FACULTY OF HEALTH, EDUCATION, MEDICINE AND SOCIAL CARE

FITNESS TO PRACTICE WITHIN PRE-REGISTRATION NURSE EDUCATION - WHOSE RESPONSIBILITY?

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A thesis in partial fulfilment of the requirements of Anglia Ruskin University for the Professional Doctorate in Health and Social Care (DProf)

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Mum and Dad - your love and support.
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Husband:

"What manner of men are these that wear the maroon beret?". They are firstly all volunteers and are toughened by physical training…They have 'jumped' from the air and by doing so have conquered fear'…They are in fact - men apart - every man an emperor'.

You helped me conquer my fears and you are my emperor.

Anglia Ruskin University

Abstract

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Fitness to Practice Within Pre-Registration Nurse Education- Whose Responsibility?

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In the United Kingdom standards for pre-registration nurse education are set out by the professional nursing body, The Nursing & Midwifery Council who address what nursing students must do to achieve entry to the register. Their academic training is delivered by Higher Education Institution's with Practice Learning partners acting as placement providers.

Clinical practice is a fundamental aspect of pre-registration nurse education, with registered nurses acting as mentors, responsible for the assessment of competence which establishes a students' fitness for practice. The academic institution awards a recognised qualification, the student then applies to join the professional register.

This thesis is an examination of the perceived responsibilities between the symbiotic pre-registration nurse education partnership; professional body, academic institution and the practice setting when managing fitness to practice. The term fitness for practice and fitness to practice is an intermingled concept and remains an enigma with general definition and process defying clarity. This has resulted in confusion and regionalised responsibility between the academic and practice partner.

The aim of this study is to explore how fitness to practice is perceived and managed between the three-way partnership and to explore the possible discourses of responsibility and ownership of nursing students. Through a qualitative single exploratory case study approach, themes have been built using a framework matrix of ownership, focus groups of academic and practice mentor participants, to scrutinise collaborative demarcations of fitness to practice management.

By developing 'The Ownership Gap' three key themes were identified: Education, Clinical Practice and Professionalism. Through this model, the findings suggest that fitness to practice remains separated between process and responsibility between the academic and clinical partnership, coined as the 'ownership gap'. The study offers recommendations to influence and enhance collaboration between the academic institution and practice to procedurally maintain fitness to practice processes.

In conclusion, the study has shown that a gap in ownership exists between the partnership and that responsibility is a default of the academic institution.

GLOSSARY

CfC - Cause for Concern

CoP - Community of Practice

DoS - Director of Studies

EC - Education Champion

ENB - English National Board

FtP - Fitness to Practice

GNC - General Nursing Council

HCA - Health Care Assistant

HEI - Higher Education Institution

IRAS - Integrated Research Application System

M - Mentor

NHS - National Health Service

NMC - Nursing & Midwifery Council

PAD - Practice Assessment Document

PEF - Practice Education Facilitator

PT - Personal Tutor

R&D - Research & Development

RN - Registered Nurse

SoN - School of Nursing

UKCC - United Kingdom Central Council

UK - United Kingdom

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Chapter One – Background

1.1 Introduction

The focus of this study is to examine how the university the researcher works for as a Director of Studies (DoS) implements the Fitness to Practice (FtP) regulations that may affect the key stakeholder's sense of role and responsibility within process. The three stakeholders are the Higher Education Institution, Practice Learning partner and the professional regulatory body, the Nursing & Midwifery Council. This tripartite relationship is critical in the management and responsibility within the researcher's own university between the professional body requirements and the local Practice Learning partners.

The Nursing & Midwifery Council (NMC) as part of this tripartite arrangement requires all Higher Education Institution's (HEI) in the United Kingdom (UK) to implement a nursing curriculum which produces after three years a nurse fit to practice. While this is particularly important in the researcher's role of DoS, for the purposes of this study the main exploration will be student's ability to be fit to practice during their nursing studies. The two terms Fitness to Practice and Fitness for Practice often appear interchangeable however this is not the case and while they will both be discussed the focus of this study will always be Fitness to Practice (FtP).

Holland et al. (2010) established that fitness to practice as an acquisition of skills, knowledge, and attitudes. They suggest that fitness for practice appears to be used to refer to professional competence, that is having sufficient knowledge and skills to be able to practice safely, and the term fitness to practice is more frequently associated with health and conduct.

Managing FtP within the nursing profession is critical. Stakeholders, employers, and the public must have confidence in clinical competency and regulatory processes of the profession. The main purpose to uphold the profession, standard guidance and regulatory policy which enables the NMC to fulfil its statutory objective of protecting the public in the UK. Protecting public safety through education standards and policies must therefore be consistent, transparent, and robust (NMC, 2015).

The NMC set education standards which shape the content and design of programmes, but curricula are delivered by their approved partner institutions. Programmes across the UK determine the nature of the theoretical learning and practice is supported by the Practice Learning partner. The Practice Learning Partner provides a range of placement experiences within the National Health Service (NHS) and other independent and voluntary sectors to achieve the expected professional outcomes.

To become a registered nurse or midwife, students must complete a three-year programme which leads to professional registration and academic accreditation. Since 1860, Florence Nightingale's training school St Thomas's Hospital taught nursing and midwifery as a formal profession within a School of Nursing. The standardisation of nurse training is therefore not a new concept with the legal requirement of subjects for nursing programmes dating back to 1919 when nurses became regulated by legislation through the Nurse Registration Act 1919 in the UK (Carney, 2016).

However, a new approach to training nurses began in 1989 with the advent of Project 2000. Replacing the apprenticeship model, Project 2000 educated nursing students in the NMC approved HEIs. HEIs then became the programme providers responsible

for the delivery of pre-registration education entitling nursing students to full student status.

Being fit to practice according to the NMC is a professional requirement that a nurse, midwife or nursing associate must have the skills, knowledge, health, and character to do their job safely and effectively (NMC, 2015). Fundamentally however, the NMC no longer regulate nursing students, this is addressed by the HEI. Policy statements of FtP clearly articulate the NMC's position regarding a registrant, but pre-registration nursing students are subject to university regulation.

The focus of this study is to examine how university FtP regulations affect the three stakeholder's sense of role within the process and is critical in the examination of responsibility.

This chapter will provide the background to evolving responsibility of FtP through historical, contemporary, and key educational events, local university policy and pre-registration nurse education literature. To support the notion that responsibility for managing FtP appeared to become misaligned between the academic, professional and placement setting, this chapter will scrutinise the chronological sequence of events between stakeholders.

Chapter two will discuss the search strategy utilised for the literature review. Through an appropriate search strategy, exploration of literature around the concepts and beliefs between the partnership for FtP responsibility will be considered. The following 3 chapters will then discuss methodology, methods and findings providing a rationale for the study itself and subsequent discussion chapter. The approach from a qualitative perspective will be explored throughout the thesis and limitations discussed in chapter 7 and considers further study objectives.

Through exploration of the links between the academic, professional and Practice Learning partner perspectives for FtP responsibility, the theory framework used within this study, as suggested by Durham et al (2015) is to move from a descriptive stance to a conceptualisation of the study to gain useful information of the key stakeholders' perceptions of responsibility and ownership to FtP.

This exploration is depicted in a framework matrix which is a way of summarising background documentation and policy and is used as a method to encourage the organisation and summarisation of the research to manage and interpret the data. The framework matrix developed is reflective of the stakeholders involved, due to the practical nature of the study, to represent the foundation of responsibility and partnership implications within the researcher's university.

The core features of the framework matrix are built to visually represent themes, provide a data summary which has direct links to the primary research to capture the context and provides a systematic method for creating and populating the matrix (https://www.betterevaluation.org/en/evaluation-options/framework_matrices#:~:text=A%20framework%20matrix%20is%20a,the%20columns%20of%20the%20matrix).

By adopting this approach, the researcher will visually represent the tripartite relationship and their connection to local management of process has occurred titled 'The Ownership Matrix' (page 104). Acting as a map to design the research, The Ownership Matrix will offer a cohesive format of background knowledge of relevant literature, conceptual links and relevant methodology for the study and its implication for a professional doctorate and to act as a practical application for FtP management between stakeholders and will enable the adaption of the findings to practice.

1.2 The move to Higher Education - Professional regulation and the Practice Learning Partner

Universities were commissioned by the UK Government Department of Health (DoH) to deliver pre-registration nurse education courses to meet professional body standards by integrating nursing, and midwifery, into Higher Education. The aim was to '…*work more closely together and the National Health Service (NHS), as a major investor in education and champion for patients, needs to give a stronger lead to the universities'* (DoH, 1999p.24).

This newly established tripartite partnership between the professional body, university and NHS sought to ensure a greater consistency in the knowledge and skills nursing students attain upon completion of their educational programme. The NHS is the main provider of clinical practice placements for nursing students in the UK but throughout the thesis the researcher will refer to the Practice Learning Partner which encompasses all placement opportunities pre-registration nursing students experience, including but not limited to, those in the independent sector, community, mental health, learning disability, adult, child, and midwifery.

The nursing students' three-year programme requires confirmation to the professional body that both practice and theory parts have been successfully achieved in partnership with the university as the awarding body (Nursing & Midwifery Council, 2008). Educational and professional standards require the student to develop identified competence in clinical skills, knowledge, good health, and good character to practice safely and effectively at the end of their university course (NMC, 2015).

Standards framework for nursing and midwifery education enable nursing and midwifery students to achieve proficiencies and programme outcomes and must be practised in line with the requirements of 'The Code' (NMC, May 2015). 'The Code'

provides detailed information about the professional standards of practice and behaviour and are not negotiable or discretionary (NMC, 2015). For example, 'The Code' sets out common standards of conduct and behaviour based on four elements:

- *Prioritise people*
- *Practise effectively*
- *Preserve Safety*
- *Promote professionalism and trust.*

(NMC,2015).

Furthermore, the professional body will investigate a registrant if an allegation is made that they do not meet the standards for skills, education, and behaviour. 'The Code' however, only relates to registered nurses, midwives and nursing associates and does not apply to pre-registration nursing students, they are subject to university regulations (NMC, 2018). The expectation is for nursing students to apply the code in principle but are subject to university code of conduct which reflects the NMCs.

University regulations to address nursing students' fitness to practice were implemented following the NMC's 2006 recommendation that HEIs should establish processes to respond to matters that arose about the student through their disciplinary processes. Therefore, for the duration of the three-year programme, FtP becomes a university procedure which reflects the professional body standards framework of personable and professional attributes a nurse is expected to exercise. FtP assures that the student has met the necessary professional standards, but FtP is the process whereby the student has been subject to university disciplinary proceedings (Keogh, 2013).

The subject of university disciplinary proceedings if a concern is raised about a nursing student within the researcher's own HEI are reported to the Director of

Studies (DoS). The researcher of this study is the DoS for the Faculty of Health, Education, Medicine and Social Care who has the responsibility for the FtP investigation. The DoS takes appropriate action for courses which qualify students for professional accreditation by another organisation. If, concerns are raised because of the investigation, the DoS calls for a meeting of the university FtP Committee and will transfer over to the committee secretary, a written statement with the reason/s for the concern.

This reporting process ensures the HEI maintains its responsibility for attending to issues during the nursing students programme for public protection and professional safeguarding measures.

1.3 Professional, Academic & Clinical – a new educative and practice connect

At the beginning of the 20th century formalised syllabuses for nurse training began in 1923 following the Nurse Registration Act 1919 which established the General Nursing Council (GNC) with responsibility to maintain a register of qualified nurses (cited in Carney,2016). The GNC was replaced by the Nurses, Midwives and Health Visitors Act of 1979 which received royal assent on 4 April 1979 and provided a Central Council for Nursing, Midwifery and Health Visiting (with national boards for the four countries of the UK) to make provision with respect to the education, training, regulation, and disciplinary action. The Nurses, Midwives and Health Visitors Act 1979 also required the council to establish and maintain a single professional register. (http://www.legislation.gov.uk/ukpga/1979/36/contents accessed August 2017).

As a result, the nursing profession became responsible for its own self-regulation which meant that for the first-time, nursing could implement their own educational direction and a minimum standard was set for each nurse's clinical responsibility

(Nursing Midwifery Council, 2010). Furthermore, the Nurses, Midwives and Health Visitors Act 1979 presented the profession with a new status of autonomy and competency and the last formalized syllabus from the GNC was issued in 1977 (Carney,2016) with the United Kingdom Central Council (UKCC) as the successor.

The UKCC governed the search for a new direction in pre-registration nurse education and approval of such registration changed from a programme delivered via approved Schools of Nursing (SoN) at certificate level, to Higher Education diploma level, or higher degree, through the HEIs. What followed was a reformation of pre-registration nurse education in 1985, which replaced SoN with a more fluid and creative method of educational development by Higher Education (Ousey, 2011).

This development initiated the move of pre-registration nurse education into HEI's and the traditional philosophy of 'chalk and talk' and 'learning on the job,' aligned to hospital based SoN, to empowering nursing students with supernumerary status in the clinical setting (Bentley, 1996). Student nurses were no longer health authority employees but had full student status and the UKCC's response for the new thinking of nurse preparation proposed that "programmes of education and training, must be given the right combination of educational stimulus and supervision" (United Kingdom Central Council, 1986,7.1,p.54). The Project 2000 curriculum was this innovation and provision of placements remained with the NHS and other practice learning opportunities which remains key today.

Project 2000 was based on an equal delivery of theory and practice with the educational assumption that "*nurses would benefit…as rounded and developed individuals rather than qua patient carers, producing a managerially capable nurse by extending the educational needs of the students than existed previously*" (Bradshaw, 2001c p.33). It had been argued by the UKCC that entering the Higher Education

arena would herald the acquisition of core clinical skills required by students to demonstrate competence in a *"specified range of nursing skills and responsibilities, compatible with current nursing theory"* (United Kingdom Central Council, 1986,p.8).

In 1989, the reformed pre-registration nurse education programme commenced, Project 2000 was designed to ensure fitness to practice. The nursing and midwifery professional regulatory body, the UKCC, asserted that Project 2000 would produce a nurse fit for practice at the point of registration (Bradshaw, 2001a).

However, following a decade of implementation, Project 2000 drew negative attention about the levels of preparedness for practice at the point of registration, and the acquisition of clinical skills at the point of entry to the register, had been *"weakened on implementation because of ongoing clinical developments in the National Health Service and in education*" (United Kingdom Central Council, 1999 ,p.3). Fragilities in Project 2000 became evident with the UKCC stating that "*fitness for practice was difficult to define - its meaning cannot be fixed*" (United Kingdom Central Council, 1999 4.5, p.34).

1.4 Placing students - The clinical dichotomy of Project 2000 and Higher Education

To achieve the correct balance between academia and clinical practice, the UKCC called for the systematic planning of placements, stating that "*the overall structure within which education takes place must be that it fosters that delicate balance between theory and practice*" (United Kingdom Central Council, 1986,7.1,p.54). The forging of a new partnership between the academic environment and clinical setting was to be maximized in Project 2000 and was seen to act as the conduit for professionalism through accountability of the '*mastery of skills'* (Watson, 2006).

The concept of an equally divided programme, whilst allowing for consolidation of theoretical underpinnings for clinical practice, would provide the solution to producing competent nurses and was to act as the UKCC's attempt to strike an appropriate balance between academic understanding and clinical competence as achieved in other health professional course such as Physiotherapy and Occupational Therapy. It was argued by the UKCC that entering the Higher Education arena would herald the acquisition of the core clinical skills required by students to demonstrate competence in a "*specified range of nursing skills and responsibilities, compatible with current nursing theory*" (United Kingdom Central Council, 1986,p.8). Essentially however, the clinical area held responsibility for consolidation of clinical competency.

The proposal to offer initiatives in general education and vocational education was crucial, but there was recognition that when nursing and Higher Education came together, the reformed partnership needed time to adjust to delivery changes and to collaborating with each other (Allen, 2009). However, cracks soon emerged, and condemnations of Project 2000 became increasingly difficult to ignore, with wide acceptance that theory had overtaken practice (Bradshaw, 2001c). For example, Clancy et al. (2000, p.259) stated that maintaining theory and clinical competence was not conducive to practice development as "*students were not as confident as staff that they could explain the biological basis of their practice, they wanted to understand more about the clinical conditions they meet*".

However, Rafferty (1992) had proposed that Project 2000 was revolutionary, not in itself, but in its implementation. The new curriculum opted for an alternative system from the original apprenticeship model in which students were heavily involved in service needs with application of a theory and practice working relationship. Principally, Rafferty (1992) argued that every aspect of education must be carefully planned, and whilst Project 2000 had quite an extensive preparation planning

document, the art of nursing had been affected by several factors within the curriculum. For example, learning opportunities within the clinical setting (NHS) centre on teaching but clinical and staffing issues within the NHS and the (dated) view of nursing sick people, was not mindful of the curricular principle of developing a reasoning, critical thinking, and self-motivating student (Rafferty, 1992).

The application of learned theory within a placement had, according to Rafferty (1992) required several elements to facilitate reality and the ideal. Thus, Rafferty argued that the need to focus on the delivery of nursing theory to support clinical practice would bring the element of applied learning to the clinical setting.

This was considered as essential for greater nursing knowledge between the partners with Rafferty (1992) arguing that through Project 2000 theory and practice would allow for the development of skill learning to make '*practice meaningful'* by forging the links between the two elements. However, unless learning opportunities are used to formulate and guide clinical practice, learners will not make links themselves and Farrand et al. (2006,p.98) went as far to say, shortfalls in the development and practice of clinical skills were '*affected by the arising emphasis on academic theory at the expense of practice-based training' and that nurses had not entered the register as expected".*

This expectation was researched by MacLeod Clark et al. (1997) as part of their comprehensive study of perceptions of the philosophy and practice of Project 2000 preparation. MacLeod Clark et al. (1997) collected data from students and newly qualified diplomates supported by focus group interviews held with nurse managers and G grade practitioners (ward manager level). The aim of their study was to examine students' and diplomates' perceptions of their future professional contribution in the light of practice preparation, alongside ward managers and G

grade perceptions of Project 2000 nurses entering the profession. Thus, all participants were invited to discuss preparation for practice with the focus of reflecting on (their) Project 2000 course. The researchers did not identify a specific methodological approach other than simply gaining insight into the two centres studied and the participants involved.

Data collection involved questionnaires, in-depth interviews, and focus group interviews in two study centres, one in the North of England and one in the South. The study consisted of four cohorts of Project 2000 students, newly qualified diplomates and managers/practitioners in each centre completing questionnaires at 9 monthly intervals, over an 18-month period. The managers and G grades were interviewed in separate focus groups. Two cohorts of students in each centre learnt under Project 2000 were examined to explore the differences in perceptions between the student's preparation and the diplomates perceptions in their professional contribution. Reflections in terms of subject content, teaching and its relevance were sought using questionnaires about preparation for practice, with results expressing findings that most respondents felt well prepared from a response rate of 74% (of 181) at the 18-month interval stage (18 months, 27 months, end of course and 6 months' post course).

In total 1200 questionnaires from 494 students (leading onto being diplomates) on three occasions at 9-monthly intervals produced figures that remained quite static at the 27-month point with 78% still feeling prepared. However, a rise to 88% felt prepared but with a drop to 75% six months post qualifying. This presents an interesting perspective that students felt well prepared for practice initially, but with a 13% drop post-qualification six months into registration may have been their reflections once the reality of practice became evident.

These findings however are reflective of only post qualifying Project 2000 nurses but the findings within the focus groups of senior nurse managers and practitioners acknowledged the need for balance between theory and practice and the initial skill deficit/support and supervision were similar in perceptions of those of the Project 2000 diplomates. Managers and practitioners were generally positive about the emerging Project 2000 diplomates and would employ them but recognised that preceptorship, support, and balance was required.

The study by MacLeod Clark et al. (1997) does not demonstrate the specific thoughts and feelings of the managers and G grades who were interviewed in focus groups. Furthermore, even though the respondents were from two organisations, there may have been some element of bias within their own practice areas. For example, whilst the participant's response rate seemed reasonable, there were no clear indicators as to which site the respondents were employed. Also, the results did not clearly identify who had responded to what i.e., whether they were the students, newly qualified diplomates or managers or G grades.

However, what can be gleaned from the collected data was a need for preceptorship, getting the balance right in terms of theory at the expense of practice and preparation for a role in the community. Fundamentally the relevance of MacLeod Clark et al. (1997) study within this literature review, is their suggestion that the need for a reduction in general theory at the expense of practice had, as its basis, an issue on the equal delivery of theory and practice. The programme structure of Project 2000 comprised two halves - 18-months Common Foundation Programme (CFP) and 18-months branch. The CFP consolidated theory in readiness for branch, with branch amalgamating theory into clinical competency.

The participants in the Macleod Clark et al. (1997) study identified that between the CFP and branch, the initial was too long and the latter too short, and this was a key finding in their research. They drew the conclusion that the participant's perceptions were at odds with the (perceived) mismatch of balance between CFP/theory and branch/practice suggesting that a reduction in stress for both students. Furthermore, as suggested by Rafferty (1992), practitioners may have been able to enhance practice if students had felt more confident in some basic aspects of nursing care at an earlier stage in the course.

Project 2000 had been created as a way forward for pre-registration nurse education but, does appear to have influenced the student's ability to achieve clinical experience, as argued by Macleod Clark et al. (1997). The two separated elements of theory and practice consolidation had produced not only a delay in allowing students to fully engage and integrate within practice, but with the greater emphasis on the CFP biological and life sciences, there was a loss of clinical confidence at the point of registration.

The split between CFP and clinical branch of Project 2000 was originally intended as a curriculum to redress the balance of pre-registration nurse knowledge. This redress was examined in detail by Cope et al. (2000) of recently qualified nurses in Scotland and the aim of the study was to examine their experience on placements. The study was conducted with two groups consisting of two groups recently qualifying nurses from two different intake cohorts, one had recently completed their nurse learning from the last 1982 curriculum scheme. The second group was made up of student's completing the first Project 2000 curriculum scheme of 1992. A random sample of 10% from each cohort were selected using student registration numbers, resulting in 11 from the 1982-scheme (82-group) and 19 from the 1992- scheme (92-group). The data was collected through questionnaires supporting discussion for the semi-

structured interviews. Semi-structured interviews were carried out and the content of the questionnaire used in the interview identified several areas of the curriculum.

One of the striking results was the similarity of the responses describing their placement experience between the 82-group and the 92-group. According to Cope et al. (2000) the 82-group devoted around 20% to theory and 80% to placement but the 92-group undertook around 40% theory with 60% practice. This presents some dichotomy to the study in-so-far that the programmes are quite different in content, context, and delivery style but similar themes did emerge. However, it is of relevance that the variations in practice were key. For example, the curriculum of 1982 is markedly different from the 1992 group version as they were trained under the 'traditional' apprenticeship style course compared to the student status of curriculum of Project 2000 furthermore, consideration of the differences between the two cohorts was reflective of the delivery and timing of placements. Furthermore, the 1982 group had qualified the previous year and issues with participant recall were noted.

Attendance in the clinical setting for the 82-group equated to approximately 118 weeks' practice time compared to 88 weeks for the 92-group. This is a clinical experience loss for the 92-group of 25% and fundamentally timing of placement does not appear to have been considered as relevant to the study. Therefore, it can only be assumed that the findings are reflective of each groups' feeling based purely on their attendance within placement. Differences between the two programmes such as sense of community, the contextualization of learning and the support of learning in practice, were described and the conclusions drawn by Cope et al (2000) suggested that for both groups, a similar experience within placement was encountered.

However, one of the differences between the groups was the 92-group reporting induction difficulties associated with shorter placements in practice compared to the

82- group. Overall, though, the experience itself was considered as significant to contextualizing nursing practice. However, Cope et al. (2000) suggested that one of the problems was that there was a long delay before students had the opportunity to practice hands-on, and this may well have contributed to a gap between learned theory and the opportunity to put into practice. Their research was also indicative of the specific learning delay for the chosen branch between theory and practice between entry to the CFP and branch in-so-far of the 18-month time difference.

Aside from any limitations, the complexities of professional practice therefore are bound in the clinical setting underpinned by a well-developed knowledge base and the theoretical perspectives presented in the college components of the course and the realities of practice deepen in their meaning Macleod-Clark et al. (1997). It became clear that the placement setting was to set learning into a meaningful context and this had a powerful situating effect on its meaning. Essentially, placement experience and learning remain a fundamental aspect of nurse education and therefore has relevance in my study.

1.5 Reporting on Fitness for Practice – The Criticisms Leading to Fitness to Practice

As a result of the criticisms of Project 2000, the UKCC commissioned a review of pre-registration nurse education programmes. Titled '*Fitness for practice, The UKCC Commission for Nursing and Midwifery Education'* the review sought to re-examine educational needs of nurses and support mechanisms post Project 2000 with proclamations from the chair Sir Leonard Peach, that professional contributions of the nursing and midwifery profession to the health service were immeasurable but shortcomings existed within the preparation of registration (United Kingdom Central Council, 1999). Recommendations from the report aimed to build on achievements

and make good the deficiencies in the curriculum (United Kingdom Central Council, 1999).

Supported by the UKCC findings, the DoH aimed to produce a strategy to make changes in nurse education "*to prepare a way forward for pre-registration nursing and midwifery education that enables fitness for practice based on health care need*" (Department of Health, 1999,2.26,p.14). The Governments strategy, intended to apply a stronger practical orientation to pre-registration education and training, was implemented through the 'Making a Difference' strategy (Department of Health, 1999). The strategy acknowledged that "*in recent years' students completing training have not been equipped at the point of qualification with the full range of skills they need*" with recognition by the DoH that the provision of clinical placements was seen a vital part of nurse education (Department of Health, 1999).

The fulfilment and acquisition of clinical skills for newly qualified nurses was neither satisfactory nor conducive to practice development (DOH 1999). Between higher education and the placement providers, producing a nurse fit for practice at the point of registration had not been achieved and the aim of the strategy was for nurse education to make explicit the sense of responsibility between the education setting and clinical area. Therefore objectives to prepare the largest "*professional group in the National Health Service (NHS) to produce practitioners who are fit for purpose*" (Department of Health, 1999,p.23) were acknowledged to strengthen pre-registration nurse education and training by advocating a clear shared commitment between the partners.

The emphasis on partnerships changed focus with Section 13 '*Working in Partnership'* "*closer working partnerships between HEI's and service providers- are of relevance to all parts of the United Kingdom*" (United Kingdom Central Council,

1999,13,p.4). This was implemented through recommendation 25: "*Recognising that no one individual can provide the full range of expertise required…service providers and HEIs should work together…"* (United Kingdom Central Council, 1999,5.22,p.48). Problems with the organisation and supervision of practice placements, however, hindered the facilitation of practice skills with the UKCC stating that: "*The assessment of fitness for practice depends on the scope and nature of practice…"* (United Kingdom Central Council, 1999,4.4,p.34). Fundamentally, the UKCC commission report found that the timing of placements were too condensed with allocation of placements being "*too short and lacking relevance*" (United Kingdom Central Council, 1999,4.29,p.38). Thus, greater attention in the future would be paid to the provision of placements which led to the recommendation for earlier, field specific placements. This new approach would help nursing students gain better practical skills compared to the current 18-month CFP (DoH, 1999).

Principally however, the structure of delivery for pre-registration nurse education is stipulated by the professional body so that practice experience continued to make up 50% of the nursing curricula (United Kingdom Central Council, 1999,4.4,p.34). The programme structure of pre-registration education remains as standard today in the UK on an equal delivery pattern of 50% theory and 50% practice but essentially the clinical area now holds responsibility for consolidation of clinical competency. Emphasis is placed upon the Practice Learning partner and arguably if fitness for practice is the domain of the clinical setting, placements had, through curriculum and equal delivery, sufficient time to impart clinical knowledge for preparing nursing students for entry to the register, the dichotomy being that service was re-defining the delivery of education rather than education re-defining service. Thus, the clinical area historically holds responsibility for clinical competency, but it would appear the move from 'in-house' SoN training to external provider, HEI, caused practice conflict and this sense of responsibility was questioned by Meerabeau (2001, p.431) who stated

that numerous "*articles overlooked the fact that the NHS is not just a purchaser but is also a provider of education in that it provides many of the clinical placements and clinical teaching*".

However, comments that student nurses were ill-prepared for practice placements, which were also poorly planned and short, and referred to competitive consortia and bureaucracy questioning whether employers, or HEIs, were in a position "*to meet the requirements of the contract, particularly regarding the number and quality of clinical placements*" (UKCC 1999, 5.4, p,.45). In essence, the background suggests that the professional body advises the HEI of curriculum content, the HEI deliver the content and the placement provider delivers the practice experience. Therefore, it could be argued that the academic body *'owns'* the student in a regulatory way and the placement providers are responsible for achieving clinical proficiency with the professional body stepping back to allow the academic and practice partnership to work together in synchronicity.

The change of provision from the on-site SoN (and therefore in-house training) to HEI's, was granted as a contractual obligation for service delivery provision. This was regarded by the UKCC as key to working in partnership stating that "*students were no longer employees of the service provider and are now regarded as the charge of the HEI"* (United Kingdom Central Council, 1999,5.1,p.45). Practice should be planned to promote integration of knowledge, attitudes and skills, paying attention to the full 24-hour and seven day a week nature of health and would require joint collaboration of partners (O'Mara et al., 2014).

The focus at this stage of pre-registration nurse education appeared to revolve around nursing students being fit for practice at the end of their programme for entry to the register. *'For'* implies '*in support of or in favour of'* which is suggestive of pre-

registration curriculum being in support of a person or policy, but policy and curriculum had not met expectations. The shift of focus on how better the partnership would work together was considered as a fundamental shift in the way curriculum and placements operated between the partnership would move forward.

The planners of the future direction of pre-registration nurse education should had understood the implications of separating out education into the HEI arena but with the delivery of placements being separated out to the Practice Learning environment. Delivery of in-house training had altered each partner's perspective of their position and therefore responsibility with pre-registration nursing students. Therefore, reaching the '*end of a range or after a period'* is similar but different in its context. And hence FtP became the way forward following the recommendations of the UKCC Commission report to act on how the partnership could operate more coherently.

