientific rigour of this research.

Whilst the number of participants was representative of the cohort, I have not described the demographics of participants in order to protect their identity. Students and mentors were, however, of mixed age and gender, with students ranging in age from 20s to 40s. Whilst readers might benefit from knowing whether participants are male or female, the sample size is so small, and numbers of males so minimal, that participants would almost certainly be recognisable. Hence to protect anonymity as far as possible, gender neutral names were assigned. Please note that wherever possible findings have been identified as deriving from students, mentors or both. There appeared to be no marked differences in the views of students and mentors, although mentors were less perceptive of the emotional impact that the dual roles had on the students' ability to protect their role identity. This may have been because there were only two mentors participating and the individual HCA/students they supported were better able to cope with the emotive issues, or because the mentors

themselves were able to recognise and adapt their mentorship to better support their HCA/students. The core theme arising from the data was role identity, supported by five sub-themes, illustrated in Figure 5.1.

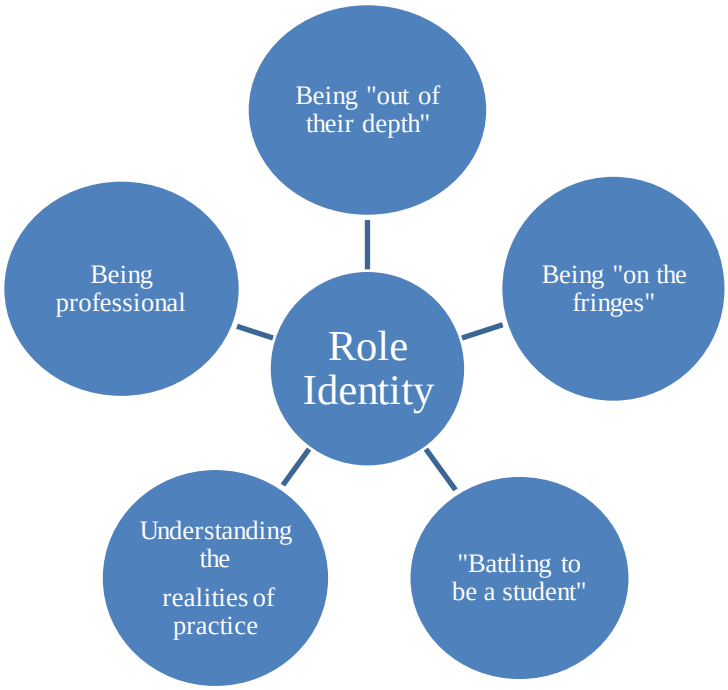

Figure 5.1: Role identity: the core theme underpinned by the five sub-themes

The five sub-themes underpinning the core theme are each explored in the following sections. This will culminate in a summary review of the findings against the specific research questions and aims for this phase of the exploratory sequential MMR.

5.1 Being “out of their depth”

This sub-theme relates to the manner in which the students perceived their HCA and student nurse roles, the expectations others had of them and the impact of their dual roles on their practice experience. Students were often surprised by the breadth of nursing practice that was going on outside of their prior HCA experiences, although they felt quite expert at times

in their own areas. This caused them to feel '*out of their depth'* in their student role – especially in external placements. The students' understanding of what nursing was, and the boundaries of the nursing role, was limited to their exposure of it within their area of practice as an HCA. Whilst some students felt quite expert in their HCA roles, recognising the wider nursing role outside their area of practice tended to reduce their confidence.

All students had experienced some difficulty in trying to maintain distinct student and HCA roles, particularly within the same team:

> *"Trying to get your head round a completely different role. I think that was possibly, to start off with, the main thing that I'd found difficult has been getting used to being a student nurse and an HCA in the same team." Sam (Student).*

Some students perceived that there was little preparation for them to take on the student role and that spending the initial period in the home placement hampered their ability to truly understand their student role. In contrast, external placements were very much seen by all students as allowing them to feel like a student. Whilst the initial ten days of their programme was spent in their home placement, with the perception of little structured guidance and support in becoming a student, one student in particular felt this time was wasted:

> *"Those are the* hardest *ten days you'll ever work. Because you just haven't got the foggiest. It's not until you go on your actual first placement, outside of your core, that you have any vague understanding of what it is to be a student. ... I didn't do anything. On those ten days. Except say to myself "What am I doing?" "Am I doing right?"" Kris (Student).*

However, other students felt that there were benefits in commencing the programme in their familiar home placement because they had such good support from colleagues and their mentor and were less inhibited when making minor mistakes or asking questions. These

students were less afraid of appearing foolish in front of familiar work colleagues in this way than in front of a new placement team. Students felt it was easier maintaining a student identity in external placements because the external teams had no prior expectation of them, whereas in the home placement, students felt all the prior knowledge of them as an HCA prejudiced the home team's expectations of them as a student:

> *"External((ly)) you are treated as a student. That's how they know you. Um, so they might know you little bits from your work role, but you're a student there and so they don't assume that you know things. Whereas in your sort of home, core placement bit, I think there's the expectation that you already know?" Danny (Student).*

*C*onversely, some students criticised external placements for not recognising their existing skills. While this probably supported the lack of expectation placed upon them, since external placement teams were unfamiliar with their HCA scope of practice, the students felt restricted in practice as a result. In addition, the expectation that the home placement had of them as an HCA also tended to increase as they progressed through the course. This resulted in more responsibility being placed on them as HCAs, with expectations often greater within their HCA as well as student roles. Some students enjoyed this extra responsibility, but others felt it further blurred role boundaries. Some students were asked to take on activities which were inappropriate to their HCA role and this necessitated a firm stance in ensuring role boundaries were protected.

Some students talked about the notion of the '*comfort zone'* which they related to the students' recognition of their home placements primarily as a familiar, comfortable and safe environment. Leaving this '*comfort zone'* could be quite scary, especially the first time, but the students saw the opportunity for leaving it as a welcome challenge, albeit a bit of a reality shock at times:

> *"But when I went onto children's recently, I felt a little bit out of my depth, you see, because it was* "OH MYGOD! CHILDREN!" *(laughs) But I got over it, but it was a bit tough at first. A bit of a challenge, cos you have to change the way you talk and all that." Sam (Student).*

They also referred to the '*comfort zone*' of fulfilling the familiar HCA role on student days. This was largely taken up in response to the care needs of patients, and/or support needs of other staff, as opposed to an avoidance tactic for avoiding the challenges of the student role as identified in the literature review. Students articulated through this their continued need to put patients first at all times. Practice learning was not usually felt to be compromised by this:

> *"As a HCA I know what needs to be done and I can see that my colleagues are struggling. If I'm not necessarily doing anything there's no reason why I can't go and help. But also, on the other side, as a qualified nurse, there is absolutely no reason why I can't still go and get people washed and dressed." Kris (Student).*

Mentors recognised this too and reinforced that students were not necessarily asked to revert to HCA roles, but rather recognised the need to step in:

> *"Um ……. I tend to think of it as actually they're more likely to offer ((to undertake HCA tasks)). Because they know what needs doing. And they can see it needs doing. Um, so they're more likely to offer. But, even so I still try and put it to them in a more … kind of preparation for student nursing in considering what their role is, you know, in terms of taking on more of a supervisory role*." *Lou (Mentor).*

This would suggest that when fulfilling their student role, these students saw themselves as care providers first and students second, with priority going to supporting patients and colleagues in practice. They would not neglect their learning outcomes in order to support patients but negotiated compromises so that both patient needs and learning needs could be met. One student (Sam) felt they were abused at times because of the HCA skills they brought with them:

> *"Um, I mean in my first year, definitely. Um, especially in the two that I had on the in-patient wards, yeah I was used as an HCA, definitely. Um, you know, once they found out that I was OK with obs, it was* "Morning, oh *((name))* do all them…" *you know, straight away….um …* "Oh, you can do the afternoon meds with me, but could you do that first, cos you know we're rushed in the morning." *But yes, definitely I was used." Sam (student).*

This misuse of their student nurse role could lead to further blurring of role boundaries. Sam, however, also demonstrated the ability to mitigate this through negotiating with the wider team to ensure the learning outcomes were still met:

> *"Yeah, so I didn't find it detrimental, I wouldn't say that. Umm, it was, umm ((pauses to think about response))… I didn't, not, not really. I could tell they were under pressure in the morning, and it's my way of helping them. But as long as, if at the end of the day when they then come to sign my thing and I say "look…" I would bring it up … "look, we didn't do the meds", you know. And then it's like, "Oh yeah" and then if a couple of times it would continue, then it would become a problem, but it didn't, but I did sort of mention* "well I've done you a favour, now can you do me one back?"*" Sam (Student).*

The challenges of negotiating between roles becomes even more difficult when trying to separate out the HCA and student role identities. Establishing some definition around these roles was compounded by lack of clarity around roles and responsibilities. Some students felt the role of the student in the first year was very similar to that of an HCA but felt that the differences between roles were more obvious in the second year. This was more apparent in senior (Band 4) HCAs who may be employed as Assistant Practitioners. Students demonstrated various levels of insight into the differences in the roles of HCA/Student/RN. One student believed that they were already doing most things a trained nurse would do in their HCA role, although they did recognise the value of learning new skills in external placements. This lack of insight is explored later in this chapter.

Despite the emphasis from the education provider on maintaining role boundaries, one student failed to recognise the significance of this as an issue initially and only appreciated the difficulties over time:

> *"I was thinking* "Really??? Do we need to be going down this route???" ***((****Incredulous))* *... I don't think it struck me straight away, it was something that struck me a little way in. I was thinking* "Jesus, this is actually quite difficult to manage", *you know, just trying to keep them completely separate." Jordan (Student).*

Whilst students in general recognised there were differences between the two roles, they often found it difficult to voice these differences. What they were able to articulate was that as a student they were working more holistically, and less task focused on individual processes, than as an HCA.

Because of the lack of distinction between HCA and student roles, it was clear that there was a regular blurring of boundaries. Whilst the issues of maintaining distinct role boundaries are emphasised on the programme, and students advised to clearly separate the two roles (working distinct HCA or student shifts), some students felt it better suited their needs to mix their roles within the set boundaries:

> *"I'll go in on a student day, and I'll say I'm a student day, but I won't stick, you know. I mean at the beginning I was being quite rigid on a student day but now I'm a bit, I'm a lot more transferable, in myself. Because that's how I'm happy. That, you know, works for me. It works for my team." Kris (Student).*

Both mentors interviewed recognised the importance of setting clear expectations with the student from the outset, recognising this supported the student in maintaining role boundaries. One mentor even suggested having student charters in each placement area which reinforced expectations from placement and students. Neither mentor interviewed

particularly perceived role duality to be an issue for students, both agreeing that establishing student expectations was key, particularly in managing good communications and clarifying role boundaries.

Some students and mentors identified strategies to help protect their student role. These included moving the student to an alternative home placement, resulting in the student working within three distinct communities of practice; HCA employed area, home student placement and external student placements. Student participants working to this model were more likely to be able to protect role boundaries and less likely to be affected by role duality issues. One student, who had experienced a shared and separate HCA/home placement area, felt it was very beneficial to separate the two. This meant they only had one clear role in each setting, whereas students who were placed in their employed areas were fulfilling both roles within the same setting. Swapping students between HCA employed areas, where Trusts had two or more students on the programme, was perceived to be a good way of managing this. From a mentor perspective this was also beneficial because of the potential difficulties for a failing student to be managed in their employed HCA area:

> *"Because if you are failing as a student in the same area that you are working as an HCA it becomes very hard for the staff to separate those things." Kim (Mentor).*

There is a perceived discord between the students' desire to expand their learning through external placement experiences, and the feeling of being '*out of their depth*' this then generates in comparison with the comfort of their home placements. This was compounded by the expectation others placed on them and the students' belief in their ability to meet these. However, the students welcomed this challenge and certainly saw external placement experience as an opportunity rather than a risk.

5.2 Being "on the fringes"

This sub-theme focuses on the progression of the students' sense of self between their HCA and student roles. Given that they were not truly able to leave behind their pre-existing HCA identity in order to fully adopt their new student nurse identity (as discussed in the initial literature review), there was a possibility that the student could end up in the *neutral zone* or *'on the fringes'* between the two identities (Bridges and Bridges, 2009). This sub-theme also explores some of the perceived challenges and benefits of undertaking the concurrent roles and how the perceptions of others affects the student nurses' developing sense of self.

The students demonstrated differing levels of self-awareness in relation to their transition between the two roles and there was no clear pattern to where they felt they now belonged (their sense of self). One student, as previously stated, felt they were already working largely as a trained nurse within the HCA role and could see little difference between tasks they could perform as an HCA and those undertaken by the student nurse or RN:

> *"…. A lot of the skills, and things like that, especially at being a Band 4 now, my role has quite extended. I do … The only thing that I don't do from a Band 5 is male catheters and PRs, enemas." Sam (Student).*

Others could clearly recognise the transition taking place between being an HCA and student, and how they were moving away from a sense of belonging with other HCAs. Some felt they were truly half-HCA and half-student or recognised that they had partially transitioned into a student already:

> *"There's a part of me that feels I'm exiting that group ((HCAs)). I'm sort of there on the fringes. Not fully a part of …. And it's not because anyone's made me feel that way. It's my own, sort of, not fully a part of …. And it almost feels, and I'm not sure that next year will be even more so, it feels like the beginning of the transition.* Sort of into something else *((whispers))." Jordan (Student).*

It seemed the progression from HCA to student was a gradual one and did not occur immediately for all those who raised this:

> *"If you actually had to say "this is … at the current moment in time, this is the group that I feel I most belong in," which group would it be?" Christine (Researcher).*
>
> *"My student group, yeah. ((No hesitation))." Jordan (Student).*
>
> *"Where would you have been a year ago?" Christine (Researcher).*
>
> *"My HCA group." Jordan (Student).*

One student felt that as the limits of the student role were expanding and they were taking on more student-related activities, they were transitioning into the role accordingly. This was not the case for all students, where some felt restricted by the expectations of others in their team. It is also worth noting that the students' sense of identity in relation to that transition was strongly affected by the perceptions of their team. Where their team treated them as, and perceived them as, an HCA rather than a student, this is how the students perceived themselves and vice versa. The perceptions of others in their team often led to a non-recognition of the student role. They felt others perceived them to be *'HCAs training to be nurses'* or as '*an HCA who's doing extra'* as opposed to a true student nurse. This was also compounded when the student was placed in their employed HCA area on student days. Their employed team was more likely to perceive them as an HCA because that was familiar to them and they had an expectation of the HCA/student in that role. The exploration of this through engagement with Danny highlights this:

> *"If you had to label yourself, would you label yourself as an HCA or a student?" Christine (Researcher).*
>
> *"At this moment? HCA." Danny (Student).*
>
> *"HCA?" Christine (Researcher).*

"Mmm. I would. Because I just think that ((sighs)) …. Because you're working three days a week every week, that role is always there and your team expect it." Danny (Student).

"That's always your key role? Your core role?" Christine (Researcher).

"And your team expect that. There's always that expectation there. That you have to fit in that role. So you have to see that client group, you have to make sure your work's done, you have to …. So for me, I find that I have very ((sighs)) little extra time to just, sort of, take a step back in the student role." *Danny (Student).*

Overall, students were much more likely to feel like students in alternative placements than within their home placement.

Compounding role duality issues and difficulties in maintaining their student identity, which has not been recognised in the literature before, is the issue of being asked to act as students on their HCA days. This is likely to be in recognition of their transition towards developing a student identity and perceptions their colleagues had of the potential benefits of their enhanced abilities as an HCA. This was often seen as beneficial by the student and tended to make them feel valued. However, they recognised the potential danger of stepping outside their roles and were cognisant of protecting role boundaries from an accountability perspective (they were not prepared to undertake skills outside their HCA remit on those days). However, they also recognised the potential benefits they gained from additional learning opportunities offered as a result:

"It's … a bit more like a privilege, in a way, because I kind of take it as a good sign because it means that people are recognising that I'm learning and I'm beginning to step up … And saying "OK … You're on an HCA day but you do that as a student, can you go and do that?" I don't take it as somebody trying to palm off work, I take it as a, you know, people are seeing that I'm becoming more and more competent in the new skills that I'm learning." Kris (Student).

> *"… and some people will question me, which, I find really frustrating. Because if I haven't got my student nurse head on, and they'll be like "Oh, so if I was going to do this, why wouldn't I give that drug?" and I'm like "I DON'T KNOW! I'M NOT THINKING ABOUT THAT TODAY!" Jo (Student).*

As one mentor commented:

> *"…. learning doesn't stop just because they haven't got the top on ((uniform))." Lou (Mentor).*

In addition, students recognised that they were not necessarily challenged enough in their core placements, because they were more familiar with the skills needed and less likely to be treated as students due to the primacy of their employed HCA roles:

> *"So I would say in my own opinion, you don't reflect that sort of same way. Um, and I think you're probably not challenged as much either, is the other thing I would say,* because your colleagues know you *((quieter))*." *Danny (Student).*

The primacy of their HCA role also impacted the students' ability to transition into the student role due to the difficulty in being a student only two days per week. They found that mentors and placement areas forgot they were supposed to be there, and this impacted on their ability to build meaningful relationships within their external placement team and therapeutic relationships with patients:

> *"... So you don't get that therapeutic relationship, but you can build up some form of relationship. And some form of relationship is better than nothing … You have to know that, it's going to be tough. And you have to go in and you have to make yourself be confident and talkative and eager to get in there. Because you know that you'll not be back for the five days. And you kind of become like an "out of sight, out of mind". I don't know how many times I've walked in and they've said* "Oh, I forgot you were here" *((both laugh)) and you know it's not intentional, but ...*" *Kris (Student).*

Being *'forgotten'* was also an issue in their home placements, where colleagues were used to them being HCAs and forgot to include them in student related activities:

> *"But I think you're forgotten as well, as a ((non-traditional)) student. I've had that a few* times*." Danny (Student).*
>
> *"What, they take all the ((traditional)) students off and leave you behind?" Christine (Researcher).*
>
> "*Yeah. "I forgot about you*."" *Danny (Student).*
>
> "*How did that make you feel at the time*?" *Christine (Researcher).*
>
> *"It's frustrating… I think you're in a catch 22 situation because it's your team, so they know you, so you can't really ((sighs)) you've got to work with them, so you don't really want to cause too many problems if that makes sense? … That's where, when you were saying "Where do you think you sit, student or HCA?" you end up sitting more on your role." Danny (Student).*

When forgotten, whether in home or external placements, this resulted in students feeling frustrated and uncertain how to address this, recognising their need to fit in to placements and not wishing to alienate familiar co-workers. This compounded their ability to transition into the student nurse role.

The students generally perceived their transition from HCA to student nurse to be different from traditional students. This resulted from their entry to the programme from a different starting point, due to their existing HCA skills and knowledge, some of which were quite specialist. It was perceived that from a practice perspective it was easier to have this type of knowledge and experience than the *'book knowledge'* that traditional students were perceived to have:

> *"But when you're coming in and you've already got that knowledge, and you're building on the theory behind that knowledge, I think it's … for me it's been a lot easier to just* go out and do." *Kris (Student).*

These skills were often not recognised by external placement mentors due to their lack of familiarity with the programme and lack of knowledge of the students, which could be frustrating for the students:

> *"They don't really understand that I've got, I think as the placement went on they realised* "Oh, this girl's got skills, already, and it's embedded in her" "Ooh, she knows how to talk, she knows how to do the fluid balance chart, mm.*"((surprised voice)) and it will, all of a sudden they've woken up." Sam (Student).*

The students valued their existing core of skills above traditional academic skills and raised concerns about traditional students in practice not having the essential nursing skills and the potential consequences:

> *"... even now you have students who come on for their first placement in their first year and they have absolutely* no idea *how to talk to people, how to do basic tasks like washing and dressing and feeding ... And it is, you know, really hard at times because, especially for those who are young – 18, 19, 20 – when you come on, especially onto an area like this, and you are faced with washing and dressing people it's very daunting. Because all of a sudden you're in a very intimate situation with somebody and it ... if you're not prepared for that, you can find it very embarrassing." Kris (Student).*

This was a common perception:

> *"And actually there's other ((traditional students)) that I've met and I've thought "MY GOD!* If you ever have to care for me I will push you out of the room. *Whether you're qualified or not. Because, you don't have the people skills. You've never worked." They might develop over the next three years, but you've never ... You don't know how to talk to someone when they're completely naked stood at the end of there in front of you." Jo (Student).*

The students recognised that the HCA skills they had developed were often specific to the areas they worked in and recognised the need to gain a deeper, wider range of skills which could be transferable to other settings. This was possibly less so for community HCAs,

where skills appeared more generalisable. This advancing of transferable skills was variously described as '*putting the flesh on the bones'*, '*padding out what they already know'*, '*broadening out'*, '*becoming well-rounded'* and was a well-recognised phenomenon amongst students. This was largely supported by time spent in alternative placements where previously unknown areas of practice were experienced:

> *((Talking about community HCAs)) "I think I know my stuff here, as an HCA, and you have that sort of, maybe almost cockiness, going; "If I know this, then surely everything else can be easy, because these people have had really complicated …" And you go out and sort of "Have you seen a diabetic foot?" "Eh? What's a diabetic foot?* NO!" You see these holes in people's feet? *((Incredulous)). And they're doing these dressings, and … and they're not qualified nurses, and no registration, and you think* "Wow!" *Jo (Student).*

This phenomenon of building student practice from a specialist HCA base was described eloquently by Jo as necessitating the digging of foundations (of broader nursing knowledge and skills) to underpin the first two stories of a virtual house (of existing HCA skills):

> "*… I've built the top two floors without, they have no foundations, for me to go in as a student, and you go out in the community and other placements, get all these skills, and you come home to your home placement and you sort of hone those skills and perfect them, in a comfortable environment*." *Jo (Student).*

In order for students to be assessed on the programme as independent in these skills, no matter how competent they were, the foundations underpinning the tasks (such as knowledge of what and why rather than just how) were essential:

> *((Regarding HCA transition to student)) "And sometimes, you know, they are very skilled at the tasks that they are doing, um, but it's almost as though you've built a house without foundations." Kim (Mentor).*
>
> *"Because to give you an example, it was something like do physical observations, blood pressure, pulse, respirations, so they kind of can do those as a HCA perfectly confidently, and that's fine, so they feel that they can do that. But, then you say "OK, so what happens if someone's got really low blood pressure, really high pulse, then*

what do you do?" "Oh, I'd come and tell the nurse in charge" "OK, well you're the nurse in charge, what do you do?" ((Both laugh)). You know. That's a big ... that's a bit of a step." *Lou (Mentor).*

In comparison to traditional students, a model was put forward of an inverted triangle with a starting tip of specialist skills for non-traditional students which broadened out as more generalisable skills were developed. By contrast, a standard wide based triangle was suggested for traditional students representing their development of generalised skills initially, which probably did not build into specialist skills until qualifying. These are depicted in Figures 5.2 and 5.3 below.

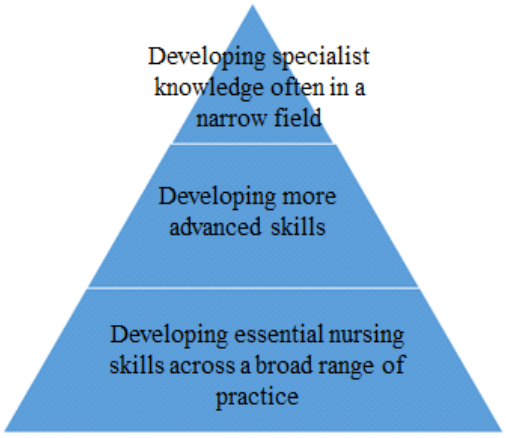

Figure 5.2: Traditional students building practice experience: narrowing generalist to specialist

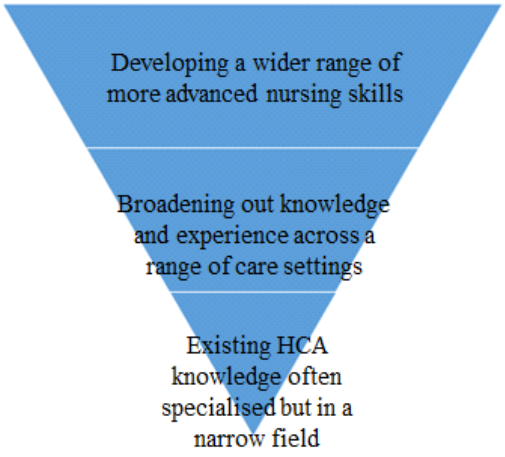

Figure 5.3: HCAs/students building practice experience: broadening specialist to generalist

This phenomenon was derived from the interview with the second student. All subsequent student and mentor interviews seemed to acknowledge this as an accurate representation. Some felt it was more like; building a large bubble from lots of different, smaller bubbles of practice, derived from external practice placements, or building up a holistic picture of

practice experiences in order to develop RN skills. However, the basic premise of this model was agreed. The external placement experiences students gained were seen as key to this development.

The acquisition of academic knowledge was perceived to be an important part of their development and, whilst they criticised traditional students for the '*book knowledge*' they had at the expense of caring skills, Jo recognised that the second year was very much about having that *'eureka'* moment of being able to bridge theory and practice to gain an understanding of how the two fit together:

> *"Whereas now, the sort of knowledge base is coming. It's sort of actually I can be lovely and friendly, but then still when people ask about medications now I can then say; "Actually, you're on this because of this and that, and you shouldn't do this because…" "… But yeah, I think that sort of eureka moment I think is definitely what happened and it's nice."* (*Jo, Student).*

This appeared to be a defining moment, where the existing caring and minor technical nursing skills, that were inherent in Jo as an HCA, were being underpinned by a greater knowledge and understanding of the wider health implications of the nursing care. Jordan offers a similar articulation of the different roles experienced:

> *"I suppose as an HCA, you're very focused, um, on individual processes and pieces of work, and directed by the care co-ordinators. Um, whereas now, um, as a student, it's looking more at the whole picture, looking at everything, looking at, um, somebody's care in a holistic, sort of, the whole person rather than just that individual targeted piece of work. And now, as much as it* frightens the life out of me*, being independent. ((Both laugh)).* It terrifies me. *Um, I'm starting to get that and starting to work towards that, um, planning, in collaboration with somebody, but sort of looking at the whole picture and looking at what could be best and communicating that, being part of that bigger team." (Jordan, Student).*

This provides an insight into the potential transition process that HCAs and traditional student nurses go through during their RN programme. However, this level of self-awareness was not necessarily present for all students, as demonstrated by Sam earlier in the chapter, when there was a failure to recognise the differences between their HCA role and the role of the RN. What Jo has succinctly articulated is that there is a differentiation between undertaking tasks per se and in understanding the rationale behind the task and what the consequent implications of the task might be. This is one of the main differences articulated between the HCA and student roles.

In addition to the specialist HCA skills they had developed, students also recognised the importance of the life skills they brought with them built from life experience and maturity and which enhanced their emotional intelligence.

5.3 "Battling" to be a student

This is the most emotive of these sub-themes and focuses on the students' need to defend their student status and rights of access to, for example, learning opportunities and appropriate support in practice. This is compounded by the lack of familiarity of the programme amongst mentors, particularly external placements. It also looks at mitigating actions students and mentors take to address this.

It was perceived, from talking to all students, that they felt that the wider mentor community knew little about the programme, resulting in confusion about the student role and difficulty for students in protecting role boundaries. This led to the most emotive topic for the students, which was the necessity to protect their student status. This was demonstrated through non-

verbal behaviours and a choice of language which was often very combative in relation to having to '*battle'* or '*fight'* to be a student in practice. Whilst this was generally considered less of a problem in relation to their more familiar home mentors, even two years into the programme some students still reported a perceived lack of understanding of the programme within their own teams:

> *"Um, I guess what I would say how I found it is that there's a lot of explaining. To professionals within the team.* Loads of it! *((Laughs)).* Like *"Well, what do you mean you're a student two days of the week?" and then* "What are you today?" "Well how does this work?" *And no matter where you go, there's a lot of that that happens. So it takes a good few weeks before anyone sort of understands*." *Danny (Student).*
>
> "*And is that within your own team as well as your external ...*" *Christine (Researcher).*
>
> *"Yes, definitely within my own team. I think my own team has been the hardest. Is my experience of the course. Um, it has been really hard sort of one day being able to do one thing and then the next day be like "Well I can't do that today." And for them to understand why." Danny (Student).*

Students felt this confusion added to their inability to protect their student role since there was a perceived lack of formal and consistent reinforcement from the programme provider. Protection of the student role was emphasised at induction for students and mentors and through practice visits. However, when students were out on placement on an everyday basis, it was perceived that there was no formal, written guidance and students had to constantly '*battle'* to retain their student status. This appears to be a regular occurrence for most students, and it was clear that over time this could wear the student down:

> "*… and you're almost battling a lot. That's the best way to describe it. Because you could be there and you're not on an HCA day, but someone will say "do this", and it's how you balance the two up. Because I've had that, where I've ended up having to go and do something on my student day that's for my job role" ... "you feel a bit like a parrot at times when you just keep repeating* "I'm a student!" "I'm a student!" "I'm a student!" *((Laughs, but appears very emotional)). Danny (Student).*

This even impacted on the expectations of employers in relation to the organisation of placements, where one student found themselves expected to organise their own external placements and faced a different battle – one of credibility in relation to accessing the placements:

> *"And because I was a student I couldn't fight ((my Trust's)) corner or the ((programme provider)) and I spent a whole day on a practice day with all these telephone calls, ringing round, doing my whole 20 days. I did it, but not without a struggle and sometimes really frustrated*." *Sam (Student).*

As identified in the literature review, it is essential for WBL to be successful that students are able to access the placement COP with its consequent resources such as mentor support and learning opportunities. Where this was a challenge, students felt let down and frustrated by their need to fight for access.

Two of the most confusing aspects of the programme, for both students and mentors, appeared to be developing an understanding of both the role differences (between student and HCA) and levels of achievement on the programme. Where this was the case it caused challenges for both home mentors and students. Students had to constantly reinforce their position whilst mentors had to provide additional support to external mentors which was resource intensive and caused further frustrations.

As well-developed HCAs or Assistant Practitioners in their employed roles, it was often difficult for students themselves to grasp why they were not automatically assessed at the level of 'Independence' as students. The mentors interviewed appeared to have a good grasp of this. Mentor participants recognised that independence in their HCA roles was associated with task completion, whereas in their student role it was necessary (for example) to

demonstrate the underpinning rationale or the potential implications of the task. Some students had a more advanced grasp of this than others, and this appeared to link to their levels of self-awareness and understanding of their dual roles.

This was also perceived to be a common issue for mentors unfamiliar with the programme. Mentors interviewed perceived that unfamiliar mentors often expected that, due to their HCA experience, students would be performing at a level of *'Independent'* in a range of skills. They failed to recognise this need for greater underpinning knowledge and consequences of actions, which were not always well developed in the HCAs in early stages of the programme. Furthermore, mentor participants recognised difficulties in some external placements' understanding of the assessment process. This was therefore perceived to impact at times on the support and expectations students experienced on placement. One mentor had adapted the student documentation to support guided feedback from external placement mentors and had regular contact with them (via telephone and personal visits). This was felt to provide better support to both student and external mentor. It was recognised, however, that this was a resource intensive process and that most mentors would not be able to offer this level of support and for most students this was therefore an issue. This lack of understanding of the particular needs of these students was compounded by the high numbers of students from the traditional, more familiar, programme sharing the same placement areas.

In addition, the traditional students were full-time and therefore perceived to be more visible and more consistently in attendance. Even when mentors had grasped the programme, this could be short-lived:

> *"... And she took it all away every now and again ((the paperwork)) and then when she could read it on the busy ward it was "Right, we've got to do this then, OK." And then come back "What have we got to do again?" and get the paperwork out again*." Sam (Student).

The single most important factor in reinforcing the student identity appeared to be the use of artefacts. The student uniform was felt by the vast majority, students and mentors, to be a visual reinforcement of the student role, reducing the necessity for the students to have to explain their role. Both adult students wore uniform and of the three mental health students, one never wore uniform, one had opted to wear an informal uniform and one wore uniform when they felt the need to reinforce the student role. The student who chose not to wear uniform, failing to recognise its potential impact (Danny), appeared to be having the most difficulty in protecting the student identity.

Uniform alone did not protect student status, but was a visual reminder to others that they were working as a student:

> *"If you are wearing a HCA uniform then you are seen as an assistant to the HCA work. If you are in a student uniform you are here to learn and you are here to be taught and you are here to have an experience. You are not here as a fundamental assistant to the work.*" *Kim (Mentor).*

> "*I think the way other staff treat them, um, when they've got the student uniform on so they're clearly identified, um, as a student, I think that does make a difference. They are less likely to be asked to do things that aren't appropriate as a student." Lou (Mentor).*

In addition, the act of wearing the uniform changed the way the students felt – providing a role reinforcement for the students themselves, conferring a sense of increased professionalism and need to act as role models to others:

> *"You put it on, and it ... You feel different. Um, and I used it for a short period of time to sort of refocus me. To say "Hold on", you know, it just pulled me back. The boundaries had just gone. And that did help*." *Jordan (Student).*

Where students did not wear uniform, they created their own sense of uniform by dressing differently on student days. One student denoted this by wearing plain socks on a student day but comedy socks on an HCA day. Students also tended to take more pride in their appearance:

> *"But do you feel different when you're a student nurse?" Christine (Researcher).*
>
> *"Yes, I really do. And it's nice actually I think if I didn't then I'd probably struggle with the transition. But I do wake up and I go downstairs and I clean my shoes every time and I have a different tunic every day and I make sure I've got my creases in my trousers*." *Jo (Student).*

The value of name badges was recognised too, although these were felt to not go far enough in conferring student status, since they related more to the employing organisation than the academic programme provider. This could cause confusion on placements outside their employing organisation. Other aspects of uniform also attempted to convey their student identity:

> *"I put my name badge straight on my student nurse uniform and my fob watch underneath,* one pen, two pens, torch and highlighter. *((Laughs)). It's that sort of like ((mimes how they make sure everything is in order))*." *Jo (Student).*

The participants indicated the emotional impact of having to fight for recognition of their student status and protect their student role. They also identified a number of factors that supported role recognition through reinforcement of their student status, with the most prominent being the wearing of uniform, either formal, informal or through associated artefacts (such as clip-on pens, torch and name badge). Furthermore, some students who did not routinely wear uniform recognised the valuable role this could have in reinforcing the student identity.

5.4 Understanding the realities of practice

This sub-theme explores how pre-existing HCA experiences help students better understand the realities of practice (or not) and the impact this has on their progress as student nurses. It also explores the mitigations they have adopted to ensure that they meet their learning needs and the sense of ownership that they have for their learning in practice. Whilst this was not a comparative study, mentors provided their perspectives of the differences between these HCA/students and more traditional nursing students. The theme also incorporates students' perceptions of mentorship and what best meets their needs in practice.

Students recognised the importance of their HCA backgrounds in supporting their understanding of the realities of the practice component of the programme:

> "*And I think there's ... an awareness of the real world. As a ((non-traditional student)). An awareness of what it actually means to be a mental health nurse or general, or whichever one. That you've got that real world experience. Where, I guess you see sometimes that a ((traditional)) student would be like "Let's do this and this and this" And you know it's never going to work. ((laughs)). But you're both students. And obviously you're coming from a completely different way of thinking." Danny (Student).*

Overall, mentors did not feel when questioned that there were any major differences between traditional and non-traditional students in relation to their behaviour, performance, attitude or support needs. However, on further questioning it was apparent that there were perceived differences between them. One mentor (who was the more experienced of the two, having been involved in supporting a number of these students) identified the more pragmatic, less anxious attitude of non-traditional students to competing mentor priorities:

> "*But also, the student* knows you. *So, for instance, if you have to cancel your meeting with your student, they're not anxious that they're not going to see me … They'll be heading down the stairs to come to see me for the mentorship meeting and I'm going* "*A call's just gone out". They know that actually they can catch me tomorrow ... whereas a traditional student gets really anxious about "Well ((the mentor)) never has time. They're always really busy.*"" *Kim (Mentor).*

It was also perceived that these students have a different level of motivation and attitude towards the programme than traditional students:

> *"You traditionally saw mid-second year into the start of the third year, you saw this dip in motivation and* "Oh, it's all a bit of a slog, and I've still got another …" *You know you don't hear the ((non-traditional)) students going "Oh, I've still got another three years." You hear them say* "Three years and I'm finished!" *Its … there's a … their language, it has a different spin. And I'm not seeing in ((the student)), who's now heading almost to mid-way in the course, I'm not seeing this dip in motivation. ((The student)) is still …* "I'm really excited about this next module and this is what's going to come up, and this is how I'm going to plan it and this is how I'm going to do it."" *Kim (Mentor).*

It was perceived that these non-traditional students appear far more self-sufficient and are less critical about mentorship than traditional students. This may stem from their more realistic perception of the dual roles of a RN/mentor and the demands such a role exerts upon them:

> "*Um, I've had mentors that I've not had a great deal to do with, but I do know that they are paying attention. I'm fine with that, because, you know, I'm one of these that I like to learn by doing. I don't like to be taken around on a lead." Kris (Student).*

Whilst students were less critical of mentors, they had also endeavoured themselves to resolve issues resulting from lack of time to mentor. Students were also quite adept at developing strategies to compensate for mentors who were struggling with competing demands:

> *"What I've tried to do for myself is, I know there's a number of competencies that I am quite clear about, my competencies I need right from the beginning, um, and there's practical stuff that I can get done. For instance, meds management, which is what I'm working on at the moment, I've done a number of administering meds and I will write up a summary account and then take it to the mentor and say "look, this is my understanding, can you please read it when you get a moment, and then if you agree with it, then sign it for me." And that's how I've tried to approach it". Jordan (Student).*

The students seemed to seek little support from their mentors unless they really needed it. They appeared to be more likely to take the lead in student/mentor relationships – appearing increasing likely to have a partnership learning approach with their core mentors but leading that relationship with away placements. This was recognised by the mentors:

> *"Everything is very self-directed, everything is very motivated from themselves, so they have a different learning motivation*." *Kim (Mentor).*

Kim believed that the work-based, open learning nature of the course was providing the students with skills, for example high motivation, self-directed learning and ability to problem-solve, which carry over to practice. This, it was perceived, was making them more solution-focused, rather than problem-focused.

> *"So I think the ((non-traditional)) course is potentially teaching, encouraging, a different way of dealing with nursing challenges." Kim (Mentor).*
>
> *" I'm definitely more directive. I don't know if that's just because it's me, or because it's the course. Um, I suppose I'm just sort of letting it go and taking the lead." Jordan (Student).*

It was also giving the students ownership of their learning, both in practice and theory and generating a sense of pride in their abilities. Kim (below) identified a situation where she discussed a case scenario in practice with non-traditional students and newly qualified nurses in which staff were unfamiliar. While the non-traditional students sought resolution,

demonstrating their ownership of their learning, the newly qualified nurses just stated they didn't know what to do:

> *"The only person who would be responsible for them not knowing that was them. Whereas what the newly qualified nurses were saying was the reason that they didn't know it was because they'd learnt it in their first year ((having subsequently not remembered))." Kim (Mentor).*

This sense of ownership was also demonstrated by one student's beliefs about taking responsibility for settling into new placements. They recognised that they had a responsibility to fit in by being engaged, developing good relationships and trying to fit in with the placement area's routine (rather than trying to impose their routine on the area). This student articulated the way in which traditional students often wanted to test out new routines in practice, not recognising the rationale behind the routines in place that were tried and tested. This was recognised as causing disharmony between the students and co-workers as a result and they had avoided this themselves when in new placement areas.

Students did not just rely on their mentor to support them in practice, and perhaps this is where differing expectations and a more pragmatic approach (derived from their existing experiences of practice) resulted in better satisfaction with the support they received:

> *"Every placement I have a mentor. I don't specifically aim for them. Because that's just one person. If you've got a team of ten people, you've got a team of ten different views, ideas, experiences, knowledge. You know, and I never, ever want to limit myself to just my mentor and one line of thinking." Kris (Student).*

Returning to home placements was also seen as beneficial in relation to the additional support students found from their work colleagues, especially when they were experiencing difficulties:

> *"… and that particular time I'd come back here and bounced off ((mentor)) really. Um … and a few other members of staff here are like "Sam needs to let off steam" and they've just sat there and listened.*" *Sam (Student).*

Despite having realistic expectations of mentorship and how this was affected by competing service priorities, students were not prepared to compromise their learning through acceptance of poor mentorship. Only one student identified experiences of poor mentorship – firstly, where they felt *'dumped'* into practice as no mentor had been allocated and secondly, where another nurse seemed to have forgotten what it was like to be a student and had used her positional power to intimidate both the student and her mentor:

> *"I was on ((area)) and I was allowed to go into theatres and my mentor had asked, um, three people that were booked in for caesareans and asked if I could go along. … Asked the consultant, he was fine, asked various other people, um, and forgot this one woman who thought it was her theatres" ….. "And all I did was stand at the back, and she just made a bee line for me.* "What are you doing here? …" *in front of the consultant and everyone.* …."I just can't have anybody in here …" *and the woman was about to come in, you know, and he turned round and said, as a joke, "leave her alone, she's only standing in the corner and we're all happy with it, and the main person that can say no is the patient that's coming in, and she's fine…" "*Oh, right, but I'll have a word with you later …." *So I knew that I was still going to get it ….." "And, when I got out, the word had already got back* ((Laughing)), *and my mentor was absolutely* horrified *that I was spoken to like that." Sam (Student).*

This was the only example of mentors' misuse of power that arose, and the only real concern raised about poor mentorship from all participants. All other issues raised related to lack of understanding of the programme or mentors reacting to the pressures of practice. These necessitated students to prioritise service needs through, for example, participating in care giving and negotiating student hours or learning opportunities to be met elsewhere. Hence, whilst students were prepared for the realities of practice and its impact on mentors, they mitigated this through taking the ownership of their learning. However, they maintained an expectation that mentors would be supportive, encouraging and facilitate them to meet their learning outcomes.

All students highlighted the excellent mentorship they received from their home mentor, with the main issues in mentorship relating to lack of familiarity with the programme and associated assessment processes. Mentors were described as '*fantastic*' and '*amazing*', with one student saying they would be '*distraught*' if they were to lose their current home mentor. Good mentorship was articulated by students as:

- *'doing it by the book'* – delivering recognised best practice in mentorship;
- making the student feel included as part of the team;
- challenging the student to improve through critical questioning;
- demonstrating the ability to empathise with the student, through remembering what it was like to be a student.

One of the concerns for local employers in implementing this programme has been the perceived potential difficulty in failing a student who is also a long-term colleague. This recognised the realities of long-term working relationships and the potential impact this might have on both student and mentor. Both mentors were confident that they would be able to fail the student should the need arise, although acknowledging the personal distress this might cause to both parties. One mentor felt that supporting the student for the duration of the programme, thus getting to know them far better than traditional students, would potentially give them greater credibility in making those pass/fail decisions:

> *"*I'm going to say something controversial. *((Quieter)). I think, because you know your student well, you are more credible to be able to … I'm not sure if credible is the right word? To be able to make that decision. Yes? Whereas a mentor on a ward that you've had for 6-8 weeks, doesn't really know that student." Kim (Mentor).*

Mentors found supporting the student for the programme duration was satisfying in allowing the mentor to see the development of the student over a period of time, the alternative view for one mentor was the increased sense of responsibility and accountability resulting from this. All students identified the challenges presented in working 22.5 hours per week as an HCA, combined with 15 hours per week as a student and 10 hours per week self-study. However, they equally agreed that it was both the hardest thing and the best thing they had ever done and none of them regretted taking this opportunity to become a RN.

5.5 Developing professionalism

In this sub-theme students and mentors acknowledged the behavioural differences in the students' dual roles and changing relationships with employers, mentors, traditional students and co-workers that resulted. This includes the perceptions the students had regarding reciprocal expectations of their employers and the benefits and challenges associated with being an employed student. The impact of their dual roles on service users was also explored.

When questioned, both students and mentors felt their relationship with each other was no different when they were HCA/RN than when they were student/mentor. However, when this was delved into further, it was recognised that students tended to be more professional than when they were in their employed HCA role and less '*jokey*'. They also acknowledged that the content of conversations had changed to allow a more teaching/learning focus, identifying the evidence behind practice:

> "*And I think for me, I should act, and I think everybody should act differently to your role, you have got to anyway. But especially in front of your mentor, your core mentor, cos you are their student … 'cos then it keeps you in good stead then when you're off patch. Out of respect and your own professionalism really, I think you should act differently, and I do behave differently to them*." *Sam (Student).*

Generally speaking, students found no hostility from co-workers, including other HCAs, and in fact found them mostly very supportive and helpful. Where issues did arise from other HCAs who perhaps felt jealous of the opportunity these students had, the student's themselves felt assertive enough to deal with this:

> *"And there's been a certain person like that and* "Oh, don't you look funny in your uniform!" *And it got to the point I said* "Hey, have you got a problem?" *Like, "Are you jealous? Do you want to be a student?" "Oh, no. It's not for me." So I was like, "Well, stop making comments then." But never really any … sort of, repercussions*." *Jo (Student).*

In addition, they felt that their existing working relationships were strong enough that their colleagues were pleased for them:

> *"I think because we worked together beforehand and, you know, there is a friendship, um … it's just kind of, you know, I'm progressing in my career and I think most people are just happy to see that." Kris (Student).*

Where relationships had changed it was often in respect to RN co-workers having a greater expectation of the HCA, offering professional support and advice, or providing additional learning opportunities within their HCA role. One student found themselves increasingly critical of their fellow HCAs and the unsupported judgements they made about service users or practice situations. This resulted in frustration and a distancing from their HCA colleagues. The student recognised this as part of a natural transition from being an HCA to being a student, but this did not totally alleviate the resulting anxiety:

> *"I think that I behave and feel different within my own HCA group. Um, to where I was. And there's certain judgements that people make that now I'm thinking,* "You really shouldn't be making that judgement. It's not your judgement to make". *And then sometimes that actually makes me feel like a fraud, because I think, "Hold on", you know, "I'm comfortable making those decisions myself, and judgements – what right have you really got to tell somebody they shouldn't be?" Jordan (Student).*

In addition, students were more likely to recognise issues of poor practice and felt more empowered as students to challenge this than they would as HCAs:

> *"We had an incident, um, I've just done my three nights, that we have to do, and there was something that happened that wasn't good practice at all. Um, and I felt confident enough to stand up and say "No I don't agree with that. That's not, um, quite right."" (Jordan, Student).*

In most cases students did not see the same patients when they were in their student role as they did when working as HCAs, therefore for them there was little perceived impact on service users. For an adult community student, whose caseload often included the same patients for months or years, patients found the dual roles confusing and, even when the student explained the purpose, could not seem to grasp the purpose of the dual roles:

> *"And what about patients? How have patients found it do you think?" Christine (Researcher).*
>
> *"*HARD. *I mean, some of ours, you know, that we've been going into for years, and it's like* "Well why are you in a different uniform for?" *and* "Why are you here today? What are you learning then because you KNOW this?" *And they're elderly as well, so for them to grasp that"* …. "I think some of them have been very confused." *Sam (Student).*

For mental health service users, where the same patients were seen by participants in both their HCA and student role, this was not perceived to be an issue:

> *"I'm not even sure our service users really differentiate between different people. They just see a homogenous group of people who are helping them and they're on the whole grateful for that, and not too bothered about looking too much further into it." Lou (Mentor).*

Whilst it was therefore largely perceived that the impact of the HCA/students' dual roles on service users was variable, separating out the roles of HCA and students through different home placement and employed area (as described in 5.1) would likely be beneficial in avoiding any confusion.

Most student participants reported good relationships with traditional students when sharing placements with them. They had developed a greater empathy for them since becoming students themselves, recognising that they were '*all in the same boat*'. Most students recognised that they took a managerial role with traditional students, often delegating to them or organising them as the traditional students were perceived to be less likely to '*get stuck in*' than the non-traditional students. Several non-traditional students recognised that they often sacrificed their own learning opportunities in favour of traditional students – particularly when they knew that they would get further opportunities themselves in future to practice those skills or experience those aspects of practice. This empathy for the traditional students spilled over into their HCA roles where some felt they were more likely to support traditional students on placement than previously.

Unlike traditional students, these WBL students who were also employed HCAs, had to have the support of their organisation in order to undertake the programme. This resulted in a perceived obligation to the employer, with the HCA/students needing to achieve a sense of balance between resultant feelings of being valued as an employee, but also the need for an enhanced professionalism to ensure they met the perceived expectations they felt the employer now had of them. This will be further explored through this next section.

Students felt the need to behave in a manner beyond reproach as a result of the progression opportunity provided by their employers. One student in particular voiced concern about etting people down if they failed to complete the programme or failed to live up to the expectations of the organisation. However, being valued as a student was really important to them and something that almost all of them mentioned. They felt very valued to be on the

programme, particularly where employers had fully supported salaries for student days which is optional for employers:

> "*They've agreed to say "Look, we've got the confidence in you, we're going to lose you for 15hrs a week, but we'll still give you money for it 'cos you're going to come back as a great nurse at the end of it." Yeah it … Yeah. It's nice*."" *Jo (Student).*

Many students had been selected to apply by their line managers and this heightened their feelings of self-esteem, as they felt honoured to have been chosen:

> *"The fact that they've asked you to do it, the fact that for me … the fact that I was asked "Do you want to do this?" and I was supported to do this and… it makes you, you know, it makes you feel worthwhile as a … as a person I guess? As an HCA? It means you're doing your job right, it means they're looking at you and seeing that potential which is really important …*" *Kris (Student).*

Students also felt valued when they received praise from their mentors – it gave them an enhanced sense of pride and self-worth. This seemed to compensate in some way for the sacrifices they were making to complete the programme. Students also appeared to express an increased sense of self-worth in relation to the level of interest from co-workers:

> *"I'd say probably ninety per cent of them ((nurses in the department)) will know that I'm doing the course and they regularly ask about it. And that's really, really nice, like. And the amount that say "Oh, I've got some old books" or even newly qualifieds who come to us go "Oh, do you want to borrow this?" ……. But yeah, it is really nice that people are so interested and that's Matrons, Sisters, everyone, yeah." Jo (Student).*

Students took a great deal of pride in being a non-traditional student. Some of this came from their gratitude for being given the opportunity to train as a nurse. Often this had been a life-long ambition which they never thought they would have the opportunity to undertake for financial, family or academic reasons.

Pride was also expressed regarding the following:

- wearing their student uniform, including accompanying artefacts such as fob watches, pens, torch;
- having the commitment to make sacrifices in their personal lives to undertake the study elements of the course;
- taking more pride than usual in their appearance on student days;
- taking pride in their assessments, because they are self-directed and take ownership of them.

It would appear that becoming students had given the HCAs a different perspective on roles and relationships, impacting not only on their own role and self-management, but also on their peer relationships with other HCAs, as demonstrated by Jordan (student). This new perspective has also given them an empathy for other, traditional students that was previously missing. This has allowed them to support the students better in practice, seemingly both in their HCA and student roles. It has also encouraged them to develop a different relationship with the RN/mentor which has a more professional underpinning.

The following section reviews the conclusions from this phase of research, informed by the original research questions.

5.6 Conclusions from the qualitative interviews

In drawing conclusions from these findings, I have returned to the three research questions posed in the design of this qualitative phase of research:

1. ***What are the experiences of both HCA/students and their RN/mentors regarding the duality of their roles?***

Whilst only two mentors, one each from adult and mental health fields, participated in the study, neither perceived any role duality issues themselves. This may be due to the multiple roles that qualified nurses tend to fulfil on a regular basis, for example nurse, manager, mentor, assessor and/or clinical lead. There were also no obvious differences in responses between students and mentors from the different fields. There appear to be a number of factors affected by the dual roles of HCA/students which impact on the student experience and transition into the student role. These include trying to protect student identity, managing expectations of home placement teams and explaining their particular needs to external mentors (explored in Chapter Six). However, the student role appears to be reinforced by items which convey student identity, such as uniforms and name badges, and by not using their employed area as a student placement.

2. ***Is the mentor role in relation to mentoring the non-traditional student different to that of mentoring traditional students, and if so, how?***

These students are perceived to be more self-reliant and less dependent on their mentors than traditional students. This leads to a student more willing to work in partnership with the mentor and who takes more responsibility for their learning. They appear to be more aware of the realities of practice and therefore are more adaptable and flexible in their learning approach, fitting in achievement of learning outcomes around real-life situations. The students are vulnerable to exploitation of their dual roles, however, and mentors need to understand the programme and role boundaries in order to ensure student status is protected.

3. ***Does the relationship between the HCA/students and their RN/mentors differ when they are working as HCA and RN differ from when they are working as student and mentor? If so, how?***

The students perceive themselves to be more professional in their student roles, developing a more respectful relationship with their mentor and leading to conversations where a greater degree of critical challenge and learning is applied.

These main findings were fed back to participants for verification, thereby contributing to the trustworthiness and rigour of the research. Section 5.7 describes this feedback process and participants' priority actions for the quantitative intervention phase of research.

5.7 Feedback of findings to participants and prioritising actions

While the iterative nature of the interviews allowed findings from early interviews to be validated by subsequent interviews, more formal feedback on the overall findings was invited from participants to support the trustworthiness of findings. All participants from the qualitative interviews were invited to feedback.

Feedback was provided to participants either electronically or through face-to-face discussion. The original ethical approval process did not allow for involving participants in decisions about the intervention and pilot evaluation phase of research, thus amendments to the approval were sought. As a result, the education provider denied SRPP approval for two of the mental health student participants and for a further student the Trust R&D approval deadline passed before the student responded. A further student and mentor were provided with electronic feedback but failed to comment on findings. Consequently, only one mentor and one student fed back directly in relation to the study findings. Whilst it could be construed that failure to feedback could signify that participants were happy with the findings this is an assumption that has no evidence base.

One of the mentors, Lou, supported the findings and recognised their truthfulness in relation to their experiences. Lou had not previously recognised the benefits of supporting the student throughout the four-year programme, but on reading the comments from the other mentor (Kim) reflected on how this would increase validity of pass/fail decisions, raise credibility of the mentor and give more time to address issues that might arise in practice. Lou felt that providing a mechanism for increasing mentor awareness of the programme would be beneficial and that ensuring students wore uniform, formal or informal, would also help confer student status. The student who fed back on the findings strongly endorsed them and contributed to the suggested recommendations set out in Chapter Six.

Findings were also fed back at the annual Open GYOOG meeting at which a number of students, mentors, practice tutors and employer leads were present. This meeting also included further study participants who had not previously taken the opportunity to feedback through the study itself. The findings were presented, including an overview of the main theme and sub-themes supported by direct quotes from participants. All those present endorsed the findings, with several examples from their own experiences provided in support. In addition, a series of suggested recommendations were made to the group which derived either directly from the research participants or as a result of the findings. These recommendations were endorsed by attendees and are discussed in Chapter Six.

In summary, the qualitative phase of this exploratory sequential MMR has addressed the research questions posed and identified a number of issues which impact positively and negatively on these student nurses' ability to fully adopt the student nurse role. Chapter Six considers these findings in the context of the relevant literature and how this informed the second phase of the study.

CHAPTER SIX

Phase One Discussion: Developing a Student Nurse Identity

The original literature review helped narrow the focus of the research aims and question by identifying gaps in existing knowledge, particularly those relating to the transition of the HCAs to their student nurse role. This drove the exploratory phase of qualitative interviews where a number of sub-themes were identified, all of which linked to role identity. The data indicates that these non-traditional students experienced various degrees of difficulty in adopting a student identity. This was largely due to the simultaneous need to fulfil their HCA role and thus maintain their HCA identity. This chapter discusses these findings in relation to the wider literature, drawing on related theoretical perspectives to support a better understanding of participant accounts, closely linking the wider theory to the study findings. This theoretical underpinning of the findings concludes with a series of recommendations for practice.

6.1 Setting the context

This section explores a number of key concepts and their ascribed meaning within this study. These include socialisation (primary and secondary), identity (social, personal and organisational) and how we develop a sense of self. These are inextricably linked and intertwined, each impacting on, and affected by, the others. This section provides further clarity regarding the way in which we develop our identity and sense of self, and how the socialisation process and impacting factors affect the transition process, otherwise known

as the *status passage* (Bradby, 1990a; 1990b). For the HCA/students in this research, the professional socialisation that takes place within and between each transition stage will determine their ability to successfully transition to the student role.