Increasingly there has been debate nationally and internationally regarding how nursing education programmes protect the public (MacLaren et al., 2016). It has been suggested that the university has responsibility for the monitoring of the FtP of pre-registration students during their programme, while the practice area has responsible for the practical aspects of *"on the job"* learning. The (National Nursing Research Unit, 2009) suggest that there are varying understandings of competence and a disparity between the university based perception of competence and that of competence in practice. On the one hand in practice competence is reductionist and depends upon whether the student nurse is capable in the performance of skilled tasks. While academically at university competence is seen as the ability to be able to link practice-based knowledge and theoretical critical thinking.

Goudreau et al, (2009) suggests that competency is based on you being able to mobilise knowledge, skills, attitudes and external resources and then applying them

appropriately to situations. Scott (2008) concluded that competency standards must be achieved for entry onto the register, but evidence is further required of collaboration between education and service providers. This suggests that whilst power is transferred to the mentors or supervisors/assessors, the weight of accountability and responsibility in terms of passing or failing students can be confused by the differing agendas between the chosen university and the students current Practice Learning partner setting. Even so by supporting the learning environment, the mentor, supervisors/assessors evaluated competency and appraises the students' needs to achieve satisfactory standards of proficiency and must be considered key to ensuring FtP.

Policies and educative changes implemented from the eighties, sanctioned a new tripartite relationship between the professional body, academia, and practice placement setting endorsing a new approach to training nurses from the apprenticeship model delivered within the SoN to HEI delivery of Project 2000. Reformed decision-making processes highlighted competing demands between the tripartite relationship through modifications and transformation of education, instrumental to FtP which can be attributed to key government documents, professional body standards and higher education within those periods.

The continuum of change, pertinent to each phase, can be seen to alter responsibility through historical application of key documents which can be charted to the relevant phase of pre-registration nurse education and will set out the nature and complexity of FtP management to enforce the researchers case study approach of using multiple sources of documentation.

Key milestones within each phase, offer significant educative adaptions, rulings, and strategy to the management of FtP and stakeholders perceived sense of

responsibility. Therefore Table 1 Key Documents was created to catalogue in chronological order government, professional body, and higher education policy to charter important events. Each new development was crucial to change in responsibility for FtP.

Therefore, this order of changes, respective of the policy at the time, will identify key change for the stakeholders to enhance discussion of responsibility and ownership throughout the study. Key Documents adopted by the stakeholders in the lead to change from the SoN to the HEI from the period 1979 to 1986 and allows for discussion. This can be considered as the Pre-Project 2000 phase with documentation 1986 to 2006, reflecting the Project 2000 era and changes made to pre-registration nurse education. The latter key documents reflect changes made within Project 2000 to present day. Furthermore, the era and subsequent change charted, will be reflected throughout the study to provide definitions which will underline key concepts and findings explored within the study. The key documents to facilitate this discussion and underlining of definitions and flow of reason throughout, were focused mainly on the Project 2000 and Post-Project 2000 era for responsibility and ownership concepts.

Documents **2, 4, 6,** and **18** were fundamental to the study as they offered significant analyse on how the professional body implemented change and how higher education responded and the implications on the practice setting, thus aiding development of the research aims and questions.

Table 1 Key Documents

Nos.	Key Documents	Author	Year
1	The Nurses, Midwives and Health Visitors Act	English National Board	1979
2	Project 2000: A New Preparation for Practice	United Kingdom Central Council	1986
3	The Need For Change In Nurse Education: A Literature Review. *Nurse Education Today,* 16, 131-136.	Bentley, H.	1996
4	Fitness for Practice. The UKCC Commission for Nursing and Midwifery Education.	United Kingdom Central Council	1999
5	Making A Difference.	Department of Health	1999
6	The Project 2000 Nurse	Ann Bradshaw	2001
7	Standards To Support Learning And Assessment In Practice	Nursing & Midwifery Council	2006
8	Pre-Registration Nurse Education. The NMC Review and The Issues	Royal College of Nursing	2007
9	Standards to Support Learning and Assessment in Practice. NMC Standards for Mentors, Practice Teachers and Teachers	Nursing & Midwifery Council	2007
10	Guidance for The Introduction of The Essential Skills Clusters for Pre-Registration Nursing Programme.	Nursing & Midwifery Council	2007
11	Nursing Competence 10 Years On: Fit For Practice And Purpose Yet? *Journal of Clinical Nursing*, 1263-1269.	Bradshaw, A. & Merriman, C.	2007
12	NMC Standards For Mentors, Practice Teachers. *2.1 NMC Mentor Standard.*	Nursing & Midwifery Council	2008
13	Standards To Support Learning And Assessment In Practice. *3.2.3 Allocated Learning Time For Mentor Activity.*	Nursing & Midwifery Council	2008
14	Guidance on Professional Conduct of Nursing and Midwifery Students	Nursing & Midwifery Council	2009
15	The Legacy of Project 2000. *Nursing Standard,* 23, 18-21.	Allen, D	2009
16	Guidance On Professional Conduct. *What Does The NMC Do?*	Nursing & Midwifery Council	2009
17	Good Health and Good Character: Guidance for Approved Education Institutions	Nursing & Midwifery Council	2010
18	Standards For Pre-Registration Nursing Education. *Section 1: Introduction.*	Nursing & Midwifery Council	2010
19	Independent Inquiry Into The Colin Norris Incidents At Leeds Teaching Hospitals NHS Trust In 2002. Yorkshire And The Humber Strategic Health Authority:	Proctor, S.	2010
20	The Code Professional Standards Of Practice And Behaviour For Nurses And Midwives	Nursing & Midwifery Council	2015 2018
21	Practice Assessment Document	ARU	2018
22	FtP strategy	ARU	2018
23	University Regulations	ARU	2018

1.6 Chapter summary

Project 2000 was developed as an equal theory/practice-based alternative to the long running apprenticeship model. A new partnership between universities and practice was created underlining a shared commitment to preparation of nursing; "*the largest professional group in the NHS, to produce practitioners who were fit for purpose"* (Department of Health, 1999,p.23). However, after a decade of education nurses under Project 2000, showed practical skills deficiency which was a concern post-Project 2000 and managers argued that newly qualified nurses were not fit for practice or fit for purpose. The challenge created by the deficit, and therefore ownership, for the newly modified academic/clinical partnership has focused the need to examine this area within my study.

The intellectual component taught in the HEIs was perceived as an overload of academic tasks, but the students had undertaken 50% of their mandatory 4600 hours of pre-registration education in clinical practice. This suggests that the clinical setting has the balance of time to provide learning opportunities to teach competency skills to their upcoming peers.

The UKCC urged a working partnership between the HEIs and practice learning partners. There was dual responsibility for the quality of learning in the practice area but the association for responsibility and ownership had been absent and thus focus was required to re-establish the equilibrium of pre-registration nurse education as a facilitative partnership. Curriculum of Project 2000 with its placement delivery had remained a disconnected process between the partnership.

While ownership and responsibility appeared pre-Project 2000 to be owned by the clinical setting with SoN simply orchestrating the placement contracts, the researcher

argues that Project 2000 was the beginning of a responsibility fissure between the tripartite partnership. Each stakeholder was aiming to produce a nurse fit for practice at the point of entry to the register but the question of being fit to practice was lost in the blame culture because of the loss of connection between the partnership establishing boundaries and the clinical link translation. While the clinical practice area was still interested in the student being both FtP and FtP the HEIs started to have a much stronger influence over the fitness to practice competencies.

The HEIs were delivering the pre-registration curriculum as proposed by the professional body, supported by the placement providers responsible for practice experience. However, weaknesses in responsibility included lack in transparency on a day-to-day basis for FtP and on reflection, a program offering an equal balance of theory and practice seemed ideal to facilitate such professional qualities. One of the reasons offered weaknesses in responsibility is the displacement of the student trainees from service workforce to the HEI as nursing students. Acknowledged by the UKCC in the commission report that "*students are not employees of the service provider and are now regarded as the responsibility of the HEI*" may have contributed

However, it has been argued in this chapter that a cleft in responsibility for fitness occurred in pre-registration nurse education when the practice assessment of students within practice became the responsibility of the placement providers, but the academic establishment awarded the qualification. This caused a rift in both process and responsibility (ownership).

The DoH (1999) alluded the issue of fitness towards the educational aspect which led to a large-sale review of pre-registration resulting in a report from the UKCC, 'Fitness for practice, The UKCC Commission for Nursing and Midwifery Education' which subjugated change (Department of Health, 1999). This was supported by the notion

of David and Lee-Wolf (2010) that Government and professional body reviews decreed that the NHS nursing workforce needed considerable theoretical development within pre-registration nurse education. This was achieved but the concept of partnership and sharing responsibilities appeared to be lost in its application and execution of partnering. However, following the Making a Difference strategy, the educative shift from producing a nurse fit for practice to a nurse fit to practice remained indeterminate in the decade following implementation of Project 2000.

That nursing students should be educated equally between HEIs and the Practice Learning Partner was expressed by the DoH as an attempt to equally balance theory and practice between the dynamic working partnership of programme provider and clinical setting. This was a key objective of Project 2000 to produce a nurse ‘fit for practice’ but this chapter has highlighted factors which began to affect responsibility between the tripartite partnership when pre-registration nurse education entered the HEI and FtP.

Chapter Two – Literature Review

2.1 Introduction

For this research, the literature critique serves two purposes firstly as with all literature reviews it gives background history and context to the study. However, the use of the written material has a further purpose, as the case study requires a history of nurse education pre-Project 2000 up until the completion of the case study. Therefore, the documentation both nationally from government and the regulatory nursing body and locally from the researcher's university and local Practice Learning Partner are required to be explored more forensically.

This required the researcher to explore and evaluate more historic documentation than would normally be offered for critique to enable the schism between the main parties to be evaluated from the beginning of that separation. The process of exploring the documentation will be further investigated in the methodology. This interpretation begins within the literature review by exploring the implications of Project 2000.

The effectiveness of the shared academic and practice model of Project 2000 left a responsibility legacy gap for fitness. The UK Government expressed concern that nurses had not entered the register as expected with summation by the UKCC that*:*

"The balance and emphasis of theory and practice within the curriculum should ensure that students are fit to practice on registration…programmes cited the lack of practical experience and basic skills of newly qualified nurses".

(United Kingdom Central Council, 1999,3.69,p.33).

The UKCC fitness report altered the focus of pre-registration education from fitness for practice to fitness to practice which influenced change in the following decade. HEI programmes continue to deliver the professional standards of knowledge and

breadth through curriculum with the Practice Learning Partner providing placements.

The HEIs and Practice Learning Partners work together to confer the students award of achievement (to be awarded a diploma or a degree) to provide the upcoming registrant (student nurse) with the appropriate qualification for entry to the register at the appropriate level. It is the responsibility of the approved educational institution to educate and regulate nursing students with practice assessment completed by the Practice Learning Partner (NMC, 2017).

Through examination and discussion, the consequential effect on the academic and clinical partnership following the implementation of Project 2000 will help shape the research question. Therefore, by adopting an appropriate search strategy this will determine what level of information is needed. Furthermore, as suggested by Hart (1998) the reason for searching the literature is to expose the main gaps in knowledge of the topic and identify principal areas of dispute (Hart, 1998).

This chapter will examine historical literature of the approval awarded by the Regulatory Nursing bodies, including, UKCC, ENB and the NMC, to Higher Education Institutions and how responsibility for nursing students was shaped. The design of programmes for educating nursing students emerged through professional educative standards and this literature review aims to investigate historical influences, exploring national, HEI and local university policies and professional regulator documentation related to standard setting, pre-registration nurse education and management of FtP. Furthermore, contemporary literature underpinning the reformation of nurse education and practice will facilitate the topic surrounding responsibility and ownership of FtP.

Searching for literature that is relevant to a topic helps refine a research question followed by discussion to affirm the researcher's topic. Therefore, this chapter will consist of two sections; 1. Literature search strategy and inclusion/exclusion of material and 2. Literature review discussion of the research topic.

Appraising the literature behind the tripartite partnership of HEIs, PLP, and NMC will provide the chapter with narrative inquiry for the theoretical, operational and practice learning perspectives and will reference pre-registration nurse education historical perspectives, supported by contemporary papers current at the point of publication, within the relevant time frame for this study and its application to the topic context.

2.2 Literature Search Strategy

The professional body for nursing highlighted several expectations of academic and practice engagement, but nurse education is also about safeguarding others and producing a knowledgeable practitioner, rather than 'simply attaining a qualification' (Sturgeon, 2012). Managing FtP requires examination to reveal who is considered as the primary lead of the process and to establish a sense of responsibility and ownership. If the process belongs to the programme provider, how does responsibility for the Practice Learning Partner affect this ownership. Principally public protection must be maintained so the question is if the HEI being the conduit for FtP and therefore responsible prior to the registration of a nursing student. Does this fulfil that required element of public safety or are HEI's simply the vendor of process?

The purpose of a literature search strategy is to identify current and established literature to help ascertain appropriate information and establish the most relevant resources (Moule and Goodman, 2009). A researcher needs to gain more background knowledge before the idea, query or topic of interest can be refined into

a project that is manageable and researchable and would ‘confirm’ the research question and whether it had been answered before (Moule and Goodman, 2009).

To ensure that a sound background and exploration of scholarly literature, current knowledge and practice is examined, the literature search strategy for this thesis focuses on a variety of sources relevant through multiple sources of literature background evidence. This included:

- Local Policy-both PLP and University
- Journal Articles
- Primary and Secondary Research Studies
- Books
- National Professional Policy and Directives
- Professional Standards and Guidelines
- Acts of Parliament.

These were all important to investigate local and national themes as an accurate representation of, and to, justify the gap in knowledge which highlighted the relevance of this study. The focus of this Professional Doctorate is an exploration of localised management of FtP within the researchers own university and local Practice Learning Partner and therefore, a pragmatic view to the international perspective will be exercised.

According to Moule and Goodman (2009) to develop a research question, some basic understanding of the topic, before embarking on the actual searching, assists the researcher to grasp the key issues. They suggest 5 stages in the literature searching process:

1) Confirming the research question
2) Creating a set of search terms

3) Deciding what are the most appropriate sources of information.
4) Performing a search
5) Revising the search, as necessary, and replicating it in other sources

Therefore, the literature search strategy will be based on the 5 stages of Moule and Goodman (2009) through a systematic approach of:

- Journal Searches
- Electronic and Hard Copy Databases
- Bibliography of Books
- Peer Articles
- Key Professional Regulator Literature
- Local and National HEI Policies
- Governmental Policies

The search spanning the last four decades raised a variety of documentation and literature it is essential to explore latter day contemporary perceptions and understandings of responsibility and ownership of FtP between the tripartite partnership.

1) Confirming the Research Question

Creswell (2009) suggests that in qualitative research, inquirers use the literature in a manner consistent with assumptions of learning from the research participants and one of the chief reasons is that the study is exploratory. Creswell (2009) further suggests that in case studies, literature is less often used to set the stage for the study in comparison to theoretically oriented studies (ethnography, critical theory) but rather it is used to frame the problem in the introduction to the study. This can only be achieved through the process of the literature review to focus on what exactly you are looking for.

The objective of this study is to explore and understand perceptions between the researcher's university and local Practice Learning Partner and their shared sense of responsibility and ownership when managing fitness to practice. Through the researcher's university position as the DoS, referrals, prior to this study, were received without written supporting evidence from the Practice Learning Partner making it very difficult to establish a case or call a meeting of the university Fitness to Practise Committee to protect the public and address the matter raise. Hence the questions which initially arise:

- What are the factors that exist between academia and practice that enable or constrain the partnering of nursing students if there is fitness to practice issue?
- What are the perceived understandings of fitness to practice between the partners?
- Are misconduct and disciplinary processes transparent between the academic and clinical setting?

2) Creating Search Terms

The search for literature, as suggested by Moule and Goodman (2009), has been made far easier using electronic databases making the actual searching more convenient and faster. Through the researcher's own university electronic library database; British Nursing Index, CINAHL, MEDLINE, ScienceDirect and the British Library were utilised to search for key text journals and books through the nursing subject guides. These were chosen as the key search databases for nursing literature as they produced quality and rigorous research literature for review both qualitative and quantitative in nature. Searching also extended to hard copy examination of key policy, education material and FtP documentation used by the DoS within her own

institution and both electronic and hard copies were considered as the most relevant sources.

The initial phrase ‘who owns fitness to practice within pre-registration nurse education in the UK’ as the opening wide-ranging search term was inputted into the electronic database and produced 320 hits. However, these were dismissed as they produced obscure, non-specific FtP titles unrelated to pre-registration nurse education. Therefore, not being topic specific a more defined search strategy of the electronic library databases was required. This refinement aimed to collect, catalogue, and determine salient works to refine the topic of what is known. Thus, an inclusion criterion of predefined characteristics focusing on UK based pre-registration nurse education system, professional body documentation, higher education and Government policy was applied. However, a limited number of European sources were revealed within the inclusion criteria due to similarities to the UK pre-registration nurse education system.

Key inclusion criteria, as Velasco (2012) suggests ‘must be selected carefully based on a review of the literature, in-depth knowledge of the theoretical framework, and the feasibility and logistic applicability of the criteria’ therefore eligible literature concentrated on material from a historical and contemporary perspective spanning forty years. This was to optimise the external and internal validity of the study to improve its feasibility and the homogeneity of the sample targeted population of the academic and clinical participants, HEIs, professional body and the Practice Placement provider. The inclusion criteria, therefore, comprised of primary and secondary research, English language, inclusion of local policy and pre-registration nurse education from a HEI and Practice Learning partner perspective through the library data-base search guide. This established pivotal, national literature relevant to

UK pre-registration nurse education and Higher Education material, supported by a review of local University policy only.

Exclusion criteria according to Velasco (2012) are a set of predefined definitions that are used to identify subjects who are not included. Therefore, for this study the use of qualified registered nurses was discounted as they would not be representative or generalisable for the focus of the topic or of the target population. This exclusion helped decrease the number of search hits and helped define the search more explicitly. Furthermore, an exclusion criterion of international studies was adopted as the study aims to explore local process and policy change within the UK.

Keywords inputted into the electronic database search including a combination of specific fields and commonly used phraseology:

- ‘fitness to practice/practise’
- ‘responsibility for fitness to practice/practise’
- ‘fitness for practice/practise’
- ‘NMC fitness for practice/practise’
- ‘NMC fitness to practice/practise’
- ‘failing students’.
- ‘practice setting for fitness for practice/practise’.
- ‘practice setting for fitness to practice/practise’
- ‘managing student nurses/nursing’.
- ‘NMC standards’
- ‘Code of Conduct’
- ‘ownership’
- ‘university policy fitness for practice/practise’
- ‘university policy fitness to practice/practise’

- ‘responsibility for fitness for practice/practise’
- ‘responsibility for fitness to practice/practise’
- ‘management of fitness’

Alternative spelling variations were used due to the different spellings of practice/practise and the timeline for literature was left open and did not focus on a specific decade. Furthermore, some European sources were included due to similarities to the UK pre-registration nurse education system. This would make the inclusion criteria more explicit to the wording of the study. However, key phrases such as ‘responsibility for fitness for practice/practise’; ‘ownership of fitness to practice/practise’; ‘ownership of fitness for practice/practise’ produced no hits which assured me that the topic area of the study was original.

Key words that were excluded from the search were:

- ‘Mentoring’
- ‘Competency’
- ‘Registered nurses’
- ‘Post Registration’
- ‘Associate Practitioner’

3) Deciding the Most Appropriate Sources of Information

There were two main sources of information for the study: primary and secondary sources. Primary sources are usually published in journals by the researcher and secondary sources refer to the original research by someone other than the researcher (Moule and Goodman, 2009). The sources included in this study focused on both primary sources and secondary sources as they both offer different viewpoints to the topic of FtP.

Primary sources contain new information that has been analysed and interpreted by the authors of the research and maybe considered as more credible than secondary sources which are re-interpreted or re-evaluated by secondary reviewers. However, some secondary sources which use structured approaches such as systematic reviews have benefits over one data collection source as there is less potential for research biases. Each must be considered carefully for its merits within this study and are only discounted based on the inclusion criteria as detailed earlier. A further example of inclusive data source is the use of the university's own policies, and other relevant documentation adopted by the faculty, which is neither primary nor secondary sources but are of relevance to the study when managing students in the Practice Learning setting.

In the practice setting, the nursing students' Practice Assessment Document (PAD) was considered as a key source of documentation due to its use between the researcher's university and Practice Learning Partners. Furthermore, the PAD details the faculty Cause for Concern (CfC) process for practice partners to complete. These documents were all relevant for examination of process, understanding and clarity of management to the topic and for local understanding between the partners. The Table 1 Key Documents details the key nursing documents used as part of the historical chronology of pre-registration nurse education to contemporary policies.

4) and 5) Performing and Revising a Search

These two stages are interlinked as performing and revising the search there will be repetition, or too many or too few results. When the term 'who owns fitness to practice within pre-registration nurse education UK' resulted in a limited and obscure return, albeit non-specific, whose hits were reviewed and discounted as they did not meet the criteria. This search heading was not surprising for the retrieval of results, as it

suggested that that this study could provide a new perspective towards ownership of fitness to practice. Whilst frustrating, the sentence did help refine the search strategy into shortened terms of fitness as per the list produced earlier.

Therefore, through the university electronic library database spanning a forty-year period, 'fitness to practice' produced 181,597 Peer-reviewed journals and 414,640 Full Text Online hits. This was clearly too many and as stated by Burns and Grove (2011) too many results are not uncommon. Therefore, the search criteria terms were reduced with English being a necessary criterion which reduced the hits to 403,640.

These were further narrowed down to the inclusion and exclusion criteria applied with the final number of relevant hits totalling 161 from the library search databases. This resulted in referenced material including 131 peer-reviewed full online text, 6 articles (opinion), 5 Government documents cited, and 5 key professional body citations and 14 hard copy books referenced.

This is an amalgamation of all the search engines but after adopting the inclusion/exclusion criteria, were determined as a valid source of literature by scrutinizing titles and reading abstracts for inclusion material as suggested by Bryman (2015) of what was striking as significant. Furthermore, according to Bryman (2015) case study is not a sample of one drawn from a known population and similarly, the people who are interviewed in qualitative research are not meant to be representative of a population. Therefore, compiling the literature, the method of searching was undertaken many times thus the number of final hits changed over time. The focus of key documents was to support the study and were to include a review of background pre-registration nursing education, professional aspects, and contemporary research. The focus of the review was mainly around local, professional, and applied Practice Learning partnership aspects (i.e., mentoring) to support the study.

The purpose of the study was to seek meaning from an interpretive approach to gain understanding of the participants thoughts and feelings. Therefore, the identification and critical appraisal criteria for the qualitative research used was essential to review and utilise sources of information for local application of this small-scale study professional doctorate.

The criteria for reviewing the reference lists of potentially important qualitative research may have been supported using the Standards for Reporting Qualitative research (SRQR) which O'Brien et al (2014) defined as standards for reporting qualitative research while preserving the requisite flexibility to accommodate various paradigms, approaches, and methods. However, upon review of the SRQR the approach of itemising material, and to understand the perspectives of groups and the contexts in which these perspectives are situated, was difficult to establish due to the limited research on the topic of ownership on reflection of Bryman's (2015) comment regarding case study and representative population.

O'Brien et al (2014) suggests that the quality of qualitative research can be difficult to evaluate because of incomplete reporting of key elements. For example, had this study focused on the actual experience of FtP, qualitative data may have been gathered through research material relating to actual cases of FtP experienced and the use of SRQR may have produced statistical data of such cases and the use of survey adopted to review elements of the 'process' as helpful.

The SRQR is a list of 21 items that O'Brien et al (2014) consider essential to complete, transparent reporting of qualitative research providing a framework and recommendations for reporting qualitative studies. However, using peer reviewed literature, professional body documentation and local policy of the topic area related to FtP and its management, the topic of ownership was limited, and aspects of the

articles and research used in the review chapter, and their qualitative relevancy, highlighted to the researcher the limited availability of referenced material. Therefore, the SRQR did not lend itself to the available limited research material. However, the merits of reflecting information essential for inclusion is valid and through the 21 items considered to measure the importance of the research, a broader use of literature may have been used.

In examination of the topic of FtP, and the sense of responsibility between the tripartite partnership, the final number of papers critically analysed and included, were part of the inclusion criteria. Thus, the literature search schemata identified the total amount as a final hit. The whole picture of FtP, ownership, and responsibility faced rigor to discount aspects that were not fundamental to the topic. A narrow perspective of FtP in relation to the methods adopted in the small-scale study did report key information about a study and its relevancy to this study and as O'Brien et al., (2014) suggests the conversion of reporting guidelines into reporting 'checklists' can inhibit creativity and imply that approaches or techniques that conform to guidelines are more valuable than those that do not. This was key to this study so that key articles were not discounted if they did not meet the SRQR criteria thus resulting in the potential loss of valuable information.

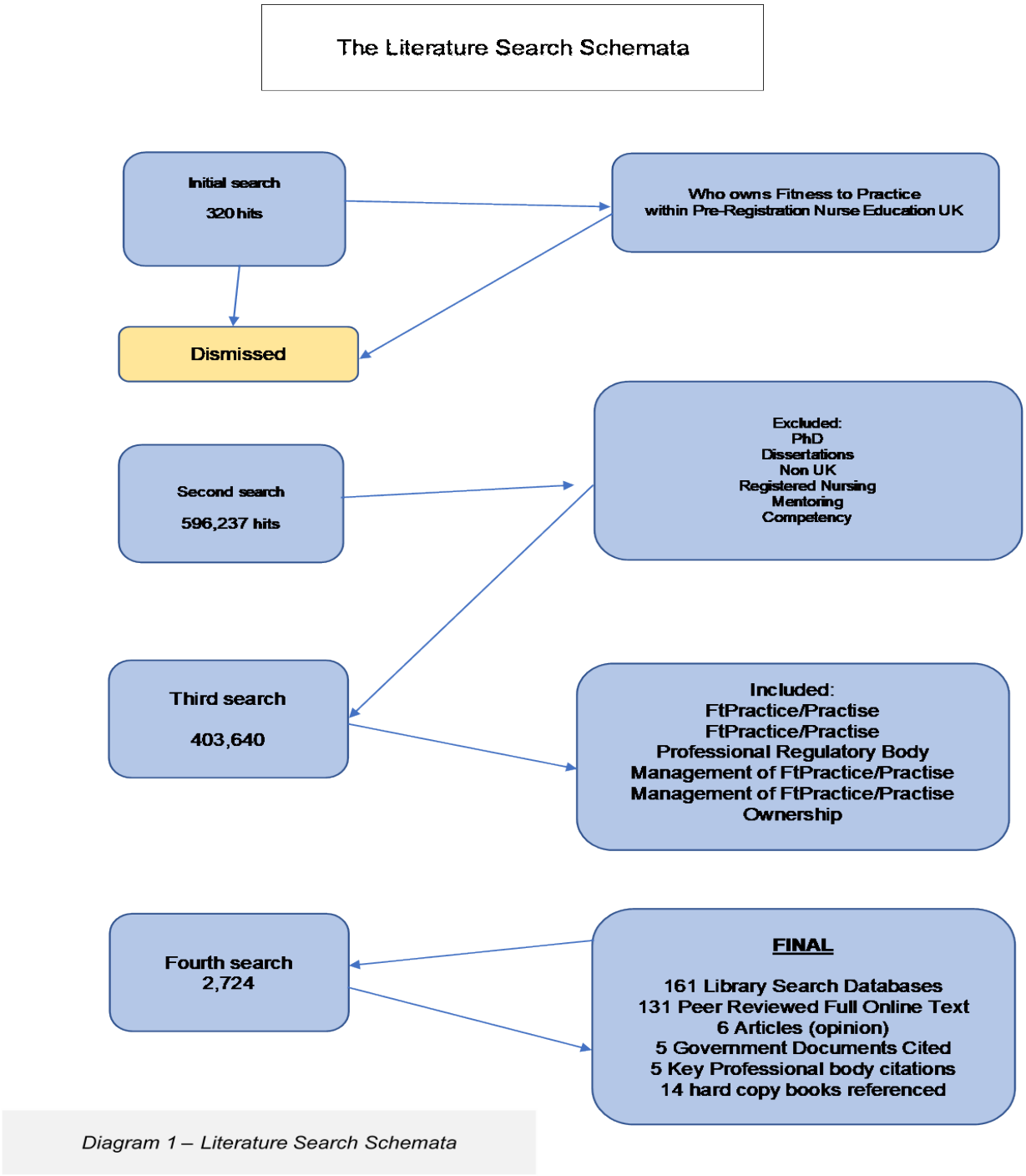


Diagram 1 – Literature Search Schemata

The studies referred to in this literature review are qualitative with pertinence to the subject matter, but duplicates were excluded with literature, which met the inclusion/exclusion criteria, saved in a file of both electronic and hard copies versions. From the generated hits and key literature finally decided upon, the researcher was able to decide upon the most appropriate sources of information to assist the actual

research project and topic. The Literature review will provide the basis for discussion separated into subject headings and should confirm what has not been answered already (Moule and Goodman, 2009).

2.3 Government review, regulatory bodies, Practice Learning environments and Higher Education Institutions

Pre-registration nurse education was re-conceptualised with project 2000 through government and professional regulator policy reform that sought to make nursing an accountable, more democratic profession, but needing to be sensitive to an expanding range of stakeholders. Whitty (2008,p.33) suggests that in most countries the characteristics of a profession are "*determined by the main stakeholder*" and this presents a deeper conundrum to the sense of ownership as pre-registration education belongs to three stakeholders: HEIs, NMC and Practice Learning Partners.

It is difficult to determine the key stakeholder as each one contributes to the teaching and learning of nursing students respectively acting as an essential component to pre-registration nurse education. Collaboration between the stakeholders is essential to deliver professional regulatory standards through HEI curriculum and supported by the practice learning environment. This is in equal measures of 50% theory and 50% practice which remains as standard in current UK nursing programmes, but the principle of responsibility and ownership altered with the student receiving student status within the clinical setting.

In the practice learning environment, nursing students' supernumerary status allowed them to develop their practical skills and proficiency with the UKCC stating that teaching in the practical setting should not be left in "*such large measures to the 'service staff' as was currently the case*" (United Kingdom Central Council, 1999,23,p.58). The perceptions of being a learner rather than a worker, gave them a

'*distinct*' advantage but the counterbalance to this status, was the effect that many students felt they were not part of a team, which in turn inhibited practical skill acquisition and a lack of continuity of care was attributed to this (Macleod-Clark et al., 1997).