Socialisation: Fulcher and Scott (2011) perceive socialisation simply to be a learning journey through which individuals acquire the necessary knowledge to join a particular society. This could, however, equally relate to entering a COP.

Primary socialisation occurs in childhood and is linked to the role of family in supporting development of core communication and interaction skills (Giddens, 2006; Thomas-Gregory, 2012). Secondary socialisation occurs throughout life, with the wider influence of peer groups, education, work and media (Thomas-Gregory, 2012). Thomas-Gregory (2012) asserts that it is through these socialisation processes that a sense of identity is developed. Hence individuals within a given society (or COP) can be seen to conform to agreed notions of what is, and what is not, acceptable behaviour.

Goffman (1959) links socialisation to wider society and argues that the role we play within society is shaped by the situations we find ourselves in. These are learned social roles which we adopt in our interactions with others (Fulcher and Scott, 2011). When entering the nursing profession, there is a necessity to develop a professional identity through the professional socialisation process. Goldenberg and Iwasiw (1993) describe this process of professional socialisation as:

> "…a complex interactive process by which the content of the professional role (skills, knowledge, behaviour) is learned, and the values, attitudes and goals integral to the profession and sense of occupational identity which are characteristic of a member of that profession are internalised." (p.4).

However, White and Ewan (1991) promote a different perspective, separating out the academic components of the programme which lead to the development of skills, behaviours and knowledge necessary to competent practice, from the professional socialisation process. They believe this socialisation leads to development of the culture of nursing:

> "… that combination of symbols, customs and shared meanings which makes nursing distinctive." (White and Ewan, 1991, p.189).

The process of professional socialisation appears to be affected by the individual's pre-nursing idealism – that is their preconceived notions of what nursing is against the dichotomy of the reality of nursing practice (Shinyashiki et al, 2006). Shinyashiki et al (2006) and Hasson, McKenna and Keeney (2013b) argue that these preconceived notions can be a barrier to successful professional socialisation since they may not align with the desired outcomes of the pre-registration education programme. Hasson, McKenna and Keeney (2013b) found individuals with no previous healthcare experience had an idealistic view of the role of the nurse and hence a reality shock took place when faced with nursing as it is in the real world. In order to progress through the professional socialisation process, individuals need to reconcile the reality of nursing with their pre-entry idealism.

Shinyashiki et al (2006) also assert that whilst academia provides early nursing standards and values, it is the role of practice experiences to refine these. Having a strong background in healthcare at the point of entry to the programme, the students in this study are likely to have a much more realistic idea of what nursing is from the outset.

The effects of institution identity (divestiture): The effects of institutional influence on the developing sense of identity is otherwise known as *divestiture*. Divestiture is defined as the:

> "… attempt of the organisation to strip the individual of his or her own identity in order that conformity with the institution's needs will occur." (Bradby, 1990a, p.1222).

Thomas-Gregory (2012) acknowledges the importance of divestiture in conforming organisations such as the NHS. The consequence of divestiture is the loss of personal identity, which Bradby (1990a) found nurses sought to replace in their relationships with patients and people outside the organisation. Hence personal identity is reinforced when they go home. Students mourn the loss of personal identity and seek to fit in with peers and workplace (Bradby, 1990a), hence the tendency to seek a sense of belongingness on placement. For the employed HCAs in this study, it might have been easier to maintain a sense of belongingness due to their ability to return to their familiar employed area for three days per week. It is likely that whilst the role duality may have compounded the transition to the student role, it may have mitigated the effects of their loss of their familiar HCA identity.

Social Identity: The notion of social identity within the context of this study is defined as '… being recognised as a certain "kind of person", in a given context.' (Gee, 2001, p.99). Gee (2001) proposes that identity is both ambiguous and complex, since the individual's identity can vary depending on the situation and most individuals therefore demonstrate multiple identities. These are often connected to performance rather than reality. Goffman (1959), in his traditional sociological theories on self and socialisation, recognised that society uses a number of clues to our identity, such as appearance and behaviour, when they have limited information to apply. Society will also reflect on their previous experiences of

similar individuals to determine what they might expect from the individual and what the individual might expect of them in return. This can lead to a belief by the individual themselves that this is who they are, even if this is not a true representation.

In this study this was evidenced by the study participants' belief that they were still HCAs because that is how they were perceived by co-workers. Only when this preconceived social identity has been allocated will the actual deeds, attitudes and interactions from the individual influence the beliefs that others have about them (Goffman, 1959). Social identity is critical to the individual's way of being (Fulcher and Scott, 2011).

Gee (2001) advocates four ways in which to view identity which are set out in Table 6.1. These identities recognise the nature/nurture debate in relation to what attributes are inherent in us and those we adopt, often under the influence of others. In reality, it is likely that our identities are made up of a combination of all four factors.

Table 6.1: The four ways to view identity (adapted from Gee, 2001)

Identity Factor	Development of Identity Factor
Nature-identity: a state	Developed from forces in nature.
Institution-identity: a position	Authorised by authorities within institutions.
Discourse-identity: an individual trait	Recognised in the discourse/dialogue of or with 'rational' individuals.
Affinity-identity: experiences	Shared in the practices of 'affinity groups' (such as nurses).

Personal identity: Fulcher and Scott (2011) suggest that personal identity is the bridge between the social identity and sense of self. Our personal identity is likely to be a truer descriptor of who we are. This is often made up of multiple facets of ourselves and the various inherent traits within us. This is in contrast to our social identity, which is based on the various roles we act out (for example parent, sibling, worker) and the response others have to these. There are many times nurses express how they become different people when they put their uniforms on and was alluded to by one of the students (Jo) in the individual qualitative interviews. This suggests the roles we have as professionals are different to the roles we have as individuals. This is recognised by Goffman (1959) as role distance, where there is a clear divide between role and self. Fulcher and Scott (2011) concur, arguing that there is often a dichotomy between social and personal identities.

Developing a sense of self: Our sense of self is our uniqueness, in other words our reflections on what makes us who we are (Fulcher and Scott, 2011). Gergen (1971), in his seminal work on The Concept of Self, identifies four factors to developing a sense of self:

- Developing an identity (who am I?);
- Performing a self-evaluation and identifying areas where they feel valued;
- Identifying where the self sits in relation to society;
- Recognising the limitations and restrictions of the identity.

In her literature review, Thomas-Gregory (2012) identifies the multi-faceted aspects of historical socialisation that build a sense of self. For the HCAs undertaking this study, this historical socialisation was likely to include close family experiences, educational experiences and life experiences which have contributed to their sense of self. However, they will also have had work experiences, including those as HCAs, and exposure to the culture of nursing which will have contributed to their socialisation and developing sense of identity.

Status passage: As identified earlier, there is a distinct transition process necessary to adoption of a new role or identity. The transition theories of Van Gennep (1960), Barton (2007) and Bridges and Bridges (2009) were analysed in the original literature review (Chapter Two). In summary, there are three distinct phases (or rites of passage) to transition (Van Gennep, 1960):

- Rites of separation – a letting go of the previous role or identity
- Rites of transition – a process of transition or role evolution which can constitute the 'no-man's land' between the original and new roles or identities
- Rites of incorporation – the resocialisation into the new experience and adoption of the new role or identity.

Bradby (1990a; 1990b) recognises this transition process as a *status passage*, which:

> "…includes anticipations, entry, reporting of contrasts and changes which are often accompanied by surprise and reality shock before making sense of the passage." (Bradby, 1990a, p.1220).

Bradby undertook a study of four female nursing cohorts in two schools of nursing and found that the process of *status passage* included preparation, such as acquiring a better understanding of the role or gaining work experience, and crossing the threshold of the new role, often by entering a new building (Bradby, 1990a). In the case of nursing students, entry into a new placement area would constitute crossing the threshold of the new role. The rites of passage were perceived to be the acquisition of the title *nurse* and the application of the uniform (Bradby, 1990b). Furthermore, shift rotas were often a key factor in *status passage and* the consequent socialisation process (Bradby, 1990a). HCA/students would be familiar with shift patterns and it is likely the reason this has not had the same effect in this doctoral study. Entry into the COP, the placement area, was characterised by 'excitements and anxieties', while the transition from lay person to nurse was perceived to be denoted by the development of those aspects nurses do automatically and without conscious thought (Bradby, 1990b, p.1363).

Whilst this study took place over twenty years ago, it remains a key study in the identification of socialisation processes, despite more recent changes to nurse education. It was found that those nursing students with higher self-esteem and lower anxiety scores tended to find *status passage* easier to navigate (Bradby, 1990a).

In summary, the HCAs will have developed an identity at the start of the nursing programme made up of both primary socialisation (early childhood experiences) and secondary experiences (from school, college, friends, family and HCA work experiences). They will have:

- Developed an identity of who they are;
- Performed a self-evaluation and identified areas where they feel valued;
- Identified where their 'self' sits in relation to society, measured against their experiences and the reactions of others;
- Recognised the limitations and restrictions of their identity;
- Had some experience of divestiture, particularly in relation to their conformity to NHS values and organisational expectations, but not at that stage to professional values and expectations;
- Had experiences of wearing an HCA uniform and any consequent identity links;
- Completed the preparatory stages of *status passage*, through prior experience and to some extent conferring of status (HCA uniform and title), having not yet crossed the threshold into clinical placements.

Following this, and by the second year of their programme, they will have commenced their *status passage* towards being a student nurse. Chapter five described how one of the challenges to developing a student identity was their social identity, the way in which they were perceived by their co-workers, and the impact that this had on their developing sense of self.

The following section focuses on the professional socialisation process necessary for the transition of these HCA/students and is aligned to a recognised socialisation framework. The study findings have been interlinked with wider theory, including Holland's (1999) study into the transition from student nurse to RN and the UKCC's (1986) concept of becoming a knowledgeable carer. This is underpinned by a range of related literature.

6.2 Transition: 'being' a student nurse

The work of Holland (1999) was excluded from the initial literature review (Chapter Two) as it was perceived that her work focused more towards the transition from student to registered nurse. However, on revisiting her work it was apparent that there were some relevant aspects, particularly the transition into the student nurse role. Holland (1999) carried out an ethnographic study using participant observation and interviews within practice and non-participant observation in the academic setting. These were supported by an open-ended questionnaire to maximise data available for analysis within the agreed timeframe.

Whilst Holland's work was undertaken twenty years ago, it remains relevant to other more contemporary work and is one of the few studies that focuses on the initial transition needed to become a student nurse. There is a relatively large body of work relating to professional socialisation generally in nursing, particularly transition from student to RN. However, this is less extensive for socialisation to student nurse roles and further restricted for students working as HCAs alongside their student nurse role. All these important aspects are considered in this study by Holland (1999).

Through this research, Holland (1999) identified three key stages for student nurses transitioning into the registered nurse role:

- *Becoming a student nurse* – during this phase the individual was at the very start of their transitional journey. They were learning to implement the societal role associated with being a nurse through participating in nursing duties. This phase was found to be linked to a task-oriented approach to care and an apprentice style of observing rather than doing.

- *Being a student nurse* – during this phase the student progressed towards developing a professional nursing mind set. However, this phase tended to cause role confusion for staff carrying out additional HCA roles outside their normal student hours. This could be seen as a potential barrier to being a student given; the uncertainty around how they could adopt a professional and occupational role culture, assumptions about their competency to practice as a student nurse if they had demonstrated competency at HCA level, with consequent lack of skills training and assessment.

- *Becoming a qualified nurse* – this was the final phase of their student transition. In preparing for registration, student nurses were often focused on passing tests, rather than learning the craft of nursing. These were not necessarily a test of their student nurse ability, but of their ability as a future registrant.

Holland (1999) identified that when 'being a student nurse' a hierarchy of care was identified by the students, with basic nursing care, nursing care and technical nursing care recognised. Students perceived that anyone could carry out basic nursing care (for example, untrained carers and families), but only nurses could carry out nursing care and only more specialised staff (for example ITU nurses) could carry out very technical care (Holland, 1999). Similarly, Stevens and Crouch (1995) assert that nurses tend to place more value on technical, scientific aspects of their role than essential care. Traditionally, *curing* has been seen as a predominantly medical role and *caring* a nursing role. The changes in nursing roles and responsibilities have seen an increase in technical, *curing* nursing responsibilities (Sykes and Durham, 2014) with students valuing these aspects ahead of *caring* focused responsibilities (Stevens and Crouch, 1995). This contrasts with the majority of students' values on entry to the programme.

This perspective was not replicated by the participants in the exploratory phase of this MMR study – possibly because of the huge progression in patient acuity, nursing skill mix and nursing responsibilities. The students often gave examples of very technical nursing care which they undertook in their HCA/Assistant Practitioner roles, meaning the technical aspects were not necessarily a novelty for them. It could also be because they better recognise the importance of caring – for example in Chapter Five where Kris (student) identified the importance of supporting struggling colleagues in order to ensure patients received the necessary care. In addition, Holland (1999) found that novice practitioners were not expected to provide holistic care in the same way as experienced staff. Thus, part of the transition for Holland's (1999) sample seemed to focus on a progression from task focused to holistic focused care. This was one of the transitional role criteria given by students in this doctoral study, in that they felt they were more task focused in their HCA roles, but more holistic in their student roles. Section 6.4 further explores issues of caring relating to the professional socialisation process.

Holland (1999, p.232) also recognised the role of those becoming a student nurse as 'knowledgeable doers' (UKCC, 1986). Knowledgeable doers provide care based on knowledge of theory and procedure without necessarily being a knowledgeable carer, who provides holistic care and is aware of the implications and impact of that care. This stage of *knowledgeable caring* was more likely to occur as they were being a student nurse. This resonates with my own study findings regarding the '*book knowledge'* that participants believed traditional students brought with them on entry to the programme without having the people skills and ability to provide nursing care in practice (see Figure 6.1).

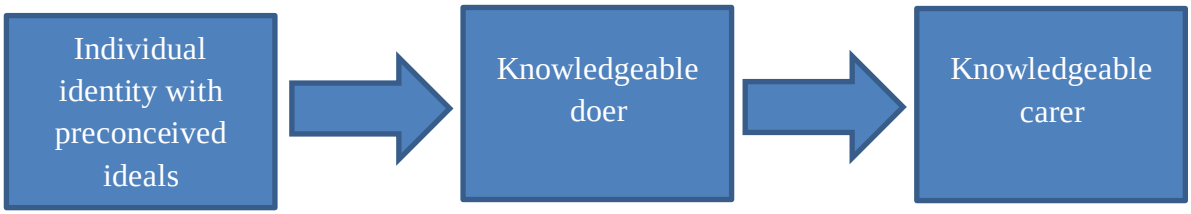

Figure 6.1: Traditional students' transition to a knowledgeable carer (drawing on UKCC, 1986 and Holland, 1999)

By comparison, as existing HCAs, students in this study felt they brought the opposite, which is the ability to provide skilful nursing care without necessarily having the underpinning knowledge to support that. In relation to Holland's terminology I have termed this a *caring doer* (see Figure 6.2). Figures 6.1 and 6.2 depict this concept of becoming a knowledgeable carer from the traditional student and HCA/student perspectives.

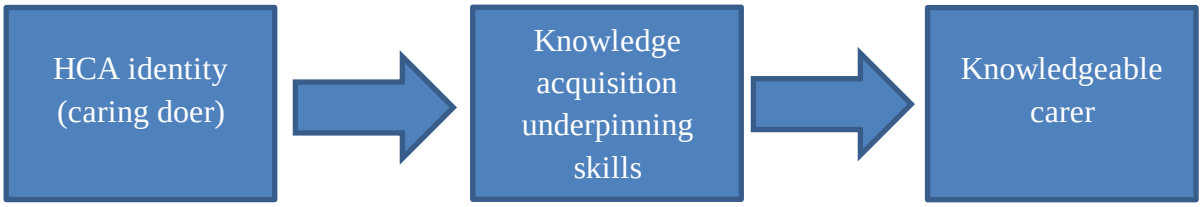

Figure 6.2: HCA/students' transition to a knowledgeable carer (drawing on UKCC, 1986 and Holland, 1999)

It is implicit through Holland's three stage transition process, that for student nurses to develop a nursing identity, the key to successful transition is the professional socialisation that takes place within and between each transition stage. Nursing students need to follow a professional socialisation process in order to develop their professional identity and build

nurse/patient relationships (Shinyashiki et al, 2006). The following section examines the professional socialisation process, what factors support or challenge the process for nursing students and how the literature informs the findings of this study.

6.3 Developing professional socialisation

Whilst there is little UK literature relating to professional socialisation for student nurses (Brown, Stevens and Kermode, 2013) there are several international studies (largely Scandinavian, American and Australian) which, whilst taking account of programme differences, are still beneficial in describing comparable socialisation processes. Two key frameworks for the professional socialisation of nursing students were analysed in relation to the findings. The first, a six-stage doctrinal conversion theory by Davis (1975) is a longitudinal study over five years of five successive cohorts of American nursing students through observational study, questionnaires and panel depth interview. The framework identifies six sequential stages that students experience (see Table 6.2) and, despite the age of this study, it remains relevant to the study findings and other socialisation theories.

Table 6.2: Davis' six stage doctrinal conversion theory (adapted from Davis, 1975)

Stage of Socialisation	Characteristics	General Timing in Relation to Training
Initial innocence	Lack of understanding of what nursing is	Generally occur by the end of Year One
Labelled recognition of incongruity	Misalignment between expectation and need for instruction	
Psyching out	Students challenged tutors to clarify their expectations	
Role simulation	Demonstrate manipulative behaviour which allows for *psyching out* and tend to pretend the role of the nurse in order to convince others.	Generally occur during the course of the next two years
Provisional internalisation	Student commits to the role of the nurse and is critical of poor performance by other nurses.	
Stable internalisation	Student takes confidence in their ability to perform the nursing role.	

However, participants in Davis' (1975) study were mostly young, white middle to upper class women and Davis himself recognises the limitations of this in that findings would potentially differ if the study were to be replicated in a different time or for a different population. In addition, the study mainly focuses on the academic aspects of professional socialisation rather than practice and thus was of limited benefit. Davis' framework will be applied to some of the findings later in this chapter (see Section 6.7).

The second, more recent, study is Australian and forms the qualitative stage of a larger study (Brown, Stevens and Kermode, 2012). Participants were seven recent graduates and seven clinical teachers. Data were collected through short, semi-structured interviews. The findings are potentially restrictive when related to this doctoral research, since the aim of Brown, Stevens and Kermode (2012) was to explore through perceptions of clinical teachers, their role in the socialisation of the nursing students. Questions were therefore very specific and not broad enough to allow data around other impacting factors such as mentors and practice

staff to be considered. However, this was part of a bigger study leading to development of a quantitative tool which was used in a further phase exploring a number of socialising agents (Brown, Stevens and Kermode, 2013). Both papers have been used to inform this chapter.

Brown, Stevens and Kermode (2012) identified seven domains deemed crucial to the development of professional socialisation. The seven domains are detailed below and, since they closely relate to other relevant literature, the remainder of this section is framed using these domains:

- Professional role concept, including role conflict, role ambiguity, citizenship and occupational identity;
- Acculturation;
- Acquisition of knowledge;
- Acquisition of skills;
- Acquisition of professional values;
- Assimilation of the organisation;
- Role model attributes.

Professional role concept - Lack of clarity around the differences in roles and responsibilities between being an HCA and being a nursing student meant that participants were unable to articulate their student role to mentors. This led to a blurring of role boundaries for students, mentors and other team members, particularly within their home placements. Higginson (2006) reported similar findings in his study of first year student nurses who were equally unable to articulate their role. He found that this was exacerbated for students who also had HCA experience (either prior to or during the programme). Role confusion was also more

pronounced when the student returned to an area where they had previously been employed as an HCA and one student even expressed the belief that there was no difference between the roles (Higginson, 2006). This was similar to the findings in this study where general consensus was that role boundaries were blurred, particularly in their employed areas when undertaking the student role. There was also an example of perceived blurring of boundaries between HCA and RN roles, where one student participant felt that any role difference in their employed area was limited to their inability as a Band 4 HCA to undertake male catheterisations and rectal examinations.

There were also several examples of when, as students, the participants felt a different sense of self – believing themselves to behave differently when in their student role than when in their HCA role. This related to an increased sense of professionalism when working as students than when working as HCAs. These were defined as:

- Being less *'jokey';*
- Participating in more professional conversations, relating for example to evidence-based practice;
- Critically analysing behaviours of other HCAs;
- Recognising the responsibility they had to represent the organisations who had invested in them by supporting them on the programme;
- Taking pride in their appearance;
- Taking pride in their performance through assessments.

Therefore, a clear sense of professionalism has been developed in the participants by the time they are in their second year of training.

Acculturation – This is defined as the 'cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture' or 'a merging of cultures as a result of prolonged contact' (Merriam-Webster, 2015). It can be likened to the institution-identity and affinity-identity highlighted by Gee (2001) and to theories of divestiture (Bradby, 1990a). Greenwood (1993) argues that students suffer a dichotomy in the values/beliefs promoted through the professional socialisation process which impacts on their acculturation. This includes inconsistencies between those values and beliefs taught in academia, such as evidence-based practice delivered through holistic, patient centred care, and the perceived reality shock of the real world of practice.

It is a similar reality shock which was identified in Kramer's (1974) well recognised study as the key reason for nurses leaving the profession. This can therefore be problematic for students trying to adopt an organisational culture. In order to fit in to the nursing community of practice, several studies have recognised the need for students to adopt the placement or team culture (Nolan, 1998; Mackintosh, 2006; Levett-Jones and Lathlean, 2007; 2009a; Brennan and Timmins, 2012) even when this differs from what they are taught in academia. Previous research has suggested that students see nurse training as a 'game' and recognise the need to develop survival strategies in order to cope (Kevern and Webb, 2004, p.297). Nolan (1998) recognised the students' perception that conformity was one such strategy necessary to this survival.

This was not particularly apparent in this study and therefore suggests nursing students with prior healthcare experience, or part-time students with socialisation opportunities in their employed roles, have already acculturated, thus potentially having learnt the game (Nesler et al, 2001; Phillips et al, 2012). This prior orientation and socialisation for students with

additional healthcare experience was found to better support their transition on qualification (Phillips et al, 2012). In the qualitative interviews, one student spoke about the need to follow routines and provided a clear rationale for this, recognising that most routines had developed through previous trial and error approaches in order to achieve patient centred practice. Thus, as a regular team member, it could be very frustrating when students came along and worked outside this without seeking clarification as to why the routine was in place. This spoke more about the development of real-world practice, than the need to conform and demonstrates a different perspective of acculturation through a trial and error approach.

Davies (1993), in a Grounded Theory study of six first year student nurses, found that the students valued learning practice routines, since it was often through these that tacit knowledge (not consciously thought about by experienced nurses) was passed on, which supported professional socialisation. This was perceived by Bradby (1990a; 1990b) to be the final stage of *status passage* and the domain of the registered nurse. For existing healthcare assistants, the exposure that they would have had to a number of RNs working to their code of practice (NMC, 2015) will undoubtedly have had an effect on both their performance and their understanding of professional expectations for their student nurse roles.

Levett-Jones and Lathlean (2008; 2009a; 2009b) and Levett-Jones et al (2007; 2008) undertook a multi-site international study of eighteen third year students which is a seminal piece of work relating to students' sense of belongingness in clinical practice. Belongingness in this context is defined as:

> "…the degree to which an individual feels a) secure, accepted, included, valued and respected by a defined group, b) connected with or integral to the group and c) that their professional and/or personal values are in harmony with those of the group." (Levett-Jones and Lathlean, 2009a, p.2872).

The study found that while students generally feared that the challenging of adverse cultural norms might result in reprisals from staff, those who felt accepted in practice and secure within the team were more likely to critically challenge poor cultural practice (Levett-Jones and Lathlean, 2009b). However, the study also recognised that students who did not feel included in practice were more likely to conform to practices they disagreed with, since they did not feel confident to challenge these practices with the team. Students also appeared to become adept at adopting the cultural norms between placements. This fits with the notion that identity is largely formed by others' perceptions of the individual, and the individual's behavioural modification as a result of feedback or reactions to them (Fulcher and Scott, 2011). This also links to the notion of role distance set out by Goffman (1959) when recognising the divide between role and self.

By contrast, students in this doctoral research did not appear to be as influenced by the need to conform, possibly because much of their practice time is spent in their employed organisation where acculturation will already have occurred. Students were also able to give examples of challenging poor practice, for example Jordan provided evidence of this following an incident during her night shifts. These participants were assessed at interview for their assertiveness – since they need to be able to protect their student supernumerary status when in practice. Perhaps it is these assertiveness skills, alongside existing healthcare experience and life skills, which better prepare these students to critically challenge as opposed to conforming. Alternatively, it could be that these HCA students have greater self-esteem and lower anxiety than traditional students which Bradby (1990a) found to be beneficial in navigating *status passage*.

Levett-Jones et al (2007; 2008) identified the need for nursing students to have a sense of belongingness in practice in order to maximise learning and develop professional socialisation. Their study recognised several themes which students perceived to facilitate either their belongingness or alienation from the practice team (Table 6.3).

Table 6.3: Themes facilitating belongingness (adapted from Levett-Jones et al, 2008)

Themes facilitating inclusion	Themes facilitating exclusion	Overarching theme
Made to feel welcome	Lack of acknowledgement	Receptiveness of nursing staff
Involved and included	Exclusion from patient care	Inclusion/Exclusion
Informal socialisation	Social exclusion	
A valid and valued role	Just a nuisance	Legitimisation of the student role
Trusted and valued	In the way	Recognition and appreciation
Pushing the boundaries	Expecting too much	Challenge and support
Being held back	Undermining confidence	

In summary, it is apparent that fostering a sense of belongingness in students is beneficial in a number of ways, not least since this appears to be a critical factor in developing a sense of self or identity. The study participants demonstrated a sense of belongingness in their employed areas, but this was not always apparent in alternative placement areas.

Acquisition of knowledge – Whilst knowledge acquisition is key to developing competent practitioners, Brown, Stevens and Kermode (2012) recognise the additional importance of critical challenge and the ability to link theory to practice in developing professional

socialisation. Levett-Jones et al (2008) found that students' sense of belonging also impacted on their ability to acquire knowledge with four themes relating to this:

- *motivation to learn* – students who felt alienated from the team focused on trying to gain acceptance at the expense of their learning. Conversely, students who felt included were able to maximise learning opportunities.
- *self-directed learning* was more likely when students felt they belonged. Self-directed learning helped develop independent learning skills beyond knowledge acquisition which was valued by both academia and practice.
- *anxiety* – learning was reduced when students found placements stressful.
- *confidence to ask questions* – students who felt welcome were more comfortable raising questions and engaging in meaningful communication while alienated students were more reticent, feared making mistakes or gaining unfavourable responses from the team.

Participants in this doctoral research were clearly very motivated to learn, all demonstrating the difficulties in working full-time in dual roles whilst simultaneously undertaking self-directed learning in their own time. Their motivation came from an intrinsic desire to be a qualified nurse, which they were able to articulate passionately, and their long-held belief that they would not be able to achieve this due to financial or academic constraints. Through both mentor and student perspectives it appears that these students acquired knowledge necessary to demonstrate a high level of independent thinking. Their own perceptions, supported by those of the mentor participants, are that they are self-directed learners, both academically and in practice, with a lower reliance on mentors and less anxiety than traditional students. One student expressed a belief that they were more comfortable having

their initial placement in their employed area as they were less afraid of being judged for making mistakes. This suggests they too might be more anxious about making minor errors or asking questions in less familiar clinical placement environments.

Acquisition of skills – Grealish and Trevitt (2005), in an Australian focus group study of six student nurses which was part of a larger study, found that workplace learning was less controllable than learning in academic settings. This entailed addressing dynamic and evolving clinical situations, those which cannot be planned or prepared for. Learning to cope with, and adapt to, these dynamic situations is therefore important in developing professional identity. Grealish and Trevitt (2005) further recognised that development of communication, problem-solving and teamwork skills, developed through these dynamic situations, were necessary for professional development and not just clinical skills. Dolan (2003) argues that one of the barriers to developing the skills to address these dynamic clinical situations is that students often tend to focus on getting clinical competencies signed-off, promoting the learning of task focused care, rather than exploring broader opportunities for holistic development.

In this study, one of the mentors interviewed (Kim) specifically addressed the issue of traditional students being focused on signing-off competencies and valued students on the programme under study for being more holistic. Overall, participants believed this programme focused less on individual skills acquisition and more on holistic care development. That is not to say skills are not acquired, but they are, according to student and mentor perceptions, acquired in a more meaningful way. Students already bring a high level of skill with them to the programme, particularly those working at Assistant Practitioner level.

Acquisition of professional values – The introduction of the *NHS Constitution* (DOH, 2012a), set professional values which every NHS health care worker is expected to adopt. Education providers are benchmarked for quality in recruitment and curriculum content against these values, with placement providers needing to demonstrate recruitment and appraisal of staff to them. As a result, student nurses should be very familiar with the values and associated behaviours expected of them. However, where there is a dissonance between the values or behaviours demonstrated by the team and those of the student, this can lead to alienation from the team. Levett-Jones et al (2007) found that occasionally students deliberately chose to withdraw from the team rather than collude with staff to perpetuate the delivery of poor care. This then often led to their alienation. Whilst this was not an ideal situation and potentially impacted on the students' learning, it was no doubt part of a coping mechanism the students developed to survive a negative placement experience.

Through the interviews, the participants in this study demonstrated a wide range of appropriate values and beliefs. The assimilation of organisational cultural norms and the impact this can have on individual values and behaviours is explored below. The acquisition of professional values is also important to support the development of a professional identity which will be further explored in 6.5.

Assimilation of the organisation – In order to become assimilated into the organisation, the student needs to be accepted and adopted into the organisational community of practice. This is aligned to the notion of divestiture and tends to be acquired at the loss of personal identity (Bradby, 1990a). Whilst the introduction of Project 2000 in the early 1990s was heralded by many as a breakthrough in the provision of protected clinical learning, away from the pressures of service need, it has been argued that this form of university-based training

isolated students from the clinical learning environment (Levett-Jones et al, 2007; 2009). Although university-based training has progressed to a programme which better integrates theory and practice, it is believed that historically, hospital-based training placed learning needs secondary to patient care needs (Melia, 1984; 1987; Holland, 1999). By contrast, nursing students who are university based are more likely to have recognition of their learning needs as their primary consideration. This has been perceived to have led to a barrier in the development of professional identity in nursing students (Levett-Jones et al, 2007; 2009; Brennan and Timmins, 2012).

While it was clear from the literature that students value workplace learning to help them fit into the practice setting, Grealish and Trevitt (2005) argue that this could be to the detriment of learning best practice. This could result in students colluding with other staff in the delivery of poor practice in order to fit in (Brennan and Timmins, 2012). Many students in the Levett-Jones et al (2007; 2008) and Levett-Jones and Lathlean (2009a) study felt being perceived as a worker, rather than a student, was conducive to gaining acceptance in practice, even when this was at the expense of their supernumerary status. This mirrors findings from Elcock, Curtis and Sharples (2007) who found students chose to act as a pair of hands, in favour of a quality learning experience, in order to gain acceptance. This was also a key finding in the literature review. For many, the need for belongingness also came at the expense of providing quality patient care (Levett-Jones and Lathlean, 2009a).

This study's findings were contrary to this, in that students were relatively comfortable within their own organisations and fields of practice. Where they were more challenged, which they welcomed, was outside their field and scope of practice. There were no obvious examples, however, of collusion with poor practice in order to gain acceptance. If anything,

students chose to withdraw from the team and become alienated (as described previously) rather than perpetuate poor practice or compromise their own standards. One example of this was the student (Jordan) who recognised their withdrawal from their long-term HCA colleagues because of the inappropriate judgemental attitudes they had. This left the student feeling alienated from the group, although they had sufficient insight to recognise this was probably part of their transition, or professional socialisation, process.

Role model attributes – Role modelling is believed to provide the *what* and *how* of nursing rather than the more academic *why* (Davies, 1993). Taylor, Westcott and Bartlett (2001) suggest that students develop professional identity and self-esteem through interaction with role models and assessing the reactions these role models have to their role performance. This is in line with the socialisation theories set out in Section 6.1. Davies (1993) found students particularly valued role models who demonstrated caring and compassionate attitudes and saw holistic care as desirable. Whilst role modelling is important, students have different learning styles and consequently differing support needs. Brown, Stevens and Kermode (2013) found nursing students from more diverse backgrounds (including mature students) to be more self-sufficient in developing professional socialisation, building professional credibility and addressing challenges of practice. In addition, Fleming and McKee (2005) found that the life experiences mature students brought with them to the programme helped reduce the reality shock of adapting to new situations in practice.

This mirrors the findings of this study, with students therefore potentially being advantaged by their maturity. The student participants all had existing healthcare experience, so any reality shock may have been reduced. However, they did demonstrate some level of shock regarding the perceived high level and complexity of patient care other HCA/students in

their cohort were delivering. This suggests their expectations are derived from the exposure they have had as HCAs and that perceived realities of practice were restricted to their own previous experiences.

Students clearly valued the role of their mentors and actively sought out those who they felt could most benefit their learning, as demonstrated by Kris (student), rather than always seeking out their named mentor. Student participants reported acting as role models to other students and usually took the lead when working with them. Students also benefited from the ability to return to their employed base on HCA days where they had on-going access to their employed RN/mentor. Sam recognised how beneficial this was in dealing with mentor/student issues in the external placement and valued the support received from the home mentor and wider team.

In summary, it is unclear whether the apparent self-sufficiency of these non-traditional students stems from the learning philosophy of the programme, their pre-existing HCA experience or the diverse group demographics (eg mature students, pre-existing life experiences). However, the findings demonstrate a link to the wider literature in relation to the importance and value placed on good role models.

Brown, Stevens and Kermode's (2012) seven domains of professional socialisation development have provided a useful framework against which to explore the study findings and wider literature. Whilst there were some similarities between these domains and the six sequential stages described by Davis (1975), there is no suggestion that the seven domains occur in a linear or sequential order or that students experience all these domains. In relation to this study, many of the domains provide clear alignment to the experiences of the students.

In particular, developing a professional role concept was challenging as was the acquisition of knowledge. It would appear that some of the domains they had achieved or progressed whilst undergoing their professional socialisation as an HCA. One example of this is the acculturation, which has clearly occurred within their employed area. Furthermore, acculturation is more of a challenge in other placement areas, particularly within different fields of nursing.

Overall, the study findings and underpinning literature support the domains, making this is a credible framework for developing professional socialisation in nursing students. The chapter now goes on to consider the potential negative consequences of professional socialisation, how professional identity develops, the impact of working part-time as HCAs on the socialisation of nursing students and the role of the mentor in supporting both professional socialisation and development of a professional identity.

6.4 Potential negative consequences of professional socialisation

The potential for negative consequences of professional socialisation were identified by Mackintosh (2006) in a longitudinal, qualitative study of sixteen pre-registration nursing students from their fourth week in practice. Findings included:

- a lack of critical awareness of professional practice;
- the continuance of ritualised practice and traditional views;
- the importance of assumed set of professional nursing characteristics and loss of idealism, including caring.

Given that professional socialisation requires the modification of unrealistic pre-nursing idealistic mind sets (Shinyashiki et al, 2006), then assuming a more realistic set of nursing characteristics at the expense of such idealism is not necessarily a negative aspect. More importantly, based on Mackintosh's (2006) findings, there is a danger that participants in this study could be perpetuating ritualised practice, as their perceptions of their experiences and practice may differ from those of their placement team. However, the additional data from mentors does not highlight any concerns in that regard and recognises the professionalism and critical thinking applied by the students in the study.

Whilst the progression from an idealistic stance to a more realistic view of nursing is necessary, reports in the literature about the loss of care ideals is of concern. This loss was a key factor in the Mid-Staffordshire NHS Foundation Trust Public Inquiry (chaired by Robert Francis QC) (2013) and the driver behind the introduction of the 6Cs (DOH, 2012b). Ohlen and Segesten (1998) argue that within professionalism, caring is either embraced by it (Ohlen and Segesten, 1993) or excluded and obstructed from it (Gardner, 1992). There are a number of studies that recognise the contribution that the humanisation of patients has to the delivery of care, recognising that seeing patients as individuals is more likely to lead to greater compassion and respect for dignity (Heijkenskjold, Ekstedt and Lindwall, 2010; Lindwall et al, 2012; Fawcett, 2013), than objectifying them and seeing them as a diagnosis or failing to treat them as adults.

Mackintosh (2006) found that the caring aspects of professional socialisation diminished over time, with students 6-9 months from completion less likely to use the word *care*, providing negative examples of care and demonstrating growing cynicism of patients and

personal disillusionment about care, compared with 6-9 months from the start of their training. This de-caring aspect of professional socialisation is thought to result from:

- pre-nursing ideals being unrealistic (Davies, 1993);
- exposure to poor role modelling leading to a de-valuing of personal care (Davies, 1993; Stevens and Crouch, 1995);
- adoption of a coping mechanism against the emotional demands of the student and carer role (Bradby, 1990a; 1990b).

Thus, professional socialisation can also result in a shift from patient-centred, humanistic care to role proficiency at the expense of pre-entry care ideals (Mackintosh, 2006).

Melia (1984; 1987) undertook a study into the socialisation of hospital trained nurses and found three key themes: the need to get the work done, the need to fit in and the need to learn the rules. Despite the introduction of supernumerary status and the move away from a service-needs to a learning-needs based practice approach in the early 1990s, the literature explored in this chapter suggests Melia's findings still resonate, particularly with the traditional nursing students' experience. Findings in this study of non-traditional students differ from this in that:

- whilst the students recognised the need to get the work done, it was driven more from a desire to put patients first and support other staff than a desire to fit in.
- students felt a need to fit in but were not prepared to have their professional values compromised in order to do so. They would still escalate concerns about poor practice rather than adopt adverse behaviours.

- students appeared to understand the rules and, in some cases, emphasised the need for traditional students to follow those rules. This included, for example, fitting in with team routines which were tried and tested.

Thus, it appeared that the students interviewed in this study had not begun the professional socialisation process at the expense of caring for their patients, colleagues and other students. The following section looks at the development of professional identity and how the socialisation process supports this.

6.5 Developing professional identity and the function of uniform

In order for successful professional socialisation to occur, it is essential that nursing communities share:

> "…a unified professional identity where members of the profession (junior to senior) share common perspectives and values" (Brown, Stevens and Kermode, 2012, p.609).

These common perspectives and values are recognised as a key concept of professional socialisation with Ousey (2009) identifying the need for the student to give up cultural views from society and media and adopt those of their profession.

Higginson (2006) undertook a Grounded Theory study of the first-year training experiences of five nursing students in the UK. He found that participants were concerned that patients and staff would have unrealistic expectations of them as students and identified that they did not feel like students straight away. This demonstrates that they have insight into their existing identity and recognise that they have not become a student overnight. This mirrors

the findings in this study where students were at different places in relation to identity. One student in particular clearly articulated that they felt like an HCA in the first year but more like a student in their second year. It is therefore key that they are exposed to good cultural role models so that an appropriate culture develops. Rassin (2010) recognises the reality and rhetoric of adopting appropriate values and asserts that it is only through the practical experience necessary for professional socialisation that this can be achieved.

The close links between identity and artefacts such as uniform and name badges have previously been identified in the literature review (Chapter Two) and interview findings (Chapter Five). The work of Goffman (1959) suggests that appearance is one of the key factors society uses to form an individual's social identity. Thus, it is an important function of uniform to help forge this link and this section focuses on the role of uniform in supporting identity. Whilst it was challenging to find literature relevant to the role of uniform in conferring or supporting role identity in nurses, there were papers providing some historical context and wider discussion. Colville (2003), in his paper regarding the role of naval uniform in shaping identity, recognised that not only did it help confer class and gender, but the officer's uniform also conveyed:

> "key upper middle class qualities of leadership ability, self-discipline and restraint" (p. 110).

Naval personnel became part of an elite club, with sailors forgiven misdemeanours carried out in uniform that would have been punishable for civilians and naval officers having access to areas beyond that which may have been open to them by socio-economic birth alone (Colville, 2003). As a result, the wearing of uniform provided a unique identity for the individual.

From the particular perspective of nursing uniforms, there had been a similar historical gender/class element to uniforms, with uniforms used to convey the public expectations of what a nurse should look like (Hallam, 2000). Despite the popularity, comfort and freedom of movement offered by trousers for women since the 1950's and 60's, it wasn't until the 1990's that trousers and tunics for nurses became popular. Even the titles bestowed on nurses (Sister, Matron) conveyed the identity of a female steeped in religious or motherly attributes. Since the 1940s and 50s. nursing has been plagued with the social identity dichotomy of *angel* versus *sexy nurse*, with the more recent modernisation of nursing uniforms intended to break away from this image (Hallam, 2000).

In her study, Hallam (2000) found that for the novice nurse, uniform portrayed an image of authority and status which gave them the confidence to approach the patient, a relative stranger, to carry out nursing care. It provided a protective function, both actual and metaphorical, and was an integral part of their identity. Patients related uniform to the nurse, regardless of colour or style of uniform, with no distinction of status. This mirrors the view of some study participants, in that most patients did not care who was looking after them as long as somebody was. Conversely, organisations used uniform as a professional divide, using it to classify status within the nursing hierarchy (Hallam, 2000). Newly qualified nurses in a more recent study were surprised how much people's attitudes to them changed once they acquired their new RN uniform (Draper, 2018).

Sparrow (1991) undertook a two-month pilot on an acute medical ward where staff wore their own clothes in place of uniform. It was perceived by patients that they had more confidence in nurses who wore uniform, and nurses who preferred uniform believed that this increased confidence not only for the patient but also for the nurse themselves. The uniform

was also seen as a *passport* allowing automatic access to areas without further need for identification. It also gave nurses the right to approach patients and deliver the appropriate care, although this was perceived by some to reduce the patient to a work object – someone to be done to rather than done with (Sparrow, 1991). Bradby (1990a) found that while some nurses perceived uniform as a reward, others found it affected their sense of personal identity. From a care perspective, patients were less likely to call on a non-uniformed nurse to help them and were more likely to attempt independence, as opposed to a uniformed nurse (Bradby, 1990a; 1990b). Hence the wearing of uniform may be linked with conferring the identity of the nurse as a carer or healer.

This perceived confidence and sense of pride can be recognised from study participants such as Jo, who clearly articulated the pride taken in presenting themselves as a student with all the accompanying accoutrements to the role. Ohlen and Segesten (1998) believe that such professional pride is a pre-requisite for developing professional self-image. This also links to Bradby's (1990a) assertions that the student uniform is seen as a reward. The ability of the uniform to reinforce the student role was identified by Jordan who used it to *'refocus'* and *'pull back'* the boundaries of the student nurse role. In addition, both students and mentors recognised the significance of the student nurse uniform in relation to changing the perceptions and expectations of other staff.

Having explored a number of factors which support or impede the professional socialisation process leading to development of professional identity, the chapter now goes on to consider the impact of working part-time as an HCA whilst also being a student nurse on the programme. This will help inform barriers and enablers which might need to be addressed within the next phase of the study.

6.6 The impact of working part-time as HCAs

Whilst the literature relating to professional socialisation for nursing students is useful, on the whole it fails to account for the additional impact that the study sample has in continuing to work as an HCA. The RCN (2008) estimated that 83% of nursing students also worked as HCAs alongside their training programme. Following the publication of findings from the *Raising the Bar: Shape of Caring Review*, chaired by Lord Willis, (HEE, 2015) on nurse training and local recommendations for work-based learning nurse training programmes for existing HCAs (HEE, 2014), programmes similar to those in this study, are likely to increase. A study by Hasson, McKenna and Keeney (2013b) of 45 nursing students, 27 of whom had HCA experience either prior to or during their programme, found two themes and five sub-themes that influenced their socialisation. These are explored below with critical comparison against findings from this study and wider related literature.

6.6.1 Benefits

Confidence and experience: Hasson, McKenna and Keeney (2013b) found students were less anxious about their clinical placements due to familiarity with practice settings than those without experience who feared the unknown. In this study this was the case where students were placed within their employed organisation. When they went to placements outside their employing organisation, or to a different field of nursing, students became more anxious. Hasson, McKenna and Keeney (2013b) also identified that students were more familiar with routines and so did not need to wait to be told what to do. This was something several students identified through the MMR qualitative interviews. They perceived traditional students as needing to be led by their mentor whereas they *'got stuck in'*. Students in Hasson, McKenna and Keeney's (2013b) study were more confident, particularly in dealing with other members of the healthcare team. Evidence suggests that while roles in

retail and hospitality strengthened skills in time management, dealing with conflict and communication skills, student nurses employed as HCAs during their training had better decision making, skills proficiency and team working than those who did not (Phillips et al, 2012). Therefore, whilst working part-time in other roles such as retail and hospitality proved beneficial to development of transferable skills, student nurses working in healthcare settings believed this best supported their transition to RN practice (Phillips et al, 2012). In this study students felt more confident because they were familiar with organisational policies and procedures. They also appeared relatively confident dealing with other team members, although this was also dependent on the seniority and attitude of staff involved.

Prepared for the realities of nursing practice: Evidence from Australian studies suggests being employed as an HCA during student nurse training better prepares students for the realities of practice on qualification (Kenny et al, 2012; Phillips et al, 2012). Hasson, McKenna and Keeney (2013b) found students demonstrated they were aware of the realities of practice (such as coping with staff shortages) and that they understood both the HCA and student roles. They perceived direct patient care to often be the responsibility of HCAs rather than the nurse. These aspects created a reality shock for students without HCA experience who had not anticipated this (Hasson, McKenna and Keeney, 2013b). In this MMR study there was no obvious common understanding of role differences between HCA and student. Most were clear about working within their competence, but it was apparent that role boundaries were blurred. There was some reality shock for community-based HCAs being placed in a hospital (and vice versa) but this was perceived as a welcome challenge, albeit a bit '*scary'*.

6.6.2 Challenges

Treatment on wards: Hasson, McKenna and Keeney (2013b, p876) found that HCAs who were also students were treated as 'knowledgeable HCAs' by RNs rather than as learners; where areas knew they were an HCA they tended to provide less supervision and support. In addition, it was found that time spent undertaking essential care (HCA role) could cause them to miss out on other learning opportunities. Again, this mirrors these study findings where students were perceived as '*HCAs doing extra'* as opposed to being student nurses. While none of the participants explicitly stated that supervision or support was reduced because of their HCA status, the necessity to negotiate time with mentors in return for undertaking an HCA type role probably supports this. Students were clear, however, that they ensured that they still met their learning outcomes and did not allow themselves to miss out. However, there were occasions when students were *'forgotten'* by mentors and wider teams.

Questioning the value of the placement: Some students were unable to see the benefit of low acuity placements as they already perceived themselves to be independent in the basic nursing care implemented there and could not identify additional learning opportunities (Hasson, McKenna and Keeney, 2013b). In this doctoral study students demonstrated good insight into their ability to provide basic nursing care, but that to be independent as a student nurse they needed to develop the underpinning knowledge and more holistic care skills. They valued their alternate placements as an opportunity to extend their scope of practice beyond their familiar employed areas, regardless of the acuity of the placement. Hence their focus appeared to be on breadth of practice rather than acuity of care.

Role confusion: Hasson, McKenna and Keeney (2013b, p877) identified that some students often found it difficult to internalise the student role due to their existing HCA mind set. As a consequence, they found themselves returning to the familiar HCA role which acted as a 'safety net'. Some even voiced concern about being pulled from the HCA role. This was not a finding from the qualitative interviews in this study. While lack of role boundaries proved frustrating for second and third-year nurses, roles became more defined in the third year when a more managerially focused role developed (Hasson, McKenna and Keeney, 2013b). Participants in this doctoral study, where students reverted to an HCA type role, clearly identified that this was as a result of service pressures and undertaken to support high quality patient care. Students did not relinquish learning as a result, but rather renegotiated student hours to compensate. Lack of role clarity was frustrating for all students to some extent, but it was too soon in the programme to tell whether greater clarity will emerge over time.

While it was perceived that the experience of being an HCA was beneficial to the transition to registered nurse, the dual roles of HCA and student nurse were found to cause confusion amongst other staff and were perceived as a barrier to adopting a professional identity due to the prevailing HCA mind set (Hasson, McKenna and Keeney, 2013b). As with the original literature review, reported in Chapter Two, Hasson, McKenna and Keeney (2013b) also recognised that students struggled to exit the HCA role and at times consciously chose to revert back into that role when on student placements. This is not something that was apparent through this study where students were making conscious efforts to leave the HCA role to transition to a student nurse identity.

The following section will identify how the mentor role is instrumental to supporting the development of professional identity.

6.7 Professional socialisation, professional identity and the mentor role

Throughout this chapter the importance of professional socialisation in the transition of HCAs to student nurses has been clear. In Davis' (1975) six sequential stages of doctrinal conversion in the process of professional socialisation, the fifth and sixth stages are *provisional internalisation* and *stable internalisation*. The former recognises the student's commitment to being a nurse and criticism of poor practice by others, the latter acknowledges development of an assured stance of nursing performance.

Goldenberg and Isawsiw (1993) recognise that such internalisation of professionalism can only be gained through interaction with experienced professionals. Similarly, socialisation into nursing has been found to be strengthened by mentor/preceptor support (Carlson, Pilhammer and Wann-Hansson, 2010). In the literature review (Chapter Two) this support role was identified through provision of an 'old-timer' as a sponsor to support the student to gain acceptance into the community of practice (Spouse, 2000, p737). It is also evident that the presence or absence of an appropriate mentor and wider team support is crucial to a successful transition process. Hood (2010) recognises that for professional identity to be developed, the student nurse needs to be comfortable and competent in experimenting with the nursing role and be able to communicate to others a commitment to the ideology of the profession.

Support from RNs/Mentors is seen as crucial to developing a sense of belongingness in gaining professional identity for student nurses (Levett-Jones et al, 2008). Where this was not the case in this study, students felt let down by the mentor. Some students felt they were '*forgotten'* at times by the team, which they found difficult to address, particularly when it was their employed team involved. In addition, students and mentors in this study recognised the difficulty, from a practice perspective, in understanding the programme, levels of achievement (practice assessment) and role boundaries. Davies (1993) similarly found a lack of objective understanding amongst students, mentors and clinical teachers about the assessment process and amount of evidence needed to support this. She recommended improved preparation for all involved in the assessment process as a result. This is reflected in comments from mentors in the qualitative interviews of this MMR study, who have also taken actions themselves to better support external mentors.

In Chapter Two, various aspects of mentorship were critically discussed, recognising that traditional methods of nurse mentorship might not adequately equip mentors with the necessary skills to support work-based learning. Wareing (2008; 2011) found that WBL students' relationship with their mentors, due to the situatedness of the work-based learner in the clinical team, lends itself to a less hierarchical and more partnership approach to learner:mentor relationships. This supports a more coaching style of mentorship, congruent with the reflections of Kim (mentor), regarding the development and application of the students critical thinking and clinical reasoning, and general participant perceptions about students taking ownership of their learning. Participants in the study also recognised the more informed capability of the mentor in assessing the student. This arose from the mentor's support for the student through the duration of the programme, rather than just for one placement, and how well they come to know the student and their abilities. Wareing

(2011 p.550) identifies the importance of these 'knowledge signifiers' in relation to the learner:mentor relationship. This endorses the findings of Swallow (2007) in relation to the benefits of students having an existing familiarity with their mentors, and these study findings in relation to participants' supportive home placement mentors.

The role duality difficulties for the participants in this study in protecting their student status, particularly in their employed areas (explored in Chapter Five), is a critical barrier to students' professional socialisation. With their HCA and student roles lacking defined role boundaries, co-workers' and mentors' lack of understanding of the programme and students having to constantly reinforce their role, transition to a new student nurse identity is likely to remain problematic. The role of practice mentors in supporting these aspects of professional socialisation is of paramount importance.

The final section of this chapter further highlights this and sets out a framework, conceptualising how the professional socialisation for these non-traditional students differs from traditional students, and how better support from practice mentors might alleviate these barriers. This has been derived from the findings of the qualitative interviews (Chapter Five) underpinned by the wider theory set out in this chapter.

6.8 Conceptual framework

A conceptual framework provides intellectual scaffolding which underpins the research process. It provides a tool for researchers to help structure their concepts and ideas, supporting the researcher in contextualising data within those concepts (Leshem and Trafford, 2007). The conceptual framework allows the researcher to review the key variables, identifying which are the most important and relevant themes and necessitating

the rejection of those thought to be less meaningful (Miles and Huberman, 1994). It is developmental in nature, with the need for modification through the research process as increasing amounts of new data become available and new concepts or theories emerge. As such, it is useful in drawing together the concepts derived from Chapters Five and Six into one overarching framework to support our understanding of the transition of these HCA/students to the student nurse role.

Miles and Huberman (1994, p.22) offer key tips for development of conceptual frameworks which have been applied in this research as follows:

- The framework has been 'depicted diagrammatically' to allow all phenomena, relationships and variables to be viewed and explored in a single page.
- There will be a need to undertake 'several iterations' – it is unlikely it will be right first time and conceptualisation skills are likely to improve with experience. The conceptual framework was developmental in that it evolved through the exploratory, qualitative interviews. Early concepts were rejected, built on or added to, depending upon the qualitative interview findings and related theory.
- While a 'no-risk framework' (one which is very broad and has no focusing or bounding decisions within it) has not been developed formally, this probably was the starting point for the literature review to avoid any preconceptions. The literature review allowed informal refinement whilst the qualitative interviews and subsequent wider critical analysis have identified key phenomena, relationships and variables to be legitimately conceptualised within it.
- 'Prior theorising and empirical research' have been used to shape the framework through the literature review and qualitative interviews.

The findings of the exploratory, qualitative phase of MMR (Chapter Five) combined with the discussion in this chapter have led to the development of this conceptual framework, which draws on aspects of the nursing transition model of Holland (1999).

In summary, this chapter proposes that a process of professional socialisation needs to take place which supports internalisation of the following (Brown, Stevens and Kermode, 2012);

- professional role concept;
- acculturation;
- acquisition of knowledge;
- acquisition of skills;
- acquisition of professional values;
- assimilation of the organisation;
- role model attributes.

For socialisation to successfully occur in practice, consistent mentor support is needed which ensures exposure to high standards of care, development of a sense of belongingness, support to critically challenge and supported student status. There are, however, numerous factors which particularly relate to nursing students who also work as HCAs. The study findings recognise the challenges for these HCA/student participants, including recognition and valuing of student status and lack of clearly defined role boundaries. Additionally, the wider literature identifies different challenges for non-HCA (more traditional) students such as lack of confidence and experience. This results in, for example, anxiety around placements, lack of familiarity with routines and an idealistic view of nursing, leaving traditional students less prepared for the reality of practice.

Drawing on this information, and the additional findings from Chapter Five, the conceptual framework proposes a transitional process for professional socialisation in nursing students. Within this framework, two models are contrasted; one for traditional students and one for work-based learning students who experience role duality as HCAs and students. The conceptual frameworks (Figures 6.3 and 6.4) build on the first two stages of student nurse transition suggested by Holland (1999). This evolved framework allows for recognition of the personal identity that both types of student brings with them at programme entry, in addition to the stages of 'becoming a student' and 'being a student'.

I have not included the final stage of 'becoming a qualified nurse' (Holland, 1999), as in this study students had not reached this stage of their programme. The conceptual frameworks also include a set of enablers and barriers, identified in the data and wider literature. Figure 6.3 illustrates how traditional students may be hampered by the preconceptions they may bring with them to the programme. There are a number of domains and wider attributes the traditional students need to complete from entry to 'become' student nurses. These are often denoted by the preparation phase of the *status passage* identified in 6.3. By contrast, the HCAs (Figure 6.4) have already demonstrated several of the domains and wider attributes at the point of entry, including preparation for *status passage*. Hence, they acquire most of the other attributes and domains during the process of 'becoming a student'.