Supporting the nursing students in the practice learning area was accepted to be the responsibility of the registered nurse who acted as a mentor. However, mentorship had been ill-defined at the inception of Project 2000 and there were inconsistencies in the quality of mentorship being given to students (United Kingdom Central Council, 1999). The lack of a clearly defined mentoring system and expectations meant that the drivers for the achievement of competency led outcomes were inconsistent and went unchecked and were one of the major areas of concern.

Students were going into clinical practice with inadequate mentorship and the variability of mentorship was reviewed under the UKCC fitness commission report which sought to "*take a broad view of the wide range of circumstances…diversity of the present arrangements, the different structures supporting pre-registration nurse education*" (United Kingdom Central Council, 1999,p.2). This report raised the debate of Project 2000 as to the balance equity of clinical skills challenging perceptions of the nurses' levels of competency in the clinical setting, (Macleod-Clark et al., 1997). Furthermore, the argument that curriculum and student managed learning within placement was based fundamentally upon the mentoring role, but that the role of the mentor was not clarified in terms of the clinical experience for both student and mentor (Watson, 1999).

The level of acquired competency was also considered by Watson (1999) with the suggestion that newly qualified Project 2000 nurses displayed inadequate clinical skills as a consequence of the support imbalance from mentoring. This imbalance

was addressed by the chair of the Fitness report, Sir Leonard Peach, who proposed that preparing staff for practice "*is a complex task for which there is no single, successful formula*" (United Kingdom Central Council, 1999). Peach also concluded that mentors/assessors were "*often ill prepared for the task*" and was one of the four most frequently mentioned improvements required of pre-registration education (United Kingdom Central Council, 1999,p.2). Thus, the UKCC undertook to make "*an explicit resource commitment to supporting and assessing students in the practice context and funding staff for development for mentor training*" (United Kingdom Central Council, 1999, p.36). At this point in pre-registration nurse education, the practice learning area were appearing to fail in their delivery of mentoring for competency to the nursing students. The notion of fitness at this point appears forsaken in practice responsibility and the notion of a fitness to practice process remained invisible.

Underpinning practice however had already been recognised as an issue for placement experience, with perceptions that the quality of the clinical learning environment has a major impact on learning (Wells and McLoughlin, 2014). Wells and McLoughlin (2014) conducted a literature review confined to 2003-2013, exploring the mandatory standards governing the role of the mentor in the UK. Articles were considered of relevance to the issue of feedback in relation to a failing student with several key themes identified; Benefits of applying effective feedback, barriers to giving feedback and consequences of not undertaking effective feedback.

The relevance of the paper by Wells and McLoughlin (2014) is the suggestion that one of the barriers to effective feedback is that mentor's participation in feedback settings is a vastly different experience to that undertaken at the university. HEIs deliver the mentorship training courses and the paper suggests that a university lecturer's feedback is indirect and written compared to the mentor's face-to-face

feedback. This face-to-face approach is often challenging and difficult when identifying areas for future development or failure. This therefore presents the dichotomy of mentors completing a mentorship programme delivered by the HEI but as Wells and McLoughlin (2014) suggest, in a profession like nursing feedback on performance in practice is extremely important for the development of competent practitioners. This therefore emphasises the sense of responsibility and ownership to the practice learning environment but is disconnected by HEI delivery and this disconnection may facilitate the fissure in ownership. This, therefore, has relevancy to this study for the notion of delivering education and effecting in practice between two worlds.

The notion of competency was explored by MacLeod Clark et al. (1997) who, through a study of nursing students, examined their understanding of philosophy and practice during the Project 2000 programme. Alongside teachers, practitioners and managers, the research was undertaken over a three-year period from two programmes commenced in 1989 spanning two centres, one in the North of the UK and the other in South UK.

Two data collection methods were adopted using questionnaires at staged access points with interviews conducted with two distinct participant groups at timed course periods. Overall, out of four hundred and ninety-eight nursing students a response rate of 33% was received. Student questionnaire findings revealed perceptions of theory and research being the basis of nursing practice with all respondents being '*fierce proponents of delivering high quality care and of patient advocacy'* MacLeod Clark et al. B (1997, p.1630). Principally, whilst a broader perspective was offered to care for patients from the qualified respondents, essential nursing care was a unique aspect of nursing and should remain the domain of the nurse.

However, the study also set out to explore the changes of perceptions in philosophy but found that the participants could see the relevancy of theory to nursing care. This suggests that the marriage of a Higher Education and practice could be seen to be valuable and that the two main stakeholders were working together and essentially so were the students and mentors. The partnership always seemed relatively cemented and 'seemed to be more able to hold only nursing values as taught in the college by putting the patient first (MacLeod Clark et al. 1997, p.167).

It would appear from the findings of MacLeod Clark et al. (1997, p.176) that HEIs were facilitating a different socialisation approach toward a theoretical way rather than just '*getting through the work'* of patient care. However, compared to Wells and McLoughlin paper (2014) of disconnect between teachings in the HEI and the practice learning environment, the MacLeod Clark et al. 1997 study is more connected to the development of theory to practice and demonstrate the positive connection between the HEI and practice learning environment. Principally collaboration between the HEI and Practice Learning Partners in the allocation of teaching students is ideally a cyclical process between the two stakeholders.

Fundamentally, as Cope et al. (2000) suggest, the contribution of the expert mentor can be passed on by situating knowledge in authentic contexts, namely learning in the Practice Learning environment. However, teaching mentorship in the HEI presents a disconnect dichotomy as they are not in an authentic context. Therefore, whilst theoretical components of the course were ideally situated in a context arising from placement, placements were the support mechanisms for student endorsement of becoming competent (Cope et al., 2000).

Practical skill acquisition was recognised in a study conducted in Hong Kong by Chun-Heung and French (1997). The purpose of Chun-Heung and French's (1997) study

was to gain understanding of how local Hong Kong pre-registration nursing students perceive their practice experience considering the curriculum and educational paradigm. Their approach to the study was to use a broad qualitative methodology derived from phenomenological perspectives which they considered as a relevant approach to understand the meaning of the informant's experience. Central to Chun-Hueng and French's (1997) study was their attempt to seek meaning from the students experience of placement and therefore has relevancy within this literature review.

Eight schools of nursing were recruited, and the target population were those student nurses studying on hospital-based pre-registration programmes in Hong Kong. Informants should be recruited from all eight nursing schools that had agreed, out of ten, to participate. End-of-second-year students were recruited and felt to be the best informants for their study (Chun-Heung and French, 1997). The rationale for end of second year students was that they would have had sufficient clinical experience and the total number of informants was 16.

Open-ended semi-structured interviews were conducted as the data collection method with both structural and content analysis as methods of data analysis. The results produced by Chun-Heung and French (1997) uncovered 11 themes such as 'ward climate' and 'students' experience' with perceptions around ward climate being found as busy and toilsome. Additionally, and more pertinent to the present study, the participants indicated that a supportive clinical learning environment was of paramount importance in providing an environment where learning opportunities could be seized. The participants indicated that senior students were the most significant people when considering clinical supervision, with reliance on fellow students, but principally the research highlighted the need for a mentorship system

to enable qualified nurse to act as role models, guides and as a means of emotional support (Chun-Heung and French, 1997).

The Hong Kong mode of training had parallel issues of placement experience like that of Project 2000 in so far as student nurses indicated the practice setting being the most influential context when it came to '*acquiring skills'* (Chun-Heung and French, 1997). More suggestive of their findings is the notion that the practice setting further accentuated professional socialisation. Furthermore, the experience element of their study has relevancy to my study as their findings presented indications that they (the student nurses) felt that forms of knowledge embedded in their practice experience failed to prepare nurse learners to develop a kind of conceptual scheme for holistic patient care through critical and systematic thinking (Chun-Heung and French, 1997).

Practice experience, or the way people experience things, is discussed by Abalos et al. (2016) as qualitative nursing inquiry study through the perspective of phenomenology, one of the naturalistic paradigms as a method to reflect a belief in subjective reality. The authors also refer to phenomenology as a person's unique experience, there are meanings in experience (Abalos et al., 2016). Effective clinical nursing education is critical to prepare nurses for a theory-practice-based profession and is suggested by O'Mara et al. (2014) to be complex process, to encompass theoretical knowledge to build clinical judgment. By exploring the relationship between students learning experiences and the clinical learning environment, O'Mara et al. (2004) undertook an interpretive descriptive method of exploring student's perceptions of Challenging Clinical Learning Environments (CCLE).

The participants, through purposive sampling, in O'Mara et al. (2014) study spanned two Canadian sites with self-identified students as having experienced CCLE and were all on undergraduate nursing programmes. Data was collected from site 1, over

two semesters, followed by two semesters at site 2. Students at site 1 were also asked to complete a reflective journal following the focus group but only 3 did – they submitted clinical journals.

Fifty-four participants of undergraduate nursing students were recruited whom had experienced a challenging placement. Data was collected from focus groups over two semesters with one group completing a reflective journal with data collection and analysis occurring concurrently. The findings found two main sources of challenge: the context within which their learning experiences occurs, and the relationships with others in the CCLE. Thus, the findings of the participants found relationships (with their mentors) were both positive and negative and that the learning is always influenced by relationships, curricular and the nursing culture.

This, therefore, has relevancy to this study as the dynamics were focused on not going into clinical until the second year. Key insights and notes were taken from the focus groups and the results were analysed with thematic analysis. Similarities and themes were produced with insight sought into the student's experience of CCLE's with one challenge indicated that support from the staff nurse (qualified nurse) acted as a strong influence with their overall findings suggesting that clinical learning is influenced by relationships in context; nursing unit context, and culture (O'Mara et al., 2014). In conclusion, O'Mara et al. (2014) found that clinical learning remains crucial to nursing education through a positive environment.

The need to support student learning within the clinical setting was explored in a study conducted by Wilson-Barnett et al. (1995). Their paper reported on research commissioned by the English National Board (ENB), one of 4 professional regulators at the time, into mentorship and clinical support arrangements for Project 2000 nursing students in adult/mental health settings. Semi-structured interviews and

observations were conducted in three centres in two main stages; stage 1 30 students, 17 practitioners' and 17 tutors in adult branch; 23 students, 20 practitioners and eight tutors in the mental health branch. Stage 2 consisted of six case studies cross adult/mental health in different practice learning settings through non-participant observation of staff and students interviews and review of assessment and student documents. Purposive sampling was adopted and spanned three centres running Project 2000 with most involved in the two branch programmes and clinical support arrangements (tutors and practitioners) and the most relevant sets of students.

The findings suggested that the term mentorship was commonly used alongside '*supervisor', 'assessor'* and *'key worker'* and the biggest hurdle of support was time with each other (student/mentor). This was mainly associated to the '*newness*' of Project 2000. However, their discussion from the data, elicited five themes: mentorship, team spirit, theory and practice, diploma level practice and organisation of nursing teams. The latter theme is relevant to this study due to the finding that a positive learning environment helps the students feel content. This afforded continuity of support or mentoring and therefore more knowledge acquisition. Their research provided insight into the factors that influenced support such as appropriate use of supernumerary status, staff committed to teaching, students working closely with practitioners, link tutors in regular contact, well-planned learning experiences, staff with a good capacity to be supportive and good team spirit.

Overall, the study by Wilson-Barnett et al. (1995) looked at the supervision of students and demonstrated from their findings that support was primarily mentorship, and team spirit and these were key factors in satisfaction. Their discussion provided an example in which students who worked closely with practitioners was key. Their research suggested that giving time to teach through well-planned experiences combined with

capacity to be supportive, were identified as beneficial to the student's (clinical) learning experience. Thus, the connection of placement success and mentorship from peers can be considered as key to the maintenance of a profession such a nursing. The study by Wilson-Barnett et al. (1995) suggested that support for students was given renewed attention in the clinical setting with their data and themes alluding to dissatisfaction with support as a contributory factor to a negative learning experience.

Essentially mentors were to help students achieve a broader set of competency outcomes as a new pre-cursor to the new preparation for practice (Macleod et al., 1997). Hence, when the Nurses, Midwives and Health Visitors Act 1979 came into force in 1983, the English National Board was given the legal responsibility for approving institutions in England where professional nursing and allied courses were provided. The ENB was a turning point as it acknowledged nursing as a profession. However, it has been difficult to find primary sources related to this specific period. Therefore, there is an element of relying upon the credulity of secondary sources when discussing their fundamental role in the development of nurse education.

The English National Board (ENB) approved institutions ranging from centres of Higher and Further Education to major teaching hospitals and small hospices (some of which are not part of the NHS) (http://discovery.nationalarchives.gov.uk). Furthermore, the ENB stipulated that in practical placements qualified staff are expected to pursue a pattern of duty hours which will render them available as teachers, mentors, or supervisors for students, as appropriate, with further instruction that each student have a named mentor (ENB, 1987, p.53 section 13.5.1). The ENB provided a programme to prepare mentors titled 'English National Board Teaching and Assessing in Clinical Practice' and was coded as the ENB 998. The ENB 998 was an approved programme to fulfil the national requirement for mentor preparation

and ostensibly was designed to prepare staff for the role of clinical educator that is either a mentor or preceptor (Watson, 1999).

The ENB offered a three-principal guideline to mentoring as one who supervises and assesses students in the practice setting. This was examined by Watson (2004) for registered nurses who undertook the ENB 998, and highlighted that mentors facilitate student learning across pre-and post-registration programs. Including supervising, supporting, and guiding students in practice in institutional and non-institutional settings and implement approved assessment procedures (Watson, 2004).

An investigative case study by Watson (1999) examined the mentoring experiences and perceptions of 35 pre-registration nursing students on the Common Foundation Programme (CFP) of Project 2000 alongside 15 allocated mentors in one organization using semi-structured interviews. Nursing students and staff interviewed were chosen from one clinical setting (not identified) of local hospitals providing a variety of acute services. Students had been placed across seven wards (35) and staff were chosen based on their availability (15 mentors). Mentoring, as described by Watson (1999, p.259), is a widely used method within pre-registration nursing education and his findings suggest that all staff saw their role as assessor, role model, and clinical support but "*they did not identify planning as part of their remit and mentors did not see their role as one of planning, students did".*

Drawing on phenomenological perspectives, the study sought to investigate diploma and degree students through a case study of students from one module and some of their supervisors (not wholly detailed in the paper and therefore may have limitations). Their limitations did, however, detail some difficulty in recruiting participants due to staff shortages.

The study conducted by Watson (2004) sought to explore the assumption that potential participants (registered nurses) undertaking the ENB 998 were motivated by a commitment to become a mentor. Conducted through questionnaires, 127 participants within two secondary care trusts and several primary care trusts were recruited with a 90.6% response rate. However, their findings suggested that motivation was calculated on professional self-interest, professional development and as a means of obtaining a higher grade and not on the commitment to support students in the clinical setting. This conclusion however placed a dichotomy that a mentor should be someone selected by the student to assist, befriend, guide, advice, and counsel but who would not normally be involved in the formal supervision or assessment of that student.

The study considered the extent to which students' understanding and expectations matched their actual experiences and was conducted through semi-structured interviews within the clinical setting of the wards on which the students were placed. Furthermore, Watson's (1999) findings suggested that whilst mentoring was expected in the clinical setting, staff and students made their own assumptions of what is involved. Additionally, Watson (1999) also found that the participants wanted clarification of roles and expectations to enhance the role and in turn this would enhance the clinical experience for both. For example, students saw planning as a key feature of the mentor's role to plan their learning menu in the clinical setting.

The study concluded a mutual agreement that preparation for the role of mentor was lacking and there was no prescribed preparation. Moreover, younger trained Project 2000 mentors struggled with 'assertive senior staff'. This study condones the previous behaviour of '*peer support'* and may be reflective of their own preparation and preparedness of mentoring for the teaching of students. It would seem that if one were to establish such a working partnership as suggested by the ENB 998 scheme,

mentoring would be a positive experience but as Watson (2004) note having a good mentor and good placement is often associated with luck rather than routine, although usually the two coincide.

The positive experience of a mentor was corroborated by a study conducted by Lloyd-Jones et al. (2001). Their qualitative study of student/mentor contact for Project 2000 students was undertaken to examine the cost-benefit activity study of clinical placements through time spent with mentors. The research project, commissioned by the Sheffield and North Trent College of Nursing and Midwifery, asked mentors and students to keep an activity diary and data was collected from activity diaries of two hundred and seventy students and named mentors. The participants were contacted and asked to complete a week-long activity diary which comprised of tick box questions and space for comments. A total of 125 students and 117 mentors completed and returned diaries but only 81 student-mentor pairs were known to have completed the diary for the same week. The overall response rate was 46.3% with highest response rate for second year students.

Noting the significance of the ENB ruling that each student was to have a named mentor in practice, the study by Lloyd-Jones et al. (2001) through the data collected, was useful to inform their cost benefit study, but the data cast light on the extent to which mentors were available to students. The study illuminated the importance of mentor's availability for spending time with their student and their findings suggest that the availability of time spent with their named mentor, namely the frequency of shifts worked, directly affected the student experience and learning. When named mentors who were absent, the student spent significantly more time working with a non-mentor i.e. another qualified nurse and this affected individual attention for the education-related activity (Lloyd-Jones et al., 2001).

Data analysis and the findings of the 46.3% who completed, is only reflective of the student/named mentor who had remained in pairs. Principally, Lloyd Jones et al. (2001) attributed this statistic to a higher response from student/mentors in the community setting where the 1:1 ratio of direct contact is increased. Additionally, the lower response rate may be attributed to mentor-student contact time in busy ward areas and therefore are more likely to have been lower. This limitation of findings was recognised by Lloyd-Jones et al. (2001) and concluded that there seemed to be a perceived over estimation of the amount of time spent by staff in mentoring students which acted as a contributing factor to time spent with students. This finding suggests that the collaborative student/mentor relationship has a greater impact on the student's development and is a key relationship and legitimate "*peripheral participation is crucial in enabling students to enter the world of nursing and engage increasingly complex activities whilst developing their sense of identity as members of the nursing community*" (Lloyd-Jones et al., 2001, p.158).

However, whilst the findings of their study demonstrated the impact of mentor-student contact on activity, with findings suggesting that mentors did take responsibility for the overall educational experience and for the quality of the placement. Alternatively, students did not necessarily regard such constant interaction as a prerequisite of successful mentorship within the clinical setting but principally as the Lloyd Jones et al. (2001) study has captured, the importance of time spent between the mentor-student is important to skills acquisition as has already been discussed.

Their findings are suggestive of the impact to the quality of the educational experience on the placement with this relationship being key and essentially, whilst it was never intended that students would spend all their time supervised by their mentors, the benefits of the close learning relationship have clearly been established.

The nature of supervision within the practice learning setting was examined by Papastavrou et al. (2010). Their study focused on the Cypriot hospital-based education system with six hundred and forty-five undergraduate students. As the only Public School of Nursing in Cyprus, the participants were the last students of this mode of training which is reflective of the apprenticeship system once adopted in the UK. Therefore, their paper has relevancy to the UK prior to Project 2000 with direct associations to this study.

A sample of 463 undergraduate nursing students from three universities in Cyprus were recruited. A self-report questionnaire was designed to measure the student's satisfaction of the Clinical Learning Environment (CLE). The questionnaire consisted of 34 items classified into 5 dimensions: pedagogical atmosphere on the ward; supervisory relationships; leadership style of the ward manager; premise of nursing on the ward; and role of the nurse tutor in clinical practice through a Likert-type scale response 'very satisfied' to 'very dissatisfied'. The initial results suggested that the supervisory relationship of mentor-student was found problematic with 30% of the students having a 'failed supervisory relationship' mainly due to the occurrence and organization of supervision.

Papastavrou et al. (2010) highlighted six areas that influence the supervisory relationship models with identified team supervision. In one supervisory model, students had several supervisors (mentors) and the finding suggested that was generally utilised due to the individual mentors' workload. From the study, it was shown that up to 58% of students experienced this style of mentoring compared to a relatively low number of students with personal supervision at 27%. The shared model of mentorship impacted on student satisfaction for their clinical/supervisory experience that was recorded as low compared to the personal supervision model

with 27% of the respondents expressing dissatisfaction with the latter approach of mentor-student relationship.

Fundamentally, the findings from the clinical placements of respondents traversed several sites inclusive of 226 first year students, 195 second years and 138 third year students. The most attended placement was the medical ward accounting for 24% of clinical experience. However, they do not detail how many and which year of student was in attendance and thus may affect the findings in terms of mentor supervision time allowance. However, Papastavrou et al. (2010) study does relate to what they termed as ward atmosphere, premise of nursing care, premise of learning and leadership style of the ward manager as part of the factor analysis in order of importance.

Overall, the study conducted by Papastavrou et al. (2010) found that experiences of learning in practice within the Cypriot style of pre-registration learning demonstrates similar issues to the UK. For example, their study highlighted the clinical environment as a complex social entity that influences student learning outcomes. These learning outcomes relate to student supervision and clinical practice but if mentoring, as suggested by O'Driscoll et al. (2010) is internalized through practice, practitioners are more likely to implement the required practices. Clearly student satisfaction and experience are causally related to working with a mentor whether individual or as a team supervisory model as illustrated by Papastavrou et al. (2010) study. Fundamentally, the Cypriots also devolved nurse education from the apprenticeship model (practice-based workforce) to the HEI's and it is interesting the similarities of the UK model of nurse education. Hence, the study by Papastavrou et al. (2010) has significance to the study since it regards the role of mentoring "*if not to internalise practice for peers*" as suggested by Teatheredge (2010) who examined the perceived characteristics of a mentor and concluded that they may be guides, as well as

advisors and companions and meeting a student's needs' is a key characteristic of a mentorship.

According to Cassidy (2009, p.41) the student-mentor relationship becomes more about "*the process of enquiry, than the product of what is taught*". Competence assessment according to Cassidy (2009) needs to be set against the practical concerns of mentors when student learning is situated in a holistic context of care, involving patient's experiences, aided by reflexive and inclusive mentors to be a successful process. This finding follows Cassidy's (2009) literature review paper which explores how mentors interpret competence in their assessment of nursing students. Cassidy fundamentally suggests that acting as a mentor requires a registered nurse to have clinical knowledge and experience and an informed appreciation of student assessment processes which is clearly an essential component for the assessment of students.

However, whilst Cassidy recognises the history of the relationship to the assessment of students (for fitness to practice) and the UKCC 1999 report, his literature paper does not wholly address the matter of the relationship between competence and the professional body and curriculum delivery by the HEI but does state that 'connections between formal theory underpinning practice and informally acquired clinical knowledge' is expressed (Cassidy, 2009, p.43). The literature review has more of an empathise on the attainment of competency to meet the NMC standards for fitness but there was relevance to this study in terms of the association to mentors and the connection to educational criteria albeit loosely.

Overall, Cassidy examined 41 research studies, 14 opinion articles and eight literature reviews and organised his findings into three themes; clarifying the issue of competence: adequate or holistic care; dilemmas influencing the holistic assessment of competence; and achieving holistic assessment of competence. Essentially the

themes focused on areas of competence and the complexities of professional practice therefore are bound in the clinical setting underpinned by a well-developed knowledge base. This is supported by the claims by Cope et al. (2000) who suggested that the theoretical perspectives presented in the HEI's components of the course and the realities of practice deepen in their meaning (Cope et al., 2000).

The study conducted by Cope et al. (2000) interviewed nurses who had either completed a traditional nursing programme or came from the cohort of first qualified Project 2000 nurses in Scotland. The interviews focused on the way in which the student had learned in their practice placement, but the two different programmes are so different, as already reviewed in this chapter, that the validity of Cope et al. (2000) is questionable. However, the results did suggest that the placement is a complex social and cognitive experience in which there are elements of situated learning which is undisputable and has been demonstrated to be the case. The pre-Project 2000 programme devoted around 20% of this time to theoretical input from the SoN compared to Project 2000 which spent around 40% of time in university. The weighting of the programme is therefore quite different in its context of delivery.

It became clear that the student placement was to set learning in a meaningful context and this had a powerful situating effect on its meaning. Collaboration between the HEIs and service providers in the allocation of students to appropriate practice placement areas, should ideally be a cyclical process in which theoretical components of the course were situated in a context arising from placement, and placements, were the support mechanisms for student endorsement of becoming increasingly competent (Cope et al., 2000). Essentially, placement experience and learning remain a fundamental aspect of nurse education and therefore has relevance to the present study.

2.4 The (Better) Beginnings of Mentoring Students

Technical competence and professional interpersonal skills according to Cope et al. (2000) encompass both the moral obligations and the education fundamentals to practical skills required of nurses and as argued, students create interactions which become learning experiences for themselves and others. Putting theory into practice was the paramount desire to enhance evidence-based practice and to develop the competencies required of a health professional. This offers a clear relationship between the learning environment, practice, and professional expectations of fitness and competence (Cope et al. (2000), Bray and Nettleton (2007).

This manifested in the formalisation of standards to prepare, support and feedback to mentors of pre-registration students (Nursing & Midwifery Council, 2006). Allocated time for teaching and learning was to be a standardised mentorship criterion. To enable mentors to foster knowledge and skills development in their students the NMC clearly state that "*Whilst giving direct care in the practice setting at least 40% of a student's time must be spent being supervised (directly or indirectly) by a mentor/practice teacher"* (Nursing Midwifery Council, 2008,p.39).

Planning had been identified as an important aspect of mentoring and students identified it as lost opportunity for direction when the mentor was absent (Watson, 1999). Thus the mentoring initiative, and a mentorship programme, became an integral part of the registered nurses' responsibilities whose role was also to conduct the assessment of the student (Nursing & Midwifery Council, 2006).To provide this clinical support the NMC outlined standards for supporting students in the clinical setting. Hence in 2006 the NMC developed mentorship training with mandatory standards to support the learning and assessment of students in practice. Titled '*Standards To Support Learning And Assessment In Practice For Mentors, Practice Teachers And Teachers'* the standards aimed to define a framework that described

knowledge and skills nurses and midwives need to apply in practice when they support and assess students undertaking NMC approved programmes that lead to registration (Nursing & Midwifery Council, 2006).

Mentors were formally recognised as assessors of the students' clinical proficiency for entry to the professional register, however for the determination of eligibility to the register both academic and clinical achievements were required. The principal purpose of the standards of mentors is to assess competence in practice and confirm that students are capable of safe and effective practice (NMC,2008). The standards set out specific outcomes by placing responsibility on the mentor to apply and act as resource guide for the student and the framework ensures that students are fit for practice at the point of registration (NMC,2008).

2.5 Higher Education and the Practice Learning Setting – A Mentoring Partnership

From September 2007 all new entrants to mentor programmes were required to meet the NMC learning and assessment standards and to have been prepared for the role, by undertaking an approved programme of study that meets the NMC mentor standards (Nursing & Midwifery Council, 2008). For this purpose, a mentor was defined as one who "*Facilitates learning and supervises and assess students in a practice setting."* (Nursing & Midwifery Council, 2008,p.56).

Therefore the learning and assessment standards were set to ensure that students on NMC approved pre-registration nursing education programmes, leading to registration on the nurses' part of the register, were supported by a mandated requirement of mentorship (Nursing & Midwifery Council, 2008). Furthermore, the allocated time given to mentoring is an identified proportion of the mentor's workload with clear statement from the NMC regarding allocate mentoring hours.

This is a direct enhancement for student support from the UKCC's fitness commission's original understanding that changes in the NHS resulted in less time available for '*practice staff to supervise and mentor students' thereby reduced time to teach student trainees'* (United Kingdom Central Council, 1999,4.42,p.40). The UKCC's comments of staff shortages seemed to further exacerbate the time for registered nurses to teach with their students by their side. The pressure of staffing levels, service demands and finding enough qualified staff to act as supervisors (mentors) and the heavy burden of supervision in terms of time and responsibility were noted as having an effect on the working relationship (Elkan and Robinson, 1995).

Elkan and Robinson (1995) published research spanning 1990 to 1994. Their paper, commissioned by the Department of Health, England, covered the work of nine research teams who had published findings: The National Audit Office, The National Federation for Educational Research, and several different authors. Their findings offered eleven summaries and six key discussion points one of which focused on links with Higher Education. The discussion expressed concern that both students and staff (of Project 2000) were isolated from wider educational contacts and experiences. This suggestion is based on their findings that the nature of the link to Higher Education has by '*no means been achieved'* and that links with HEI's vary considerably (Elkan and Robinson, 1995, p.391). This may not be the case in current HEI and Practice Learning environments but does resonate with the notion that disconnection has occurred and this study further gives recognition of the gap in responsibility and ownership. Identifying the current situation is essential to this study in recognition of a possible gap in responsibility and ownership.

Meeting a student's needs is a key characteristic of mentorship and the perceived characteristics of a mentors acting as guides, as well as advisors and companions, is well documented (Royal College of Nursing, 2007). Mentors provide student support

and guidance in the practice area with continuous assessment throughout the placement period but essentially it is equally important that the evidencing of learning has taken place which should match the students learning objectives (Clark and Casey, 2016). Furthermore, in a study conducted by Teatheredge (2010) she demonstrated that areas that were '*less busy'* meant that students received more support with one student in her study concluding that time could be spent on the book (*Practice Assessment Document*) to question the student before signing. This was in direct contrast of another students' comment that "*in hospital, time is precious'* (Teatheredge, 2010,p.21). This does not sound so dissimilar from Project 2000 student concerns.

The research conducted by Teatheredge (2010) was undertaken as part of a larger scale study, but the overall aim was to explore what constitutes a successful mentor. This involved interviewing eight third year mental health students and sending postal questionnaires to 270 qualified mentors. A response rate of 23% was received from the questionaries' and data from the eight interviews signposted effective mentoring as dependent on a secure, productive relationship and that both parties commit to this process. Whilst the response for the questionnaires may have been relatively small, there is indication from her study that the mentoring relationship is bound not only in imparting clinical information but is also bound in enabling students to practice their theoretical knowledge and skills in clinical areas and enhancing their practice (Teatheredge, 2010).