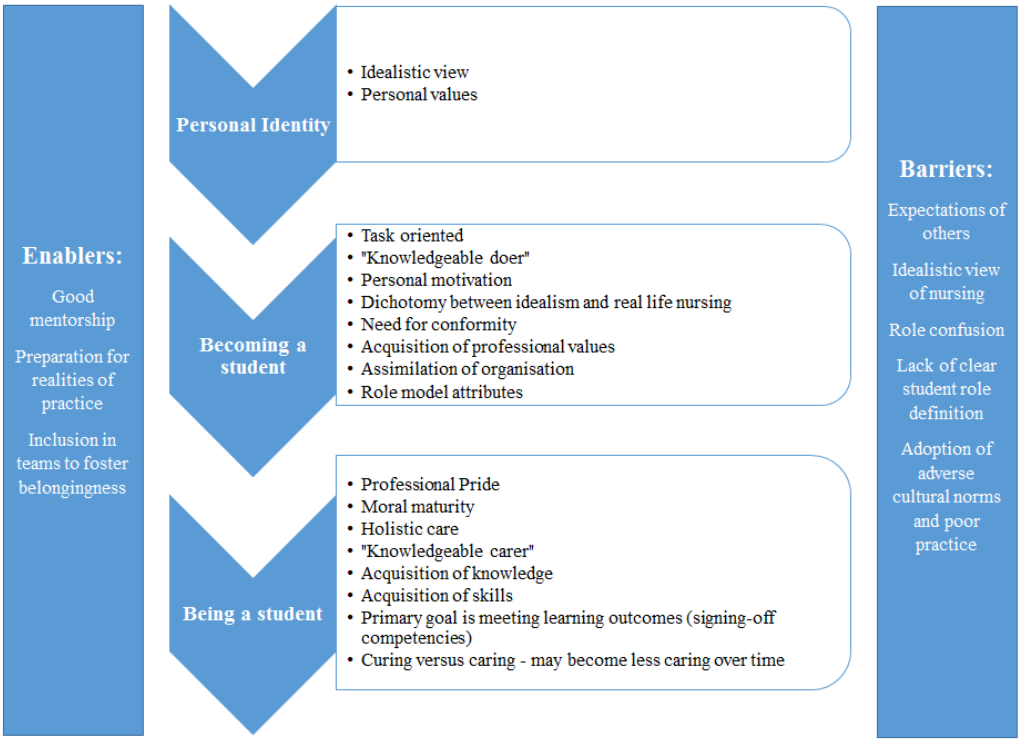

Figure 6.3: Professional socialisation - traditional entry candidates' transition to 'be' a student nurse (drawing on Holland, 1999)

Whilst traditional students still have several outstanding domains and wider attributes to acquire in order to progress from 'becoming' to 'being' a student (Figure 6.3), it is suggested that the non-traditional HCA/students have only two outstanding domains. They have yet to achieve a defined professional role concept and acquisition of knowledge plus the overall goal of being a 'knowledgeable carer' in order to 'be' a student nurse (Figure 6.4).

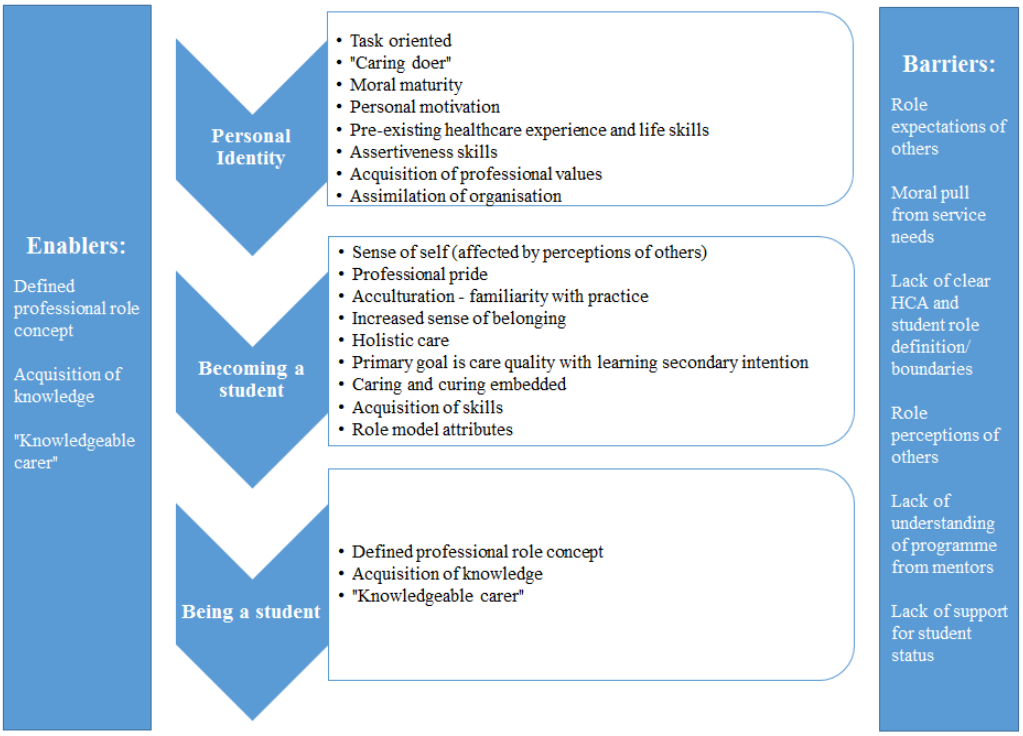

Figure 6.4: Professional socialisation - existing HCAs' transition to 'be' a student nurse (drawing on Holland, 1999)

The traditional students may demonstrate a lack of awareness of the realities of nursing at the outset and often bring idealistic expectations of nursing with them. By contrast the HCA/students, supported by study findings and wider literature, seem to have a clearer understanding of the realities of practice. They will have successfully adopted many of the skills, attitudes and behaviours as part of their social identity that traditional students do not achieve until they 'become' nursing students.

In 'being a student', the study participants demonstrated a need to be able to clearly define and articulate the role differences, between being an HCA and being a student, and to acquire the underpinning knowledge necessary to 'be' a nursing student. This appeared to be the final barrier to being a 'knowledgeable carer' and was beginning to be demonstrated

by a couple of the students interviewed. It is apparent that the second year of the programme is crucial to this transition process due to the student participants' mixed responses and perceptions in relation to their roles, and perceived differences between first and second year. It was equally clear that the impact that barriers and enablers had was sufficient to impede or support that transition.

6.9 Conclusions and recommendations

The conceptual framework recognises the very different starting points for HCAs undertaking this pre-registration nurse education route in comparison with traditional students. Consequently, the HCAs have potentially fewer barriers to professional socialisation than traditional students, particularly at the start of the socialisation process, due to their previous healthcare experience and organisational familiarity. The study participants appeared to have adapted well in many aspects of the programme and for them the main barriers between those who perceived themselves as students and those who did not appear to be:

- The role confusion resulting from others' perceptions and expectations of them due to lack of defined roles. This was compounded by students undertaking placements in their employed HCA areas.
- The acquisition of knowledge necessary to becoming a 'knowledgeable carer', one of the final barriers to being a student. Students perceived themselves to be developing the knowledge base previously missing and were demonstrating an increased awareness of the implications of their care and impact it had on others. Transition into a 'knowledgeable carer' was therefore well on the way to being

developed, but again was compounded by the impact of how others perceived the student, particularly when they were placed as students in employed areas, and consequently their ability to be a student.

The conceptual framework suggests that reducing the barriers to socialisation and ensuring that the enablers are in place would better support the professional socialisation of these students. Therefore, the following recommendations were developed and then fed back to the GYOOG. This discussion contributed to the validation of the recommendations for further action and supported the research design for the subsequent auxiliary quantitative phase of research – the intervention and pilot evaluation.

Recommendations:

1. All students wherever possible should be encouraged to wear uniform (either formal or informal) as this was perceived to act as a visual reinforcement of the student identity.

2. Similarly, all students wherever possible should wear name badges which clearly identify the student's name, university and start/finish dates. This will help others identify the student's stage of training and was requested by one participant who felt it would help manage expectations of others. Currently, students wear their existing employer name badge which causes confusion, particularly when placed in other NHS organisations.

3. All students, wherever possible, should be allocated to placements outside of their area of HCA employment because this could help to reduce role ambiguities. This physical crossing the threshold has been identified as a key part of *status passage* (Bradby, 1990a). This may mean swapping students within the employed organisation so that they have separate employed area and home placement area.

4. A more detailed information booklet should be developed to better support mentors and students in understanding; a) the professional socialisation needs of these students, b) the need for supernumerary status on student days and c) how to support students to become 'knowledgeable carers' and not just *caring doers*.

The recommendation to develop a booklet to better inform mentors and wider practice teams about the programme was explored through the annual GYOOG event, which included students and mentors. Attendees felt that this warranted implementation as the focus for the quantitative phase of this exploratory sequential MMR.

Whilst some universities have guidance in place for students working as HCAs (Hasson, McKenna and Keeney, 2013b), it appears that clearer guidance is needed for students working in dual HCA/student roles. This will help protect role boundaries and promote professional socialisation, thus leading to a strong professional identity for the student. This guidance should be available to students, mentors and clinical teachers to ensure a shared understanding is achieved.

The following chapter (Chapter Seven) describes the auxiliary quantitative phases of the exploratory sequential MMR, which has been driven by the findings from Phase One. Phase Two focuses on the design and implementation of the booklet and Phase Three the pilot evaluation to determine its efficacy in practice.

CHAPTER SEVEN

The Booklet: Implementation and Pilot Evaluation

The previous chapters explored the role duality experiences of study participants culminating in the development of a conceptual framework. One of the recommendations arising from Phase One of this MMR study was the introduction of a booklet offering guidance to mentors and wider support staff to better support the students in practice. It was thought this would facilitate their professional socialisation and transition to the student nurse identity.

The introduction of this booklet *Top Tips for Supporting Work-based Learning Nursing Students* (Appendix N), required a change management initiative to support the change and reduce impediments to its successful implementation. Drawing on change management and leadership theory, this chapter sets out the process of planning and implementing the booklet (Phase Two) and goes on to explore the research design, application of methods and research findings for the pilot evaluation (Phase Three).

The following sections focus on the design and implementation of the booklet, including the force-field analysis for the change and consequent change leadership approach.

7.1 Design and development of the booklet

The content for the booklet (Appendix N) was driven directly by the qualitative research findings and thereby introduces a point of interface for this exploratory sequential MMR through this iterative approach (see 3.8). In relation to the design:

- Page one gives a general background and overview of the booklet, providing a rationale;
- Page two relates directly to the HCA/student's need to develop and protect their student nurse role;
- Page three combines the qualitative findings with the wider theory of professional socialisation and focuses on how the HCA/student can be better supported through the transition to 'be' a student nurse;
- Page four is a continuation of the qualitative findings and wider transitional support. It also contains space to add in practice tutor contact details so that they are readily available to mentors and wider teams.

The content was developed in collaboration with the GYOOG, who suggested areas to be included and provided feedback on draft content. These were incorporated into the final version (Appendix N). The booklet was also endorsed by Health Education England as appropriate to support mentors, students and wider nursing teams.

7.2 Force-field analysis: barriers to change and mitigations

In any change intervention it is important to minimise potential barriers and maximise potential enablers to the change. This needs to be considered as part of the planning process. This section therefore provides a critical analysis of the perceived barriers to change and how these were mitigated. The drivers for change were largely explored in the earlier chapters and therefore will not be a focus of this section. For the purpose of this thesis, those individuals involved in implementing the change have been designated *change implementers* and those in receipt of the change initiative the *change recipients*.

Undertaking a change management initiative across multiple organisations is particularly challenging. Networks of individuals working across multiple organisations can suffer issues such as individual domination, failure to agree or make decisions and lack of ability to achieve effective resolution (McGuire and Agranoff, 2007). These issues can affect the success of any collaboration. In addition, non-functional individuals will often impede progress by blocking, being disruptive or aggressive (Benne and Sheats, 1948). Figure 7.1 (below) gives an overview of the individual and organisational barriers and mitigations to successful change which will be further explored through this section and Section 7.3.

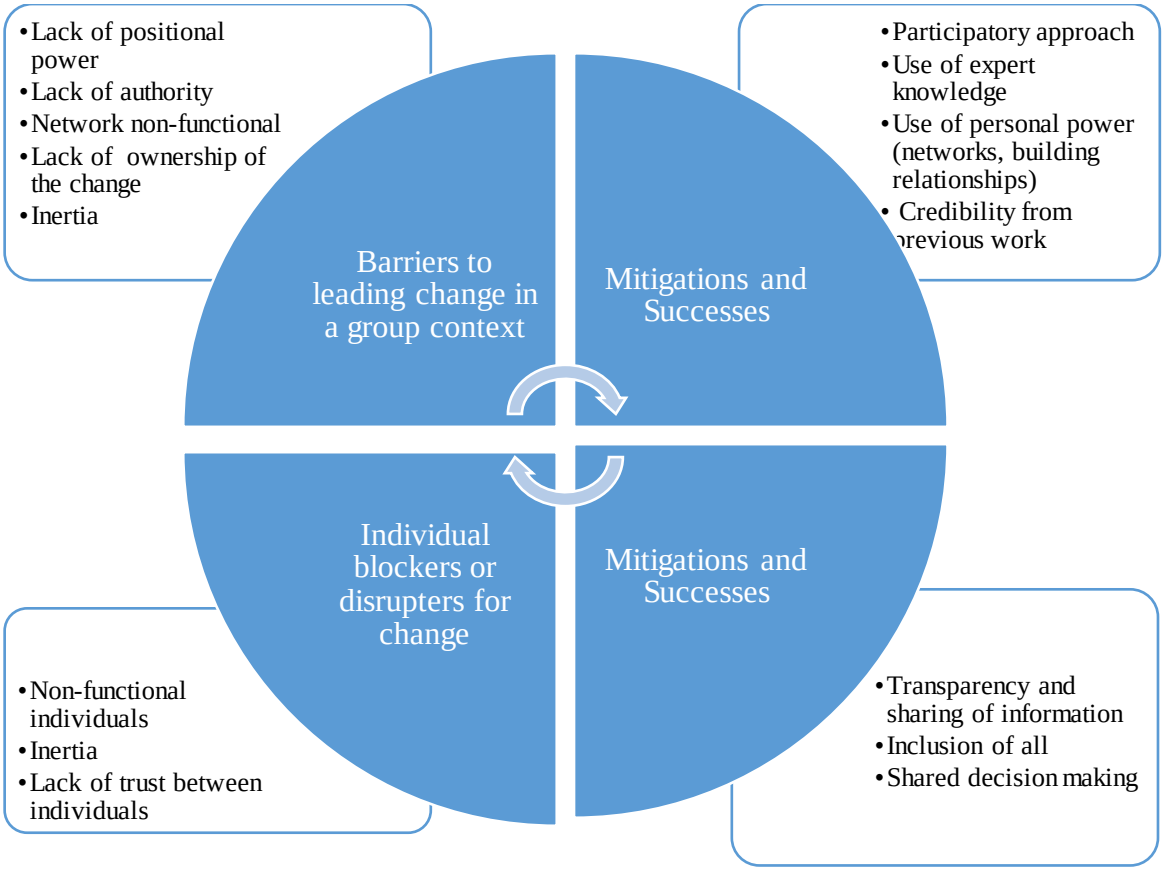

Figure 7.1: Group and individual barriers and mitigations to successful change

No leader can work in isolation and needs to create a team of followers in order to achieve their vision. This study is no exception, with the need to create a collaborative team of followers from all participating organisations. Hence the ability to mitigate identified issues was key to the success of this intervention.

7.2.1 Barriers and mitigations to leading change in a group context

One of the main difficulties in collaboration has been identified as inertia (Huxham and Vangen, 2004) where collaboration is impeded by lack of progress, achievement, satisfaction and possibly even collapse of the collaborative network. There can be many reasons for this,

particularly disparity of aims or intentions of the group, individuals or member organisations, dominance of powerful group members or lack of trust between members. McGuire and Agranoff (2007) recognise that a transformative process takes place within the networks between identifying a knowledge gap and intervention implementation which requires more understanding. They believe that by collectively sharing knowledge, exploring and debating potential problems and solutions, and participating in mutual learning, groups can improve network capability and facilitate goal achievement. Thus, it was important that true collaboration was achieved and that the key stakeholders shared the vision for the intervention phase, through the application of an appropriate change management and change leadership approach. This needed to ensure mitigation through a participatory approach which prevented stakeholders from perceiving a lack of ownership for the change which might in turn inhibit success.

In order to mitigate my lack of positional power and lack of authority within the group, which could lead the network to become a non-functional group (McGuire and Agranoff, 2007), I was able to use some professional attributes:

- my expert knowledge, based on the findings from the exploratory interviews and wider literature;
- my personal power, through existing networks and relationships I had developed with all the key stakeholders;
- the credibility that I had within the group from previous work that I had successfully delivered on.

These all created a personal power which is recognised for its ability to influence others in lieu of authority or positional power (Handy, 1999).

7.2.2 Individual blockers or disrupters for the change

In relation to non-functional individuals seeking to disrupt or block the change, I had concerns that the change implementers (practice tutors and education links) might feel usurped or insulted, due to a perceived criticism of their preparation for mentors and/or support for students, through the identified need of the booklet. This preconception was probably related to a perceived lack of trust between individuals, which is difficult to address. As a result, there was a concern that some change implementers might react as non-functional or even blockers to the change (Benne and Sheats, 1948; McGuire and Agranoff, 2007). This needed to be accounted for when designing the change management and leadership approaches to ensure inclusivity and ownership of the change intervention. Furthermore, in mitigating issues of lack of trust, inertia or blocking of the change at an individual level, the application of my personal power led to an engaged group with no obvious blockers or disruptive members.

The following section explores the change management and leadership approaches to the intervention which sought to mitigate the barriers and enhance the enablers for change.

7.3 Leading the change

This section explores the change management process and leadership of the intervention and pilot evaluation phase. It provides a critical analysis of professional role and leadership attributes applied to the change management process, particularly within the context of the

multiple organisations involved. It will also focus on my role as a practitioner-researcher in leading the change and aligns to the facilitative leadership approach proposed in Chapter One.

7.3.1 The value of a normative-re-educative approach

In applying change management theory, it was important to determine an approach which maximised chances of successful change implementation. In their key contribution to change management theory, Chin and Benne (1985) identified three different approaches to change management. While they each have common elements, such as knowledge or power, 'their philosophical foundations and processes are fundamentally dissimilar' (Szabler and Schwandt, 2006, p.71). The three approaches are highlighted below (Chin and Benne, 1985):

- *empirical-rational* approaches emphasise the rationale and/or evidence behind the change presuming that the necessary change will occur as a result, providing it appeals to the self-interest of change implementers. There is an assumption that change recipients are guided by reason and that they use logic to drive the behavioural change.
- *normative-re-educative* approaches are more active, with the recognition of a re-educative element to move the change implementers from their original position to the changed position. They assume that change will take place if those involved are able to participate in the problem-solving process.
- *power-coercive* approaches tend to be top down, with those in a power position gaining compliance through applying their power to change recipients.

It was assumed that support for students in practice would be enhanced if a booklet were introduced to reinforce the student role, given this was as a direct result of participant feedback. This was supported by further feedback provided by other mentors and students (change recipients) at the Open GYOOG and was endorsed by wider stakeholder engagement (including change implementers). This reflects an empirical-rational approach to change. However, normative-re-educative approaches have been found to be more successful due to the participative, re-educative, facilitative and inspirational appeals included in this approach (Szabla and Shwandt, 2006). By involving change implementers directly in the change management process, they are more likely to have ownership of it, which should increase sustainability for the change. Therefore, for the change to be effective and sustained, I believed that a more effective approach could be achieved through; a) promoting greater ownership for the change amongst change implementers and b) providing a re-educative element to give change recipients a greater understanding of the change.

In other words, we needed to set out clearly what we were expecting mentors and wider nursing teams to do differently to better support these students and protect their student status. This was a better fit with a normative-re-educative approach, since this is based on participation and involvement. The intention was to create an informed culture for change through collaboration with the change implementers (Chin and Benne, 1985). This also met the intentions for reducing the barriers to change identified in both individuals and group settings (explored in 7.2).

7.3.2 Facilitative leadership in change management

The implementation of an interventionist project is more complex than an interaction between leader and followers, but necessitates other activities resulting in the development

of a culture and infrastructure to support that change (Gifford et al, 2007). My dual role of practitioner-researcher, having credibility within both academic-researcher and clinician-practitioner communities of practice and working across multiple organisations, meant that I was ideally placed to lead the project (Sykes, 2012a). In addition, the ability within my employed role to influence regional policy decisions meant that major barriers to implementing and sustaining change might be minimised.

In Chapter One, the leadership approach for this exploratory sequential mixed methods study was set out. A facilitative leadership style was applied which fitted with my professional role and relationship with the key stakeholders. The application of facilitative leadership promoted a continuum of approaches from persuasion, through collaboration, to facilitation (Rees, 1998) and necessitated the acceptance, satisfaction and commitment of followers to make the change implementation successful (Bass and Bass, 2008). Kurt Lewin's (1951) force-field model recognises three stages of change; unfreezing, change and refreezing. The unfreezing stage allows participants to recognise that the current situation is not effective and identify the need for change. The change stage allows participants to seek new ways of working while the refreezing stage involves the implementation and embedding of the change initiative.

This has since been adapted by other researchers, including Kotter and Cohen (2002) who produced a more detailed eight stage process for successful large-scale change. This was derived following two sets of interviews in the mid 1990's and early 2000's, where they identified that changing behaviour is the most difficult phase of implementing change. The eight stages are identified below and have been aligned to the implementation of the booklet (Kotter and Cohen, 2002, p.3-7):

1. *Create a sense of urgency* – a sense of urgency was created initially with clear timeframes communicated to stakeholders. This was reinforced with regular contact through the employer links and practice tutors.

2. *Create a guiding team* with credibility, skills, connections, good reputation and formal authority to provide change leadership. This enabled the guiding team to build good relationships with the key stakeholders. This necessitated the demonstration of attributes such as excellent networking, collaboration and partnership working, which the literature recognises as being key skills for educational facilitators such as myself (Randle et al, 2005; McArthur and Burns, 2008). The employer links and practice tutors, who were implementing the change initiative, had all the required attributes and thus were an exemplar guiding team.

3. *Create a vision* that is clear and achievable. The vision was readily adopted by key stakeholders, students and mentors. The input that they had to building this vision and developing the booklet itself supported the shared vision.

4. *Effective communication* of the vision. This was communicated, for example, through attending relevant meetings and inviting participation in developing the communication tools (including participant information resources and booklet). The rationale and evidence base for the change initiative is clearly stated in the booklet.

5. *Empowerment* – whilst true empowerment is often mistaken for devolvement of power (Couto, Hippensteen Hall and Goetz, 2010), in this context it supports the notion of encouraging participation and representation of the group in making

decisions about the project. One example of how this was applied was in mitigating concerns about the true engagement of the practice tutors in the change initiative. The draft booklet and draft questionnaire were shared with the practice tutor group for feedback, with the intention of giving them some ownership of this. This ensured an inclusive approach with transparency and shared decision making. The practice tutors provided useful feedback which was incorporated into the booklet and the value of their input was publicised through the GYOOG.

6. *Produce short term wins* – this was difficult given the need to meet ethical requirements. However, the use of existing forums and communication networks to drive the change initiative was beneficial in gaining quick wins in relation to resource development.

7. *Don't let up* – this stage suggests creating wave after wave of change rather than trying to do too much too soon. This was applied through inclusion and regular review of progress with key stakeholders. The other recommendations from the exploratory phase of research were adopted about a year prior to the implementation of the booklet, hence the changes were not all implemented at the same time.

8. *Make change stick* – nurture a cultural change. This process is still on-going and will continue beyond the life of this study. Tentative study findings have been shared with key stakeholders, including membership of the regional GYOOG.

This leadership approach was adopted to address the issues identified as barriers to the change management process and to maximise enablers (such as inclusion, facilitation, informing and empowering the change implementers).

7.3.3 Dissemination

It was agreed through the GYOOG that the dissemination of the booklet, and the accompanying support for implementation, would be a joint responsibility between employers and the programme provider. The membership of the GYOOG consisted of employer links for each placement provider, practice tutor representatives, HEE representatives and senior programme provider representative. It was agreed, therefore, that employers would make copies available in all practice placement areas and that practice tutors would disseminate the booklet to all students to take out with them to practice. There was to be reinforcement of the use and purpose of the booklet at practice visits through meetings with mentors and students, and at mentor and student events at course commencement.

Booklets were initially disseminated to students and mentors through employer leads and practice tutors at the end of September (2015). This coincided with the ethical and R&D application. The dissemination of the booklets was not necessarily linked to data collection. In other words, should ethical approval for data collection not be given, the booklets were still disseminated as part of my professional role remit. The booklets were disseminated to all students on the programme (not just those who had taken part in the research), since it was anticipated that there may be some transferable benefits to all students and that it would have been unethical to withhold the booklet from others who might gain some benefit.

It was intended that through having a strong participatory approach, with clear rationale and evidence base for the change, this change intervention would be perceived positively. Through the agreed on-going support and reinforcement of the implementation of the booklet it was anticipated that this would be a sustainable solution, beyond the life of this research study. Feedback was received from the practice tutors who were very supportive of the introduction of the booklet and felt it would be beneficial in improving the support students received in practice. Employer leads were also in favour of its introduction and the amendments requested, regarding the wording of certain components, were adopted.

Having identified the drivers and process for the intervention, the following section establishes the importance of this phase of the exploratory sequential MMR, setting out the aims, research questions and methods applied to the pilot evaluation.

7.4 Research aims, questions and methods

The overarching interpretive approach for this research is an abductive one. The previous, qualitative, phase was towards the inductive end of the abductive spectrum, with no a priori theory. This mixing of deductive and inductive approaches provides a further point of connection for this MMR study. This quantitative phase tested the efficacy of the booklet to identify whether or not it facilitated mentors and/or students to better protect the student identity and, in so doing, supported their transition to 'being' a student nurse.

This phase was of prime importance because:

- the testing of the theory arising from the exploratory qualitative phase was intended to provide a validation mechanism of the method and findings;
- undertaking the pilot evaluation of the effectiveness of the booklet and survey method was essential to understanding the impact it had produced and to inform future practice and research;
- understanding how the intervention could be improved through the pilot evaluation allowed further amendments to be made to better support future students.

7.4.1 Research aims

The aims of the pilot evaluation were to:

- test the theory arising from the qualitative phase of research through evaluating the effectiveness of the booklet *Top Tips for Supporting Work-Based Learning Nursing Students* and making necessary amendments to design as a result;
- test the efficacy of the implementation approach making necessary amendments to the process ahead of any further evaluation;
- test the survey method and identify any modifications necessary to the full evaluation of the booklet.

This pilot evaluation therefore focused not just on the effectiveness of the booklet, but on how or why it was, or was not, perceived to be effective and what improvements might be made as a result.

7.4.2 Research questions

The research questions were therefore:

- *Do students perceive that the booklet helps them better understand their student role?*
- *Do students perceive that the booklet helps mentors, and/or the rest of the nursing team, better understand their student role?*
- *Do students perceive that the booklet helps reinforce their student identity?*
- *If so, how or why is the booklet beneficial to this?*

7.4.3 Methods

This quantitative, intervention/evaluation phase was an auxiliary, pilot phase of the exploratory sequential MMR, with the priority phase being the qualitative exploration of the practice experiences of students and mentors. Whilst this phase had less priority allocated, it still required a robust research design and application of methods in order to provide a valid evaluation of the design and implementation of both the booklet and the survey method.

The research questions sought to identify whether the booklet was effective and what the values and beliefs of students were in relation to its benefits, through use of a survey questionnaire combining quantitative and qualitative aspects. As a quantitative method, this allowed identification of how many students believed the booklet was effective. However, this method was insufficient to assess the meanings ascribed to such beliefs and attitudes (Silverman, 2011). This was mitigated by encouraging qualitative comments to the survey tool which provided some opportunity to explore the meanings and wider perceptions of these students (Saldana, 2013). Therefore, it was chosen as an appropriate method to meet

the research aims and questions whilst providing an expedient and resource efficient approach. An electronic survey was selected in preference to a postal administration, because the former is believed to be less costly and easier to analyse (McPeake, Bateson and O'Neill, 2014). In addition, all students on this programme, due to the open learning elements, are easily contactable by email. Postal addresses would be more difficult to access, with consequent data protection restrictions. Issues with poor response rates from electronic surveys, such as lack of familiarity with the web and unreliable internet access (Scott et al, 2011), were not perceived to be an issue for these students as their competence in both areas were assessed for entry to the programme.

Two methods of electronic survey are identified (McPeake, Bateson and O'Neill, 2014); web-based questionnaires completed on-line or questionnaires embedded in the body of an email. In this study the questionnaire was available through a web-link which was itself embedded in the body of an introductory email with supporting information attached. This was perceived to be the method to gain the better response rate (McPeake, Bateson and O'Neill, 2014).