One of the recommendations for practice offered by Teatheredge (2010) was that mentors needed protected time to develop effective, committed working relationships, which support learning. According to Teatheredge (2010) time must be devoted to the implementation of the domains to positively influence the relationship. Another similar argument presented by Gardner (2012) is the novice to expert model of skill

acquisition if properly, and fully adhered to, is for the student nurse to spend as much time as possible in clinical practice gaining experience and observing more experienced nurses at work. Gardner (2012) also suggest that mentors are essential for the knowing how and what aspect, of clinical practices that is still key for practice today (Gardner, 2012).

Clinical learning is critical to prepare nurses for their practice-based profession and provides essential opportunity for students to integrate theoretical nursing knowledge into nursing care (Cassidy, 2009). This is supported by the NMC's standards as part of the mentor role and responsibility to bridge the gap between that which has been taught in the classroom and actual application to practice (Nursing & Midwifery Council, 2008).

Essentially mentors measure competency as required by the professional body, but this has been at times subject to inconsistencies in the recording of, and evaluation for, student competency, as first identified by Duffy (2003). Duffy examined the dilemma of whether to fail a student in clinical practice. The study was influential and promoted much debate within the world of pre-registration nurse education as to the responsibility of mentors. Duffy's (2003) study was a qualitative methodology with a grounded theory approach with an aim to develop explanatory theory about common social problems experienced by mentors and lecturers (Duffy, 2003). Grounded theory according to Noble and Mitchell (2016) is a research method concerned with the generation of theory which is 'grounded' in data that has been systematically collected and analysed (Noble and Mitchell, 2016). Generating theory from data is used to uncover such things as social relationships and behaviours of groups and this methodological approach was used by Duffy (2003) to explore the thoughts and feelings of qualified nurses and lecturers who were failing to fail students. Duffy (2003) advocated the use of grounded theory as the means to gain a fresh perspective in a

familiar area given the dearth of research into the area of mentorship and student assessment.

Conducted with 14 lecturers and 26 mentors, Duffy (2003) sought to uncover mentors' and lecturers' experiences regarding the issue of failing to fail students whose competence is in question (Duffy, 2003). The advantages of grounded theory in the case of Duffy's study were integral to seeking understanding of the issue of failing to fail and the perceptions of mentors and lecturers in a fresh approach.

By using one to one interview with participants, Duffy (2003) was able to elicit the mentors' perspectives. Her research challenged such procedures that appeared to contribute to the anomaly, with significant threat of the universities appeal system. Appeals were a recurrent subject within Duffy's (2003) study with reference being made to the perception that the university system often supported the student, particularly when procedures had not been followed. For example, the student might be entitled to appeal if they had no indication that they were *'failing'* placement thus potentially overturning a mentor's decision. Fundamentally, academic regulations apply to all taught university courses for which credit is awarded on successful completion.

The process of appeal, whilst ensuring the student has opportunity for academic recourse, also is subject to any '*mark*' awarded facing scrutiny and this was of significance to Duffy (2003). Individual mentors felt pressurized into recording a *'satisfactory'* decision even when it was at odds with their own professional judgment, particularly when they had left it '*too late in the placement before identifying problems'*. This is reflective of Holland et al. (2010) broad evaluation design conducted to examine a Fitness for Practice curriculum model implemented in Scotland. Concerns that nurses were not fit for practice provided the focus for their

study to demonstrate competence at the point of entry to the register and thus begin the lifelong learning experience. They concluded that policy and practice should help reassure professional bodies and HEI's that curriculum can meet the requirements of fitness. Furthermore, their key finding is the opinion of stakeholders that nurses are fit for practice at the point of entry is paramount and provided a distinction between the merits of clinical skill attainment and partnership working between the HEI and the practice learning setting as the key. Thus, as suggested by Holland et al. (2010) from findings of Duffy's (2003) study that subjectivity in the assessment process: "*If you fail somebody and a colleague was to come and say to you' why have you failed that student?' and you couldn't say outcomes, why have you failed them- it is only your opinion?"* (Holland et al., 2010,p.463).

The outcome of an appeal meant that although another placement could be provided for a failing student, Duffy's (2003) conclusion suggested that there appeared to be a blame culture between partners in being able to '*own*' the student. This corroborates Hughes (2004) suggestion that "*Failing a student as a near impossible task, as the assessment process was disempowering to practice teachers (mentors)" (*Hughes, 2004, p.272). Ultimately it is the HEI who decides the outcome of student's academic and practice progress but as Woodcock (2009,p.21) suggests "*ensuring assessments are not declared invalid, mentors must follow the HEI assessment process precisely*". 'I*nvalid*' relates to university regulation processes, for example appeals with the suggestion, therefore, that there is a power imbalance between the academic environment and Practice Learning Partner for the overall assessment outcome of a student's competency. Project 2000 nurses, it appears, were caught between the mentor's accountability when assessing to secure the pass or fail result of a nursing student's competency which was beset against university process.

The reports and reviews post-Project 2000 had noted that student's practical skills were often deficient at the point of registration and the nursing profession asked for greater clarity of preparing practitioners by appropriately prepared nursing practitioners with a clear division of responsibility for teaching students. This was despite the responsibility being acknowledged in the UKCC commission report that "*Practice assessment should be a collaborative, constructive arrangement between academic staff, practice staff and students – Higher Education needs to recognise the unique nature…practice-based learning*" (United Kingdom Central Council, 1999,p.37).

Fundamentally, this sense of responsibility was resolved with the implementation of the NMC's learning and teaching standards following on from the fitness commission report with additions to the mentoring role being added. A sign-off mentor was introduced by the NMC to bring '*significant responsibility for clinical nurses'* (Sharples, 2007). There was also responsibility on the HEI for ensuring effective practice is considered by the assessment board along with other assessed outcomes to determine whether the student has met all requirements for successful programme completion. Universities however remained as the curriculum provider but responsibility, and ownership, were now clearly entwined within the partnership with responsibility leaning more towards the Practice Learning Partner and is a historical tipping point in pre-registration nurse education for fitness ownership. This responsibility, and subsequently ownership, was however, partly addressed by the NMC by introducing the sign-off mentor.

2.6 Sign-off Mentors - A New Breed of Mentor

All nurses supporting students must complete the professional body's mentorship programme since its implementation in 2006, the single next biggest change in

supporting students was the NMC's introduction of the '*sign-off*' mentor role. Introduced as the single nurse responsible for confirming that a student is proficient to enter the register, sign-off mentors make final judgements after reviewing all their PADs about whether a student has achieved the required standards of proficiency (NMC,2008). This role is considered by the NMC as integral to the overall programme assessment requirements which they endorse as part of programme approval. Confirmation is then given to the approved education institution assessment board that both the theoretical and practice elements have been achieved on completion of the programme.

The sign-off process is integral to the overall programme assessment requirements but sign-off mentors are only required for students on final placement with '*judgments being formed from feedback from colleagues and evidence from other sources leading to an assessment determining whether the student has achieved the required standard for safe and effective practice'* (Teatheredge, 2010). Responsibility resides with the Practice Learning Partner at this stage.

Essentially the attainment of fitness remains the domain of mentors who are ideally placed to assess students, thus the standards to support learning and assessment in practice were updated with additional information intended to ease application in practice (NMC, 2008). For example, standard *5.1 Confirmation of Proficiency*, originally implied that the sign-off mentor and/or practice teacher should provide confirmation of achievement of practice proficiency directly to the NMC. This was revised and made explicit that the role of sign-off was to "*…sign-off students as being proficient in practice and are confirming to the programme provider that the student has met the defined NMC standards of proficiency*…" (Nursing & Midwifery Council, 2008,p.9).

Fundamentally the approved education institution assessment board confer academic awards and practice achievement endorsed by the NMC as part of approval via the approved education institution assessment board (Huybrecht et al., 2011). Therefore, the sign-off mentor provides confirmation of achievement of practice proficiency at the end of the course. However, an evaluation study conducted by Rooke's (2014) study examined the perceived benefits and challenges of the sign-off role within a UK HEI. One hundred and fourteen new sign-off mentors, thirty-seven preparation for mentorship students and thirteen nursing and midwifery lecturers were recruited. The study followed an evaluation survey design to gain a wider perspective of sign-off mentors and lecturers understanding of the NMC sign-off role. This approach reflected again the fractured ownership between the HEI and Practice Learning Partner, responsibility practice and ownership HEI.

Evaluation data from participants focused on all new sign-off mentors completing a sign-off mentor workshop or sign-off mentor preparation as part of the preparation for mentorship programme delivered by the HEI. Phase one of the study included 120 questionnaires being distributed with a 95% return rate of 114 responses from attendees at a ‘sign-off’ mentor preparation session. Phase two; data evaluation from qualified nurses and midwives completing a mentor preparation programme. 83 questionnaires were distributed with 37 completed (44.6%) but there is no indication of which participants responded as participants consisted of midwives, adult, mental health, learning disability and children’s registered nurses. The last phase 3; was evaluation data from nursing and midwifery lecturers with 43 questionnaires distributed and 13 returns without respondent details.

All three phases involved questionnaires sent 2 phases via post to the participants with the expectation of being returned. However, it was noted as one of the main limitations of the study that the requirement for participants to return the

questionnaires resulted in a lower response rate. Phase one questionnaires had been completed within the preparation session and thus had had a personable quality associated to complete it (Rooke (2014).

Principally the findings did identify the maintenance of professional standards as important for students to meet the required NMC sign-off standards. This was expressed by the participants as an important aspect of the role to promote and incorporate standards more robustly in practice. Furthermore, 68% of sign-off mentors identified a greater awareness and level of accountability for assessment decisions. This was supported by perceptions that the sign-off role would help to ensure that students were correctly assessed as the role would be taken on by those who wanted to take on this responsibility (Rooke, 2014). The acceptance of responsibility seems reminiscent of Watson's (2004) study of qualified nurses undertaking the ENB 998 for professional motivation reasons.

However, with the sense of heightened responsibility expressed by the sign-off mentors, time, or rather the lack of it, was cited as a challenge. The NMC standards stipulate that all sign-off mentors must have one hour protected time per week per final placement student and 42% of the sign-off mentors considered this as a challenge compared to 92% for the lecturers (Rooke, 2014). Rooke's (2014) study also supports the importance of the sign-off role and its sense of responsibility but the study also revealed an increase in anxiety of mentoring. This was evidenced through the data that sign-off mentors, placement providers and universities are to provide "*coherent and effective responses to concerns over students' fitness to practice, true collaboration must exist*" (Rooke, 2014,p.48). Collaboration, can however, be difficult to establish.

Another study which explored mentors' thoughts and feeling around student

competence was Maclaren et al. (2016) a published qualitative, mixed-methods study of students' and mentors' understanding of fitness to practise. Their study design was in the interpretive paradigm and used qualitative mixed methods of focus groups and semi-structured interviews. Purposive sampling was used to recruit nursing students and mentors to 4 and 2 focus groups respectively with a total of 35 participants consisting of 17 pre-registration nursing students and 18 nursing mentors. There was no requirement for students to have personal experience of FtP processes, but some students were recruited who had been through their HEI's processes. The authors do refer to the limitations on recruitment and concluded that one of the factors not to participate may have been due to the sensitive issue despite confidentiality being assured.

The findings of the focus groups highlighted areas of ambiguity, differences of opinion and the interviews offered participants the opportunity to share more personal information about their experiences of FtP processes. Three themes were identified from the student and mentor data; *Conceptualising Fitness to Practise*; *Good Health and Character*; and *Fear and Anxiety surrounding Fitness to Practise Processes* with conclusions being drawn that there was a pervasive fear among students and reluctance among mentors to raise concerns about a student's fitness to practise.

> '*Catastrophic' thinking was a common thought from both participants with students fearing something was wrong if the lecturer walked onto the ward for a "...cause for concern, and the first thing that they said was 'who's done something wrong?' So, it's like if someone's walking in from the university, someone's done something wrong. And everyone was so nervous, it was like 'is it me? Is it me? What have I done?*'" (S11).

This was demonstrated in the findings and discussion theme *Fear and Anxiety*

Surrounding FtP that anxiety is experienced with the FtP process and was associated with blame and punishment with negative perceptions of FtP which can be reinforced if the HEI emphasises the punitive aspects of the process. These fearful feelings were connected to the possibility that they (the students) would be removed from the course (Maclaren et al. (2016). The mentor's perspective was a key finding suggesting that fear and negativity may discourage the honest and open acknowledgment of issues between their student and mentor relationship and the HEI.

The students commented that whilst it was an emotional process, the mentors described anxiety about instigating FtP processes. "*I think it's such a daunting prospect. Nobody wants to be the one to go to somebody's university and say 'I have concerns about one of your students'. Nobody wants to be that person."* (Maclaren et al, 2016, p.19). Thus, the study demonstrated that the process of FtP was an anxious period with students not wishing to go through it and the mentors not wishing to instigate it.

Their conclusions had conceptualised FtP, which was multifaceted and readily associated to health, character but was fraught with misunderstanding of the process itself. This was an interesting study with all participants suggesting some degree of stress in fulfilling the expectations of meeting the standards expected, but ambiguity and uncertainty of what constitutes fitness to practice was also evident. The study compared and contrasted student and mentor views suggesting that students attribute fitness to personal health and core values and mentors associate fitness to competence and ethical practice. Furthermore, the findings from the study highlighted some reluctance from the mentors to inform the HEI of an issue.

This is interesting study and following on after a decade of NMC approval for all HEI's

to have a localised process, there appears at times to be sense of hesitancy ingrained in the clinical setting for managing fitness matters. The Practice Learning Partners appear to go unnoticed or misunderstood but this study also represents the symbiotic relationship between understanding processes and concepts behind fitness to practice when managing pre-registration students within the researchers HEI.

The study by Maclaren et al. (2016) underlined how important FtP processes were as a measure to protect public safety and the UKCC fitness report, and its subsequent examination of the academic and clinical relationship, held the belief that cases had occurred where HEI's had not understood their role in public protection (UKCC, 1999). Supported with evidence from the UKCC's *Issues Arising From Professional Conduct'* of complaints received demonstrated cases of professional misconduct but were in actuality a "*number of cases referred relating to competence rather than professional misconduct"* (Bradshaw, 2001b,p.72). The UKCC admitted there were no single acts of omission serious enough to lead to removal from the register, but they decreed that the practitioner was not up to the required standard and may demonstrate a poor attitude, lack of insight and may make several errors over time.

No procedures were established however to deal with such matters and therefore the conclusions drawn from the UKCC's complaints committee focused on the competence ability of nurses at the point of entry to the register with blame assigned to a lack of competency driven standards and the still imperfect integration of theory and practice education. Thus, the recommendation that all course providers require a local '*fitness to practice'* process with panels to consider any health or character issues, and to ensure that public protection is maintained (Nursing & Midwifery Council, 2009c).

The researchers own FtP institution policy is designed to protect the public by setting

standards for professional practice and conduct (ARU, 2018). For example, possible issues such as criminal convictions, allegations of inappropriate behaviour; and psychiatric illness (this is not an exhaustive list).

No one partner had up until this point owned the fitness process but rather there had been more of an emphasis on producing a nurse fit to practice at the point of registration. 1999 was a fundamental point for responsibility, with the addition of the sign-off mentor, and with process being granted to the HEI. The HEI mirror the NMC '*The Code'* standards, through their disciplinary procedures with the Practice Learning Partners assessing the nursing student's suitability/competency through the Practice Assessment Document setting the professional body's achievement outcomes. Thus, the Practice Learning Partner are duty-bound, as are the professional body and HEI, to declare issues of concern.

A single paged article by Elcock (2014) provides a brief overview of how nine HEI's have been commissioned in the London region to deliver pre-registration nursing programmes for around 40 NHS Trusts. The article focuses on the need for the Practice Learning Partners to become familiar with the different university processes, as well as understand the different practice assessment documents and feedback from students, no details are provided, suggests that mentors are not always '*familiar with their (the students) documents'*. Responsibility at this stage focuses on mentors needing to understand several different HEIs documents and processes. Principally Sturgeon (2012) emphasised in his article on Higher Education reform and quoting the NMC that nursing students '…*are enrolled on an education and training programme that is preparing them to enter a profession which carries with it great privilege and responsibility'* (Sturgeon, 2012, p.46).

The focus of the article is reflective of changes to the way Higher Education has been restructured and the potential conflict of interest between the students as a source of income for the HEI and the student as a member of a professional organisation. The underpinning topic of the article suggests that educating nursing students should not be about getting poor candidates through but should instead be concerned with the application of rigorous professional standards (Sturgeon, 2012). The researcher would argue however that the student is learning to become a professional member guided by mentors to apply the professional body requirements in the practice learning area. The student remains subject to HEI regulations until entered onto the register. This argument provided by Sturgeon (2012) has relevancy to the notion of ownership and responsibility and therefore has relevancy to this study.

However, what has been established is the strategic process of awarding results being delivered, administered, and managed by the HEI (NMC approved educational institutions) with the clinical setting reporting the outcome of a students' practice attainment being misaligned with responsibility for managing students with disciplinary issues. Elcock (2014) provides comment in her short article that '*collaborative working and shared ownership between HEI's and placement providers is essential to ensure that the assessment of students in practice guarantees that they are fit for practice and purpose'*. That is what the DoH said in 1999 and more importantly, if the student isn't fit, why are they able to continue?

Principally, the UKCC refer to fitness for award as the marker for attainment but this has produced a dichotomy as, to satisfy the awarding bodies' regulatory attainments, students are required to pass both elements of the course-clinical and theoretical. However, the discourse of ongoing clinical assessment and the regulatory bonds of the awarding body, the researcher would argue has enhanced a sense of disconnectedness between the academic and clinical partners. The registering of

students with the HEI suggests responsibility to that half of the partnership therefore division of possession may have shifted the partnership discipline away from practice.

2.7 A Lead to The HEI's Management of Fitness to Practice

The profession wanted a nurse fit for practice, and fit for purpose, however, policy, processes and transparency of ownership only became evident in 1999 with The Fitness for Practice, Commission for Nursing and Midwifery Education document (United Kingdom Central Council, 1999). The constituent parts of academia and clinical ability appear to have been compartmentalized between education, the clinical setting, and the professional body with subsequent devolvement of responsibility between the first two partners.

Fundamentally, delivery is equal for theory and practice with Bradshaw and Merriman (2007) commenting that "*the disintegration of learning is located in practice knowledge that runs alongside formal, university knowledge" review agreed that an authoritative stance on pre-registration education was urgent*" (United Kingdom Central Council, 1999,p.4). The duality of delivery was meant to produce a clinically and educationally fit for practice nurse but both stakeholders could not adjoin a decision. This point impresses on the current research the fissure of ownership could be increasing, and the education of nurses requires a collaborative approach to monitor professional conduct and performance. However, if a student displays deficiency in clinical practice; ownership of the problem can become disaggregated. The HEI process subsumes the collaboration relationship and it is at this stage that the clinical setting appears to hand over responsibility.

Even though recommendation 25 of the UKCC commission report clearly identifies that a relationship exists, the UKCC established roles for academic and clinical staff

and that specific learning outcomes should form a formal contract to aid assessment the description offered in section 4.23 states that "*practice-based learning should be included in the assessment for an academic award*" (United Kingdom Central Council, 1999). The final review of the UKCC commission report resulted in the setting out of its outcomes and deliberations and in section 13 '*Working in Partnership'*, they concluded that joint responsibility of the service providers and HEIs to support students throughout their programme of study were to "*establish closer working partnerships between service providers and HEI's*" (United Kingdom Central Council, 1999,4.17,p.37).

However, the UKCC had noted within the commission report anecdotal evidence of newly qualified Project 2000 nurses had questionable levels of competence at the point of registration, described within the report as *'disturbing'* (United Kingdom Central Council, 1999,4.2,p.34). Fundamentally, any student unable to achieve competency was refused entry onto the register and therefore the UKCC amended the registration of students to the register. The HEI held responsibility as the awarding body for recommending the student for the register but a dichotomy exists between being awarded the professional registration, as opposed to being awarded an academic award, set against competence levels at the point of entry it can be argued that responsibilities had been defined by the HEI.

It must be remembered that the commission report was a decade on from the commencement of Project 2000 and the guiding principle behind the UKCC fitness commission report was "*To prepare a way forward for pre-registration nursing and midwifery education that enables fitness for practice based on health care need"* (United Kingdom Central Council, 1999,p.2). This suggests that the HEIs, as the awarding body, may be able to claim responsibility of the student but the point impresses on the sense of responsibility of the clinical setting to act equally in the

collaboration. Practice is responsible for all clinical aspects of the student nurses programme and the HEI for the overall academic workload and awarding ability circa to the practice passing/failing component, however, establishing the 'owner' seems to be at an impasse.

Students on NMC approved pre-registration nursing education programmes must be supported and assessed by mentors and every mentor is a registered nurse therefore have professional accountability (NMC, 2008). According to the NMC, accountability *'is the principle that individuals and organisations are responsible for their actions and may be required to explain them to others' and this will refer to patient care and supporting nursing students. Alongside accountability is responsibility which should address the matter of fitness to practice for nursing students as well as protecting the public.* The professional body have been instrumental in developing their framework standards for educational and professional conduct in order to be the NMC continue "*Fit to practise means having the skills, knowledge, good health and good character to do your job safely and effectively...Our main purpose in doing this is to safeguard the health and wellbeing of the public*" (Nursing & Midwifery Council, 2009c,p.5). Furthermore, the provide guidance which states that the university will follow the "*expected education and clinical placement providers to include this guidance in the content of their pre-registration programmes, and to use it to determine a student's fitness for practice*" (Nursing & Midwifery Council, 2009c). This is truly relevant to this literature review that academic award is concurrent with practice competency and as Watkins (2000) suggests '*clearly the public has the right to expect to have nursing care delivered by competent, safe practitioners'* (Watkins, 2000, p.340).

The discussive paper by Watkins (2000b, p.338) states that "*the benefits of a college- or university-based education were perceived in various ways, but if individuals are to be given academic awards in nursing then by definition, they should be fit for both*

award and registration concurrently". However, according to Farrand et al. (2006) the power of the HEI as the awarding body is blurred by the need to pass the practice competencies set by the professional body. This is a responsibility and ownership dichotomy as the standards required by the professional body clearly supports each partner's position within the education of students. In terms of assuring that a registrant meets the standards of proficiency for registration, there is no better placed partner for responsibility than the Practice Learning Partners they work directly with the student. They also have responsibility to address, and act, on all matters on a competence level and are required to supervise and assess students and to teach the specific learning outcomes. This should form a formal contract to aid assessment to support the description offered in section 4.23 stating that; "*practice-based learning should be included in the assessment for an academic award*" (United Kingdom Central Council, 1999, p.38).

Thus, fitness can be shown to be an equally disseminated responsibility between the academic and practice learning environment with the UKCC 1999 commission report clearly identifying practice assessment (for competence) should be a "*collaborative, constructive arrangement between academic staff, practice staff and students*" (United Kingdom Central Council, 1999).

The discourse however between award and fitness is evident in the UKCC commission report stating that; "*4.6 Fitness for award: universities are primarily concerned about fitness for award – has the student attained the appropriate level, breadth and depth of learning to be awarded a diploma or a degree? Fitness for award does not mean fitness for purpose, but most employers acknowledge established academic awards as markers of achievement."* (United Kingdom Central Council, 1999,p.34)

An example of fitness of award and FtP can be taken from one high profile case of registered nurse Colin Norris who was convicted in 2008 of murdering four older female patients. According to a journalistic report, Norris was considered an 'idle' student by his personal tutor during his three-year programme with his tutor recalling having to warn him about his attitude and poor attendance (Stokes, 2008). Norris's languid approach to attendance was reflected in his absenteeism, recorded as 73.5 days; "…*Colin Norris' attendance at clinical placements (caring for elderly people) was an ongoing problem and some placements refused to allow him to return…Witness statements also identified concern about his aggressive behaviour towards lecturers*…". (Proctor, 2010,4,p.24).

The inquiry, however, did not find him unfit at that stage of absenteeism but the findings of the inquiry do highlight the academic/clinical disconnect associated with fitness due to the sense of responsibility being placed upon the placement area and the personal tutor. Confirmed in the inquiry was that placements refusal to take him was an obvious dereliction of ownership duty for the programme providers and raises the question of how Norris was able to navigate around any disciplinary process. The question of the 'owner' of responsibility for Norris's fitness, considering this attitudinal and lackadaisical approach can be referred to the study conducted by Holland et al. (2010) that disconnect between the partner's sense of responsibility may be based on competency, knowledge, and confidence, that are paramount attributes, but Norris's case highlights the sense of disparate ownership for process between partners. However, Reid (2010) identified that each party would '*blame the other'* for a failing health care student and this point impresses on the widening fissure of responsibility.

2.8 Ownership in Mentoring

What is disturbing is the lack of engagement between the regulatory professional nursing body and the Practice learning setting, and therefore expectations, that learning within the practice setting is solely based upon the mentor. This seems to be a disrupted pattern of responsibility between the three stakeholders and as Bradshaw and Merriman (2007) suggested, the lack of clarification and definition other than mentoring being compulsory, registered nurses were only expected to meet this training requirement. The clinical experience remained ill-defined for both student and clinical staff prior to the UKCC (1999) Commission report.

The principal role of the mentor was to act as a professional role model and clinical educator, but a study conducted by Watkins (2000) defined learning outcomes as key within curriculum development and suggested that the practice assessment of students was the responsibility of the mentor whose role would be to produce a student fit to practice at the end of the educational programme. The reality, however, was that the profession had created an educational, competency-focused model but without the clarity and focus of process and management responsibilities.

Whilst the UKCC recognised that good mentoring depended on well-planned learning opportunities, the provision of support and coaching for students required better practice placement preparation (United Kingdom Central Council, 1999,p.4). This was further evidenced by the profession itself stating that to achieve fitness the standards for registration as a nurse on parts 12,13,14 and 15; "*Specify that consistent clinical supervision in a supportive learning environment during all practice placements is necessary"* (United Kingdom Central Council, 1999,4.17,p.37).

In order for a student to be considered fit to practice, "*systems must be robust for documenting concerns and not only identifying the student but of managing them that*

places both academic and professional conduct equally" (Reid, 2010,p.1042). Thereby the concept of a 'sign-off' mentor (section 1.8) was developed adding a two-layered system of mentoring and another level of professional assurance for the upload of a registrant.

Nurse mentors completed specific preparation in assessing students and were responsible for ongoing supervision and assessment in practice settings, but the sign-off mentor makes a final judgment of competence. During a period of at least 12 weeks practice learning towards the end of the programme, sign-off mentors have authority about whether a student has achieved the overall standards of competence required for entry to the register at the end of an NMC approved programme (Nursing Midwifery Council, 2010). The addition of a sign-off mentor helped protect patients, whilst protecting and supporting students who were not reaching the expected standards in practice (Rooke, 2014). This assigns responsibility to the sign-off clinical practice lead and thus not the awarding body. However challenges remain with sign-off mentorship as there was a perception of heightened responsibility and their sense of conscious of their gatekeeper role in ensuring students' fitness going forward to registration (Rooke, 2014).

Furthermore, and alternatively for the HEI, the NMC require Practice Learning Partners to hold mentor registers to ensure registrant's performance is reviewed at least once in every three years to confirm that they have maintained their ability to act in these roles (Rooke, 2014). This continues the awarding body/professional body dichotomy of HEI delivery for professional standard setting and maintenance of fitness. Whilst the NMC mandatory standards identify the responsibility and accountability of mentors, it is the responsibility of a sign-off mentor to make judgment about whether a student has achieved the overall standards of competence required for entry to the register (Nursing & Midwifery Council, 2008). However, the NMC

requires confirmation at the end of each programme that both practice and theory parts have been successfully achieved and this is in partnership with the HEI as the awarding body that all requirements have been met (Nursing & Midwifery Council, 2008).

This extra level of clinical security was established to assure that the relevant practice and academic signatures have given approval in readiness for the register, HEIs were duty bound to facilitate a local policy and interestingly not in collaboration with the practice learning partners. Recognition was the need to monitor nursing student's progress to enable appropriate entry recommendation to the register, led to consultation with nurse education providers to recognise and develop a policy process when managing practice issues before the registration.

2.9 The Move to Owning Fitness to Practice

A code for students within the UK appeared in 2009 when '*Guidance on Professional Conduct For Nursing And Midwifery Students'* was introduced by the NMC following awareness that the public could not always see the difference in accountability and responsibility between students and qualified nurses (Nursing & Midwifery Council, 2009b). The NMC (2009) code of conduct for student nurses reminds nursing students that their behaviour is important in upholding the reputation of the profession, both when they are studying and in their personal life.

However, management and the conduct of process for fitness to practice was bequeathed to the HEI 1 January 2009. The NMC bestowed the HEI with FtP process following the 1999 UKCC Fitness for Practice Commission report that recommended that all nurse training programme providers consider any health or character issues

to ensure that public protection is maintained through a local fitness to practice process (Rooke, 2014,p.48).

It is at this stage that the sense of responsibility and ownership began to dissolve with the increased emphasis on academic currency which appears to have led to a dichotomy between the professional body requirements for competency (fit to practice) at the point of registration whilst working in tandem to the HEI's awarding powers and the uploading of students to the register. The focus of FtP is around competency and the NMC's *Fitness to Practice* systems, but there is also a focus on what constitutes unsafe practice and unprofessional conduct which questions whether the educational component of pre-registration nurse training is sufficient to achieve this balance alone.(Killam et al., 2010).

The NMC gives general rather than directive guidance on when and how HEI fitness to practice processes might be used, with the recommendation that any fitness committee be represented by the HEI and Practice Learning Partner, (MacLaren et al., 2016). The NMC indicate that HEI's needed a fair and just written procedures that are implemented which also affirms responsibility to the HEI (Nursing & Midwifery Council, 2010). However the small amount of existing evidence that HEI's are achieving this suggests that the quality of such process can be uneven, either favouring the student or practice rather than looking at the evidence collected (MacLaren et al., 2016).

Guidance by the NMC on fitness processes suggested that if there is a public protection issue the student should be referred to the HEI fitness panel. However, the processes through which students are monitored, assessed, and disciplined varied considerably between HEI's (MacLaren et al., 2016).

MacLaren et al. (2016) examined fitness to practice processes in pre-registration nursing programmes in Scotland, UK. One of the aims of their study was to examine the sequence of processes and to illuminate examples of good practice developed by HEI's. Nine out of eleven Scottish HEI's from a single geopolitical region were recruited whose nursing programmes are regulated by the NMC.

Qualitative data and documentary evidence were gathered to understand institutional processes and polices to share good practice. Through a qualitative approach which enabled a rich and deeper understanding of good practices and challenges, data was collected from 11 participants who had key roles in relation to fitness to practice processes.

Data from semi-structured focus group interviews and documentary evidence provided the researchers with five key themes:

- *Stages and Thresholds of FtP*
- *Principals and Concepts Underpinning FtP*
- *Knowledge and Understanding of FtP*
- *Good Practice*
- *Issues and Challenges*

The study observed institutional differences of FtP practices and highlighted significant variations. The study observed a few HEIs using pre-FtP stages as a preventive action whilst others did not, this added stage enabled students to be dealt with more efficiently and therefore being able to return to practice sooner if applicable. Within their 2016 paper MacLaren et al. found contextualised and elucidated stages and thresholds to be diverse across the sector and were couched in different terminology. The authors suggested that there were several stages and processes set by the individual HEI's for the constitution of their fitness panel hearings and pre-

Ftp variables. This resonates with the researchers' HEI, where processes have been enhanced by ensuring evidence and actions taken are proactive wherever possible, rather than reactive.

The researchers in the MacLaren et al (2016) study mapped out the differences of processes used by the HEI's and developed a scheme of fitness to practice staging, highlighting points of progressing fitness matters. This schema presents an interesting overview of process across the Scottish HEI's and proves a comprehensive outline of the differences in managing fitness matters procedurally and within policy (MacLaren et al., 2016,p.417). The processes and polices fundamentally belong to the individual university and are therefore at their discretion. Principally, their conclusion suggested that consistency, clarity, and robustness of FtP processes should create a better process for supporting and informing students. Furthermore, MacLaren et al. (2016) concluded that the student's position as a learner should also be considered, but equitable processes also highlighted the importance of a proportional response to FtP concerns.

A study conducted by Holland et al. (2010) aimed to evaluate fitness to practice definitions within pre-registration programmes in Scotland to determine whether students achieve fitness. Using a mixed methodology approach phase one involved questionnaires, Objective Structured Clinical Examinations (OSCE) and curriculum evaluation. Phase two involved semi-structured interviews and focus groups across main stakeholders. A synopsis to the main objectives of their study, sought to evaluate the influence of educational processes, flexibility, partnership working and evaluate the impact of the programme in NHS Scotland in terms of perception for fitness for practice. This was a multi-faceted approach and one where the findings are not explicit to which data related to the themes identified. However, phase one did attempt to seek meaning of perceptions through a postal survey of pre-registration

students on self-efficacy and competence; a series of OSCE's; and a paper and pencil test of numeracy sills to determine student competence. It is not clear however, who completed each element.

Phase two involved evaluation of key stakeholder perspectives and experience of the students' fitness for practice and the NHS-HEI partnerships that ensure this. The design of phase two aimed to capture academics, managers, students, and carers/service user's perspectives. Interviews and focus groups identified several themes, but it is unclear as to who attributed to which theme. The study however does provide insight into the perspectives from several participants.

Holland et al. (2010) established distinct themes. A key theme defines fitness to practice as acquisition of skills, knowledge and attitudes, considering all as necessary and that it seems reasonable to assume that '*someone who is not fit for practice is not fit to practice'* but on the other hand, someone (who) is not fit to practice may nevertheless still be fit for practice (Holland et al., 2010,p.463). They suggested that this is because the term '*fitness for practice'* appears to be used to refer to professional competence, that is having sufficient competence, knowledge, and skills to be able to practice safely, and the term fitness to practice is more frequently associated with health and conduct. Thus no one distinct definition could be concluded from the study.

The NMC state that being *'fit to practise requires a nurse or midwife to have the skills, knowledge, good health and good character to do their job safely and effectively'* (NMC, 2017). Furthermore, the NMC will investigate various allegations including misconduct, lack of competence, criminal behaviour, and serious ill health. Therefore, the definition fitness to practice appears to be connected to an incident of a serious nature that may affect the nurse's or midwife's judgement, character, or ability.

Fitness to practice has a focus on process compared to being fit for practice where skills are required to attain registered nurse status. For this current study, the term fitness to practice will be referred to in terms of managing process between the HEI and clinical setting, during a student nurse education.

The remaining themes referred to by Holland et al. (2010) focus on the clinical setting and the partnership aspect of managing students in the practice area. Theme 2) preparation for practice; 3) being in practice and 4) partnerships in practice relate to the management of student placement providers. One of the innovative developments was the group of universities and their associated NHS stakeholders set up a Practice Placement Committee to oversee the placements for students (Nursing & Midwifery Council, 2010). Disappointingly, although theme 4: partnerships in practice highlighted great working practices for securing HEI-NHS commitment to the successful management and quality of clinical placements for students, the theme did not address matters in terms of the partnership responsibilities. This is gap in definitions gives further rationale for the current study.

Whilst Holland et al. (2010, p.467) addressed the collaborative working approach and their "*overarching observation was that there appeared to be a national commitment to partnership working and that in some instances there were local differences and tensions, there was a high level of engagement*". Reference to the clinical perspective did however demonstrate emphasis on practical ability in the clinical setting. In contrast the Holland et al. (2010) study highlighted the prominent (dis)-association and minimal reference to the academic perspective regarding ownership towards the student's ability. This was corroborated by "*Partnership working and that although there were, in some instances, local differences and tensions, there was a high level of engagement in ensuring that educational policy recommendations were in line with NHS Scotland's modernization agenda"* (Holland et al., 2010,p.467).

However debate continues with relatively little attention being paid to the HEI's ability to monitor and respond to any issues regarding fitness matters (MacLaren et al., 2016). The NMC requires all universities to have robust fitness to practice policies in place to investigate student conduct with more than 800 nursing students being subject to disciplinary proceedings in the UK (Keogh, 2013). Keogh (2013) discusses within her article the disparity with which universities use their disciplinary processes. Out of a survey of 25 universities, 805 students across the UK had been involved in allegations of plagiarism, unprofessional conduct on placement and failing to disclose criminal convictions (Keogh, 2013). Sanctions ranged from verbal warnings to expulsion but demonstrates the wide variation of potential disciplinary outcomes students may face. For example, Keogh, suggests that the regulator expects students to be fit to practice by having the skills, knowledge, good health, and good character to do the job, but common areas of concern are aggressive, violent or threatening behaviour, dishonesty, criminality, health concerns, and unprofessional behaviour such as breaching confidentiality. These expectations, however, were not cognate across all universities.

General disciplinary procedures were used compared to some institutions using the fitness to practice process reserved for matters concerning behaviour or safety. For example, one university expelled one student for failing to disclose a criminal record prior to course commencement but another was given a written warning after being arrested for assault (Keogh, 2013). This demonstrates dissonance between the regulator expectations and how the HEI use (or utilise) their disciplinary processes to manage the incident. This illogicality was recognised in an article by Tee and Jowett (2008) who supported the contradiction that when HEI's strengthened their quality control procedures for student misconduct in practice then the students procedurally belong to the HEI.

As a general principle, the gravity of a fitness issue may, in part, be reflected by the stage of a student's career (David and Lee-Wolf, 2010). This presents a dichotomy of responsibility following the 1999 UKCC report that the professional body states the objectives for fitness, but ultimately responsibility has been transferred to the HEI when dealing with clinical and academic matters. Furthermore, each educational institution needed to have fair written procedures that are followed and implemented (David and Lee-Wolf, 2010). Thus, control and responsibility were yielded to the HEI but principally whilst the NMC provides guidance to educational institutions for programme providers to consider suitability of a student whose character is in question, as Callanan (2010, p.61) suggests, there is no definitive list of unacceptable offences "*It depends entirely on the conviction*" says RCN advisor Ms Robertson. Thus, one university's judgment on a student falsifying a signature could be that it was a silly mistake whereas another might take it more seriously believing that if the student was '*prepared to do that in one setting, they might do it in another*' (Keogh, 2013, p.15).

Emphasis is placed on the HEI to action fitness matters, but the clinical setting determines the need for it. Guidance is given that a student should be assessed throughout their pre-registration programme and, if there are ever any concerns; these should be investigated and addressed by the university. The NMC go as far to suggest that students should familiarise themselves with university procedure and if in doubt to ask their academic tutor (Nursing & Midwifery Council, 2009a). However, it was deemed that the lecturer's role was only to offer advice and support to the mentors and clinical assessment remained the key objective of the mentor.

2.10 Managing Fitness to Practice the University Way

The university role of Director of Studies (DoS) that the researcher presently undertakes, is obliged to uphold the university regulatory procedures and regulations

for students which includes maintaining professional standards and according to Unsworth (2011, p.466) HEI's "*should have formally agreed mechanisms for removing students from contact with patients if their fitness is impaired*". Therefore, across the UK and within the researchers own university academic regulations, the DoS instigates university fitness process policies which have been designed to ensure that appropriate action is taken in the best interest of the public, the profession and the student (Nursing & Midwifery Council, 2009c) (ARU,2018).

Programme managers implementing the professional body sanctions and guidance through university committees was considered by Unsworth (2011) who found in his review that several specific policies highlighted areas where processes could be strengthened to avoid inconsistent decision-making. This has been supported in some part by the study conducted by MacLaren et al. (2016) where they concluded that fitness issues across HEI's in Scotland included a variety of stages; a pre-Fitness to Practice (FtP) stage 1 evidence gathering, and stage 2 threshold process.

In their study, MacLaren et al. (2016) were able to elucidate similarities and differences that allowed them to map major stages and thresholds with their results highlighting points of progression, justification, and student involvement in the process. Their study highlighted the importance of a proportional response to fitness concerns, considering the student's position as a learner (Maclaren et al., 2016). However, they found that conceptualizing fitness difficult despite the NMC definition of fitness as nurses having *"the skills, knowledge, good health and good character to do their job safely and effectively"* (Nursing & Midwifery Council, 2015).

In the researchers own HEI, a student's progress and achievement of clinical outcomes is monitored through each students Practice Assessment Document (PAD). The PAD has been designed to guide learning for each year of the course

with practice assessment based on NMC Essential Skills Clusters for progression criteria and standards for competence (Nursing Midwifery Council, 2007). Mentors assess practice on a continual basis and as part of the student's evidence of development and attainment of clinical skills (Nursing & Midwifery Council, 2010).

The mentor in the clinical setting identifies, documents, records any clinical or professional concerns they may observe during the student's placement and any concerns are formally referred to the university. This can range from competency issues to critical situations that may impact patient safety. The process of referral is through the Cause for Concern (CfC) response strategy that acts as the mode to record, collate, and address practice matters between the student/mentor to be documented with the HEI (appendix 1).

The CfC response strategy (developed by the DoS) which is implemented when any clinical incident, near miss occurrence, or 'at risk' students' are identified. Mentors are required to document and record the incident or concern and send the referral to their respective academic link Education Champion.

Education Champions are academics with registered nurse status and their key role is maintaining the collaborative working partnership between the university and clinical setting. They provide the closest link to the management of student practice through weekly visits to their clinical areas and are paramount to facilitating links to the practice setting. Part of their role is to arbitrate the CfC response strategy between the mentor and student and often the link lecturer and to gather supportive documentation, such as evidence of failed learning outcomes and/or the mentor's supportive statement of events.

Education Champions lead a team of link lecturers who are assigned to a designated Trust (PPL) site for the student's clinical placements but the uniqueness of their relationship to the clinical setting is the responsibility for academic and clinical partnership collaboration for student and mentor facilitation. Link lecturers within the researcher's own HEI, are assigned to a particular wards or clinical areas, where they are responsible for supervising the teaching of students. Rixon and Brooks (2012) suggest that link lecturers play a key role in the support and development of students in the clinical setting without teaching responsibilities. However, locally there is a heavy reliance on the Education Champions to bridge the HEI and clinical partnership rather than the Personal Tutor within the researchers own university.

Facilitation is essential for process as suggested by MacLaren et al. (2016, p.412) who suggest that during the past decade "*there has been increasing national and international debate about how nursing education programmes protect the public*". Therefore, to achieve the NMC standards of establishing processes to monitor and respond to any issues regarding the fitness of students, the DoS implemented the CfC response strategy approach, mediated by the closest academic link, the Education Champions. Procedurally all CfC response strategy forms are subject to review by the DoS. This is further justification on the use of a case study approach both as a methodology and as a method of data collection, for the present study.

HEI's strengthened their quality control procedures to maintain public safety by introducing a university process and policy, but essentially the clinical setting have to identify an issue, for the academic environment to action the raised concern (Tee and Jowett, 2008). Accordingly, a student cannot qualify or register to the profession without the HEI awarding body affirming that the student is fit for practice (Watkins, 2000). Should issues occur it is the responsibility of the DoS to consider if there are sufficient reasons for starting the university Fitness to Practise processes, for formal

presentation to the Secretary and Clerk, who would then refer the case to the Fitness to Practise Committee. It is at this conjecture that the practice area must hand over ownership to the HEI for both process and consideration of the fitness matter.

This discussion presents an element of connectedness to the institutional relationship but exposes factors that enable or constrain the partnering of students. Additionally, Reid's (2010, p.1042) editorial piece suggested that fitness of a student should be determined by both academic (passing assignments) and non-academic ability (conduct and competence) and regulatory bodies will continue to ask how certain students were ever allowed to complete the university course. Her suggestion was that the documenting of concerns, identifying problem students, and managing them in a way that "*places equal value on both the academic and non-academic aspects of fitness for practise is important*".

Strengthened by the NMC's call for a university fitness process framework to manage practice issues at any point throughout the student's course, Reid's (2010) suggestion that systems must be robust between stakeholders is key. Identification and management of issues places academic and professional conduct equally. The clinical setting has an obligation to identify and document a student's progression, before passing this on to the HEI. Therefore, the passing or failing a component of the student's ability rest with the PPL, but what constitutes being 'un-fit' is ultimately dealt with by the HEI.

However, Reid's (2010) research identified that each party would blame the other for inconsistencies. Reid's conclusion that responsibility for the issue lies with both education and practice, but this cannot be assured when each organization appears unclear as to who retains possession of the student. The university owns the process but the lack of transparency and sense of detachment over ownership between

practice and academia raises the question of who is going to pass the student. This brings into question the concept of awarding powers versus clinical ability for ownership.

Fundamentally the fulfilling of practice placements remained the realm of the clinical setting and the objective of the university as the awarding body was for academic attainment for entry to the professional register. The profession was trying to assure clinical expertise, endorse Higher Education notions and attain professional standards simultaneously and although recognition of the evolved clinical and academic relationship was noted. Therefore, a new approach to the management of professional conduct and performance was required. This may have been where the ownership fissure increased as the constituent parts of pre-registration education competed to train nurses.

2.11 Managing Fitness to Practice the Practice Learning Partner way

Assessment of students' ability to meet the NMC standards has the addition of a sign-off mentor increasing the assurance of producing a nurse fit for practice. Sign-off mentors review the student's complete clinical progression journey and make judgment during the student's final placement about their suitability to join the professional register (Lloyd-Jones et al., 2001).

The sign-off mentor works within the students final practice area so they are able to gather information from direct supervision in order to make that final judgment on proficiency (Nursing & Midwifery Council, 2009a). More importantly once satisfied, the sign-off mentor makes a decision that the student is or is not proficient to practice without supervision, supported by the evidence of all records of achievement (Gray and Smith, 2000). However, this must be recorded formally and sent to the university for consideration by the examination board. Additionally, sign-off mentors have a dual

role not only to ensure that the student is fit to practice, but that they address with their mentor colleagues, the level of accountability and responsibility involved in their role (Gosby, 2007). This places clinical competency for future registrants directly at the feet of the practice setting, whilst the learning outcomes deem a student nurse fit, collaborated between the academic setting and the NMC. It is the accountability of the role of the sign-off mentor to assure the public that the student has met all outcomes as per the NMC standards.

2.12 Case Study Evaluation of Historical Documentation and Synthesis regarding Fitness to Practice – The Ownership Matrix

The chronological sequence of events charted in Table 1 Key Documents (page 23) and the literature review has revealed the extent of educational change in pre-registration nurse education since inception of Project 2000. Entry of pre-registration nurse education into higher education was influenced by Government policy and the Regulatory Nursing body requirements, who commissioned programme delivery to HEI's. Additional to the curricular commission, was the sanction by the professional body that the HEI establish their own FtP protocols, guided by the NMC framework standards, which led to a professional obligation by the HEI to protect the public.

This professional obligation, to address and present process, created a change in responsibility and ownership between the academic and practice learning partnership bringing with its compartmentalisation of duty. Fitness to practice is an enigmatic topic and it is important to contextualise the interpreted sense of responsibility and ownership perspectives between the tripartite partnership and will be examined using a framework matrix to visually map and represent the compartmentalised division and segregation of responsibility and ownership examined through conceptual links. However, to understand Palamar et al. (2012, p.201) asked the question of '*how do things come to be owned?*'.

Nursing students were originally based in the SoN and belonged to the hospital which meant that any FtP was dealt as an internal matter or passed directly to the nursing professional body with no other parties involved. This was reflective of the period of nurse education identified in the Key Documents (Table 1) where into a new educative era of Project 2000, pre-registration nurse education changed direction. As a result, the shift of responsibility from educational and professional policies adopted by different stakeholders at different times led to the development of the framework matrix to examine the effects of policy change towards responsibility.

This change is identified in The Ownership Matrix (Diagram 2 page 112) which as a framework matrix evolved to visually represent and analyse how the key documents identified where responsibility had altered from the SoN era to Project 2000 phase, and current day, to a different stakeholder. Furthermore, as part of the multi-document case study approach, these key documents provided a valuable context to change for this study in its exploration of the qualitative approach to examining how the local focus groups perceive FtP.

Palamar et al. (2012) suggested in their discussive article, three experiments were conducted to explore the psychological processes underlying ownership and the judgements made about the establishment of ownership being dependent on the attribution of responsibility. Palamar et al. (2012) suggest that today most things are bought or received as gifts, but the ability to establish ownership is a product of social conventions, judgments about establishment of ownership over non-owned things.

The study consisted of three experiments with two-hundred and forty-three participants; Experiment 1) provides evidence that peoples judgements about establishment of ownership are influenced by agents' intent and control; Experiment 2) shows that the influence of these factors on ownership judgements are similar to

their effects on attributions of responsibility and Experiment 3A and 3B) demonstrates that people's ownership judgements are influenced by agents' intent even when intent is not confounded with agents' foresight into the outcomes of their actions.

This study has relevance for the researcher as they found that factors known to influence the attribution of responsibility also influence judgments about ownership (Palamar et al, 2012, p.207). For example, experiments 1 and 2 showed that certain actions will make the possession of an object almost impossible and performing these actions do not lead to ownership, if the agent did not originally desire the object and therefore did not specifically intend to obtain it (experiment 3A and 3B). Therefore, their proposal is that the attribution of responsibility is used to credit people for the outcomes of their actions (this could be mentors) and so their findings suggest agents may be credited (NMC or HEI) with ownership when they are responsible for making possession of an object (FtP) possible. Fundamentally, their findings suggest that *'first'* possession (making a judgment that ownership is conferred to the first person to physically possess an object) is contradictory that ownership is acquired through first possession but instead, ownership judgements depend on consideration of non-obvious factors i.e., intent, do they want to own the object and control, can they keep the object. Thus, their present findings, suggest that people consider agents' intent and control in judging who has established ownership over an object. But if information is lacking, people may establish ownership in different situations regarding the social function and a sense of reward. First possession is not the finite sense of responsibility or ownership and their limitations recognised that for responsibility-underlies-ownership account is essentially correlational and that alternative interpretations are possible.

Thus, responsibility-underlies-ownership is not based entirely on conventions but of everyday reasoning about ownership which is relevant to the philosophy offered by

Berger and Luckmann (1991). The belief of Berger and Luckmann (1991) is based upon the subjective, one of harmonizing the sense one makes of one's biography, with the sense ascribed to that biography by society (Berger and Luckmann, 1967). Fundamentally, an examination of the concept of society itself, within pre-registration nurse education is not required, but rather to examine the sense of meaning of fitness to practice (reality) and hence own, ownership and responsibility assigned to each stakeholders' meaning.

There is a sense that knowledge and reality become embedded in the institutional fabric or rather the life that the individuals exist (in society) as suggested by Berger and Luckmann and for this study, the society or life aspect relates to the tripartite partnership. Over time individuals know more about the constructed reality of their world (academics and mentors) which may have an impact on understanding the '*others*' socially constructed world (professional). What this thesis using a case study approach sets out to examine is the constructed reality connected to the institutional relationships between the HEI, professional regulator (NMC) and Practice Learning Partner.

On the levels of performance and meaning, what is the objective sense as posed by Berger and Luckmann (1991) of the order the institutions present themselves in for everyone as a given and generally known and thus socially and professionally taken as granted? This reality might otherwise be considered by Berger and Luckmann (1991) as the legitimation process described by them as the '*second-order*' objectivation of meaning. Legitimation produces new meanings that serve to "*integrate the meanings already attached to disparate institutional processes*" (Berger and Luckmann, 1991,p.110). The first-level order relates to making sense if the totality of the institution, i.e., the need to mentor students under the NMC standards through the mentor guidelines whilst acting as a registered nurse under the

constitution of the NHS institution. The mentor in this instance will recognise the *'horizontal'* level of integration relating to the total order, which includes the Practice Learning Partner and NMC.

Legitimation helps explain the institutional order by giving a normative element (Berger and Luckmann, 1991). For example, they describe this meaning as not just being a matter of values but of knowledge. Therefore, mentors are not only imparting their values of patient care (under their practice learning values system) but also of the NMC values (standards). Knowledge in this context is suggestive of defining right and wrong within the structure and the '*right'* maybe to do no harm to patients, the '*wrong*' would be to prevent a student from continuing if they are being problematic.

At this point, Berger and Luckmann (1991, p.111) concede that "*there must be 'explanations' and justifications of the salient elements of the institutional tradition*" and it can be argued that Project 2000 altered tradition and additionally through the mentor role, added to the registered nurses' responsibility, in turn questioned the sense of professional significance to which institution they connect with.

Berger and Luckmann (1991) offer the belief that the reality of everyday life is taken for granted and that it does not require verification over and beyond its simple presence. However, when managing the education of nursing students, this reality maybe challenged as the students' needs, are a different set of realities compared to theirs (the mentors'). This is suggested as the difference between '*my meanings'* and '*their meanings'* in the world but that we share a common sense of reality and this common-sense is knowledge shared with others in the '*normal, self-evident routines of everyday life'* (Berger and Luckmann, 1991p.37). For this study, the everyday life of mentors engaging with students has the '*reality*' of the practice learning environment in the management of the student. But with the registered nurses' key

focus also being on the daily management of patient care for their health needs, whilst also being responsible to mentoring their upcoming peers (students). Thus, their reality is principally focused on the duality as registered nurse and mentor role which may appear to be a secondary aspect, or extension, to their professional requirement. The requirement however is based on responsibility which has been illustrated in the need to support and assess students undertaking approved programmes that lead to registration or a recordable qualification on the professional register as required by the NMC. This is a key component of the professional role but may ask the question as to whether it may be considered by them as essential component of their daily reality objective. Patient care may usurp this.

Principally, students are on placement and need a mentor and this is part of the everyday reality that mentors work in. Mentors are allocated a student nurse with the expectation of meeting and completing learning outcomes that the profession sets. However, the partnership connection appears as a set of processes and policies standardised within pre-registration education. Processes and polices are necessary to meet the requirements of the professional body but the relationship of the various institutions and the level of performance and meaning according to Berger and Luckmann (1991), is the theoretical construction of intellectuals and other merchants of ideas.

Berger and Luckmann (1991) consider this as the reality of everyday life but also consider that beyond its simple presence, in this case the student's attendance, engagement with that knowledge '*that it is real'* requires effort (Berger and Luckmann, 1991). Effort is divided into, and associated with, sectors that are apprehended routinely, and others that "*present me with problems of one kind or another"* (Berger and Luckmann, 1991, p.38). For example, the everyday practice of performing patient care, demonstrating clinical skills, teaching, and assessing of students is

unproblematic until it is interrupted by the appearance of an issue. The suggestion by Berger and Luckmann that if an interruption of performance occurs, therefore not meeting the everyday norm, when faced with the problem, the problem transcends the boundaries of the reality of everyday life and points to an altogether different reality. Thus, other realties appear as finite provinces of meaning (Berger and Luckmann, 1991).

This finite reality is subjective to the face-to-face situation the mentor and student have together and principally each stakeholder whilst having a shared aspect, each world will present a different viewpoint of that shared perspective in a different context. Furthermore, '*institutionalization*' according to Berger and Luckmann (1991) is the reciprocity of institutional typification not only of the actions but also the actors in institutions.

This institutional concept is suggestive of mentors working in their normal practice learning environment encapsulated by professional boundaries. These boundaries include their own practice learning organisation requirements coupled with the duality of responsibility (mentorship) and accountability (registered nurse) to deliver safe and effective care whilst teaching and assessing students in the workplace simultaneously. As registered nurse's mentors must uphold their professional code whilst maintaining the mentorship standards of teaching and assessing. While academic staff have been shown in the literature review to facilitate the nursing students' theoretical journey to assess work and apply university regulations.

This impresses the difference between the academic, professional body and Practice Learning Partner responsibilities and ownership. Each '*world*' has its own everyday life but fundamentally the problem of the integration of meanings is that "*the meaningful relationship of the various institutions is an exclusively subjective one*"

(Berger and Luckmann, 1967,p.99). Whilst Bergen and Luckmann (1991) ascribe meaning to the concept of society, and that only certain types of individuals perform certain actions, the objective of the study is the concept of the society within pre-registration nurse education.

Ultimately it is the HEI who confers the students' award for their professional registration, but this decision has two parts (Woodcock, 2009). One is the need to achieve a level of clinical competence, being fit to practice, and one is an academic award to pass theoretical assignments. However, as has been suggested in this chapter, mentors must follow the HEI assessment process precisely which raised the question of whether the HEI is the gatekeeper of academic progression or the gatekeeper of the complete professional progression. It also be argued that the HEI are simply the conduit for the NMC standards and that the mentors act as the conduit between the Practice Learning Partner and the HEI (even though they are governed by the NMC).

This presents a deeper conundrum to the ownership argument that pre-registration education belongs to three stakeholders: NHS, HEI and NMC. Fundamentally the tripartite educative, professional and practice learning partnership illuminates the responsibility and ownership tension as the NMC states that "*throughout your pre-registration programme and, if there are ever concerns, these will be investigated and addressed by the university*" (Nursing & Midwifery Council, 2009a,p.6). However, there does appear to be more robust methods for the management and recording of student issues from NMC recommendation guidelines. For example the setting of standards for mentorship has facilitated management and achievement of student success with mentoring having key elements such as the role teaching, support and assessment of the students' performance in the practice area (Gray and Smith, 2000).

In essence providing directives from the NMC for the management of and procuring fitness does offer some clarity to process, even though designated to the HEI, but at this point, clinical matters remain in the practice helm whilst procedurally being HEI led and focused. Whilst procedure is individual to each educational institution, the NMC attempts to address the concept of fitness however it is disguised as a student's health or character, the process therefore, for overall ownership, appear to remain the property of the HEI.

The UKCC commissioned a fitness report which concluded with the belief that a key factor in achieving fitness to practice is an effective partnership between the health services and Higher Education to ensure the detailed transformation of their proposals into practice. However, whilst all students must pass competencies, the university remains the awarding body corroborating Scott's (2008) examination between nursing education and nursing practice that the disconnect and the cognisance of pre-registration nurse education had clearly been affected.

The result was that the revised model of education had not only affected service demand curricula competence and the co-operative model of working that had been characterized in the traditional system. But reformation of nurse education and placements had been inextricably altered. The three-way working partnership and gap in ownership had widened. Therefore, the focus of this chapter considered that fitness is not only subject to competency, attaining and awarding it was often in conflict between the professional body, programme provider and practice learning setting.

Fundamentally pre-registration programmes in the UK are delivered by the HEI but the equality of the 50/50 partition still means that within the clinical setting registered mentors hold responsibility for the clinical assessment of students' practice and

academics in the academic setting. Competency became the responsibility of the mentor with newly established standards set by the professional body, but these were not mandatory until twenty years post the introduction of Project 2000. Exact confirmation of responsibility had only then been defined by the NMC's standards for teaching and learning students implemented in 2006 now set to change again with a further revised model of nurse education.

The education of nurses requires a collaborative approach to monitor professional conduct and performance, but if a student displays deficiency in clinical practice then responsibility for the problem becomes sensitive. Therefore, understanding the ownership tensions between the academic environment and clinical setting is essential to foster remediation to cultivate partnerships when managing conduct issues. This can only be achieved however through clearer processes to facilitate a better understanding of ownership of FtP.

This is essential for the professional status of nursing and the effective communication networks between the partnership to understand factors that exist that enable or constrain the partnering of students for fitness. Addressing the value of transparency is important to ensure the profession has robust systems in place and it is important to determine the *'misunderstandings'* of ownership.

The legislative professional recognition that the clinical setting owns the practice domains and academia are the awarding body, did not clearly establish role responsibilities for the newly forged community between academia and practice. Roles appeared to become opaque in fitness to practice and the academic and clinical community appeared to lose focus for their own values. Importantly, to produce an innovative and educated managerial nurse, whose foremost role would not be that of solely addressing the patient's practical need, was considered to be paramount (Gray and Smith, 2000).

It is important that through engagement and sharing, responsibility and ownership continues to exist because it produces a "*shared practice as members engage in the collective process of learning*" (Andrew et al., 2008,p.248). Furthermore, Andrew et al. (2008) state that shared practice creates identity that gives meaning to professional practice embedded in the workplace which suggests that a professional path can be followed, understood, complements and substitutes for formal learning mechanisms. This is key as the student nurses may feel caught between the academic and clinical partnership and may be an aspect of ownership for future examination.

The literature has demonstrated that the fissure of fitness to practice ownership weakened learning systems between the academic and clinical environment and if identity is created in practice, but formal learning is governed by the HEI, nurse education is bounded in two institutions. The ties, however, are stretched between the partnership with the HEI raising the question as to which institutional setting, the academic and clinical practitioners feel fitness to practice is indebted and attributed towards. Additionally, as Andrew et al., (2008) suggest, the partnership does have the potential to release the creativity of practitioners and allow the sponsoring organization to harvest and disseminate the knowledge they produce (Andrew et al., 2008). This creativity could be argued as belonging to mentorship.