In any exploratory sequential MMR it is important to consider ethical principles and how these relate to the intervention phase. The following section reviews the ethical considerations and how these impacted on the research.

7.5 Introducing change: ethical considerations

Having focused in depth on ethical considerations in Chapter Five, this section provides an overview of those aspects which specifically pertain to the pilot evaluation phase. Consideration will therefore be given to the practical application of important ethical principles (Fulton and Costley, 2018) in line with those identified in Chapter Four.

Beneficence – assuming that the booklet might be beneficial to students, it was disseminated to all students undertaking the programme in this region, regardless of whether they were included in the research or not. This was to ensure that students were not excluded from any potential benefits it might bring.

Non-maleficence – all research can potentially have unintentional adverse effects on participants. Where interventions are introduced, this can potentially elicit unintended negative effects in participants – mentally, physically and socially (Kerr, 1996). Thus, introducing change may be counter-productive in terms of the negative impact it could have (Waterman, 1998). No guarantees were given to students that the change would be beneficial to them although the participant information stated that it was hoped that it would improve the practice experiences for them or future students. It was unlikely that the booklet would cause harm, although potentially it could have caused contention between mentor and student when students used it to reinforce or protect their student role. However, since students themselves asked for the booklet to support existing lack of role reinforcement, it was likely to result in less contentious, more objective discussions than previously.

Justice – Ensuring equal access to the booklet ensured equity with no student advantaged or disadvantaged over others. Vulnerable individuals had freedom of choice regarding their intention to participate and provision of contact details not only for myself but for my supervisors were provided should they have any concerns they wished to raise.

Respect for autonomy – The invitation letter, consent form and participant information sheet (Appendices J, K and L) set out freedom of individuals to participate and lack of penalties should they choose not to. The participant information sheet was sent out in advance in an introductory pre-information email with the letter inviting participation and consent form (Appendices J, K and L). The participant information sheets were developed to ensure participants were able to make an informed choice about whether to consent to participate. The participant information was then sent out a second time with a link to the on-line questionnaire (Appendix M), which included a built-in consent form. This provided an opportunity to either withdraw from the study or proceed to participation through completion of the questionnaire. A potential adverse effect was that the participant could not withdraw once the data was submitted since we could not identify their data. However, this approach was clearly identified in the participant information sheet and consent information.

Respect for confidentiality and anonymity – Data were provided anonymously without any identifying information returned. Because of the need for confidentiality and anonymity, there was no information requested in the pilot evaluation phase which identified participants. Therefore, it is impossible to identify how many of the participants from the qualitative phase further participated in the quantitative, pilot evaluation and how many were

new participants. Whilst being able to ascertain this information might have been beneficial, it was balanced by the intention that respect for anonymity would be more ethically acceptable and would likely attract more participants.

Fidelity and veracity – The fidelity and veracity of the approach has been provided by the participants and wider stakeholder engagement. Participants in the qualitative phase of the research had driven the development of the booklet, and information included in it. It had been validated by other students and mentors through the annual Open GYOOG. The questionnaire and booklet design had also been validated by the GYOOG members and practice teachers. Furthermore, there has been a clear and transparent reporting process throughout this phase, allowing replication of this study by others and ensuring truthfulness of resultant findings.

Full ethical approval was gained from the university (Appendix E), although submission errors within the university resulted in a three-month delay in submission to the FREP. Whilst only grammatical changes were requested by the panel, this further delay necessitated minor amendments to wording in supporting documents to reflect revised timeframes. This also impacted on organisational R&D approvals, because revised versions had to be submitted and further agreement for approval reached. R&D approval was sought from ten individual organisations including NHS Trusts, non-NHS organisations and GP practices. Some of these were amendments to existing approval granted in the qualitative phase, while some were new approvals from students not previously included in the research. In addition, approval was sought from the academic programme provider for permission to study the

sample population. In total, it took seven months to gain approval from all necessary organisations. One organisation did not approve revised versions of the participant information sheet and supporting letter in time for their students to be included.

7.6 Population, sampling and recruitment

The study population consisted of all students on the regional WBL programme with one education provider. The study sample was for three consecutive cohorts (09/12, 09/13 and 09/14) consisting of 43 RN students (adult and mental health). The cohort 09/11 qualified prior to the data collection stage and it was felt that cohort 09/15 might not have sufficient practice placement experience to provide meaningful feedback at this early stage. However, consequent delays in gaining ethical approval meant that these students could have made a meaningful contribution. Of the 43 RN (adult and mental health) students in the potential sample, the following were excluded from the study:

- one student was excluded due to lack of approval for inclusion by the programme provider due to on-going difficulties the student was having in meeting the programme requirements and potential for failing the programme;
- nine students were excluded because employing organisations failed to provide R&D approval in time for the data collection to commence;
- one student interrupted the programme and re-joined the 09/15 cohort, which was not included in this study.

In addition:

- one student was identified as withdrawing from the programme but was not precluded from participating, since they may have had a different view to other potential participants;
- one student, originally precluded through the programme providers ethical approval process due to an interrupt from the programme, was eventually permitted to participate since they had specifically asked to be involved in any further research as one of the original participants.

This provided a study population of 32 students (17 mental health and 15 adult) who met the inclusion criteria and were granted ethical approval to approach. Although this was a relatively low sample size for a survey, there was no opportunity to widen out recruitment. The main stakeholders, through the GYOO Group, endorsed the study population, sampling and data collection methods. Amendments were made to supporting documents, for example the booklet, questionnaire and supporting participant information, as a result of stakeholder engagement.

The intention was for approval to be gained by the end of December 2015, three months after dissemination of the booklets. As ethical and R&D approval was delayed, there was a consequent delay resulting in a seven-month duration between distribution of the booklet and recruitment to the study. As identified in 8.2, the initial information about the future data collection, containing the participant information sheet, supporting letter and booklet, was sent out approximately one week before the recruitment email. The recruitment email contained the link to the on-line questionnaire, plus copies of the supporting information as

a reinforcement. The process for responding to the questionnaire was for respondents to access an on-line link through which there was no mechanism for identifying them. The participant information sheet and supporting email included my contact details should the prospective participants have any further queries.

It quickly became apparent that despite the belief that all students had received copies of the booklet to share with their mentor and wider nursing teams, and that all practice areas also received the booklet, this was not in fact the case. On distributing the participant letter and information sheets, three students responded directly through email or by telephone highlighting that none had seen the booklet previously. Whilst the programme provider gave assurance that it had been distributed to all areas, with the exception of one cohort in one Trust who were subsequently provided with it, the students who made contact were not part of this group. It is therefore unclear how widely the booklet reached the intended audience or what had caused these distribution errors. On reviewing the process, both employers and Practice Tutors insisted that the information and booklets were disseminated to participants.

Therefore, based on the desire from students themselves to participate in the research, it was decided to contact all prospective participants again with the booklet, supporting information and questionnaire link, in order to extend the deadline for the survey by a further two weeks. This was to allow testing out of the booklet and completion of the survey if desired.

7.7 Data collection

The on-line questionnaire (Appendix M) was developed to allow anonymity for participants and ensure confidentiality, thereby encouraging participation. The questionnaire was developed using open and closed questions. The closed questions were used to ascertain the participants' beliefs about the impact of the intervention and open questions to explore the *how's* and *why's* of these beliefs. The presence of both open and closed questions in the chosen survey approach introduced a point of interface necessary to mixing of quantitative and qualitative methods in MMR. The questionnaire was kept short for ease of completion and to promote data return.

Whilst questionnaires typically have a low response rate, this can be improved through the following strategies (Koopman et al, 2013, p.340):

- pre-notification;
- follow-up contact, supported by McPeake, Bateson and O'Neill (2014) who recommend two reminders;
- shorter questionnaires, supported by McPeake, Bateson and O'Neill (2014) who also recommend being specific about how quickly it can be completed;
- providing a second copy of the questionnaire at follow up;
- highlighting an obligation to respond;
- university sponsorship;
- personalised questionnaires, supported by McPeake, Bateson and O'Neill (2014) who recommend personalised emails;
- an assurance of confidentiality.

Lane et al (2011) found response rates were improved by a reminder contact (letter or telephone contact) although Man et al (2011) found no evidence that electronic reminders improved either response rates or response times. This may have been affected by the fact that the original questionnaires in Man et al's (2011) study were posted and not electronic. Pre-notification can also have a beneficial effect, with Koopman et al (2013) identifying that while pre-notification tended to result in faster return rates it had no significant effect on overall return rates. Findings also indicated a small improvement in response for groups that received a second follow up with accompanying copy of the questionnaire rather than a pre-notification (Koopman et al, 2013).

Survey saturation and response burden amongst health care professionals have also been identified as key reasons for non-response (Rolstad, Adler and Ryden, 2011; McPeake, Bateson and O'Neill, 2014). Whilst significantly reduced response rates were observed with longer questionnaires, with no clear cause and effect identified, shorter questionnaires response rates varied (Rolstad, Adler and Ryden, 2011). It was recommended that length of questionnaire should be determined by quality of survey content rather than response burden (Rolstad, Adler and Ryden, 2011). This was not an issue for participants as an approval process with the education provider ensured that no students were over burdened with research participation.

All the above strategies identified by Koopman et al (2013) were employed in this study to maximise return rates, with the exception of making participants feel obligated to respond which I believe would have been unethical. Return dates suggest that with pre-notification in place two students responded the same day the survey link was disseminated, with no further responses within the original two-week deadline. Following the two-week extension,

which included further copies of the booklet and supporting information as well as the survey link, one response was received 2 days after extension email was disseminated, with further responses at days 3 (n = 1) and 12 (n = 1). This gave a total response rate of 16% (5 responses from a total sample of 32) which is below the suggested average response rates for questionnaires. The reason for poor response rate was unclear, but feedback from students themselves suggests this may be linked to lack of access to the booklet prior to the recruitment phase. This in turn may be linked to the unanticipated delay between dissemination of the booklet and ethical approval, thus losing the momentum for change. Furthermore, it may be that the particularly heavy workload for these WBL students had an impact.

The following section explores the study findings which, given the poor response rate, must be interpreted with extreme caution.

7.8 Data analysis and findings

The response rate of 16% (n=5 out of a potential sample of n=32) was disappointing. However, given the time constraints involved in completing the research, and having extended the deadline to support participation, the decision was made to:

- provide a descriptive analysis of the data, whilst recognising that inferential statistics were not viable given the poor response rate;
- identify any broader inferences from the data (both qualitative and quantitative) that were available, including softer intelligence which could be used to triangulate the information;
- identify what recommendations (if any) might be made for further actions;

- use this pilot as an opportunity to reflect on what might be learned in order both to inform the further phase of implementation and evaluation and to support my development as a researcher.

The ability to undertake a statistical and/or thematic review of the data proved impossible given the low level of participation and the small amount of qualitative data involved. The quantitative analysis of the closed questions was provided by the Survey Monkey tool, which produces descriptive findings with options for graphical representation. Closed questions were represented graphically in order to identify patterns in *yes/no* responses. The open questions were analysed to identify trends in data from which inferences were drawn. These were reviewed several times to ensure nothing of importance had been overlooked.

One student had received the booklet but had forgotten about it, and only a maximum of four students responded to the qualitative element of the questionnaire. Whilst there were five participants there were only a maximum of four qualitative comments to each question. The similarity of responses to the questions has led me to assume that the same participants responded qualitatively to each question (excluding the final question where only three responded).

7.8.1 Pilot survey results

Individual responses to each question are provided below, with complete reporting for transparency. Whilst one student clearly had not used the booklet, the response has been left in, recognising that the corresponding quantitative response cannot be identified. It should not, therefore, be assumed that they will have reported negatively.

1. **Do you feel the booklet has helped reinforce your identity as a student?**

40% Yes (n = 2) 60% No (n = 3)

Qualitative responses:

a) *It gave me the tools I needed to ensure I knew how to present myself as a student*

b) *I have not used it*

c) *People do not read the leaflet and when they become aware that I work in the Trust they treat me differently to conventional students*

d) *Unfortunately, I was on my last placement when this booklet was available. I can see it benefits future students.*

2. **Do you feel it helps mentors better understand your role as a student?**

60% Yes (n = 3) 40% No (n = 2)

Qualitative responses:

a) *In a way, most are already experienced mentors so understand the process. But it was still helpful to provide a visual reminder*

b) *I have not used it*

c) *As above. The last two placements I have been on people do not understand that I have to work still, and in my work place they do not understand the pressure*

d) *Yes, it can help future mentors and hopefully they will understand how different the (non-traditional student) is from the (traditional) student.*

3. **Do you think it helps the rest of the nursing team understand your role as a student?**

40% Yes (n = 2) 60% No (n = 3)

Qualitative responses:

a) *They have been very responsive and understood my role better*

b) *I have not used it*

c) *As above*

d) *The rest of the nursing team are not aware of the (non-traditional) student. Unless the nursing (team) are willing to read the booklet, then they assume the (non-traditional) students are like (traditional) students.*

4. **Do you feel it has better helped you understand your role as a student?**

20% Yes (n = 1) 80% No (n=4)

Qualitative responses:

a) *That came through time and working in the role to fully understand it*

b) *No, I understood it before the booklet was produced*

c) *I understand my role as a student*

d) *No, I fully understood my role by year two. I don't think the booklet helped me in that way.*

5. **Please comment on your perceptions of benefits/challenges to the introduction of the booklet:**

Qualitative responses:

a) *Good idea for new students who may have worries regarding the early transition stages. Some mentors and teams may benefit if they have little knowledge regarding the (non-traditional) course and how the process works. Some mentors and teams will be experienced to not need this booklet*

b) *I completely forgot about it so did not use it*

c) *The booklet needs to be shown before any placement and challenges are if the mentor will read it and refer back to it if need be.*

6. **Is there anything else that we could do to improve the booklet?**

Qualitative responses:

- *No*
- *No*
- *An email of the booklet should be sent to the mentors before meeting the student. It can then be discussed at their initial meeting.*

7.8.2 Additional information

In addition to the formal participant data collection, informal data were provided by three students who contacted me to highlight concerns about inability to participate due to lack of access to the booklet. Of these students, two sent emails about this phase of the study and a further student made contact through email and voicemail which I eventually followed up with a telephone call.

Of these three students:

Student One (a key participant in the qualitative phase of the study): Highlighted that they thought the booklet was *'really good'* and that, having not seen it before, they intended to discuss it with their mentor and other students in order that they could contribute meaningfully to the study. Due to the anonymisation of data provided it is unclear whether this student was one of the participants in the survey.

Student Two: Identified the value of the booklet, having also not seen it before. They particularly endorsed the element that identified how, even when students appeared self-sufficient, they might still have differing support needs to traditional students. They articulated common experiences they and their peers were having in practice, which aligned with the participant findings (Chapter 5), such as being *'forgotten'* or not receiving recognition of their student status due to colleagues who did not understand their particular support needs. The student felt this booklet would be *'really beneficial'* in helping address these role duality issues and providing more focus to the mentors supporting them. Again, this student was keen to participate fully in the study and welcomed the extension to the

survey deadline. Whilst it is unclear whether this student participated in the survey, the qualitative data collected does not reflect the comments that Student Two provided directly. Therefore, it is assumed that this student did not participate.

Student Three: Provided no direct comments about the booklet but raised concerns that they had not seen the booklet prior to the invitation to participate in the study.

This further feedback has contributed to my overall understanding of the processes for the implementation and pilot evaluation of the booklet. This will support further improvements.

7.8.3 Scientific rigour

Given the low survey response rates, there has been no major attempt at reviewing the rigour of the findings. The rationale for this is strengthened by the fact that this was a pilot evaluation as the auxiliary phase of quantitative research, with the primary qualitative phase already complete. The intention of this research phase (see 7.4.1) was to test the efficacy of the booklet and survey method in order to make any necessary adjustments ahead of a full evaluation. Thus, although the efficacy of the booklet is inconclusive, this phase has been useful in identifying areas for improvement which will be explored in Section 7.9.

There is a possibility that the results are also misleading, given that one student who contributed to the quantitative findings admitted to not having used the booklet. Hence whilst there were five responses only a maximum of four are based on actual experiences. However, this data was included given the quantitative responses provided could have represented the participants' beliefs and perceptions about the booklet, based on their experiences on the

programme. This enhances our understanding of the issues, since it emphasises the importance of ensuring for future evaluations that either all participants need to have used the booklet, or for us to better identify through the evaluation the reasons why they haven't used it.

The final section of this chapter explores the learning from this phase of the research and how this might be applied to the future evaluation in concluding this research study. It culminates with a highlight summary and tentative inferences drawn from the quantitative phase of this exploratory sequential MMR, which must be taken with extreme caution due to the poor response rate.

7.9 Application of learning to the research

This section provides a reflective account of the auxiliary quantitative phase – the pilot evaluation of the booklet. Factors outside the control of the researcher, such as the influence of others or competing practice priorities, can result in unintended consequences.
Hence the importance of reflection in practice-based research has been identified as crucial to identifying areas where the researcher may need to either refocus or adjust the approach (Fook, 2019).

The remainder of this section has been framed within a critical reflection recognising that the knowledge of experts can only be learned by recording such reflections-on-action (Benner, 2001). This is undertaken through a description of:

- what has occurred;
- an analysis of why it may have happened;
- subsequent cognitive realignment which identifies whether the learner's schema (or view of the world) needs to be adapted in light of the learning.

Where necessary, the examples given refer directly to responses to the pilot evaluation questions found in Section 7.8.1. The intention of this section is to enable a greater understanding of the issues relating to the implementation and evaluation of the booklet so that any improvements can be made ahead of the final evaluation which will be undertaken outside of this doctoral thesis.

7.9.1 Description of the issues

This quantitative phase, whilst auxiliary to the main exploratory phase of the research, was nonetheless important to understanding the contribution of the intervention to improving practice. Having explored the approach already in this chapter, in summary it appears to have been hampered by a number of factors including:

- poor response rate and variable responses resulting in the:
    - inability to derive any firm conclusions;
    - inability to address the research questions;
    - inability to adequately test the research assumption.

- ethical delays, which may have resulted in a loss of momentum for the change.
- inadequate implementation (the booklet did not reach all the intended recipients).

7.9.2 Analysis of the issues

Poor response rate and variable responses: Whilst Silverman (2011) suggests inclusion of open questions supports the testing of meanings behind beliefs or perceptions, Claydon (2015) believes these to be better addressed through qualitative methods. Therefore, on reflection, the survey method may not have fully addressed the research questions and aims, even if there had been a greater response. Use of a more qualitative data collection method, providing opportunities to explore data more fully, may have yielded richer results and allowed respondents to expand on their responses. This would have been more achievable given the small population available for sampling.

One of the challenges with a survey questionnaire is that if respondents do not fully understand or correctly interpret the question, there is no opportunity for further exploration. With an interview or focus group there are opportunities to reframe the question, provide examples of what you are asking or get participants to expand on their responses. In the qualitative interviews, when initially asked about how well supported they were, participants responded positively. It was only when responses were further explored, informed by body language and tone of voice, that the richer data concerning what was happening in terms of support was identified. Given the disparity between the survey questionnaire responses, it would have been very helpful to have the opportunity to explore responses further through exploratory interviews.

Ethical delays: There are a number of issues that may have arisen from the unanticipated ethical delays. Firstly, the six-month delay between disseminating the booklets and carrying out the survey will have affected responses due to the progression of the students on the programme. Responses suggested the booklet may have been more helpful at the beginning of the programme. Secondly, this will have affected the ability to keep up the momentum for change, part of the change leadership process needed for success. Thirdly, the delay between implementation of the booklet and invitation letters, resulted in students and mentors forgetting about the booklet. Whilst change implementers reported reinforcing the booklet in practice, this does not appear to have been the case and this may have impacted on the number of responses to the survey.

Inadequate implementation of the booklet: Whilst response rates were too low to be meaningful, it appeared that where the booklet had reached its intended audience of students and mentors, it may have been of some benefit to the participants. While the booklet may have been of some benefit in supporting mentors to better understand the student role, the application of the survey did not allow this to be tested with mentors to see whether they concur and thus triangulate the data. The issues that arose appear to have resulted from the process of disseminating the booklet, rather than the content of the booklet per se. All three students who responded qualitatively to Question Six indicated that no refinement to the booklet design was needed.

This therefore suggests there were issues with the change management process and demonstrates the challenges of facilitative leadership, where there is a lack of direct influence or control over the operationalisation of the initiative. Participants recognised that

there was a further issue in that mentors and wider team members were either not reading or not applying the information in the booklet. This would need to be tested more widely with both students and mentors to evidence whether this is the case.

These issues were compounded by the difficulty in conducting research in areas where the researcher has limited influence, authority and access. It is an issue which was not sufficiently identified or addressed in the planning phase and should have been picked up through the force-field analysis more specifically. This necessitated reliance on the information provided by those in control of disseminating the booklet and provided no ability to access students or mentors to check whether they had received the booklet in advance of the research. Whilst the practice tutors and education links reported having disseminated the booklet, there may not have been sufficient embedding of associated understanding of its rationale, importance or uptake for mentors and/or students themselves.

Impact of the early adoption of other recommendations: This phase of research may also have been impacted by the early adoption of recommendations from the exploratory phase ahead of the official intervention phase. These included wearing a uniform (formal or informal), having more explicitly identifying name badges and not being placed in their employed areas on student days. Given the participants felt that these actions would better support their professional socialisation, it was not possible to determine any impact from their early adoption. It may be that they had a positive impact, negating some of the issues identified in the qualitative interviews and therefore reducing students' drive to participate in the quantitative, pilot evaluation phase. It may also have mitigated practice issues and minimised the need for, and benefits of, the booklet. If this was the case it may have affected

both questionnaire responses and response rate. However, having identified potential benefits from the qualitative interviews it would have been unethical not to share the findings with stakeholders and allow them to benefit from their early implementation.

Change leadership approach: In Chapter One it was recognised that participative leaders set boundaries and expectations with minimal additional input, while directive leaders tend to be dictatorial, expecting compliance without having to provide evidence for decisions. Facilitative leaders empower others by supporting them to undertake change management (Rees, 1998). However, it was also recognised that leaders need to adopt a position across the continuum from participative to directive leadership depending on circumstances. It may be that there was an inappropriate level of empowerment, given the apparent ineffectiveness of the dissemination and application of the booklet and it is difficult to ascertain the reason for this. There is the danger through empowering individuals of devolving too much responsibility to individuals unable to perform at that level, or in an abdication of responsibility (Bass and Bass, 2008). These are characteristics of a laissez faire or inactive leadership style described by Bass and Bass (2008, p.144) as consistently appearing in studies to be 'the least satisfying and least effective' leadership style. However, in abdicating responsibility to the change implementers, the change management roles they were undertaking were well within their professional capabilities and there were clear boundaries to the autonomy of their roles which were characteristic of an empowering leadership style (Bass and Bass, 2008).

7.9.3 Cognitive realignment

The two elements of the intervention which have been challenged through this research will be reflected on in light of the analysis; the implementation and pilot evaluation of the

booklet. This will lead to recommendations regarding improvements that might be made to support further embedding of the booklet and future research.

The implementation: There needs to be a better promotion of the booklet, with an improved educative approach for practice teams and an accompanying support framework for implementation. This would need to include an education package for change recipients, to support an understanding of the importance of the application of the booklet, and regular reinforcement of its use. The biggest issue appears to have been a dissonance between the actions agreed by the service providers and education provider and the actual actions in relation to the dissemination of the booklet.

Mitigation of this could have been provided by asking employer leads and practice tutors to check that all students had received the booklet. However, there are blurred boundaries between actions which are allowed as part of standard service provision and those which form part of the research process. In my original PEF role, I would have had the ability to engage with students and mentors and ascertain their understanding of the booklet and reinforce its application. However, subsequent roles would not allow this outside my role as a researcher. No allowance was explicitly made for this within the ethical/R&D approval process which negated further action. This would need to be taken into consideration in any future study.

In order to achieve success, it is unlikely that one leadership style can be applied in isolation. Had I identified earlier that the booklet had not been disseminated to all areas, or that it was not being appropriately applied by mentors, I could have adopted a more directive approach or increased my level of support. Whilst I believed the support that I provided them through

the normative-re-educative approach should have been sufficient to underpin the necessary facilitative leadership model, this was clearly not the case. In addition, I had relied on the identified change implementers to educate the mentors and students themselves about the booklet and its benefits. Kotter and Cohen (2002) recognise that for behaviour change to occur, leaders need to invoke strong emotions in change recipients and help them visualise both the issue and the change vision. This is more successful in changing behaviours than education alone.

My approach, through educating and impassioning the change implementers, had not taken this into account and it is likely that more should have been done to influence the behaviours of the mentors themselves. This will be taken into account for any future change initiatives and further phases of this research.

The pilot evaluation: In the exploratory phase of this research, some of the students when asked whether they were experiencing any issues in practice started off by saying that they were not. It was only when they were probed about their actual experiences and responses further explored that they articulated the issues arising. The inability through the survey method to probe or check the students understanding of the meaning ascribed to the questions, may have been a barrier to success. Therefore, further exploratory research, through focus group or individual interviews, would be helpful to identify whether and how the booklet has impacted on the students' understanding of their role and the efficacy of the mentor's role post implementation. It will also support an understanding, where students haven't used it, why that might be the case. In addition, there was no opportunity through this survey to explore the efficacy of the booklet from the mentors' perspective, which may

have differed from the students' perceptions. Hence additional focus groups or individual interviews to ascertain the mentors' perspective may add a further dimension to our understanding.

7.9.4 Summary

No conclusions can be derived from this pilot phase of the research, given the low participation rate and mixed responses. However, whilst there is no convincing evidence base for its efficacy as demonstrated in this pilot evaluation, the booklet has been found to be credible by the wider GYOOG (including mentors and students) and has been subsequently adopted in practice across the region.

For the booklet to be effective, inferences drawn from participants in this study would suggest that it needs to reach its target audience in a timely and supported manner and be appropriately applied. Any further evaluation needs to allow for deeper exploration of the meaning behind responses and thus would be appropriate to a further qualitative phase of evaluation.

This phase of the MMR study has been fully reported so that others might learn from it, whilst recognising that further exploration of the booklet is required to fully answer the research questions. All activities, including goals, scope and process, associated with change initiatives should be reviewed regularly during practice research projects, particularly where unexpected issues or outcomes are experienced (Clark, 2019). This is essential to any successful change management initiative.

Whilst the doctoral research is finite, my professional role is not. The opportunity therefore exists beyond the life of this thesis to address the issues identified and undertake a further evaluation of the change initiative to ensure it is effective, embedded and sustained.

The following chapters provide the conclusion for this thesis. Chapter Eight sets out the strengths and limitations of the study, while Chapter Nine justifies the thesis findings in relation to the unique contribution they make to the development of new knowledge and improvements to practice. This includes recommendations for future research and practice in the field of health, social care and education.

CHAPTER EIGHT

Strengths and Limitations

The purpose of this chapter is to highlight the key strengths of the study and any potential limitations, identifying why they occurred and how they were mitigated, thereby minimising any adverse impact on the study outcomes. In addition, it provides an opportunity to reflect on what might be done differently in future as a result, providing a key learning opportunity for myself and other researchers.

8.1 Strengths of the study

There were a number of key areas of strength in the study, the main ones being the inter-subjectivity of the MMR approach, transparency and truthfulness of reporting and the participant and stakeholder voice that influenced the research. These will each be explored through this section.

8.1.1 Objectivity and subjectivity of the researcher (inter-subjectivity)

The application of a MMR methodology, supports the flexibility to move between the two positions of subjectivity and objectivity (inter-subjectivity). Objectivity was applied to the data collection and data analysis processes to ensure the student voice, as opposed to the researcher voice, was heard. However, this was often backed up with a subjective overlay, using my professional knowledge, to contextualise the analysis and allow a deeper meaning

to be assigned. In order to demonstrate transparency and provide assurance of the appropriateness of this inter-subjectivity, Table 8.1 recognises the objectivity and subjectivity position through examples of how these perspectives were applied.

Table 8.1: Inter-subjectivity - application of researcher stance

Method	Objective Stance	Subjective Stance
Data Collection: individual interviews	Actively listen to the interviews without assigning meanings to the verbal responses.	Recognising the significance of verbal accounts, particularly when eliciting an emotional response, which allowed further probing during the interview.
Data Analysis	Endeavouring to analyse data with an open mind and assign early codes based on the actual words/phrases used by the participants.	Application of wider professional knowledge to assigning meaning through coding, categorisation and early memos.
Data Analysis	Applying objective knowledge derived from the early literature review where commonalities or differences were noted.	Applying wider experiential knowledge to identify significance of findings. This often led to the need for wider reading and subsequent assignment of meanings in Chapter Eight.