Mentors can utilise a gatekeeper approach to clinical knowledge and according to Andrew et al. (2008,p.251) can provide "*a vehicle for the creation and management of knowledge systems, and of who have the potential to release the creativity of practitioners and allow the sponsoring organization to harvest and disseminate the knowledge they produce*". Mentors are the emancipators of creativity, as they have become the essential component in a nursing students' life. Although competence is

delivered through HEI and professional body documentation; mentorship could be viewed as part of the ownership discourse.

The literature between the academic and practice setting have disconnect with policy decisions and process being compartmentalised as three components appear to consist of professional, academic, and clinical segments. This may in part have caused the deconstruction of ownership and the chronological sequence of pre-registration nurse education has demonstrated compartmentalised perspectives between Higher Education values and university regulations, to the clinically based competency management of students. This demonstrates that professional body requirements and HEI's academic regulation produced poorly defined responsibilities of fitness management between partners.

Thus, difficulties in establishing responsibility are a challenge and the literature review has revealed sectionalized management and ownership altered the sense of ownership since the HEI were awarded responsibility for the procedural management of fitness. Through the NMC's 2009 standard requirements for a localized university panel, the HEI's are explicitly able to manage, convene and govern process. Therefore, with fitness neatly cossetted in the HEI, heralded by professional policy, the argument presented suggests that the relation between the academic environment and the clinical setting faced uncertainty for ownership of FtP.

The viewpoint adopted were that colloquial discussions were favoured but were divided between practice and education with the correlation of theory to practice ratio producing insufficient material of the institutional bond between the training programme partners. However, the unique position the profession holds within both public safety and perceptions and involvement of such scrutiny partners are subject to. By devising the phrase '*ownership'* to explore the sense of meaning applied to the

possession of student's fitness, it is quintessential for partners to cultivate collaborative relationships to mediate fitness processes.

To examine in finer detail the elements of partnering and the opaque responsibility awarded to each of the stakeholders, Green (2014) described conceptual frameworks as an approach to frame and visualise the research coherently throughout the design and for those who find diagrammatic representation helpful, the use of models as a way of illustrating the framework for others should be encouraged. This provided the researcher for this study an illustrative way of systemising the themes of 'own', 'ownership' and 'responsibility' revealed from Key Documents Table 1 and literature review. Furthermore, Green (2014) suggests that conceptual frameworks help with the development of the research questions by giving direction to a study or be identified as an outcome. This culminates in The Ownership Matrix Diagram 2 (page 112).

For the purpose of this study 'own', 'ownership' and 'responsibility' are defined according to that provided by the English Oxford dictionary; Own; Used with a possessive to emphasize that someone or something belongs or relates to the person mentioned; Ownership; *The act, state, or right of possessing something and Responsibility; The state or fact of having a duty to deal with something or of having control over someone'* (Oxford English Dictionary). These terms will be reflected in discussion around The Ownership Matrix as a measure to map the literature and offer a rationale for the study and will further support the approach taken for commonly used sources in doing case studies: documentation, archival records and focus groups interviews (Yin, 2009). Furthermore, from the background and literature chapter, the reflective definitions of changes from the three periods of pre-registration nurse education phases identified in Key Documents Table 1 (page 23); Pre-Project 2000, Project 2000 and Post-Project 2000 have been instrumental in determining the

framework to illustrate how the changes have been made. Therefore, rather than a conceptual framework, the researcher has chosen a matrix to illustrate the chronicled policy change.

Green (2014) suggests that frameworks can help outline the research through diagrammatic illustration and the article by Green (2014) was a discussive piece determining the differences between conceptual and theoretical frameworks. Her Ph.D. study, using a case study approach, was to consider the professional jurisdictions of nursing and medicine in relation to the supply and prescription of medicines by nurses in the acute hospital setting with Green aiming to examine the attitudes of doctors and nurses in relation to their professional boundaries in the light of the legalising of prescribing for nurses and used a framework to guide the study and aid the way it was organised.

However, through the literature and background key documents, three key education milestones were created with relevancy to the concept of responsibility and ownership within pre-registration nurse education. These interrelated relationships, and the means to understand the problem, or the nature of it within a case study, according to Green (2014) can be used to specify the nature of the variables and these variables are the three education milestones developed by the researcher into a framework matrix titled The Ownership Matrix (page 112).

The development of a matrix or framework as a method for mapping the study allowed the researcher to scope literature around the three stakeholders: HEI (academic provider), NMC (professional body) and the Practice Learning Partner (placement provider). This led to several influences on the symbiotic academic and practice relationship and has been proved useful in exploring the three-way process of delivering and applying the necessary standards between the awarding body,

professional regulator and Practice Learning Partner assigned to manage the student in placement.

Each headed section demonstrates the documental and literal sense of responsibility and ownership from the documentation used at the time. Analysis of the Key Documents (Table 1) facilitated development of The Ownership Matrix (Diagram 2) by providing the chronological sequence of events. Documentation and policy relating to pre-registration nurse education before the major change of Project 2000 is focused on in-house training, professional regulatory standards, and a lead towards change for education. This leading change was Project 2000 and key documents from this phase focused on governmental changes and educative adaptations needed to facilitate a difference in training nursing students. Documents and policy of great importance related to key documents from 1996 onwards. Not only was the training of nurses remodelled, but government interventions also asked for clarity of ownership through the professional body standards. This led to what the researcher titles the Post-Project 2000 phase were removing the legacy left-over from Project 2000 towards a new system of mentoring (implementation of the sign-off mentor) and with the HEI leading the process for FtP was key.

Depicting these chronological educative changes, culminated in The Ownership Matrix (Diagram 2) which sectionalises educational and policy differences between the emergent themes of own, ownership and responsibility examined within the literature and their application to pre-registration nurse education within that milestone phase. These were ordered into three headed milestone sections; P*re-Project 2000*; *Project 2000* and P*ost-Project 2000* and depicts the interrelated partnership between the academic SoN and HEI, Practice Learning Partner and Regulatory Nursing body since inception of Project 2000 to 2017. The Ownership Matrix was developed to demonstrate how the interconnectedness of the partnership

affects transcends institutional boundaries Pre-Project 2000 of SoN and the apprenticeship model to Project 2000 and HEI delivery which led to the HEI, NHS and NMC tripartite relationship.

Within the Pre-Project 2000 phase, pre-registration nurse education was owned by the School of Nursing delivered in an apprenticeship approach. Delivered in-house by nurse educators, employed within the clinical setting otherwise regarded as the NHS, they owned the curricular, and nursing students, guided by regulatory body standards. Responsibility focused on the SoN and standards.

The second phase of change to responsibility and ownership focused on Project 2000. As an educative course, divided away from the practice setting, ownership of delivery and curricular was transferred to the HEI and separated from the SoN. A new three-way partnership was introduced; HEI, NHS and NMC. The responsibility and role of the practice setting was to supply placements with the HEI delivering curriculum for the professional body. The HEI however, remained key within process with its academic regulations.

A further move forward in this phase was the implementation of mentor, and latterly the sign-off mentor role, which is placed directly under this three-way partnership to demonstrate their shift towards Post-Project 2000 and the fundamental role of the mentors towards the sign-off and FtP. However, the shift within this phase suggests that the mentors may hold responsibility to the NHS (placement provider) and NMC but not with the HEI.

This shift of responsibility was altered in the final phase of change, Post-Project 2000. This phase had its sense of responsibility and ownership based around HEI delivery, government changes and a renewed focus on FtP. The practice setting became

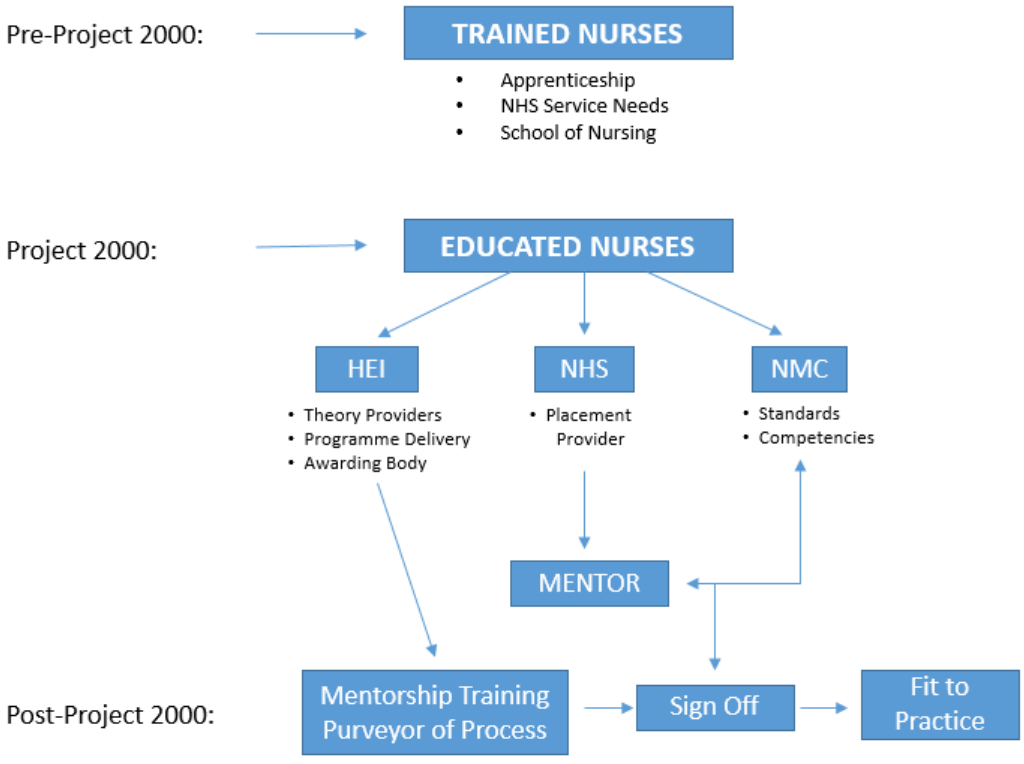
isolated from the process entirely, as they had already within Project 2000, but FtP process was cemented by the NMC to the HEI thus the HEI becoming the purveyor of process and regulation.

In support of 'The Ownership Matrix', the philosophy offered by Berger and Luckmann (1991) that world reality and the sense that individuals have a created reality in their everyday lives within an institution, has shown that mentors are governed by different institutions at given moments. As registered nurses acting as registered mentors, they are compelled for mostly by their necessity to provide safe and effective patient care but with mentorship being a secondary institutional requirement set by the professional body.

For example, whilst the principal role of a registered nurse is to look after patients, their secondary role within the Practice Learning environment was introduced in Project 2000 to teach and assess nursing students which provided them with a new meaning to their role. This, however, has got caught between the tripartite relationship for responsibility and ownership of process and managing nursing students' fitness to practice which Post-Project 2000 has shown the dichotomy that mentors face when problems arise.

Therefore, to identify this relationship and the connected variables of the partnership, by adopting Berger and Luckmann (1991) contention that '*reality*' and *'knowledge'* are terms that are intertwined as qualities appertaining to phenomena and that knowledge are recognised as the certainty that phenomena are real as characteristics individuals possess. Therefore, based on Berger and Luckmann's concept, to demonstrate the socially constructed relationship between the academic, professional, and clinical setting, the matrix approach adopted within the study has been designed to determine the relationship.

This examination requires a framework, foundation, on which to map the territory as suggested by Durham et al. (2015) to underpin and connect the elements of study. In this study, the relationship between the stakeholders to help shape the research question, literature review and the design (Durham et al., 2015). The use of conceptual frameworks within nursing research has according to Edwardson (2007) emerged as an especially useful tool to nursing investigations. The concepts used for studying phenomena of interest to nursing in that many researchers find it necessary to use frameworks directly applicable to their area of interest (Edwardson, 2007).



Conceptual Framework

Diagram 2 – The Ownership Matrix

2.13 Chapter summary

In this literature review discussion has focused on historical, national, and relevant nursing research to provide a background from pre-Project 2000 to 2017 regarding the issues around fitness to practice. The non-research documentation including UKCC and NMC papers, has enabled the researcher to start to collect evidence about the conflicts surrounding fitness to practice within the tripartite system. This has led to a greater understanding of the differing responsibilities of the stakeholders and their perspectives in managing FtP.

In essence at this point the literature and non-research documentation suggests that as the academic body the HEI appears to own the student, but the Regulatory Nursing body advise the HEI their requisites for process and education of nursing students. The literature and non-research documentation have also shown that understanding of, and the subsequent use of documentation, between the partnership may not be transparent but they do have, according to the principle of responsibility, a duty to deal with something (students) they have control over.

Fundamentally someone from the academic environment must implement the FtP process and if pre-registration nurse education is based on an institutional bond; clarification of fitness systems and responsibility between providers needs to be cooperative, transparent, and owned by each individual partner.

The current study seeks to explore that transparency and whilst ownership of the operation is conceded to the HEI, this exposes which part the Practice Learning Partner plays within the process. In summary looking at the extent educational development has affected the ownership of fitness is essential. A strong academic

and clinical relationship exists but the question is whether it is in isolation of each other to produce nurses who are fit to practice.

Each partner plays a crucial role in the education and clinical development of student nurses, but the literature has shown that gaps in the partnership fractured responsibility in the sense of ownership. This fractured sense of ownership has been attributed to key changes within the delivery pattern of the programme bestowed to the HEI. The Regulatory Nursing body expected that an educational model, based on equal parts of theory and practice, would provide the cohesive bond required to meet service needs but the syllabus, dictated by the professional body, was embedded within curriculum by the HEI at the cost of shared ownership.

The Practice Learning Partner facilitates fitness in practice however, the tripartite relationship of education, policy and profession assuredness has culminated with one or two parties appearing to lead decision making. For example, the NMC decided to initiate the assurance of fitness through the sign-off mentor for fitness at the point of entry to the register. However, the HEI are responsible for delivering the mentorship course and the Practice Learning partner are bound to apply it in practice.

If legitimation is the way individuals objectify their understanding of institutional processes, then confusion around student ownership may remain. Legitimation tells an individual "*why he should perform one action and not another; it also tells him why things are what they are*" (Berger and Luckmann, 1991) but what remains as "*sociologically essential, legitimation processes are human products: their existence has in its base in their lives of concrete individuals, and has not empirical status apart from these lives*" (Berger and Luckmann, 1991.p146).

The creation of The Ownership Matrix (Diagram 2), guided by conceptual beliefs, was developed to outline the chronological sequence of events of how the literature and non-research documentation from government, local and Regulatory Nursing body requirements have altered the sense of responsibility. The Ownership Matrix illustrates how responsibility has been filtered and separated into silos from the apprenticeship model, SoN to Project 2000 to current practices. This depicts the dissonance mentors have regarding managing their duality of assessing and teaching students' alongside patient care. They are obliged to their professional body and local Practice Learning Partner, whilst acting as peers to future registrants. Responsibility and ownership rights altered within this tripartite phase and the focus on managing FtP appeared more fluid like in the Project 2000 phase when policy and process were ill-defined compared to Post-Project 2000. Ownership, own and responsibility of nursing students became segregated into role and supplier rather than as a peer-support process. Namely mentors held responsibility and accountability through their own nursing professional body to their students but did not have authority to process FtP 'discipline' which they knew remained the remit of the HEI.

Siloed in their world of professionalism this disconnect stems from an altered sense of responsibility decreed from policy makers and Higher Education versus the professional body. Orchestration of process has faced delegation from the Regulatory Nursing body to the HEI. Needing to adapt their regulations to address fitness. Thus, the differences between the literature, key documents and non-research documentation needs an approach to review archival, professional, and contemporary literature as a valid means to understanding how the beliefs of ownership for fitness originated between the working partnership.

Captured through The Ownership Matrix, the research questions aim to explore the impact Higher Education and professional body changes, and the choice of methodology, has had on responsibility explored in Chapter 3.

Chapter Three - Methodology

3.1 Introduction

The literature review has informed this study that HEIs were acquisitioned in the 1990s to act as programme providers for pre-registration nurse education with the clinical setting providing placements. Through Government and professional changes, the HEI became the purveyor of fitness to practice process with the clinical setting required to decide whether a student has achieved the NMC standards of proficiency for safe and effective practice for entry to the register. The HEI remain as the academic awarding body. A crucial question to consider is if this is where the sense of '*ownership*' tension arose and how research can interpret the meaning of ownership. This was captured in The Ownership Matrix which encapsulates the chronological sequence of responsibility from each partner pre-Project 2000 to current arrangements.

Understanding FtP between the stakeholders appears disconnected and therefore if ownership is to be understood, an examination of the partnership perspectives is needed. In this chapter, an outline and justification of the chosen research design is offered to explore the meaning and sense of responsibility between the academic and clinical partnership. The study design should be appropriate to examine the perceived sense of responsibility between the academic and clinical providers who support the learning of student nurses. Therefore, this chapter will provide a rationale for the chosen methodology of case study as the research design, the research questions and there will be an example of case study research to enhance the rationale for the approach.

The scope of the literature review incorporated archival, professional, and contemporary literature as a valid means to understanding how the beliefs of ownership for fitness originated between the working partnership as part of the

evidence of a case study approach to explore the issue, inclusive of literature and non-research documentation (Yin, 2009).

This chapter will also outline the process of ethics, rigour and trustworthiness supported by Lincoln and Guba (1985) evaluative criteria. Evaluative criteria include credibility, transferability, dependability, and confirmability to establish that the study has achieved the criteria to conduct research. This is essential to ensure credibility of process and method.

3.2 Research problem

A research design according to Creswell (2009), involves several decisions, to plan, collect and analyse data that needs to be collected to study the topic. There are three main types of design; qualitative, quantitative, and mixed methods and according to Creswell (2009) should not be viewed as opposites but representative of ends of a continuum. For example, a study tends to be more qualitative than quantitative or vice versa (Creswell, 2009, p.3).

The purpose of this study is to investigate the sense of ownership and responsibility of fitness to practice between the partnerships of HEI, NMC, PLP. The literature has demonstrated that professional body requirements inform the academic provider of the educational needs for curriculum of pre-registration nurse education, and that clinical learning remains the domain of the practice area. Illustrated in The Ownership Matrix (Diagram 2), the headed sections P*re-Project 2000*; *Project 2000* to P*ost-Project 2000,* determined how responsibility and ownership altered through documentation and policy change for the HEI and Practice Learning Partner.

Whilst professional learning is achieved through NMC approved learning outcomes specifically expressed in clinical aptitude outcomes, the Ownership Matrix detailed how each section brokered FtP management.

The significance of The Ownership Matrix offers clarity for the study questions to examine how the three phases have adapted role and responsibility for the stakeholders. The change in process across the phases affects current practices within pre-registration nurse education and the perceptions of documentation and policy is crucial in assuring transparency, effectiveness, and role for action to key stakeholders. Thus, a methodology to understand perceptions of key stakeholders, examination through a qualitative design was required.

The professional body governs the clinical setting, expecting standards to be achieved by actively deploying the '*pass or fail'* mark within the practice competencies. However, the Ownership Matrix identified three constituent parts of pre-registration nurse education and has established a need to unravel responsibility and ownership which are clearly collaborative in the need to foster educational and clinical achievement for a pre-registered nursing student.

Research questions:

- *What are the factors that exist between academia and practice that enable or constrain the partnering of nursing students if there is a fitness to practice issue?*
- *What are the perceived understandings of fitness to practice between the partners?*
- *Are misconduct and disciplinary processes transparent between the academic and clinical setting?*

3.3 Ontology and Epistemology

The purpose of research is to generate knowledge and insights into our world and the nature of that inquiry will depend upon the stance of the '*truth*' as being either universal or context specific (Watson et al., 2008). For this study, the context is specific between the partnership and for fitness to practice ownership responsibility between them. If, however, examining a universal approach, the '*truth*' would be viewed as '*external and concrete'* as a measured representation. For example, the number of fitness to practice referrals regarding qualified RNs to the NMC between 2011-2013 dropped by 7% revealing 4,407 cases in 2011/12 and 4,106 cases in 2012/13 (Nursing Standard, 2013). This data, however, does not address the issue surrounding the drop-in cases, rather it was a statistical figure informing the numerical value of cases held. Furthermore to this statistical data, 100 cases revealed the need for significant improvement in the regulators procedures as a matter of urgency but the cases or the procedures were not identified (Sprinks, 2012).

In conclusion of Sprinks (2012) findings, weaknesses were identified in the audit process which identified '*persistent and serious weaknesses'* but without contextual background of those issues so therefore in actuality, this statistical data can only act as a numerical representation of fitness to practice cases without contextualised experience behind the decline (Sprinks, 2012). This example therefore provides an external and concrete data response and if considered across a number of programme providers the universal truth would have to be replicated in numerical value thus it would have been replicable within that contextualised '*truth'* (Watson et al., 2008).

This replicability is characterized under the quantitative approach as various approaches: experimental, surveys, structured interviews or observations, Randomized Controlled Trials (RCT's) and control groups. All measures and bias

maybe neutralized with conditions conducted in a randomized, rigorous, and blind manner to measure the impact. This will produce a demonstrably positive impact resulting in the symbolized universal truth (Watson et al., 2008). This universal (*truth*) approach relates to the world view of positivism which represents the traditional form of research (Creswell,2009).

This suggestion by Creswell (2009) that developing numeric measures of observation and studying in the scientific method collects data that either supports or refutes the theory and then the researcher can make revisions before additional tests (Creswell, 2009). Additionally, Watson et al. (2008) suggest that to generate or test theory based on the belief structure, the '*truth*' can be represented either by quantitative measures or through qualitative approaches. The quantitative approach, however, is not relevant for the study as it is not aiming to gain numeric description on fitness to practice cases, as this is covered extensively by the NMC. Rather the aim is to explore the context of fitness to practice with academic and clinical participants in the study setting.

This is essential within the present study that the thoughts and feelings are not just based on actual fitness events i.e., an actual act of misconduct or an omission in professional accountability, rather the meaning fitness has to the individuals or how the process is perceived. For example, Sprinks (2012) revealed an audit of 100 NMC FtP cases had revealed the need for significant change in their procedures. The audit results from November 2011 to April 2012 showed failure in due process with several cases being closed without proper investigation. Therefore, as a numerical observation the data is not conducive to knowing what had happened without full enquiry into why it had happened. Hence, a suggestive for the need of a qualitative approach. Understanding what had gone wrong (or right) compared to the statistical

number of cases dropping was recognised with the audit showing the discrepancy in numbers but understanding that there were reasons behind this.

To seek meaning behind the partnership perspectives of fitness to practice, examination into thoughts and feelings appears to be the most relevant approach and as Watson et al. (2008) suggest, qualitative research approaches such as phenomenology, grounded theory or ethnography, and case study are representative of the human experience to produce the fluid findings of that human experience. As a result qualitative research approaches are based in some part in a subjective manner but are concerned with how people understand their experiences (Watson et al., 2008). In contrast, quantitative research is based on numerical data used as a deductive method from a positivist approach of producing a result which is objective and generalisable.

Principally, the field of fitness to practice has not identified ownership concepts thus generation of new theory is required to examine the boundaries of responsibility between the partnership. Thus, the quantitative approach is not considered as essential for application within the study primarily as it did not sit comfortably with seeking the truth of perceptions and, whilst a survey could have been conducted to infer the numbers of cases, attitudinal beliefs on a Likert scale or experiment, this would not be a useful approach to find meaning.

The different criteria between qualitative and quantitative approaches were characterised by Fisher and Stenner (2011) as the former gathering thick descriptions compared to the latter having an interest in broader generalities that remain stable across specific contexts. Qualitative research however, focuses on the exploration and understanding of meaning individuals or groups ascribe to a social or human problem (Fisher and Stenner, 2011). To search that meaning within an ascribed

group, Racher and Robinson (2002) suggest that through the interpretivist approach, knowledge, and construction of the complex world of lived experience maybe elicited. The ontological assumption is that reality is complex, holistic and context-dependant (Watson et al., 2008). Therefore, the interpretivist approach for the study is appropriate to seek meaning and understanding of what enables or constrains ownership responsibilities within the pre-registration programme. This approach allowed me to view the academic and clinical participant's multiple realities which in turn construed tensions of ownership from the academic and clinical perspective. Furthermore, this chosen research design sought to discover and to describe in narrative reporting what particular meaning and kinds of beliefs that make a difference to that meaning as required Watson et al. (2008).

Interpretive paradigms, according to Denzin and Lincoln (2003), present some of the major strategies of inquiry a researcher may use. This is relevant to this inquiry insofar that the research design needed to locate and connect me to the institutions and empirical world where meaning was being sought. Therefore, by locating the reality to uncover the contextual richness of the worldviews, the multiplicity of interpretation and uniqueness of the situation requires an approach to interpret the events portrayed from the participant's perspectives. The generation of meaning can be typically collected in the participant's setting and data analysis inductively built from particulars into general themes and hence resulting in sought generalisations about meaning of that data. In this study uncovering the conceptual context of 'that' understanding means to make sense of or interpret phenomena in terms of the meanings people (academics and clinical participants) bring to them. Denzin and Lincoln (2011, p.3) consider that qualitative research is a "*situated activity that's locates the observer in the world and consists of a set of interpretive, material practices that make the world visible*". Visibility is essential to explore the partners' worlds and their situational

locality and as a qualitative study to uncover and explore such sonorous understanding is required.

It has already been argued that the newly forged partnership between Higher Education and the clinical setting appeared disconnected, therefore this study sought to understand how partnership responsibilities have been weakened. Hence, according to Denzin and Lincoln (2013), an approach was required to view the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology), which are then examined (methodology, analysis) in specific ways. Using this perspective to adopt a particular view of the '*other*' who was studied (Denzin and Lincoln, 2013,p.23).

As a primary piece of research, the design used in this study was exploration of individuals involved in pre-registration nurse education (Begley, 2008). This is key to understanding perceptions, thoughts, and feelings behind FtP. Taking a qualitative approach aims to seek meaning and the phenomenological approach of understanding the lived experiences specific to individuals. This approach is also concerned with gaining a greater understanding through the lived experience of a representative group of academics and practitioners. However, fundamentally, the basis for interpretivism is that participants have experienced the phenomenon under investigation. However, in this study, the participants would have had to experience an FtP process, but the primary aim was to seek a consensus view from the participants without having experienced an actual FtP hearing.

As an inductive process, grounded theory may have been a useful approach within the study with theory evolving continuously from the data during the process of the research (Watson et al., 2008). Grounded theory according to Cutcliffe (2008) begins with an identified area of study (Fitness to Practice) and through the process of

comparative analysis each item is labelled. Furthermore, theory can be seen to be generated from the ground up and has an emphasis on theory generation and is viewed to think about and conceptualise data from the ground up. Data could be sought from the participants from the '*ground level'* upwards thus producing a theory. Grounded theory attempts to emphasise theory generation not conceptual description, not theory verification.

As an example, Masso et al. (2014) demonstrated in their study that grounded theory was useful in adding to current knowledge about residential care and how to improve priorities for patients. Whilst the study of Masso et al. (2014) sought to implement evidence-based care into a residential care homes, an area relatively under-researched, the strength of their grounded approach found that participants with an experience of residential implementation was key to their findings. However, the current study the concern of finding specific participants with fitness to practice experience (namely of partaking within a hearing or experiencing the process) limited the recruitment of participants. This issue was like the issue of adopting the phenomenology approach whereby fitness has yet to be defined in terms of meaning within the partnership.

Ethnography was an approach considered as having potential for this study. However, according to Cruz and Higginbottom (2013) ethnography generally employs three data collection strategies: participant observation, formal and informal interviews, and examination of relevant documents. But due to the position as the DoS with the HEI and not in clinical practice, trying to seek access to the mentors for extended periods of time. When they were only dealing specifically with FtP within the NHS as an observer was not feasible. Documentation has been reviewed from the literature exploring the sense of ownership for fitness to practice but being an

observer to change practice within the clinical setting would require active involvement in the participant's life in their natural setting.

The aim is to build an evidence base on the extraordinariness of ordinary even though there are challenging perceptions in fitness, fitness may not be considered as a nursing act. This is key as Williams (2008) suggests a change in nursing practice can be produced through ethnography but it would be very difficult to 'observe' fitness to practice procedures as it is not a nursing skill, or act per se. rather it is a university process guided by academic regulations and professional body requirements.

Fundamentally, one of the strengths of the qualitative approach is the emphasis on a specific case and influences of the local context are not stripped away but the "*possibility for understanding latent, underlying, or nonobvious issues are strong"* (Miles and Huberman, 1994,p.10). The choice of design is therefore important for my study when researching the thoughts and feelings of stakeholders associated to the HEI and NHS for ownership.

3.4 Case Study

Finally, after reviewing the literature and the strengths and challenges in each qualitative approach, I settled on the case study approach, case study as a research design can be utilised to seek meaning into '*organisations*' which are key to my study, of the partnership between the HEI, NMC and NHS (Yin, 2009). As a final review, and subsequent decision to use the qualitative approach the notion offered by Yin (2009, p.18) that case study is a practical inquiry where "*the boundaries between phenomenon and context are not clearly evident*". This has clear relevance to the present study as the literature has revealed facets associated with the disconnection of nurse education from its historical clinical setting to the academic provider. The literature review and non-research documentation has highlighted historical and

contemporary responsibility (ownership gaps) residing between Higher Education and the Practice Learning Partner since HEI's became the primary purveyor of nurse education. This is especially pertinent as my study seeks to understand the complex symbolic academic and clinical partnership already demonstrated in the literature chapter.

Case study is a common research methodology in sociology and political science and its uses within the education and economic arena are all subject to researchers wanting to understand complex social phenomenon (Anthony and Jack, 2009). However, defining the concept of case study can be problematic as authors deliberate their definitions and perception of its application. Adopting the most appropriate case study methodology proved to be quite difficult as there were two key approaches deliberated between Stake (1995) and Yin (2009).