The credibility of the inter-subjective interpretation of data was further tested through the verification from the co-researcher, participants and wider stakeholders during the data analysis and reporting stages. This inter-subjectivity is important to a reflexive approach necessary for DProf research (Fook, 2019).

8.1.2 Transparency and trustworthiness of reporting

This research study has been reported in its entirety, including areas that have not yet achieved the intended outcomes, such as the pilot evaluation of the booklet. Whilst the priority phase of qualitative interviews and associated wider theoretical perspectives applied

could have been sufficient for this doctoral thesis, the intention for DProf study is to demonstrate improvements to practice. While this could have been achieved through reporting of the design and implementation of the booklet, the pilot evaluation has also been included in its entirety, identifying how the learning from this will be applied to the subsequent full evaluation.

Similarly, the thesis could have been written up without acknowledging the original intention for focus group interviews. The rationale for inclusion of both was to provide a true and accurate account of the doctoral journey from start to finish. This would allow replication of this research, allowing the avoidance of similar pitfalls, for other researchers. It has also demonstrated learning through my doctoral journey, supporting analysis of what could be improved for future approaches to overcome the challenges that occurred, which is essential for any doctoral candidate.

8.1.3 Participant and stakeholder voice

There are a significant number of areas where the voice of participants and other key stakeholders have been heard in this study and used to influence the research. This was not just through the analysis of the data findings, but also through transcribing the tapes by hand to ensure deeper listening and understanding applied to the transcriptions. Other mechanisms included the multiple points of verification of findings such as:

- revising or adding to interview questions for subsequent interviews based on outcomes of early interviews;
- feeding back to participants to check understandings and meanings are correct;

- feeding back to wider stakeholders to verify shared understandings and credibility of findings;
- facilitating participants and wider stakeholders to suggest key recommendations and drive the further phase of research;
- involving key stakeholders in designing the booklet;
- involving key stakeholders in the change intervention and adopting a facilitative leadership style intended to empower them to support the change.

I believe that this wider stakeholder involvement is one of the most powerful elements of this study.

8.2 Potential limitations of the study

The following section sets out the potential limitations of this research focusing on the literature review, phase one qualitative interviews and overall research, including the methodology. It also identifies the mitigations applied to minimise any adverse impact from these. The quantitative phase of implementation and pilot evaluation of the booklet are not further examined here, given they have been extensively explored through the previous chapter.

8.2.1 The literature review: limitations and mitigations

This section refers not only to the formal literature review (Chapter Two) but subsequent reviews associated with key themes identified (including Chapter Six). Any literature review is only as good as the ability of the researcher to access and analyse the available literature, with the risk of missing important literature as a result. Data which are readily available via

electronic sources and library services are easily accessible. However, whilst attempts were made to access less readily available sources, such as theses, these were not always successful. This may have been a limitation as mostly readily available literature was included. Library services were used to support the development of my search skills. This not only enhanced the ability to search but also improved confidence in data searching skills. The literature review was revisited regularly throughout the life of the research, with any additional literature subject to the same rigorous process. Despite additional new sources of evidence becoming available over time, little new information or themes arose, although evidence was strengthened as a result. This increased confidence that the salient points were being captured. Several additional non-published papers were accessed but subsequently discarded as not being relevant to the issues under investigation.

Throughout the thesis there is reference to literature which is outside the notionally acceptable 5-10 year cut off. Whilst this might be considered a limitation, I believe this to be a strength of this thesis. Every piece of literature used has been carefully considered regarding the significance of the data, the contextual and/or historical importance and whether it adds to the argument being made. Hence there are numerous articles of seminal importance including:

- Classic texts by authors such as Lewin (1951), Goffman (1959), Van Gennep (1960) and Wenger (1998) who are still considered experts in their subject areas.
- Articles which add to the building of a contextual or historical narrative such as government and professional body papers.

- Articles related to the broader topics of methodology and leadership accessed not just from the world of health and social care but from areas such as broader education (Hood, 1982; Hord, 1992).

The combination of data used to construct this thesis has added to its richness. The mixed age, source, context and topics of the literature included in this thesis provide a broad basis for the arguments contained within it. In addition, the reality of a part-time doctoral study is that research which is newly published at the outset will already be several years old by completion. There is also the possibility that other important lines of enquiry, such as whether mentors can better support students given their allocation throughout the four-year duration of the programme, have not been pursued. However, the time constraints and word limits applied to a thesis necessitate difficult choices in relation to data inclusion and for every reference used it is likely many more will have been excluded.

A further potential limitation of the literature review is that wider literature relating to work-based learning students who were also HCAs had to be taken into account, since there was very limited data relating to these particular non-traditional students. The study from Wareing (2008; 2010a; 2010b) is one example of this, with a population of HCAs undertaking a Foundation Degree rather than a pre-registration nursing programme. Despite the lack of literature about the specific programme under study, processes associated with the practice element of the programmes included were similar enough to this study population to be relevant. Where there are differences these have been highlighted as far as possible. The literature has been critically reviewed against a wide body of current literature which strengthens the themes arising.

The literature review is a critical element in focusing the study aims and questions and it is essential that this was undertaken with sufficient rigour. The ability to determine what should and should not be included in the review is a critical element and it is easy for the researcher to become overwhelmed by the sheer volume of available literature. This was initially the case, therefore in order to manage the literature, I tabulated the key studies and annotated the key points in each article. This allowed easy reference, comparing and contrasting of evidence and supported the development of the main themes and sub-themes.

8.2.2 Phase one (qualitative interviews): limitations and mitigations

The original choice of method for this phase was focus group interviews. However, insufficient numbers of mentors and students were recruited in time to allow for these to be undertaken. The individual interviews may, therefore, have been a limitation given that there was an inability for the students to directly explore, expand on and confirm/refute the comments of others. In addition, there was no opportunity for inter-participant engagement, or wider discussion introduced by participants themselves. These are all elements that could have been enriched through focus group interviews. Whilst qualitative data are not dependent on large sample sizes, the numbers of participants were lower than anticipated. This is largely due to the small population of this cohort of students and consequent mentors and it was probably overly naïve to plan focus group interviews given the recognised recruitment difficulties associated with them.

The other compounding difficulty was the inability to provide clarity of information around date, time and venue of the focus group. The intention was to arrange the focus group interviews at a time and venue convenient to participants to increase uptake, given their widespread locations. This probably had the opposite effect and it is likely that students

failed to participate as lack of clarity existed around these parameters (Krueger and Casey, 2000). Telephone interviews may have yielded a higher response rate but would not have allowed non-verbal responses to be captured.

Conversely, the flexibility to undertake individual interviews (in order to meet time constraints of the study and approval conditions) potentially allowed student participants to demonstrate a high level of emotion and honesty that might not have transpired in a group setting. To minimise potential limitations, and staying true to the methodology, each interview built on the data from the previous participant. This allowed sub-questions (underpinning the topic guide) to be added or expanded to further explore areas identified by previous candidates and enabled common understandings to be explored. The apparent success of the individual interviews perhaps suggests they should have been the primary choice at the outset. The research intention was to explore individual experiences and the only real benefit of focus groups would have been the additional validation group members may have given one another. This was achieved, however, through other means. This demonstrates the importance of exploring all data collection methods when designing research and gaining an in-depth understanding of the benefits and challenges to each approach.

8.2.3 Potential preconceptions and impact on findings

Through this doctoral research, necessitating an early literature review to drive the research design and research question, it is impossible to implement the methods without some preconceptions (identified in Section 4.8). There was the potential for these to have compromised the internal validity of the topic guides and questioning for the qualitative interviews (Williamson, 2012), since questions were focused on the topics of interest and

might be construed as leading the recipients. This did not prove to be the case since participants frequently gave varied responses to questions and did not agree with some of the concepts raised (for example hostility amongst co-workers). They simply acted as a broad topic guide, with specific questions and follow up driven by participants' line of response and evolving conversations. Objectivity was provided to the analysis of the data wherever possible and supported by the verification of findings by the co-researcher and feedback by participants and wider stakeholders. The appropriate application of subjectivity and objectivity through this research (highlighted in 8.1.1) also supports the mitigation of any preconceptions arising.

8.2.4 Implications of limited feedback from qualitative interview findings

The feedback received from participants in relation to the qualitative interview findings was limited with only one student (from five participants) and one mentor (from two participants) providing direct feedback. However, this was mitigated by further participants being involved in the GYOOG meeting at which the study findings were disseminated who further endorsed the study findings. Other non-participant students and mentors also endorsed the findings through this meeting, sharing their own similar experiences and identifying how the recommendations arising could better support them.

The following section provides a reflection on the methodology and its appropriateness to this research. It reviews the points of connection where mixing of methods occurred, to what extent this was successful (or not) and what changes need to be made for future phases of this research.

8.3 Reflections on the methodology

It is a critical element of any research study to reflect on the research process and identify what worked well and what could have been improved. There were a number of elements identified as purposeful to an MMR methodology (see Chapter Three). Those that were key for this research study are explored through this section.

8.3.1 Adoption of both qualitative and quantitative methods within the same study

There were four points of connection in this study where the two methods were mixed (as set out in 3.8). The effectiveness of each will be explored here:

The iterative approach to the research with the participants in the priority qualitative phase driving the quantitative phase: This was implemented through identification of a number of recommendations, through the interviews themselves and the subsequent feedback on findings, including the implementation and pilot evaluation of the booklet (phases two and three). There were a number of other opportunities for participant and wider stakeholder engagement (highlighted in 8.1.3) which helped drive these subsequent phases of implementation and pilot evaluation. Hence there was an iterative approach to phases two and three derived from the first phase.

The use of abductive reasoning, with both inductive and deductive approaches: This was not entirely successful, given the absence of sufficient data in the quantitative phase to fully adopt a deductive approach. However, the wider theoretical perspectives applied to the interview findings (Chapter Six) supported an abductive approach, with a broadening and modification of the explanation based on an iterative cycle of analysis and review of

the findings against the wider theory (Levi-Rozalis, 2004). Given the research is not yet complete, with a further evaluation still to come, the opportunity exists for further application of a deductive element to support the abductive approach.

The use of open and closed questions in the quantitative questionnaire: The responses to questions demonstrated the effectiveness of having open and closed questions. However, a qualitative method would likely have been better to explore the meaning behind responses and the poor response rate rendered this method ineffective. Had the response rate been higher this may well have been an appropriate method, but only wider testing on a larger population of HCA/students would be able to demonstrate this.

The use of an overarching research question with underpinning sub-questions for the qualitative and quantitative phases: The overarching research question identified in Chapter Two was underpinned by a series of sub-questions for phase one (qualitative interviews) which were successfully answered by the findings in Section 6.6 and aligned to the core theme of role identity. These responses drove further sub-questions for the phase three pilot evaluation and responses to these can be found in Section 7.8.1. However, poor response rates rendered the results inconclusive and therefore necessitate a further embedding of the implementation and more robust evaluation of the booklet based, on the recommendations for improvement from Chapter Seven. However, given the distinctly different phases of research, having an overarching research question with separate, but related, sub-questions for each phase of qualitative and quantitative research to guide each phase was beneficial. The opportunity for completion of the research, through a further evaluation phase, will support further testing of the overarching research question.

Given these multiple points of connection, I believe there has been sufficient mixing of methods to demonstrate integrity of the MMR methodology.

8.3.2 The ability to allow for intervention development and testing

Whilst phases two and three of the MMR study were less successful than anticipated, the ability exists within MMR for testing/piloting of the approach. As a pilot, testing not only the efficacy of the booklet but the implementation and evaluation processes has been beneficial in gaining an understanding of the issues arising. My professional role outside the DProf study will allow further embedding of the booklet and an improved implementation process, whilst supporting a future, more robust evaluation of the booklet.

8.3.3 The ability to build research expertise

This DProf has allowed me to build my expertise in both qualitative and quantitative approaches. Whilst the poor response rate in the phase three pilot evaluation did not allow me to fully develop expertise in quantitative analysis, it did allow exploration of the research design and data collection method (the electronic survey). It has also enabled development of knowledge and practice in qualitative methods and of MMR in its own right, including the importance of points of connection and complementarity of approach. This has provided expertise beyond that which could have been achieved through application of a single method (qualitative or quantitative) approach.

The concluding chapter (Chapter Nine) sets out the contributions this study has made to new knowledge and improvements to practice, including further recommendations for future research and practice.

CHAPTER NINE

Conclusions and Recommendations

9.1 Introduction

This chapter provides an overview of the research, drawing together the key themes, contextualising the body of work and explicitly stating its 'importance, significance and implications' (Lovitts, 2007, p47) not only to the field of nursing, but also to that of the wider health and social care workforce. This research has made a significant contribution to our understanding of the experiences of these non-traditional student nurses in relation to role duality. In particular:

- it has added new knowledge in relation to the benefits this programme has to offer to existing HCAs where; placements outside employed HCA areas are maximised, co-workers support learning on HCA days, use of artefacts (especially uniforms) are encouraged and role boundaries of HCAs and students are reinforced and supported;
- it has added to our understandings of existing theory in relation to; professional socialisation, transition from HCA to student nurse and potential challenges and benefits of WBL programmes;
- it has contributed to improvements to practice through sharing findings to increase understandings of others and the uptake of recommendations from the phase one qualitative phase of research. These recommendations included; the use of artefacts such as uniforms and name badges, not using employed HCA areas as placement areas for the student, development and implementation of a booklet to improve understandings of professional socialisation issues and to reinforce student identity.

These contributions will be explored in detail through this chapter, followed by recommendations for further research and practice.

9.2 Understanding the experiences of study participants

The new knowledge gained from this research in relation to role duality derived from the five themes arising from the phase one qualitative interviews. A summary of these themes is provided here in response to the original research question:

"What are the role duality issues facing healthcare assistants undertaking a work-based learning programme and their RN/mentors and how can these be mitigated by an intervention derived from the exploratory findings?"

"Being out of their depth": Students felt out of their depth due to their recognition of wider practice issues through exposure to external placements outside their existing scope of HCA practice. They often felt unprepared for this, given their level of HCA expertise in their employed areas. As a result, students often felt restricted by their home placements if these were in their employed HCA areas. This was compounded by the prior expectations co-workers had of them, particularly in their familiar home placement, which affected their student experiences. Furthermore, and contrary to other current literature, although they recognised the *'comfort zone'* of their home placement, they relished the challenge of alternative placements since these better allowed them to be students. Students and mentors recognised the students' ability to negotiate and flex between roles of student and HCA in order to support service needs, but that they were not prepared to do this at the expense of meeting their learning needs.

Being 'on the fringes': The lack of clear transition from HCA to student leaves students *'on the fringes'* with mixed feelings about where they belong (student or HCA). Their belief about where they are situated in relation to this is influenced by perceptions of their employed area colleagues. Student participants, in their transition to 'being a student', recognised the need to build their foundations of knowledge, but also valued the life skills they bring with them to the programme. This was endorsed by mentor participants.

Students reported being forgotten by mentors in their home placements and not necessarily being challenged enough to progress learning. However, they also benefitted from the ability to access learning from colleagues on non-student days and being able to return to familiar employed areas for additional support.

'Battling' to be a student: Students found themselves competing for placements with traditional students and struggling to gain recognition as a student. This was a very emotive topic for students, some of whom articulated this need to defend their student status through combative terms, for example '*battling'* and '*fighting'*. This was compounded by confusion over boundaries between their HCA and student roles. Participants found there was very little known about the programme, particularly amongst staff in alternative placements. Although students valued the support from practice tutors and employers, there was little, if any, reinforcement of programme or role requirements explicitly relating to their particular student needs between visits. Students and mentors found artefacts beneficial in visually reinforcing student role identity – particularly uniform (formal and informal).

Understanding the realities of practice: Both student and mentor participants identified a self-reliance in the students. Whilst this may be attributable to the open-learning philosophy of the programme, other studies (for example Hasson, McKenna and Keeney, 2013b) have found this more likely in diverse student groups and with mature students such as this sample group. The professional maturity these study participants brought with them allowed them to appreciate the multiple competing priorities of practice, and consequent impact on mentors, enabling them to work within the parameters of this. They worked largely in partnership with mentors, often taking the lead for their learning and demonstrating that they were taking responsibility for their learning needs. Mentors suggested that the in-depth relationship developed with their student over the four-year duration of the programme strengthened their ability to supervise and assess these students, affording assessment decisions increased credibility. The students gave many examples of choosing to compromise their own learning for the best interests of patients and staff. However, they only felt aggrieved if they were unable to negotiate replacement learning opportunities or where their student status or needs went unrecognised.

Being professional: Students perceived themselves to be thinking and acting differently on their student days, having more professional conversations and taking things more seriously. They dressed differently, being smarter and taking more pride in their appearance. This was perceived to demonstrate more tangibly their transition towards 'being a student'. They also felt that they had a better understanding and empathy for traditional students.

Mentor participants did not identify any role duality issues for their RN/mentor roles. The significance of the student participants role duality within the wider context of professional socialisation theory and development of a student nurse identity was explored in Chapter

Six. This culminated in a conceptual framework specifically regarding the professional socialisation process and barriers/enablers to this. The conceptual frameworks (Figure 6.3 and 6.4) identified in Chapter Six further evolved the original professional socialisation framework identified by Holland (1999). This research has led to a greater understanding of the specific role duality barriers to the professional socialisation process that face nursing students who simultaneously undertake an HCA role and how we might better support them in practice. This research has allowed development of new knowledge and thus a new understanding of:

- the different values and behaviours an existing HCA is likely to bring with them as a starting point, as opposed to a traditional student;
- the contribution this then has to how non-traditional students develop through professional socialisation. This requires less development for them to 'become' a student nurse but they are often impeded from 'being' a student nurse by their role duality and the perceptions of those around them;
- the barriers and enablers to this professional socialisation process which can be addressed in practice to better support their transition to 'being' a student nurse.

This study has identified that HCAs undertaking a PRNP and working concurrently in both HCA and student roles can suffer from role duality challenges. These can impact on the professional socialisation process allowing them to 'be' student nurses. The second year appears to be a particularly important milestone for this process, since students, when questioned, identified themselves as feeling like HCAs during their first year but were less certain where they were in the transition process at the time of interviewing (during their second year).

This mirrors the transition model of Barton (2007) who found that student nurse practitioners were at the first phase of transition in the first year, the second phase during years one and two and tended to reach the final phase towards the end of the second year. Student participants, approaching the end of their second year in this study, appeared to be in different stages of transition. However, some students appeared to be entering the final phase including Jordan, who recognised the exiting of the HCA peer group and transitioning into *'something else',* and Jo, whose *'eureka moment'* enabled the identification of the coming together of the theory, skills and care. These are likely to be the attributes necessary to 'be' a student nurse through becoming a 'knowledgeable carer'.

Building on the discussions from all elements of this exploratory sequential MMR study, Figure 9.1 draws the whole thesis together in one overarching theoretical framework. Whilst the efficacy of the booklet is not yet proven, it was a recommendation from the phase one qualitative interviews, developed by key stakeholders (including students and mentors) and is perceived by key stakeholders to be beneficial. Hence it has been included in the theoretical framework.

The literature indicated a concern for the potential for the student to remain in the *neutral zone* of transition for the four-year duration of their programme. Whilst this now looks less likely, given evidence of some students' progression to 'being a student', recommendations have arisen from this research in which their professional socialisation process can be better supported.

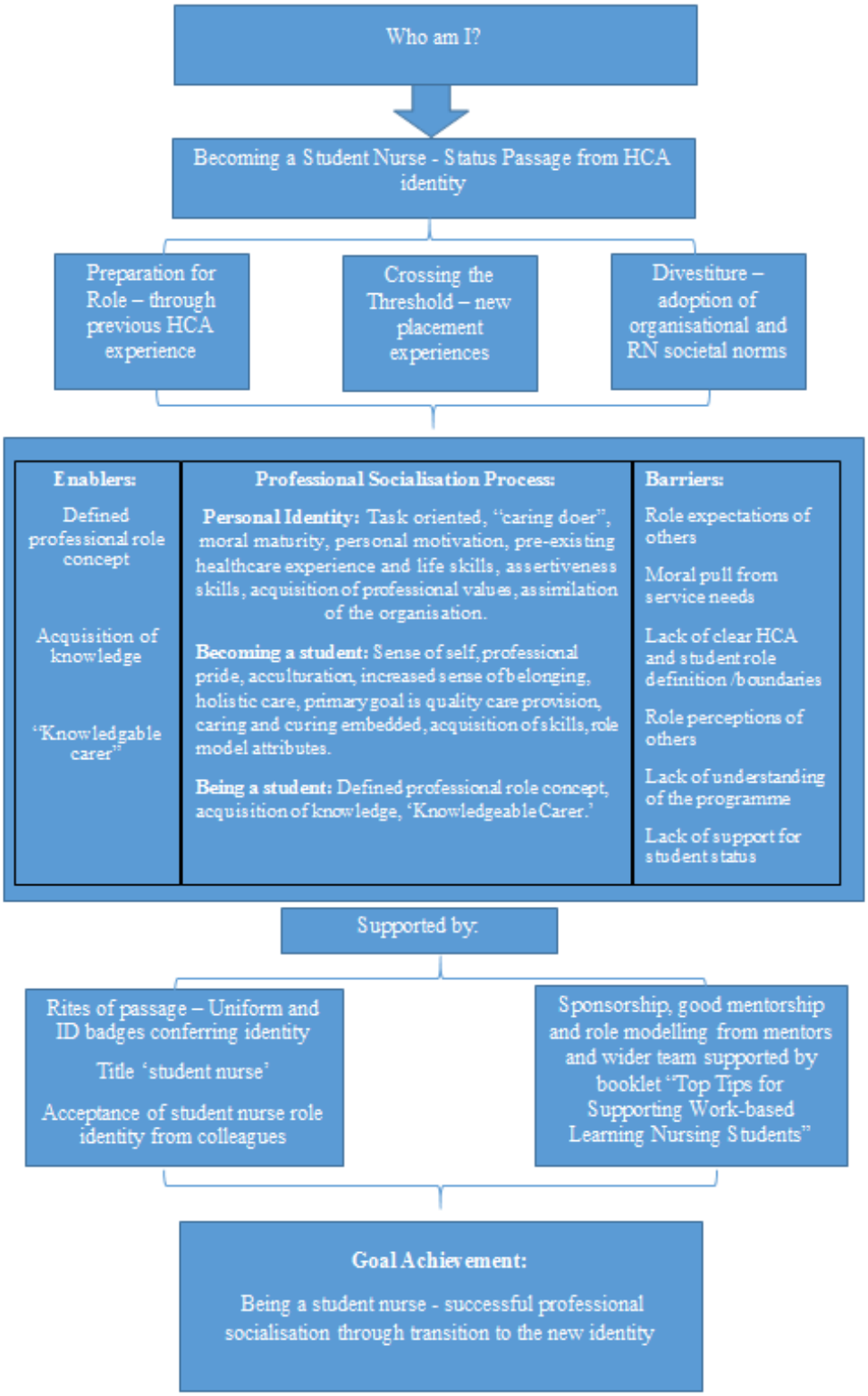

Figure 9.1: 'Being' a student nurse – theoretical framework for transition

9.3 Contributions to new knowledge and improvements to practice

The overall contribution of this research to the development of nursing practice requires the identification of how the research fills the gap in knowledge, why the research demonstrates originality, what the original contribution is and how this creates new understandings (Trafford, Leshem and Bitzer, 2014). These will be critically explored through the four dimensions of scholarship (Boyer, 1990) - see Figure 9.2. While it is not a requirement of the DProf to demonstrate all four, my intention to develop scholarship in practice, as set out in the introduction, necessitates revisiting these dimensions in relation to this research.

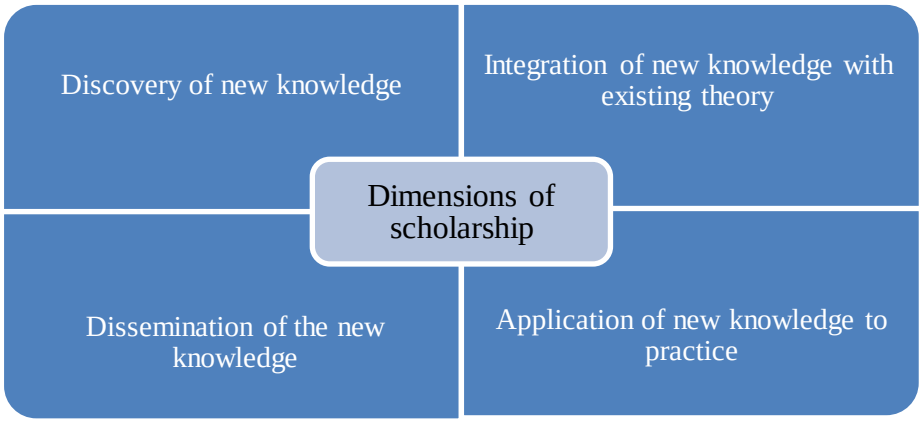

Figure 9.2: Four dimensions of scholarship (adapted from Boyer, 1990)

9.3.1 Discovery of new knowledge

There are a number of areas of new knowledge deriving from these research findings which are summarised in this section:

Building foundations of practice: Figure 5.2 (Chapter Five) identified how these HCA/students built their practice experience from their existing HCA base, widening their scope of practice from a specialist knowledge of their employed area to a more generalist

healthcare base of transferable skills. This was perceived to be in contrast to the way traditional students build knowledge from a wide, generalist base to a more specialised one on qualification (Figure 5.3).

Benefiting from being treated as a student on HCA days: Other studies had not previously identified the ability of being treated as a student nurse on HCA days and the benefits that brings with it. Students gave examples of being lent books and other resources, accessing learning opportunities and the ability to join the RN or student nurse COP when in their HCA roles.

Benefits of external clinical placements over familiar home placements: These included:

- widening the scope of practice for the HCA/student through exposure beyond the familiar home placement and associated activities;
- increased challenge from mentors, wider team and WBL activities;
- minimisation of prejudice from co-workers due to lack of prior expectations or preconceptions of the HCA;
- increased acceptance of the student nurse identity.

Students' recognition of primacy of patient care: The preparedness of participants to put patients and colleagues first (rather than maintain supernumerary student status) was highlighted in the findings. Whilst occasionally students in this doctoral study felt aggrieved that they were being used this way, generally the participants perceived this to be for the greater good and therefore often volunteered to work this way. They willingly flexed between the dual roles of HCA and student nurse whilst negotiating with colleagues how they would still meet their learning needs. In other studies, students have perceived

themselves to be used as a pair of hands in those situations. Where, for example in Levett-Jones and Lathleans' (2008) study, students sacrificed learning opportunities rather than maintain supernumerary status, this was generally undertaken in order to gain acceptance, rather than being driven by altruistic motives.

Important function of uniform (formal and informal): Findings supported previous literature regarding the importance of artefacts (including uniform and name badges) in conferring student status through visual reinforcement and legitimisation of student role. However, the difficulties this produced for students who did not work in areas where students wore uniform had not, to my knowledge, been identified elsewhere and thus suggestions for overcoming this was additional new knowledge. The use of informal uniform, such as different coloured clothing or more professional attire, was a strategy identified by affected students.

9.3.2 Integration of new knowledge with existing theory

Some findings either reinforced or refuted existing literature which has enhanced our previous understandings. These have been summarised in this section, highlighting the contribution to the gap in knowledge supported by this research.

Professional socialisation and the transition from HCA to student nurse: In Chapter Six the wider literature relating to professional socialisation for nursing students was analysed in relation to this study. The integration of professional socialisation theories with these study findings, particularly relating to role duality, has allowed further conceptualisation of the theory. This has enhanced an understanding of the professional socialisation process for HCAs to complete the transition to 'be' nursing students. It has also identified potential

differences in the professional socialisation process for traditional students to 'become' and 'be' student nurses in comparison to HCA/students. This integration of new knowledge to transition and socialisation theories has allowed the identification of barriers and enablers to this process. This has led to a number of recommendations to minimise the barriers and maximise enablers, thus potentially improving the opportunity for successful transition. It has also recognised the status of these HCAs as *caring doers* at the onset of the programme, in line with the criteria for 'knowledgeable doers' and 'knowledgeable carers' set out by UKCC (1986) and Holland (1999). This differentiates between the HCA as a *caring doer* and those without care experience as having individualised care ideals.