The philosophy offered by Stake's (1995) is that case studies focus on not being a methodological choice but a choice of what is to be studied with the suggestion that it is by whatever methods chosen to study the case. Furthermore, Stake's concept asks whether the researcher has an intrinsic interest, labelled an "*intrinsic case study compared to an instrumental case study which is a need for general understanding*" (Stake, 1995, p.3). In simplistic terms Stake's (1995) intrinsic case study could be likened it to a doctor looking at the patient's condition whereas instrumental lends towards the individual needs for the patient. However, there are no individual's needs to be considered so therefore not one single definitive case to study. This led to the debate whether Stake's (1995) philosophy of the single case as valid for the study and if it could relate to the abstract of perceptions of knowing who has responsibility for ownership.

Case study, and the complexity and definition, is according to Stake (1995, p.2) a *"bounded system' that is an object drawing attention to that rather than as a process*". Thus, suggesting that the case is a system and that boundedness and behaviour are useful concepts for specifying the case. Flyvberg (2013) however argues that a decision based on an element, referred to by Stake (1995) as bounded, is not the decision for a case study rather the demarcation of the units' boundaries and therefore he argues that drawing boundaries for the individual unit of study decides what gets to count as the case and what becomes context to the case.

Conversely, case study as defined by Yin (2009) is the unit of analysis that is based on the context and definition of the case. However when defining what the '*case*' is, selection of the appropriate unit of analysis will start when "*accurately specify your primary research questions"* (Yin, 2009,p.30). Specifying the primary research question makes methodological sense to help the researcher define the study propositions to help identify the relevant information to be collected about the individual or the individuals with a studied group. Additionally, Yin's (2009) supposition that individuals, small groups, organisations, and partnerships are key to the notion of case study is appropriate as the unit of analysis focuses on the associated ownership between the clinical and academic partnership supported by the plethora of documentation.

3.5 The Unit of Analysis

The research design of case study as offered by Yin's (2009) allowed for exploration and understanding between the stakeholders. Behind Yin's (2009) concept, and development of case study, was the notion that stakeholders can be traced back to the seminal event of the Cuban Missile crisis (Yin, 2009). In reviewing the impending nuclear confrontation between the stakeholders of the United States and the Soviet Union, the Cuban missile crisis proffered examination of a dozen plausible sequences

of events and actions that may have ended up with nuclear weapons exploding on both American and Soviet cities (Yin, 2009).

The crisis required understanding that ordinary explanations, predictions, and evaluations which are inescapably theory-based, are fundamental to self-consciousness about knowledge. Therefore, as a result, of careful explanations and an examination of the Cuban missile crisis event helped to develop the instrumental framework to provide focus for the description and explanation of the event or any other case enquiry (Yin, 2009). Therefore, with relevance to the present study, the similarity of description and explanation can help to recognise the ownership factors for and between stakeholders. Thus, required an approach where phenomenon and context which are not readily separable for a condition, but that occurs in real-life, on the wards and within the faculty, nevertheless cannot be duplicated easily when examining perspectives of responsibility and ownership following the rearrangement of course delivery (Yin, 2009). The context had clearly altered following the apprenticeship model to current practices from the policy changes and delivery method of pre-registration nurse education.

The after effect of this rearrangement is by no means comparable to the missile crisis but the views of the stakeholders are important in terms of the perspectives associated to responsibility and position. This is in direct opposition of the positivist approach that could allow for quantifying statistical data, such as determining the numerical cases of fitness cases convened. However, to explore perceptions, and produce an interrogated understanding of, on the perceived FtP matter, qualitative strategies needed to be applied. Thus, the multiple sources of documentation produced a new sense of separated responsibility to the partners and resulted in a change of process for the delivery of pre-registration nurse education and subsequent FtP management.

Hence drawing upon this approach will facilitate the depth of understanding of the 'experience' or even establish what fitness implies and the uniqueness of the case study is the captive representation of daily circumstance and situation of educating nursing students.

This study can then represent and typify experiences involved in both institutions and according to Thomas (2011) case study can trade-off the breadth for a greater depth of understanding. Thomas (2011) debates how the building of a story with meanings may provide explanation for the kind of paradoxical finding about attainment and so focus and clarity is needed to define the mission explored. The mission within this study is an exploratory single case to enquire as to the weakened state of ownership and responsibility in practice since SoN devolution. With a number of differing factors associated with fitness, there is a need to understand the case in the local partnership itself, rather than generalise to a whole population or indeed debate the essence of fitness in its own meaning Williams (2008).

According to Killam et.al. (2010) identifying an unsafe student is difficult for several reasons and the individual unit may be studied in a number of ways and Flyvberg (2013,p.301) considers that "*the demarcation of the units boundaries provide the basis for the case study and that they focus on "relation to environment," that is, context"* (Killam et al., 2010). The empirical method therefore of case study can focus on the distinctive situation and according to Simons (2009) exploration of the critical inquiry into a phenomenon is key in the accumulation of knowledge and prominence of case study in the field of social research. Case study methods are being, according to Yin (1999), rediscovered in health services research due to the multiple components of developing managed care systems. These components were termed by Yin (1999) as '*mega-systems'* which require case study as a method to gain insight

into the way health care systems are managed which may have innumerable variables.

A definition considered by Yin (2009) outlines the synthesis of qualitative case studies within qualitative research as a view to looking for detail as to the particularity and complexity of a single case and coming to understand its activity within important circumstances. The unique unit of analysis of this case study may be to consider that fitness to practice is around competency but this conflicts with a sense of ownership between the education providers and clinical setting. Therefore, determining who carries out and has responsibility for the fitness to practice process. The unit of analysis under study is not necessarily the student nurses' fitness to practice; this could be used under one single case study alone, but rather in trying to uncover the factors behind the sense of ownership or transparency of processes between the institutional relationships. There can be no generalisation about the method of nurse training and nurse education as each partnership is unique. But the context of the academic setting versus the clinical setting advocated by the professional body has further implications for this generalisable representation.

Narrowing down to a single case, for example asking the question as to why mentors are unable to fail a student by ticking a box, would imply an intrinsic approach Stake (1995), but Thomas (2011) considers that a researcher needs to look at a case from several directions and therefore a more balanced picture of the subject is developed. He suggests that a '*three-dimension view'* is essential because of the multiple factors of my devised term '*ownership tensions'*. Therefore, one must be aware of the case unit study of the three-dimension view', or three constituent parts: academic setting, clinical environment and the professional body. Whilst the context is to determine the effects of social and educational programmes essentially an improvement in policy making is required for clarity of the decision-making processes between the partners.

According to Yin (2009) social scientists still predominantly believe that case studies are only appropriate for the exploratory phase of an investigation, history and surveys being best for the descriptive phase (Yin, 2009) and yet Anthony and Jack (2009) feel case study history has a background of being a useful approach for a preliminary investigation. While the aims of the current study are to review the stakeholder's perspectives, case study has historically been embedded in the experience of curriculum as an evolving facilitative approach for the evaluation of education programmes. This approach is especially important when dealing with the humanistic aspect of research and policy development of which requires an element of understanding into what that '*evaluation*' could provide. Anthony and Jack (2009) provided an in-depth case study review in nursing research and are regarded as the key theorists on the use of case study in nursing. Their influential work suggests that the detailed integrative review provided a critical analysis of the contemporary use of case study as a methodology.

Instrumental work carried out by Anthony and Jack's (2009) study, was important for the conduction of a critical analysis of the contemporary use of Qualitative Case Study Methodology (QCSM). Anthony and Jack (2009) offered a conclusion that QCSM is becoming entrenched within nursing science and the nursing research lexicon. Nursing science and research have significant implications for practice and more importantly QSCM has implications for practice and/or policy. This was considered valuable for the study of exploring, describing and understanding phenomena in (this) real-life context and is a comprehensive research approach that provides meaning characteristics of as one aspect of a larger research study (Anthony and Jack, 2009).

Yin's (2009) concrete diagram demonstrated the connection between organisations and partnerships in a clearly identifiable manner. Knowing more about the context of higher education associated to pre-registration nurse education allowed for greater

understanding of nursing students situational learning within the Practice Learning environment. Nurse education has always had an associative bond to practitioners and according to Crook (2008,p.16) each community requires its own ideals with the suggestion that *"a profession can only be said to exist when there are bonds between practitioners, and these bonds can take but one shape – that of formal association*".

3.6 Academic and Clinical Stakeholders

Pre-registration nurse education is formed through educational and clinical interaction which as Andrew et al. (2008) considered was working to a common purpose. They consider that there are two main perspectives on situational learning with one perspective relating to an activity-based constructivist view. This is defined as the context of learning in school and in work (clinical) practice and the second perspective is that learning arises from participation in a wider social network (Andrew et al., 2008).

Therefore, parallels can be drawn within pre-registration nurse education between the three-way partnership, for example, sign-off mentors. The prerequisite for all new sign-off mentors is mandatory attendance and completion of the sign-off mentor preparation workshop as part of the Preparation for Mentorship programme (NMC, 2008). This requirement is delivered by the HEI as a proficiency standard set by the NMC. However, this presents a dichotomy for the partnership as the sign-off process is a standard of education, training and conduct that nurses need, to deliver high quality health care consistently through their careers, but approved education institutions determine locally how the programme will be taught. The enhanced role, with criteria to decide whether a student has achieved the require standards of proficiency for safe and effective practice or entry to the register, is monitored by the NMC with the NHS sending nurses to attend the course.

Whilst the NMC monitors programme approvals, programme providers are '*encouraged*' to identify their own appropriate means, and account for how they confirm that sign-off mentors meet the HEI requirements as the programme vendors (NMC,2008). The discourse of ownership revolves around this. This parallel discourse can be drawn from a case study conducted by Daniels and Khanyile (2013) who discuss the notion of collaboration dominating the Higher Education arena. As a research of Higher Education changes in South Africa, Daniels and Khanyile (2013) selected 108 participants through purposive sampling to evaluate the common teaching platform for undergraduate nursing education in line with the transformation of the Higher Education system. Semi-structured interviews were held with the staff members consisting of 18 lecturers, three deputy vice chancellors, three deans and three heads of department and 81 students interviewed across a selection of HEI's. This was because of the intervention of the South African Minister of Education who wanted to improve diversity in the programmes offered between two universities in a collaborative approach. The focus was to share resources between a more affluent university compared to its more modest counterpart institution, an approach labelled as building capital for the future.

Building capital, as suggested by Daniels and Khanyile (2013), found that the major influence on collaboration initiatives with collaborative opportunities being identified as institutional planning, were externally driven by a low-level political will and an overly complex implementation process. Whilst this has some similarity to the UK's introduction of nurse education into the HEI, Daniels and Khanyile (2013) approach had an alternative experience. They suggest that collaboration in Higher Education may result in institutions in a region remaining separate while combining theory expertise, efforts and infrastructure resources in the development and delivery of Higher Educational programmes can predict to use academic expertise, facilities and resources (Daniels and Khanyile, 2013).

Their research discusses the initiation of a collaborative approach to the sharing of best practice between HEI's across South African regions to improve academic expertise and would strengthen programmes. However, the findings revealed a lack of commitment to the collaborative initiative and a lack of shared resources. The findings also revealed that successful collaborative efforts are dependent on a shared vision of and strong commitment to the process (Daniels and Khanyile, 2013). This has therefore produced a limitation within the study, but the study is suggestive of similarities within the UK delivery system between the different partners.

The development of The Ownership Matrix, to demonstrate how the three worlds collaborated, was considered in the findings of their study, and offers a visual representation of the local complexities of collaboration between partners similar to Daniels and Khanyile, 2013. For example, the academic terms of the universities did not coincide, and the fostering of a sense of partnership and interdependency between universities was considered in cost-benefit matters rather than sharing of good practice. Therefore, this has merit within the present study, as the challenges they faced were comparable with the notion of an academic and clinical environment remaining interdependent of each other. Their study is reminiscent of the issues faced by the two communities within the UK pre-registration programme and its new delivery system that clearly cannot be separated.

Therefore, in deliberation between Stake (1995) and Yin (2009) for the study, Stake's (1995) theory was an overly complex methodology as it does not break down the elements into manageable sizes. Recognising that if applying the notion of stakeholder to Stake's (1995) theory a number of elements such as mentors, students, Higher Education, government matters, and conceptual definitions of professionalism would imply that the theory of boundedness leans towards a larger scale case study. Importantly, however, the current study is not large scale and so

requires a small-scale representative sample. Thus, Yin's (2009) simplified version of unit of analysis relates more to the topic and was therefore chosen to underpin the case study design.

The actual units were organisations involved in pre-registration nurse education with direct access to students, HEI (academics) and NHS (mentors, including sign-off mentors), and small groups, the phenomena, (organization) to the small groups (context within that phenomena for fitness to practice). This point was exemplified in Yin's (2009) diagrammatic representation of concrete partnerships and was another significant rationale for using Yin's (2009) exploratory case study as it was based on '*more concrete'* pictorial depiction (Yin, 2009 Figure 2.1, p.33). This representation aided the contextualisation of the institutional relationship, thus cementing the study's unit of analysis and is an important element considered in order to provide conceptual understanding to a social or human problem that was required (Edwards, 1999, Andrew et al., 2008). Furthermore, the depiction further contextualised the institutional relationship cementing the study's unit of analysis which is an important element considered to provide conceptual understanding to boundaries between phenomenon and context exploring whether there is enough evidence (Yin, 1993).

The pictorial depiction provided the context for the study between the academic establishment and clinical setting so the case would be the lived experience of that boundary of the tripartite relationship. That was the context, and the phenomenon was the organization of a single unit analysis that is the education of pre-registration nurses. Thus, in describing or exploring the real-life context in which the present case study has occurred, case studies can illustrate certain topics within an evaluation. Fundamentally, the study required examination of contemporaneous beliefs so that my research can gain insight, and redraw a generalisation, to address the two critical issues of representation and legitimation (Yin, 2009, p.31). Hence to describe or

explore the real-life context in which my case study has occurred, case studies can illustrate certain topics within an evaluation.

Moreover, in Yin's (2009) single exploratory case study approach, more complex or embedded subunits of analysis can be incorporated which can often add significant opportunities for extensive analysis, enhancing the insights into the single case thereby providing leverage into smaller, more manageable sections. Furthermore, by subdivision of the clinical element and academic aspect into two groups of participants; registered nurse mentors and faculty academics my study examined clinical and academic perspectives. In addition, Yin's (2009) case study methodology encapsulates perceptions from stakeholders further cementing the epistemological stance.

3.7 Data Collection

Data collection as recommended by Yin (2009) is where the major strength of case study lies, within different modes of data collection and identified six sources of evidence: documentation, archival records, interviews, direct observations, participant-observation, and physical artefacts. These six sources can be maximised further by following Yin's (2009) three principles of data collection; 1) use multiple sources of evidence, 2) create a case study database and 3) maintain a chain of evidence. All sources of evidence are potentially relevant according to Yin (2009) and selecting the relevant source of evidence is especially important.

Principle 1 is reflective of archival, national government, university and nurse education documentation, and contemporary literature and was key to the facilitation of a chronological review. Participants recruited from the clinical and academic setting added to this data. Furthermore, by examining professional, educational, clinical literature and non-research documentation, addressing fitness to practice beliefs

between the academic and clinical partners, the data presented contextualised responsibilities of how the clinical setting is expected to address and the HEI to action. Therefore, through the researcher's Ownership Matrix, the literature and non-research documentation provided background and the context of how FtP became miss-aligned between the tripartite partnership.

However, according to Yin (2009), examination of historical documentation evidence can have limitations. For example, Yin (2009, p.115) believes that histories are limited to "*events' in the 'dead' past and therefore seldom have any contemporary sources of evidence, such as direct observations of phenomenon or interviews with key actors*". The key actors within this study are the academic and clinical stakeholders responsible for the management of fitness to practice, including university academic staff and registered mentors supporting students in the clinical setting. The history of practice assessment and advent of sign-off mentors therefore is highly relevant to this study.

Using interviewing; observation or document analysis that is supported by the notion offered by Merriam (1988,p.16) that case studies' data analysis could be defined *"as an holistic description and analysis of a single entity, phenomenon or social unit".* The study relates to the phenomenon of ownership in pre-registration nurse education by interpretation of the data and the analysis of data that does not start at a particular moment (Stake, 1995). This supposition is supported with the suggestion by Simons (2009) that data analysis starts from the moment the researcher has selected their research question and study design.

Miles and Huberman (1994) advocate however that if you do not know what matters more, everything matters. To capture the patterns, Wolcott (1994) suggests that taking a systematic approach to the data from description, analysis and interpretation

allows for flexibility. Also Stake (1995) advocates that by reading and rereading the accounts, understanding of meaning creeps forward and is the moment analysis can be categorically aggregated for direct interpretation. Stake (1995) further refers analysis to the taking of something apart and that something is the data that needs scrutinizing to uncover the findings. However, focusing on broad and flexible categories to describe the process of data "*transformation*" that is, description, analysis, and interpretation, Wolcott (1994,p.16) considers that students '*tell the story'*. To seek the reflections of the participant's data was analysed through Braun and Clarke's (2006) thematic analysis. This was the chosen method to gain insight into the interviewed population. By using Braun and Clarkes approach, the findings add towards the interpretation of data which follows the interpretive and descriptive approach to compliment the data to explain the meaning of ownership.

Principle 2 of Yin's (2009) data collection method focuses on the creation of a database as a way of organising and documenting data collected. Yin (2009) suggests that developing the database is described in four component parts: notes, documents, tabular, and narratives. All notes should be organised, categorised and available later for access which was achieved through electronic filing. The many documents accrued have been annotated and organised into a chronological bibliography and tabular materials recorded electronically in readiness for presentation. The narratives from the focus groups have been transcribed and electronically filed.

Principle 3 relates to the maintenance of a chain of evidence and to increase the reliability of the information in a case study, Yin (2009) proposes that an external observer is important to follow the derivation of any evidence from initial research questions through to the case study conclusion. This was achieved through my first

and second supervisors and the critical reader. This was also supported by a mock viva.

3.8 Establishing a Meaningful Connection Between the University & Practice Learning Environment

Participants construct their lives through interactions of sociality and cultural methods and are often processed in the specific context in which they live (Andrew et al., 2008). The value of interaction in that contextual world must be considered and as a qualitative researcher understanding was sought to explore the context of that human engagement within that world by investigating the participants through interpretive enquiry.

Through engagement between the educational and professional constructs of the HEI and clinical setting, insight can be taken from their angles and subsequent connections. This engagement must be interpreted to place value or suggest possible links to perspectives and causal factors and thus may produce a largely inductive enquiry thereby generating meaning from the data collected in the field. However, the overall structure and design strategies of this enquiry, or as Creswell (2009) states research methodologies, will show how the theoretical constructions of intellectuals and other merchants of ideas may influence that common-sense reality. This is an enterprise that, although theoretical in character, is geared to the "*understanding of reality that forms the subject matter of the empirical science of sociology that is the world of everyday life*" (Creswell, 2009,p.9).

The study however is not reflective of the student trainees themselves but the academic and clinical partnership that underpins the connection binding nurse education into a professional collaboration with academia. Thus, to create a tangible, intertwined and deliberate relationship, an interpretive viewpoint is required to establish an assumption about that relationship and its meaning. The emergence of

academia into the clinical environment is inextricably interlinked and my research provides the fundamental constituents encompassed within the professional education and professional socialisation of pre-registration nurse education.

The approach to the case study relates to the qualitative researcher reporting on personal observations of the social world, including the experiences of others and a plethora of further university, local and national documentation (Denzin and Lincoln, 2013). The *'others'* within this study are the academic and clinical partners and their multiple realities that can be seen through interpretivist approach. This will enable the research as the *'knower'* to view their perspectives and this is the most suitable paradigm for examination of the reality of responsibility and ownership. The interpretivist approach is a suitable paradigm in which to understand participant's experiences about the topic. Aligned to the interpretivist approach are qualitative research methods which are used to gather the data for this paradigmatic approach.

A suggestion by Denzin and Lincoln (2013, p.7) that qualitative research involves the studies use and collection of a "*variety empirical materials-case study, personal experiences …and that describe routine and problematic moments and meanings in individuals' lives*". The nature of reality is responsibility and ownership between partners and the relationship between enquirer, the unknown, and will assure the researchers epistemological viewpoint. This produced evidence supporting the weakened sense of ownership between partners and whilst the qualitative research is interpretive, and guided by a set of beliefs and feelings about the world and how it should be understood and studied (Denzin and Lincoln, 2013).

Thus to understand the partners' perspectives, the researcher adopted a design that will relate to the most appropriate methodology to answer specific research questions and chosen strategies that are most effective for obtaining it (Yin, 2009, p.31). Case

study therefore is the appropriate epistemological approach with a research strategy of making the partners the object of study through semi-structured interviews and document analysis (Denzin and Lincoln, 2013).

3.9 Asking the Right Questions

There is a suggestion by Yin (2009) that to determine the type of research to be conducted depends on three conditions; first the type of question; secondly, the degree of investigator control possible and finally, the degree of focus on contemporary events desired. Yin (2009, p.10) summarises that the *"first and most important condition for differentiating among various research methods is to classify the type of research question being asked*". By asking what the study is about is key to understanding what the research question is and within the study the question of how and why the relocation of nurse education into higher education affected ownership between partners provides a platform for exploration.

Furthermore Yin (2009) suggests that '*how* 'and '*why*' questions are more explanatory by nature and are more likely to lead to case study. Therefore, to address the research topic through Yin's (2009) three conditions, can be addressed by the 'how' and 'why' perspective with questions such as 'why has ownership become unclear between the partnership?'. The second condition of investigator control focuses on the qualitative approach to seek meaning and understanding of the academic and clinical participants' perspectives. However, this aspect also addresses researcher ethics, bias, and safety of participants.

The third condition relates to events that are contemporary but that which have had a historical background. It is evident that ownership and management of fitness has undergone a review of process, and responsibility since guidance policy changes in 2009.

Simons (2009) deliberates that the values of qualitative case study that can address multiple perspectives of stakeholders, and participants, and observation in naturally occurring circumstances, and interpretation in context. The participants, or symbolic partners, involved in the study are NHS and HEI stakeholders which can be argued as the worldview through in which the participants constructed their world and how the researcher interprets that world (Simons, 2009).. Fundamentally, according to Thomas (2011, p.37) case study has "*broad and capacious arms: it loves all methods*" and a range of different methods for gathering and analysing data can be used. Under the umbrella of case study, Thomas (2011) suggests that researchers can choose whatever methods and subsidiary design frames necessary to help answer question the case study in question. Therefore, the chosen process of gathering data from participates to explore the personal belief features of fitness to practice ownership between the academic and clinical setting is semi-structured focus group interviews. This is alongside the documentation also examined.

Focus groups, according to Cohen and Crabtree (2006), is a method of data collection conducted through semi-structured focus group interviews. Cohen and Crabtree (2006) suggest that focus groups might be used to explore new research areas, a topic that is difficult or does not lend itself to observational techniques. Furthermore, focus groups can provide the occasion and the stimulus for collective members to articulate those normally unarticulated normative assumptions within the group (Cohen and Crabtree, 2006). Normative conversation with the participants was essential to reveal the tensions and factors that enable or constrain the partnering of students between the academic and clinical setting. Hence, participants were recruited and interviewed from one health faculty and one general ward-based setting directly involved in the teaching of student nurses.

3.10 Ethics

Details on maintaining ethically appropriate research are considered below (section 3.12); this section provides an overview of the application of ethical principles and the process of ethics approval required for me to commence the study.

Advocated by Denzin and Lincoln (2003, p.154) that qualitative researchers are "*guests in the private spaces of the world and their manners should be good and their code of ethics strict*", research shares an intense interest in personal views and circumstances. This is relevant as nurses in clinical practice have the responsibility of a professional duty to patient care as well as student learning, so the research project must ensure that any potential harm to the mentors wellbeing is minimised (Griffiths, 2006). This is especially pertinent for this topic as the study may uncover areas of professional concerns of fitness to practice witnessed by the participants. Ellis et al. (2011) discussed the significant power fitness to practice committees must bring a student's studies and future career to a halt. This bears a professional responsibility, so ethical approval was required to assure the participants that the study adheres to the necessary processes throughout for all stakeholders, academic and clinical. Ethical consideration as described by Denzin and Lincoln (2013) must also be reviewed with impetus from conscience, from stakeholders and from the research community.

To attain ethical approval within the university to engage appropriate staff in the research, the research proposal was submitted for scrutiny, and was approved by the panel and was successfully sanctioned by the Chair of the Faculty Research Ethics Panel (FREP) 2012 (Appendix 1). With this approval, under the terms of Anglia Ruskin *University Policy and Code of Practice for the Conduct of Research with Human Participants* the study must adhere to the code which identifies researcher responsibilities to ensure compliance. Furthermore, any substantial changes to the

study or reporting adverse events and incidences require amendments to be presented back to the Panel, this was not required in the study. Lastly the code highlighted above specifies that The Data Protection Act (1998) must be adhered to for any emerging legislation to protect the identities of the participants. Following FREP approval, the task of recruiting academic participants was sought through a written request to the respective Department Heads from within the faculty for any of their staff to volunteer as participants. All academic staff across the pre-registration nurse education programme were contacted via their Head of Department and eight came forward voluntarily to participate in the study.

Ethical permission and approval for health and social care research in the UK, and therefore to gain access to the clinical setting for mentor participants, was sought through the Integrated Research Application Form (IRAS). The IRAS application process is an online (web-based) system for preparing regulatory and governance applications for health and social care (hra.nhs.uk accessed 2012). It is a UK wide system and prepares researchers to conduct research in the NHS but in England additional approval is required via the Health Research Authority (HRA). The HRA reviews and approves NHS Research Ethics Committee (REC) on behalf of the participating NHS organization in England. This was sought and approved in readiness to access and recruit registered mentors from the University's major affiliated placement providers.

Recruits from the clinical setting were sought via an intermediary of the NHS Trust Research & Development Department (R&D) lead following IRAS and HRA approval. Several NHS Trust areas were approached for participants who are placement providers associated to the university. However, only one local NHS Trust responded, and the NHS R&D Trust lead was able to recruit mentor participants on the researcher's behalf following selection choice based on purposive sampling. Thus,

with participation from the relevant NHS R&D Trust lead who supported the use of focus-group interviews, three registered mentors were obtained.

3.11 Rigour - A Series of Techniques

Lincoln and Guba (1985a) posit that trustworthiness of a research study is important to evaluating its worth. Lincoln and Guba (1985b,p.290) believe that the concept of trustworthiness within naturalistic inquiry is a series of research behaviours that in comparison to the quantitative paradigm are employed to achieve validity and reliability.

Trustworthiness involves establishing four criteria: credibility, transferability, dependability, and confirmability. Credibility relates to confidence in the '*truth*' of the study, transferability must show that the findings have applicability to other studies and dependability shows consistency within the findings (Lincoln and Guba, 1985a). Confirmability detaches the researcher from the study to assure an unbiased approach to the findings and conclusion. Therefore, through the adoption of Lincoln and Guba's (1985a) evaluative criteria this section demonstrates how trustworthiness has been established through the transparency of the study process from beginning to end. This focuses on each of the four evaluative criterions and considers how each has been achieved for establishing trustworthiness for an accurate account of the case study and subsequent findings.

3.12 Evaluative Criteria and Trustworthiness

3.12.1 Credibility

Lincoln and Guba (1985a, p.296) suggest that the researcher needs to persuade the audience that his or her research provides a valid argument therefore to offer credibility the researcher's ability to be able to conduct the enquiry in such a way that the findings will be found to be believable. A qualitative study is deemed credible if it

reveals accurate descriptions of individuals' experiences (Appleton, 1995). Therefore the researcher sought to depict an accurate account of the participant's thoughts and feelings through focus group interviews, historical and contemporary documentation to seek meaning and to interpret the findings describing people acting in the events (Appleton, 1995).

This was achieved through triangulation using multiple sources in the study to produce understanding. Lincoln and Guba (1985b) view triangulation as a method for validation or verification which is relevant to this case study as the literature chapter focused on an extensive review of NHS, NMC, university policy and documentation. Through a variety of contemporary and archival pre-registration nurse education literature supporting the study, credibility was also achieved by returning to the participants to allow them to examine their transcribed focus group interview notes.

Thus, to establish credibility, the technique most suited to the study was Lincoln and Guba's (1985a) concept of triangulation and was procured through the consistent monitoring of process and accurate transcription of the focus group interviews reviewed by the researcher's supervisors. Transcribing verbatim the participant's voices provided a truthful account of their viewpoints. Seeking verification of the interview transcripts with the supervisors and by using different sources of the same information that is considered as contextual validation and is supportive of Lincoln and Guba's (1985b) triangulation process thereby assuring accuracy of findings to achieve representation of the *'truth'*. Hence by initially applying colour codes to the transcripts, this allowed for an overall perspective of the participant's viewpoints and through Braun and Clarkes (2006) thematic analysis it assisted organisation of the data into meaningful and useful data.

3.12.2 Transferability

Trustworthiness is part of the process of 'transferability' which relates to the quantitative notion of 'external validity' or generalisability' (Lincoln and Guba, 1985a) Transferability related to the study however, is reflective of what works within a description of the "*time and context in which they were found to hold*" (Lincoln and Guba, 1985b,p.316). As a means of evaluating the time and context, Lincoln and Guba (1985a) offer that '*thick description*' is a way of evaluating the extent to which the conclusions are drawn that are transferable to other times, settings, situations and people. Lincoln and Guba (1985b) also offer that thick description is necessary to enable someone interested, i.e., for a similar study topic, to reach a conclusion about whether a transfer can be contemplated as a possibility.

Hence to achieve this Lincoln and Guba (1985b) advise that thick description for transferability is to accumulate empirical evidence about a contextual similarity. This contextual similarity for this study is the culture of pre-registration nurse education between the HEI, NMC and clinical setting. Thus, what follows is a detailed description of the participants' accounts, reflective of their thoughts and beliefs to provide analysis for in-depth discussion. Alongside the documentation collected. However, through the data collected a generalised viewpoint of the participants can be considered for the interpretive assumptions and insight gained between practice and academia regarding FtP.