One of the gaps in knowledge identified in Chapter Two was the concern that students would remain in a *neutral zone* between the old HCA identity and new student identity for the duration of the programme. However, two of the students (Jordan and Jo) were able to demonstrate their successful transition to 'be' a student through:

- an ability to articulate the differences in their dual roles;
- their perceptions that they were now students rather than HCAs;
- their articulation of how they could underpin their 'caring, doing' role with a knowledgeable underpinning – a 'knowledgeable carer' (Holland, 1999, p.232).

This would support the conclusion that these students could successfully transition to the student role whilst suggesting that having student nurse placements in the same area in which they are employed in as an HCA is a distinct barrier to professional socialisation to 'be' a student nurse.

Further validation for the professional socialisation framework: This study has also acted as a validation mechanism for the seven domains of professional socialisation identified by Brown, Stevens and Kermode (2012). Each of these domains was supported by the study findings and thus increased their credibility.

Reinforcement of theory regarding challenges of WBL programmes: Revisiting the background and contextual information set out in Chapter One, a number of potential issues were identified by Boud (2001) which included conflicting work and learning priorities, student identity issues, transition issues resulting from role conflict and lack of awareness generally around their differing roles in the workplace. This study has confirmed the existence of all these issues for these particular students. However, what it has added is the knowledge around how we might mitigate the effects of this. Furthermore, it has also identified some of the unforeseen benefits of this role duality, such as being treated as a student while in their HCA role and enabling access to additional learning opportunities.

Impact of perceptions of co-workers on the students' sense of role identity: Impaired transition to the student role was clearly linked to the perceptions of their nursing colleagues and is a key to professional socialisation. This was the most emotive topic for students who displayed a sense of fatigue in the constant battle for role recognition. The identification of them by colleagues as '*HCAs doing extra'* as opposed to student nurses reinforced this. Acceptance by the peer group you wish to join is a critical factor in professional socialisation and failing to gain that acceptance and recognition as a student nurse is a clear barrier to the transition process.

Benefits of previous acculturation: There were also identified benefits to 'being' an HCA. Several aspects of professional socialisation had already occurred during their HCA experiences which have supported them in 'becoming a nurse'. These included the adoption of NHS values and behaviours, gaining a better understanding of the rules of the game and being more aware of the realities of practice. This suggests that much acculturation has already taken place.

In other areas, the study failed to support previous research. Examples of this include:

Comfort zone: Unlike other studies, these student nurses do not want to hide behind their comfortable HCA roles but are keen to push the boundaries of their student nurse roles, traversing the pathway of professional socialisation to be a student nurse. They welcome the challenges this brings, hence feeling restricted by placements in their too familiar employed areas. There are dichotomies in fulfilling dual roles as HCA and student nurse. The student role is not always recognised by colleagues and students can feel unable to transition into the student role. Rarely did students complain about being treated as HCAs on student days, unless they felt their transition was being impaired by this.

Co-worker conflict - Students did not recognise the hostility from other HCAs identified in previous studies and, on the one occasion where this had happened, had been confident enough to address this appropriately. Conversely, they had experienced overwhelming support on the whole, with colleagues going out of their way to offer advice, resources and access to learning opportunities even when they were working as employed HCAs.

9.3.3 Application of the new knowledge to practice

Uptake of the recommendations: Whilst the three phases of research ran from 2012 to 2016, study findings were being adopted by service providers and the programme provider as early as May 2015. The qualitative findings and recommendations arising were presented and validated through the annual Open GYOOG, with the academic and service providers deciding to adopt them across the region. Changes adopted included; placing students outside their employed areas, investing in improved name badges and recommending use of uniform.

Implementation of the booklet: Whilst its efficacy has yet to be proven, the booklet has also been adopted in support of this programme across the region, with stakeholders believing that it is helpful in reinforcing role identity despite the lack of evidence as yet to support this.

Potential relevance to other, similar programmes: Local employers have also chosen to adopt these recommendations (including the booklet) in support of a similar local programme (the Flexible Nursing Pathway (FNP)). This programme was based on the WBL aspects of the programme in this study and shares many commonalities, including the dual HCA/student roles for the programme duration. This decision was supported by HEE locally.

9.3.4 Dissemination of the new knowledge

The findings from the literature review and the qualitative interviews have been widely disseminated both through conference presentations (national and international) and through peer reviewed publications.

Literature review: The literature review findings were presented to much interest through a national conference (Sykes, 2012b). This led to an invitation to contribute an opinion piece identifying how *Grow Your Own* opportunities would ensure that HCAs were not excluded from progression to nurse registration through the introduction of an all degree profession (Appendix O, Sykes, 2012c).

Qualitative phase of MMR: The initial findings from the phase one qualitative interviews were presented through a symposium presentation at a national conference which generated a lot of interest and several follow up communications (Sykes, 2015). The further evolved findings, including the professional socialisation framework, were presented at a later conference (Sykes, 2016). Furthermore, the research findings were presented by invitation at the RCN Congress, alongside The Open University (OU), as part of a wider presentation highlighting the needs of HCAs undertaking work-based learning nursing programmes (Reeds and Sykes, 2016). All fourteen respondents to the evaluation of this session identified that the presentation had supported the identification of best practice in this area.

Wider contributions to knowledge from the Thesis: Other aspects of this thesis have also been disseminated in the following ways:

- An article was published, based on elements of wider reading for Chapter Six, supporting caring/curing arguments and values-based care (Appendix P, Sykes and Durham, 2014).
- In order to bridge the gap in the existing body of knowledge, an article was published focusing on the local role of the PEF. This article was based on wider reading in support of Chapters One and Seven (Appendix Q, Sykes, Urquhart and Foster, 2014).

- A further article was published with the intention of helping to ensure complex research terminology and concepts were more easily understood, allowing improved access to research (Appendix R, Durham et al, 2015). Main author with W. Durham.

Many other local opportunities to disseminate the findings have been undertaken including peer and/or academic review presentations and work-related presentations. Furthermore, I have continued to work closely with the programme provider and local employers for the studied programme, largely via the GYOOG. A full research report has been provided to:

- Programme provider;
- Local employers, including R&D departments, involved in the study;
- Health Education England.

The following section provides the recommendations arising for further research and additional improvements to practice.

9.4 Recommendations for future research and practice

This research has resulted in a number of recommendations, some for further research, some for activities intended to improve practice and others a combination of the two. Each recommendation will be set out through this section.

Recommendation One: Further embedding the booklet into the programme

It is apparent from the quantitative survey findings and triangulated feedback that the booklet has yet to be fully embedded in practice. Reports from this research, including the main

findings and recommendations for further local action, have been provided to HEE, all employers supporting the programme and the education provider. There is a commitment from them to continue to support these recommendations and this will be followed up through the GYOOG. Whilst further evidence of the efficacy of the booklet is required, there is no evidence to suggest that it is detrimental and therefore all students and mentors should continue to be provided with the booklet at the outset of the programme. This needs to be better supported through an education strategy which provides explanations from the research findings of the ethos behind it and potential benefits it can bring. This will then need to be reinforced at each meeting between practice tutor, student and mentor, where it can be used as a catalyst for exploratory and supportive conversations around role duality.

Recommendation Two: Further exploration of the efficacy of the booklet and implementation of other recommendations arising

The pilot evaluation of the booklet has resulted in the identification of a number of issues with recognition of necessary actions to address these. There therefore needs to be a redesign of the methods for further evaluating the efficacy of the booklet in the conclusion to this research. This could be undertaken through, for example, focus group or individual interviews which would allow wider discussion between students on the merits of the booklet in practice. The inclusion of mentor participants would also allow their perceptions to be captured. It could also provide an opportunity to explore the potential impact of other recommendations implemented, such as the uniforms, name badges and non-placement in employed areas. Including all students from the programme should provide a viable sample size for focus groups, particularly if participation were encouraged through linking them to occasions when students and/or mentors were already together.

Recommendation Three: Replication of this research study on a larger scale regionally to assess the generalisability of the findings.

One of the potential limitations of doctoral studies is the specific link they have to the researcher's professional practice. Whilst such subjectivity is necessary to enrich the findings and support contextualisation, the generalisability of findings may be limited to a specific population or study sample as a result. The ability to adopt these study findings more widely to other WBL programmes is therefore restricted by the absence of a generalisable evidence base. From a moral and ethical perspective, it would be unethical not to apply the recommendations from the qualitative phase to other WBL students in the region if there is the possibility that they could benefit from them. However, it is critical that the evidence base to support this is explored through replication of this research to other similar programmes (such as the FNP, nursing apprenticeships and trainee nursing associates) as well as other cohorts of this particular non-traditional programme. The likelihood is that the commonalities of these WBL programmes, and diverse mix of students both in the study sample and general population of this programme, should allow for some transferability. However, it is equally likely that there may be distinct differences, given the differing personal abilities, values and behaviours from the entrants' particular professional backgrounds. This is likely to allow further comparisons to be made between student groups and development of a greater understanding of the specific role duality issues and the barriers and enablers to transition.

Recommendation Four: Further exploration of the professional socialisation process depicted in the conceptual frameworks

The development of the conceptual frameworks, depicting the professional socialisation of these HCAs, from the personal identity they have at the outset, through becoming a student

to being a student, would benefit from further investigation. It would be useful to explore whether traditional students and non-traditional students do experience a different professional socialisation pathway. This could help identify how much of this is due to the role duality aspects of the programme's employment model and how much to the diversity of the students themselves.

Recommendation Five: Long-term review of these non-traditional students to further explore other factors identified through this research

There were a number of workforce development factors relating to these non-traditional students identified in this study which were not fully explored here due to the limited scope of this research. Factors such as:

- How the retention of these 'Grow Your Own' students compares with others, given the increased sense of value and belonging engendered through this 'Grow Your Own', non-traditional programme.
- Whether their increased solution focused approach to practice stays with them and whether this affects their career progression.
- Whether their familiarity and preparedness for the realities of practice impacts on their retention in nursing on qualification.

Given the high priority for WBL programmes to help address the national workforce crisis, it is essential that we understand as much as possible about the impact these programmes have on our workforce and the challenges and benefits to employees undertaking them. This will enable us to provide the best possible support to ensure we maximise the outcomes from student and employer perspectives.

Recommendation Six: Further dissemination of findings

There are several aspects of this thesis worthy of dissemination in order that others can benefit from the findings. It is intended that the following papers will be submitted to appropriate peer reviewed journals:

- Paper One: Based on the literature review findings.
- Paper Two: Based on the leadership paper submitted in Stage One of the doctoral programme. This identified a leadership framework for the PEF role as an agent of change and builds on the publication already released regarding the local PEF model (Sykes, Urquhart and Foster, 2014).
- Paper Three: Focusing on the study findings from the exploratory interviews and wider professional socialisation theory.

The following section provides the concluding comments for this thesis, drawing together the elements of this doctoral research to support the achievement of originality through its contributions to new theory and improvements to practice.

9.5 Summary of conclusions

The purpose of this research was to explore the role duality experiences of HCAs undertaking a WBL pre-registration nursing programme, and their registered nurse mentors, to gain a better understanding of the participants' experiences in practice and any potential barriers and enablers to this. The analysis of the data from this phase would then inform the second phase, the purpose of which was to improve the practice experiences of these HCA/students and/or their RN mentors.

Each phase of this exploratory sequential MMR had its own aims and objectives, which were addressed at the conclusion of each research phase. These have acted as a funnel for reducing the data from the broad to the specific – with the broad literature review identifying the likely factors impacting on the students and mentors and driving the research questions and aims of the exploratory, qualitative phase. The qualitative interview findings were then funnelled through the data analysis to identify the core theme, role identity.

The specific issue of role identity, compounded by the role duality of the study participants, was then further explored through a review of wider literature on identity in relation to professional socialisation and transition to better support an understanding. The benefits and challenges to professional socialisation that arose, aligned to recommendations from the qualitative phase of research, led to decisions regarding the design and implementation of a booklet, which further narrowed down the focus through the quantitative phase of the pilot evaluation. Lessons have been learned from the pilot evaluation and these will be applied to the final evaluation which will take place outside this doctoral thesis.

In summary, Boyer's (1990) well recognised definition of scholarship focused on four elements of new knowledge; discovery, integration with existing theory, application to practice and dissemination. The evidence presented demonstrates that this research has contributed new knowledge to our understanding of the role duality experiences of these work-based learning nursing students, particularly in relation to their professional socialisation and transition from HCA to student. This knowledge has been integrated with wider theory, applied locally and disseminated locally, nationally and/or internationally through a range of presentations and publications.

Having discussed the findings in the context of professional socialisation, transition and the concept of self, the final word goes to the participants themselves. The concept of this professional socialisation process is summed up succinctly by Jo (student participant) who reflects on the programme and the self-realisation of the transition that has already occurred as a result:

> *"...actually as the HCA you go "They've got a really high temperature, it's your job as a nurse to sort it out" and now that realisation that actually, as a student nurse and a* progressing *student nurse is ... they've got that temperature or whatever that situation might be" ..."you start to look at them things rather than just going "That isn't right" and you go and tell someone"... "And you start to link, cos it's all about the different body systems, and you start to link, um, the sort of, the thermoregulation, and that, and you start to think "OK, someone's warm. Why are the warm?" And you look at the increased heart rate - "Why would an increased heart rate make someone warm?" And you go* "OH, I GET IT!"*."*

Jo's recognition of the acquisition of knowledge, recognition of defined student role concept and ability to perform as a knowledgeable carer has led to his/her final transition to '*being'* a student nurse. Clearly Jo derived great pleasure from this realisation. With the right support in practice it is likely all students will be able to enjoy their *'eureka moment'* more easily too.

EPILOGUE

Development of Scholarship of Practice

The doctoral journey acts as an apprenticeship in research for the doctoral candidate with the supervisors acting as the master researchers and the candidate becoming the topic expert. Wherever possible I have endeavoured to learn from reflections on the processes and outcomes along the journey and applied this learning to later activities.

The dual roles of practitioner and researcher have many commonalities, most of which link to leadership attributes. Both experiential and theoretical learning applied in one area automatically benefit the other and greater consideration should be given to this by the academic community when assessing the contributions of DProf study. The undertaking of the thesis itself has also been beneficial in building my skills and knowledge in a number of key areas. In summary, it has:

- supported my development as a researcher in both qualitative (exploratory interviews) and quantitative (survey) methods as well as MMR;
- enhanced my ability to synthesise learning from the DProf and apply to professional practice building the breadth and depth of my professional knowledge;
- enhanced my ability to critically analyse information, particularly in time critical situations;
- enhanced my ability to produce high level reports;
- enhanced my ability to be solution focused allowing me to rapidly produce a range of viable options and identify the best fit for the situation;
- enhanced my project management skills.

Through the interlinked professional and researcher development I have achieved a number of career progression opportunities, supported and led on regional and national projects (including the development of a national leadership programme and new models of nurse coaching/mentorship). I have presented at national conferences and published multiple articles – neither of which I had done prior to the start of this doctoral journey.

The main challenge for me as a part-time student has been the length of time that it has taken to complete. During this period, progression to a more senior role in the organisation has better supported my ability to implement findings from the study, but at the expense of being further removed from the research field and having no protected time for study. This is a disadvantage for many dual practitioner-researchers and requires careful prioritisation of work/study with detailed planning, identified timelines and study milestones, and continued focus and commitment.

I believe the same attributes that make a good doctoral researcher also produce a good senior manager. The skills needed for both are interlinked and lessons learned in one arena will transfer to the other with relative ease. The key to success is maximising those learning opportunities and visualising the competing priorities and challenges as opportunities, and not barriers, to success in developing doctorateness. For DProf candidates the outcomes derived from a professional perspective should be considered alongside academic outcomes in order for maximisation of the doctoral research process to be fully understood. At the outset (see Chapter One) my aim was to achieve nursing scholarship, therefore I will identify here whether this has been achieved and, if so, to what extent.

Table 10.1: Burrage's attributes of a scholarship of practice (adapted from Burrage, 2001)

Attribute	Developing Scholarship of Practice	Application to this study	Evidenced through
Role of Investigator	Collaborative model or Change Agent.	Change agent or catalyst for change.	Ability to influence change in the system.
Communication Patterns	Avoidance of academic language.	Avoidance of academic language within the necessary boundaries of doctoral study.	Interview transcripts, reports, publications.
	Use of active listening.	Use of active listening (evidenced through identification of cues and emotions in participant interviews).	Interview transcripts, coherent thesis.
	Recognition of need for cultural appropriateness.	Applied through different choice of language in student versus mentor interviews.	Interview topic guide, participant information sheets, invitation letter, consent forms and transcripts.
Research Focus	Often formulated by the participants rather than the researcher.	Formulated by collective stakeholders, filtered through literature review and refined by participants.	Engagement with stakeholders and study participants where possible. Use of this engagement to drive subsequent study phases.
Accountability	Expectation that problem will be solved.	This would have been unrealistic and does not fit with the approach. However there was an expectation that an improvement to practice (either by action or non-action) would be the driving force.	Implementation of initiatives believed to improve practice. Will need further research to determine level and sustainability of success.
	Risk that research will produce more questions than resolutions.	Clear acknowledgement of this.	As set out in thesis.
Flexibility	Often need to be pragmatic and "go with the flow" (p.51).	Flexibility applied through (for example) change from focus groups to individual interviews, amendment to ethical approval to enable participants to feed into recommendations.	Demonstrated through adaptations to approach highlighted in thesis.
Context	Multi-faceted in many cases.	Clearly multi-faceted context.	Demonstrated through thesis.
Significance of results	Demonstrated through recognisable changes in the health of individuals, populations or communities.	Recognition through validation of findings by a range of stakeholders, significance of booklets needs further exploration but credible to key stakeholders.	Validation through stakeholder feedback but will need further research to assess impact and sustainability.
Dissemination of findings	Whilst peer reviewed journals are desirable, the aim is to reach as wide an audience as possible to share best practice.	Widely disseminated.	Publications and conference presentations.

In the introduction, Burrage's (2001) notion of the essential attributes for a Scholarship of Practice was highlighted. These attributes have been revisited in Table 10.1 to benchmark my application of them through this study in order to measure my achievement. The wide knowledge and experience I have brought to the research field, not just of nursing practice, but of nursing, education and workforce policy and practice, have been invaluable in supporting the development of theory and application of that theory to practice.

In summary I would argue that I have achieved nursing scholarship through this doctoral study combining the three essential elements of research, theory and practice through the application of Burrage's (2001) attributes of a scholarship of practice. This nursing scholarship has not only led to a successful doctoral study but has impacted on my professional development leading to more senior roles where I am able to lead practice and provide influence at a regional and national level.

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APPENDICES

Appendix A: Data search results (example)

Database	Search Terms	Results	Additional Terms Used	Results
Medline	Education, distance	1084	*and* nursing, student	15
	Education, non-traditional	14	*and* nursing, student	0
	Open learning	375	*and* nursing student	0
	Open learning (restricted to English Language only and dates (1990-present)	321	*and* nurse	37
	Work-based learning	96	*and* nurse	37
	Flexible learning	180	*and* nurse	16
	Role identity	677	*and* nurse	27
	Role change	1367	*and* nurse	97
	Role change (restricted to English Language only and dates (1990-present)		*and* nurse	84
	Experiential learning (restricted to English Language only and dates (2000-2011)	475	*and* nurse	71
	Work-based learning		*and* nursing assistant	0
	Work-based learning		*and* healthcare assistant	25
	Work-based learning		*and* nurses aides	2
	Nurses aides	3267		
	Role conflict and nurse	121	*and* restricted to English Language only and dates (1990 – present)	99
	Role conflict and nursing, student		*and* restricted to English Language and dates (1990-present)	1
	Role transition	156	and nurse	83

Appendix H: Topic guide for students (qualitative interviews)

Topic Guide (Questioning Route): HCA/Student

Consent:	• Hand out consent forms, check further queries and receive informed consent.
Ground Rules:	• Mutually agreed ground rules to be set.
Opening Question:	• Tell us your name, where you work and what prompted you to take part in this research?
Introductory Questions:	• How are you enjoying the programme so far?
Transition Questions:	• What practice aspects have been particularly good? • Is there anything that you have found particularly difficult in practice?
Key Questions:	• What have your experiences of practice been in working a dual role (working as an HCA one minute and student the next)? • How well supported have you felt in practice, and where has this support come from? • What have your experiences been of working alongside colleagues in a) your HCA role and b) your student role? • Do you think your relationship with your mentor is different when you are student/mentor than when you are RN/HCA and, if so, how is it different?
Ending Questions:	• Is there anything else that you would like to tell me about your experiences of role duality (for you or your mentor)? • If you could give advice to other HCA/students regarding role duality, what would it be? • Is there anything else that you came here wanting to say that you didn't get the chance to?

Version 1: August 2013

Appendix I: Topic guide for mentors (qualitative interviews)

Topic Guide (Questioning Route): RN/Mentor

Consent:	• Hand out consent forms, check further queries and receive informed consent.
Ground Rules:	• Mutually agreed ground rules to be set.
Opening Question:	• Tell us your name, where you work and how long you have been a mentor?
Introductory Questions:	• How are you enjoying your experiences of mentoring on the programme so far?
Transition Questions:	• What aspects of mentoring these students have been particularly good? • Is there anything that you have found particularly difficult?
Key Questions:	• If you have mentored students previously, is it different mentoring these HCA/students (compared with traditional students) and, if so, how is it different? • What have your experiences of practice been in working a dual role (mentor one minute and RN colleague the next)? • How well supported have you felt in practice, and where has this support come from? • Do you think your relationship with your student is different when you are student/mentor than when you are RN/HCA and, if so, how is it different?
Ending Questions:	• Is there anything else that you would like to tell me about your experiences of role duality (for you or your student)? • If there is any advice you would like to give to other mentors regarding this role duality, what would it be? • Is there anything else that you came here wanting to say that you didn't get the chance to?

Version 1: August 2013

Appendix M: Questionnaire (qualitative evaluation)

Participant Consent to Participate:

Please read the Participant Information Sheet which accompanied your invitation email and ensure that you understand the following:

- I understand what my role will be in this research, and all my questions have been answered to my satisfaction.
- I understand that my responses are unable to be withdrawn from the research once I have submitted this survey data since my responses are anonymised.
- I am free to ask any questions at any time before and during the study (for contacts please see Participant Information Sheet).
- I understand what will happen to the data collected from me for the research.
- I have been provided with the Participant Information Sheet.
- I understand that quotes from me may be used in the dissemination of the research but will be anonymised.

If you have understood these key aspects and are happy to participate in this research, please proceed to the questionnaire below.

Survey Monkey Questionnaire:

The booklet "Top Tips for Supporting Work-based Learning Nursing Students" was developed based on an earlier phase of this research involving local OU students and mentors. Students felt that having this as a formal reinforcement of your student role would be beneficial and I am keen to evaluate whether this is the case. I would be very grateful if you could please respond to the following:

- Do you feel the booklet has helped ***reinforce your identity*** as a student?

Yes
No
Please qualify your response below:

- Do you feel it helps ***mentors*** better understand your role as a student?

Yes
No
Please qualify your response below:

- Do you feel it helps ***the rest of the nursing team*** understand your role as a student?

Yes
No
Please qualify your response below:

- Do you feel it has helped ***you*** better understand your role as a student?

Yes
No
Please qualify your response below:

- Please comment on your perceptions of benefits/challenges to the introduction of the booklet:

- Is there anything else that we could do to improve the booklet?

Survey Monkey Questionnaire

V.2 Sept 2015

Appendix N: Booklet – "Top Tips to Support Work-based Learning Students"

The Open University

NHS

Health Education East of England

Top Tips for Supporting Work-Based Learning Nursing Students.

Health care assistants (HCAs) who are training to be nurses through work -based learning may find it particularly difficult to feel like, and fulfil the role of, a student nurse. This is because the traditional socialisation process that takes place to support this can be affected by the need for them to continue working as an HCA alongside their new student role.

There are lots of factors which act as barriers or enablers for this process, most of which you can help to improve, and this booklet will give you some key tips to better support your student with this process.

Developing people for health and healthcare

www.hee.nhs.uk
hee.enquiries@nhs.net
@NHS_HealthEdEng

Developing a sense of "self" and protecting the student role.

The students should be supernumerary at all times on their student days. This is often challenging when students are in practice due to the moral pull of providing patient care. However, you can help support this.

Enablers and barriers:

- Uniform – wearing a distinct uniform provides visual reinforcement that they are working as a student. On student days they should be encouraged to wear their particular student uniform. If you do not wear a uniform in your area, encourage them to adopt informal uniform instead (eg a different colour, more formal clothing).
- Name Badges – Encourage them to wear their student badge on the appropriate days. This will again provide visual reinforcement.
- Developing a sense of "self" – if students are perceived by their team as a student then they are more likely to feel like a student themselves. Think about how you and your team see your student. Students report being seen as an "HCA doing extra" or an "HCA learning to be a nurse" and this is not helpful for students trying to adopt a student identity.
- If your student volunteers to give up supernumerary status in order to help meet service needs, please ensure this time is given back as protected practice learning time on another day. This will ensure they are not disadvantaged and can still meet their learning objectives.

Being a student: progressing from "Caring Doer" to "Knowledgeable Carer".

HCAs tend to be very caring and can carry out some highly skilled tasks. Thus they could be described as "Caring Doers". As students, they need to be "Knowledgeable Carers" – more holistically focused and having a broader understanding of the wider contexts and impact of healthcare.

Enablers and barriers:

- Take a Critical Friend approach with your student – just because they are competent in a range of skills as an HCA does not mean they are thinking or working holistically or that they understand the context of those skills or wider implications necessary for a student. Providing challenge to your student will make them think differently and encourage learning.
- Where you are allocating them similar work to that which they carry out as an HCA, ensure they understand the learning they are intended to achieve and question them to ensure they understand the "bigger picture" regarding holistic care for their allocated patients.
- Try to allocate holistic caseloads rather than tasks – you can offer to help them with the aspects they are not yet competent to undertake.
- Ensure that you do not forget your student when they are not there (they generally have two days per week in practice) and include them as part of the team. This will make them feel valued and they will be more likely to feel comfortable questioning aspects of care they do not understand and in coming to you when there is a problem.

- Do not forget your student when traditional students are invited to attend teaching sessions and/or learning opportunities. These should be available to all students.
- Find out early on what the competency level is of your student (taking account of need for underpinning knowledge to support skills competency) as your student may be capable of more than you are allowing them to do. This can result in them becoming frustrated in their role.
- These students tend to be quite self-sufficient and may not appear to need your support. This does not mean you that they do not have support needs, but rather that you may need to explore with them what those needs are. It is often a higher level of challenge that is required, getting them to teach as well as do, or lead a group of HCAs/students rather than working in isolation.

We hope that you and your student have a positive placement experience and that as a mentor you will be rewarded by the growth in confidence and competence of your student during their time with you. If you have any further queries about the programme, please contact your OU Employer Link or OU Practice Tutor *(Add details below):*

Appendix O: Another hurdle to overcome (Publication).

Available at http://dx.doi.org/10.7748/ns2012.05.26.38.72.p8422

Appendix P: Embedding NHS values: a framework and learning tool to support practice (Publication)

Available at http://dx.doi.org/10.7748/nm2014.02.20.9.31.e1159

Appendix Q: Role of the Practice Education Facilitator (PEF): The Cambridgeshire model underpinned by a literature review of educational facilitator roles (Publication)

Available at https://doi.org/10.1016/j.nedt.2014.03.014

Appendix R: Conceptual frameworks and terminology in doctoral nursing research (Publication)

Available at https://arro.anglia.ac.uk/583134/

Appendix S: List of simplified transcription codes

- **{ -** left hand bracket indicates a point at which one speaker's speech overlaps with the other.
- **WORD** – capitals indicate loud speech (in comparison to surrounding speech).
- **(( )) –** double parenthesis indicate the researchers description rather than actual words used (to protect anonymity or describe situation).
- **.** , ? – indicate intonation of speech.
- **Word –** use of non-italics indicates changed intonation, including stress, emotional distress, laughter.

Wherever possible bracketed descriptors have been included to allow additional information (including expressions, body language and tone) to be provided.

Based on: Silverman, D., 2013.