Central to narrative is to arrange happenings and the dynamics of a story in meaningful way (Denzin and Lincoln, 2013). Lincoln and Guba (1985a) suggest that the range of information sourced is needed for inclusion in the thick description so the emergent narrative from the interpretive study must be considered and whether the findings and conclusion are transferable to other contexts. For example, Lincoln and Guba suggest that by describing a phenomenon, ownership in this study, in sufficient

detail any researcher can begin to evaluate the conclusion drawn that are then transferable to other times, settings, situations and people. Thus the accumulation of evidence is about contextual similarity because the construct studies may be peculiar to the studied group (Lincoln and Guba, 1985b). Through the provision of sufficient descriptive data, to make such similarity judgments possible, findings of the study can be considered as thick description from the established data collection methods.

3.12.3 Dependability

The third stage of trustworthiness relates to dependability through external audit. This stage involves a constant review of the preliminary findings to assess adequacy from the data collected (Lincoln and Guba, 1985a). This is especially pertinent of the focus group interviews where truth is negotiated through dialogue. Essentially the purpose according to Lincoln and Guba (1985a) relates to the accuracy and evaluate whether the findings, interpretations and conclusions are supported by the data. This is achieved by examining both the processes and product of the research study.

Furthermore, external audit provides an opportunity to summarise, assess and have feedback from the supervisors for developmental and progressive matters for the study and independent review of findings. However, as a qualitative researcher there is no object truth or reality so the external auditor, the supervisors, and researcher should allow for different understandings of the findings which may be considered to prevent bias as the findings are focused on that moment in time.

3.12.4 Conformability

Lincoln and Guba (1985b) offer the last stage of trustworthiness as reflexivity and is an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process (Appleton, 1995). More importantly, reflexivity is crucial for social researchers to

clarify their roles especially for those utilising qualitative methodology to make their research credible and according to Unluer (2012), these roles can range from complete membership of the group being studied (an insider) to stranger.

Within the current study, the researcher is known to the academic staff, but the Practice Learning participants are not aware of the DoS role. This insider researcher, recognition may affect the participant viewpoint but the advantage of being an insider was in knowing how to best approach people and have insight to the lived experience. The disadvantage is having greater familiarity which may lead to a loss of objectivity (Unluer, 2012).

3.12.5 Beneficence & Non-Maleficence

An essential consideration for both ethical approval and the recruitment of participant's, is to maintain reflexivity. This is essential because the subject topic correlates to the DoS role and responsibilities.

Ethical principles should apply to all studies and according to Greaney et al., (2012) therefore ensuring the protection of the participants, research ethics guidelines and health professionals. Treating participants with respect relates to beneficence which incorporates their wellbeing but also incorporates the principle of non-maleficence.

The principle of beneficence demands that researchers maximize any possible benefits of the research but minimizes any harm. This principle was established for the present study through the provision of Participant Information Sheet (PIS) and consent forms (Appendix 3) approved through FREP and R&D research ethics committees. The need to assure the participants that their contribution to the study was in direct context of change for fitness to practice matters was addressed through the process of ethics and confidentiality. Every participant was advised that all

information, be it hard copy or electronic, would be secured in university locked cupboards or university password protected computers. Importantly, each participant would only be identified through a coded initial, for example Personal Tutor was labelled as PT1 (of 4) throughout the transcribed notes and applied to every participant in the transcription process. This was to maintain confidentiality throughout the study. I needed to be mindful of assuring confidentiality due to the potential sensitive discussions around fitness to practice discussed by the participants.

The participants were shown all ethical approval documentation prior to the focus groups to reduce potential risks and the study objective outlined at the outset. This was achieved through information detailed in the Participant Information Sheet (PIS) and consent forms as a hard copy for their perusal to consider whether they wished to participate. By allowing the participants time prior to digest the studies objective, and their part within the study, this offered a transparent strategy to keep them informed of the purpose and use of the data. Through clear explanation of their contribution to the field of fitness to practice knowledge, the participants were informed of future publications around responsibility, partnership working and curriculum within the topic. All participants had access to their transcribed recordings at any point on request.

All hard copy documentation of the study and participants transcribed notes were secured within a locked cabinet on university grounds alongside the audio-recordings of the focus groups which were password protected on university laptop computers. This securing of data also adheres to non-maleficence (do no harm) in any research project to ensure that any potential harm is minimised and this harm can extend to psychological as well as physical (Griffiths, 2006). I was also able to offer the academic participants psychological support via the university counselling service, but this facility was not available to the clinical participants. Support was available

however, through the R&D department so a similar service was open to the participants should any matter of sensitivity require further support for the participants. This was an attempt to reduce as much risk as possible with awareness of their potential reluctance to provide a full and thorough discussion which may compromise their practice as a registered nurse or academic.

Participants ought to be treated as autonomous agents and be sufficiently protected and researchers should clarify their position so as to avoid bias or the potential to exert influence (Greaney et al., 2012). For example, a guarantee was given to the participants that the recordings and discussion were subject to rigorous safeguards and confidentiality (Watson et al., 2008). Furthermore, the principle of non-maleficence is therefore affirmed as much as possible through the PIS and consent informs in which the participants were apprised of the purpose, methods and possible future uses of the research for publication.

Therefore, as a direct result of considering beneficence and non-maleficence assurances of processes have been transparent throughout. Thus, participants volunteered free from coercion and the consent process allowed them to decide whether they wished to take part in the study. Importantly, FREP and R&D approval agreed upon the robustness of my research design as a contextualized study objective with an indicative research method and any potential risks associated to the study, and any potential conflicts of interest with the academic staff due to DOS role, were considered as minimal.

3.13 Chapter summary

The case study was the best suited methodological approach as the richness of the phenomenon and the extensiveness of the real-life context require case study investigators to cope with a technically distinctive situation (Yin, 2009,p.10).

Knowledge is cultivated to base the competency skills' set for nurse education through key professional body documentation and curriculum delivered through the HEI. The professional body devolves delivery of skills' and competency capability through the HEI developed curriculum. The distinctive situation in this study relates to the complexities of fitness to practice focused on ownership responsibilities of a three-way organizational relationship; HEI, NHS and NMC. Furthermore, as Yin (2009) suggests, the unique strength of case study is its ability to deal with a full variety of evidence-documents, artefacts, interviews, and observations which have been utilised (Yin, 2009, p.11).

The strengths of a single exploratory case study, as opposed to a positivist approach, are suggestive of allowing this study to explore a meaningful representation of real-life events between the three organisations (Yin, 2009). However, a concern about case studies is that they provide little basis for scientific generalisation, but scientific experiments are rarely based on single experiments and therefore the use of a qualitative approach based on an exploratory case study seeks to gain understanding of a specific phenomenon. The phenomena being ownership of fitness. Therefore, the use of documents, both contemporary and historical from an academic and clinical perspective are key to seeking that meaning, alongside the focus groups.

Furthermore, the boundaries between phenomenon and context are not clearly evidenced within this three-way partnership as mentioned previously, the mentors are expected to nurture and supervise the students' clinical learning and development with the academic setting facilitating the programme. These components are essential for considering Yin (2009) unit of analysis. This study is not about an individual rather a set of organisations within an entangled relationship.

In summary, the components of this research topic can be broken down into units of analysis and related to the fundamental problem of defining this case. This case study relates to the academic and clinical factors that influence or constrain the partnering of students around fitness to practice. Case study can offer the methodology to seek meaning, gain insight and address such concerns in a small-scale study with one university and one hospital Trust. The aim of the study is to cross-examine academic and clinical perspectives and the apparent weakened state of fitness to practice management to further understand HEI and NHS stakeholders' perceptions. This has been further exacerbated by the concept of mentoring, and the implications this has on developing student's clinical competence to assure the public that they have met the proficiency achievements.

The truthfulness of the study was established through Lincoln and Guba's (1985a) evaluative criteria so that credibility and confidence in its ability to transfer to other concepts is evident. Hence adoption of their evaluative criteria supported by the transparency of the research for audit for dependability and confirmability ensures a truthful account. This truthful account is also maintained through rigour and ethical approval with consideration to the participant's involvement of guaranteeing confidentiality through beneficence to reduce potential conflict. Hence a dichotomy for ownership exists.

In summary, qualitative research is endlessly creative and interpretive and these qualitative interpretations are constructed thereby creating text into a written document of what has been learned is important and case study "*will offer the interpretive measure to facilitate that*" (Altheide and Johnson, 2013,p.586). This has been considered within the rigor of the study.

Chapter Four - Methods: Fitness to Practice within Pre-Registration Nurse Education- Whose Responsibility?

4.1 Introduction

The literature chapter exploration of historical documentation and synthesis of the information contained within uncovered several elements associated with the ownership of fitness to practice between the academic and clinical setting. Through mentoring the attainment of clinical proficiency is secured, supported by educative principles applied by the professional body delivered by the HEI through curriculum. From the literature, fitness to practice appears bound in a three-way relationship between the academic, clinical, and professional body.

Whilst the partnership appears to have equal measures of responsibility, the rationale for the chosen research paradigm of a qualitative approach of Yin's (2009) single exploratory case study as the relevant method to collect data from key information and the academic and Practice Learning partners, was germane to the examination of ownership perceptions. Thus, thoughts and feelings of the participants were sought through focus group interviews, recruited from the local academic and Practice Learning Partners through purposive sampling, to provide insight into the meaning of ownership.

Explanation of the chosen method of using key documentation and focus group interviews including recruitment strategies and purposive sampling of participants, vignettes, and the analysis of data through the adoption of Braun and Clarkes (2006) thematic analysis are discussed.

Appraising the literature behind this tripartite partnership provided a narrative inquiry of the theoretical, operational and Practice Learning perspectives with reference to pre-registration nurse education historical perspectives. The documentation both

governmental and nursing within the literature review was able to identify the FtP processes between the tripartite partnerships and highlighted the confusion when considering the primary lead for the process and establishing the different senses of responsibility and ownership. If the process belongs to the programme provider, how does responsibility for the Practice Learning Partner affect ownership.

The literature review search strategy was able to identify both current and established research and nation documentation to help to ascertain appropriate information to establish the relevant resources. The researcher needed to gain more information on the context of fitness to practice refining that was manageable and researchable and would 'confirm' the research question:

- *What are the factors that exist between academia and practice that enable or constrain the partnering of nursing students if there is a fitness to practice issue?*
- *What are the perceived understandings of fitness to practice between the partners?*
- *Are misconduct and disciplinary processes transparent between the academic and clinical setting?*

It was important to investigate local and national documentation as an accurate representation of evidence to the conflicts of the tripartite regarding fitness to practice. The focus of this Professional Doctorate is an exploration of localised management of FtP within the researchers own university and local Practice Learning Partner and therefore, a pragmatic view to the international perspective will be exercised. Using focus groups also addresses how lecturers and mentors perceive their responsibility within the management of pre-registration nursing students and FtP between the two local partners.

The sources used in this study focused predominantly on several key documents previously discussed in the literature review which spanned national, government and nursing and local university and Practice Learning partner. Furthermore, it also utilised secondary sources as they offer different viewpoints to the topic of FtP in relation to the study topic and case study approach. This culminated in the Key Document Table 1.

4.2 Focus groups.

Collecting data through semi-structured focus groups was chosen as it was considered to best suit the research questions to gain understanding of participant's thoughts and feelings around fitness to practice and ownership.

Focus groups have been widely used to explore a range of issues including clinical practice. For example, Aveyard (2002), as part of a larger study, researched the implications of implied consent for nurses and used focus groups to examine the way in which nurses obtain consent prior to nursing care procedures. Aveyard's (2002) sampling strategy was purposeful, and all participants were registered general nurses with at least 1-year clinical experience. Six focus groups were conducted, and participants were asked to discuss the way in which consent is addressed prior to nursing care procedures. In addition, 30 in-depth interviews were conducted but numbers of participants within each focus group were not detailed. The findings however, were reflective of the participants holding a view that the way in which patients expressed consent was through 'implication' (implied) and that written consent was largely inappropriate in the context of nursing care and that verbal care was often replaced by implicit consent (Aveyard, 2002).

A conclusion drawn by Aveyard (2002) was that the data obtained was useful to seek meaning and understanding of implied consent because of incorporating focus

groups within her exploratory study. This is also relevant to a study conducted by Doman et al. (2004) who presented a study exploring nurses' experiences of providing high dependency care on children's wards using focus groups with a total of 12 participants. Group one comprised of five participants, group two with four participants and group three with three participants recruited to share their experiences of providing high dependency care. The three focus groups interviews were conducted away from work premises and topic guides and open questions were used to aid discussion. Doman et al. (2004) concluded that focus group interviews elicit a wide range of views and achieve the purpose of identifying key issues for the participating nurses (Doman et al., 2004). They did recognise the small numbers of participants as a limitation, but of which produced enough information to provide the study with several key themes. Thus focus groups emphasize meaning rather than measurement and require the researcher to immerse themselves in other people's lives (Redmond and Curtis, 2009).

This is mirrored by Kamberelis and Dimitriadis (2013,p.559) who equate focus groups with multifunctionality and the belief that focus group work "*also foregrounds the importance of both content and of expression*". They suggest that a focus group can reflect the function of a group whilst refracting the wider benefits exhumed by the research, in relation to their prism metaphor. Additionally, focus groups can be a small or large, directed or non-directed, with a collective conversation or group interview (Yin, 2009). Focus groups typically consist of between six and ten participants, but the size can range from as few as four but dependent on the research purposes (Litosseliti, 2003). The choice of groups upwards of six was suitable due to the scale of the study.

One sample was used for this study consisting of eleven participants who partook in three focus group interviews from the academic and clinical setting. The purpose of

the focus groups was to adequately address the relevant participants directly involved with pre-registration nurse education and the recruited participants consisted of one group of four academic Education Champions: one group of four academic Personal Tutors and one group of three registered nurse mentors. The contact point was me and each participant was provided with a participant information sheet, supported with ethical consent forms for their information.

The main criterion for participant inclusion was their direct contact with pre-registration nursing students and according to Bloor et al. (2001, p.19), they state that focus group participants are "*not selected by means of systematic random sampling*" which reinforces the notion that a random sample may not be the most appropriate strategy. However, as Denzin and Lincoln (2013) consider, random samples emphasize representativeness will seldom be able to produce the required insight into a research problem so purposive sampling was chosen to recruit participants "*on the basis of a shared characteristic*" namely that they have direct contact with nursing students, have involvement with fitness matters and are part of the academic/clinical partnership (Cousin, 2009,p.79).

Conversely, "*focus groups can provide the occasion and the stimulus for collectively members to articulate those normally unarticulated normative assumptions*" (Bloor et al., 2001, p.5). Additionally, Kamberelis and Dimitriadis (2011, p.559) support the notion of norms because focus groups "*often produce data that are seldom produced through individual interviewing and thus yields powerful knowledge and insights".* This reinforces the researcher preference of focus groups over individual interviews. Thus, the thoughts of focus groups call forth the intrinsically ambiguous character of group norms but focus groups remain the best method for accessing group norms. Furthermore, as suggested by Doody et al. (2013, a, p.16) the "*primary goal of this method is to use the interaction data generated during discussion*". This was key to

seek meaning and understanding from the participants around the beliefs of their role within fitness to practice, and not available during individual interviews.

4.3 Participant Recruitment & Sampling

Composition of the focus groups was selected by purposive sampling which according to Bloor et al. (2001) can be used where researchers are guided by their particular research questions and key characteristics which are considered relevant to examine and individuals recruited accordingly (Aveyard, 2002). Recruitment strategies need to incorporate individuals who are eligible for participation in the group (Bloor et al., 2001). However, if eligibility criterion is not particularly specific as suggested by Bloor et al. (2001), a researcher can simply recruit. However, the purpose of the study participant criteria was based on the representation of the larger population with a sample of recruits involved with academic and mentor responsibilities of nursing students. Furthermore, the choice of purposive sampling as suggested by Simons (2009) claims that where the aim is to understand or gain insight, most often in case study the sampling will be purposive. Other sampling methods such as convenience sampling were considered but due to the eligibility criteria of academics to have direct contact with nursing students within the faculty and mentors in the clinical setting, the choice of purposive sampling was key.

The choice of participant was focused on all participants being registered nurses, albeit practicing with students, but it was essential to have academic staff and mentors who have direct contact with student nurses. For the clinical staff, it was key that they held the mentorship accreditation. Through convenience sampling it may have been easy to find nurses who work with students in the clinical area, but the study required qualified nurses with the mentorship award.

Inclusion of academic and practice participants is vital to gain partnership perspectives and would help illustrate conversations relevant to their professional worlds and of the partnership, so recruitment was based on eligibility for participation as the research questions required academic and clinical participation and their perspectives to explore a range of partnership views on the topic. This led to the recruitment of participants based on the relevance purposive sampling offered to understanding the meaning of fitness to practice between the partnership and elemental to the aim of the study was to engage academic and registered mentor participants to determine their thoughts and feelings of the academic and clinical partnership.

The selection of participants was therefore logistical access and sampling relevance of working directly with pre-registration student nurses. The participants were female with ages ranging from 25 to 50 years. All participants held NMC registered nurse status, but the mentor participants also held the registered nurse mentor qualification to be eligible for the study. The academic participants were Personal Tutors and Education Champions and the composition of the focus groups consisted of two academic groups and one group of registered mentors from the clinical setting.

The eligibility criteria of the two academic groups consisted of the faculty-based Education Champions (EC) and the second focus group consisted of Personal Tutors (PT). EC's provide the clinical setting with a link to the university to all the student's clinical placements and hold responsibility for academic and clinical partnership collaboration. PT's are predominantly university based and support the student's academic and pastoral needs. They maintain responsibility for processing practice assessment outcomes for the awards board and personal tutorship extends the duration of the student's course. The group of registered mentors (M) played a key role in the support and development of students in the clinical setting. The registered

nurse mentors who met the eligibility criteria were recruited from a general surgical ward supporting predominantly first- and third-year students.

4.4 Participants

4.4.1 Education Champions

The Education Champion role is a vital collaborative link within the researchers HEI, between the academic and clinical setting and provide facilitation between students and mentors. Each EC has an identified PLP which encourages a collaborative approach for the clinical experience for all students within the placement area and a prerequisite to the role are weekly visitations to their respective NHS Trust link areas.

This role also includes involvement with their respective NHS Trust site audit process. Confirmation through audit confirms that students on NMC approved pre-registration nursing programmes are supported and assessed by mentors in the clinical setting. This guarantees each clinical area has met the clinical experience needs for students to achieve their learning competency outcomes and placement capacity is not exceeded for mentoring. Adhering to NMC standards to support learning assessment is a responsibility of the university and Trust area. Successful audit of mentors and sign-off mentors is a quality measure for the ratio of manageable student and mentor numbers as a condition of placement opportunities. The audit process also acts as the forum to discuss student matters, student capacity, providing NMC mentor updates and to consider any other local or national NHS strategies. There is an expectation that EC's attend the NHS Trust led Practice Education Facilitator (PEF) meetings. The PEF's hold responsibility for mentor support and post-registration education. The PEF meetings address and identify any mentor or student support issues and EC's often deal directly with the PEF's, mentors, and students to directly discuss university and clinical matters that may require action.

Fundamentally, one of the key roles of the EC is their face-to-face collaborative working partnership when facilitating the university driven Cause for Concern (CfC) response strategy. The CfC response strategy documents and records any 'at risk' or incidents. For example, if a student displays failing within the clinical setting, the EC may be called upon by the Trust mentor to provide mediation with the student (and mentor). This may include playing a crucial role in documentation of 'at risk' student evaluations. Assistance from the EC for the management of the CfC response strategy encouraged me to recognise them as essential participants for the study. They were considered as ideal candidates due to their direct attachment to the clinical environment and for their alliance to university process. Their role strengthens the study aims in exploring the relationship between partners. EC's provide consistency between the academic and clinical partnerships for communicating updates to each partner and is paramount to facilitating HEI links to the practice setting. The role is an empowering and evolving role developing as practice develops (Weeley, 2013).

However, the EC's may also act as Personal Tutors, and this may produce role conflict, but the study required focus groups with a variety of individuals to explore a range of views. However, the awareness of the differentials may affect the findings and analysis is required.

4.4.2 Personal Tutors

This role involves providing academic and pastoral care with responsibility for verifying the achievement of each student's clinical proficiency recorded in their individual Practice Assessment Document (PAD). This is an Award Board requirement to ensure students have met the necessary clinical outcome requirements at the end of each placement, and subsequent submission period. However, expectations of a PT do not always extend to student visitations on placement even though their names are detailed on the front page of each nursing

students' PAD and whilst they hold responsibility for reviewing the PAD, they are without clinical attachment to the specific clinical setting of their student as compared to the EC's. Therefore, as participants their link to academic award through the recording of a student's successful PAD attainment, but with often no direct link to clinical responsibility, their academic status and professional registration would provide an insightful and contextual element of ownership compared to the other focus groups.

4.4.3 Mentors

Mentors are registered nurses regulated by the NMC, and who have a statutory duty to promote the learning and development of students (Doman et al., 2004). Mentors provide the clinical assessment and proficiency status of the student nurse in preparation to enter the NMC register. Approval to be a registered mentor is awarded through the NMC Mentor Preparation Programme with updates on a yearly timeframe. Mentors assess the clinical component of clinical practice education, critical to the students' practice achievements. As a case study the research portrays one moment in time, therefore while mentors are not the revised definition moving forward, as the NMC have shifted the focus onto supervisors and assessors. For the purposes of the study the term mentor remains appropriate.

They are key within the study as their perspectives from the clinical provision aspect of the partnership and are an important source of information to gain understanding and the role they play in fitness to practice Their perspective was also key to understanding how they perceive their role in terms of having regular contact and communications with the university for collaborative engagement, mentor updates and to action the CfC response strategy in any student matters. It is important that mentors are positive role models and embrace the values of the NHS constitution to supervise students. The quality of mentorship will very often determine the quality of

a student's placement experience. It is their role to maintain professional credibility and to ensure that they are working with their students for 40% of their placement time (Anglia Ruskin University, 2013).

The mentors were recruited from one Trust site as they were the only Trust to respond to the study, but as Bloor et al. (2001) suggests the value and number of participants is more about the value and significance of the findings of the groups that cannot be understated. The size was limited due to accessibility of the nurse's shift patterns and ability to leave the ward area, so patient care was not affected. They further suggest that the number of focus groups will inevitably reflect the research plan including the variability of responses (Bloor et al., 2001). This resulted in the study being relatively small-scale.

Of the three participants two held senior ward managerial positions. They held undergraduate degrees and the NMC mentorship status with the addition of the sign-off status. The third participant was a band 5 diploma Registered Nurse (RN) with mentorship status only. The three mentors were to provide valuable insight into the management of students.

4.5 Focus group interviews.

Accessibility of the interview venue to participants is important as is the choice of venue (Bloor et al., 2001). To put the participants at ease, and to ensure participant attendance, the focus group interviews were held in work hours at their respective workplace (Bloor et al., 2001). The two academic focus groups, comprised of EC's and PT's, were conducted within university grounds and the one registered mentor focus group was conducted on-site of the participative NHS Trust. This was deemed important as familiarity with surroundings can facilitate a more natural flow to their

conversation as an important element of finding a narrative is through an in-depth focus group conversation (Bloor et al., 2001).

Whilst each venue was ethically approved, access to the mentors proved a slight challenge as the interview had to be held within the Ward Manager's office. Access to an alternative room was not possible as the nurses could not leave the ward to assure patient safety. However, the discussion was not disturbed during the focus group interview. Whilst this was not ideal, I did have the privilege of having the mentor's undivided attention for the duration of the interview. However, as Bloor et al. (2001) states, for the focus group being held in the same room as they use daily may have benefited from the association that the participants felt in comfortable surroundings. As Bloor et al. (2001,p.7) suggest, the focus group will still provide rich data on the '*group meanings'* associated with the given issue. Whilst the room setting was not ideal, the room did provide a comfortable enough area for the mentors to disclose information and facilitated willingness on the participant's behalf to attend locally (Vaughn et al., 1996).

Before each of the focus groups commenced, each participant was asked to sign a participant consent form (Appendix 3). Every participant had already received in advance the Participant Information Sheet (PIS) which was part of the ethical approval requirement (Appendix 2). This was a useful precursor for the participant's expectations of the study topic. I used a digital recorder to audio-record all interviews. All recordings were immediately transcribed verbatim onto a secure computer file after each interview via a second party transcribing company. This proved especially useful as an immediate recollection of discussion for each participant within each focus group. Following the transcribed recordings, the typed notes were initialled with individual codes denoting each participant. Furthermore, repetitive listening ensured

the accuracy of the voices and initials given to denote each person, allowing for the accurate representation of participant's conversation to interpret events.

Each focus group was conducted over an 80-minute timeframe and each focus group and each individual voice was captured providing the best method to identify who is talking and provide nuances of the discussion to replay for analysis. Furthermore, one of my doctoral supervisory team acted as a note taker for cross-referencing purposes to capture non-verbal clues. Therefore, if any 'gaps' appeared during the transcription phase, I could return to these notes or to access participants for their clarification. Lastly, all participants were able to review their transcribed notes, and should they feel concerned the comments can be reflective of the context. Furthermore, participants have the right to seek assurances that their autonomy is respected and informed consent sought (Griffiths, 2006).

4.6 Semi-structured Questions & Prompt Sheets

The selection of participants is a key feature of focus group method and has to be sufficient to encourage discussion (Bloor et al., 2001). Interviews and focus groups are commonly used methods for data collection adopted in healthcare qualitative research (Chadwick et al., 2008).

I adopted a semi-structured approach to the focus groups with open-ended questions, guided by a prompt sheet, to elicit responses to enable me to obtain several perspectives at the same time as developed by Robert Wood Johnson Foundation (2008). To support the discussion a focus group prompt guide sheet was used supported by vignettes (Appendix 4). Vignettes according to Hughes and Huby (2002) are a means of practical application within limited resource access and can be of use in the study of people's lives, their attitudes, and beliefs.

Doman et al. (2004) state that a prompt guide with open questions can be used to elicit discussion between the participants and it was a useful tool as an aide-memoir. Fundamentally a semi-structured questions within a focus group can allow for an open response in the participant's own words rather than closed answers such as yes or no (Longhurst, 2016). According to Longhurst (2016) the interviewer can prepare a list of pre-determined questions and a good interview guide will also allow for a natural progression from general questions to those of the purpose of the study (Redmond and Curtis, 2009). This semi-structured approach and prompt sheet, helped to provide a clear set of instructions necessary to produce reliable, comparable qualitative data which was based on Robert Wood Johnson Foundation (2008) structure.

The focus group prompt sheet helped prepare the focus groups in advance and the pre-determined questions were useful to elicit group answers and stimulate conversation. The prompt was a useful tool to enable me to yield as much information as possible using neutral and sensitive technique. Focus groups share many common features with less structured interviews in that they involve guided discussion on a particular topic and audio (digitally) recorded by the researcher Gill et al. (2008). According to Vaughn et al. (1996) the interviewer's guide can serve as a map to chart the course of the focus group from beginning to end and can include an introduction, warm-up, clarification of terms, easy and non-threatening questions, more difficult questions, wrap-up and member check and closing (Vaughn et al., 1996). Vaughn et al. (1996) also states that whilst it is difficult to predetermine questions, the purpose and goals of the study should inform the choice of questions.

There is a suggestion by Litosseliti (2003) that it is important to sequence questions starting with simple, factual questions before spiralling into more complex questions (Litosseliti, 2003). Thus, questions were developed to evoke discussion around the

thoughts and beliefs of fitness to practice responsibilities from the participant's perspectives and from the partnership perspective and were devised to allow for conversation and discussion from an academic and clinical point of view. For example, one question asked the participants the support systems that are in place for them when monitoring a struggling student. Furthermore, the guide helped me to capture the respondent's answers to develop an understanding of the topic of interest necessary for developing relevant and meaningful semi-structured questions. (Bloor et al., 2001).

The question topics were generalised so as to avoid bias, influence or direct assumption and were conducted face to face in order to provide opportunity for identifying new ways of seeing and understanding the topic at hand (Robert Wood Johnson Foundation, 2008). This was a valuable tool to help the conversation from straying too far from the topical questions. Hence the use of a prompt sheet of open questions helped maintain an element of structure whilst providing opportunity for the participants to express their views in their own terms (Cohen and Crabtree, 2006). At the conclusion of the group, the participants were thanked for their time and asked if there was anything they would like to add. This is supported by Vaughn et al. (2013) to present more difficult questions and wrap-up.

4.7 Vignettes

The use of vignettes in research can help understand people's attitudes, perceptions and beliefs within subjects of health care (Longhurst, 2016). Hughes and Huby (2002) also suggest that vignettes can consist of text and images but for the purpose of the study, short text-based scenarios were used as a prompt for discussion. The scenario prompt is when the researcher is trying to seek viewpoints from the participants and can be useful to explore their decision making skills (Robert Wood Johnson Foundation, 2008). Whilst recognised that vignettes can stimulate reality, that reality

is only dependant on the participant's responses, but vignettes can provide a useful focus for discussion within larger groups (Hughes and Huby, 2002).

Vignettes which were used as triggers for discussion and are hypothetical cases or scenarios with particular features which make them suggestive of real life situations and respondents were asked to indicate what course of action they should follow (Vaughn et al., 1996). While hypothetical, the vignettes were loosely based on student scenarios experienced within the capacity as the DoS (Appendix 4). The vignettes were a mixture of different scenarios that have occurred in the clinical setting to mirror or connect the participants with (realistic) scenarios. Vignettes according to Hughes and Huby (2004) refer to stimuli to which research participants are asked to respond and are appropriate to the research topic, the kinds of participants involved and the interest and relevance of the study (Hughes and Huby, 2002).

Principally the vignette aims to capture the research topic and were informed by actual academic and clinical experience, literature and guided by NMC Code of Conduct. The vignettes aimed to be as realistic as possible to elicit real responses and were an attempt to address topics better considered through '*paper*' compared to a cartoon or visual image (Hughes and Huby, 2002). The only reservation of using the vignettes was the concern that the participants would attempt to answer the vignette rather than use it as the basis for a more generalised viewpoint of fitness to practice. Fundamentally the vignettes assisted in helping to put the participants at ease allowing them time to warm up and feel comfortable before "*disclosing and responding to information*" (Litosseliti, 2003 ,p.59). Bloor et al. (2001) consider vignettes as a focusing exercise and are hypothetical cases or scenarios with features which make them suggestive of real-life situations to respondents who are asked what course of action may follow.

For the purposes of the study the vignettes were devised as part of the requirement to maintain a real-life strategy for the participants and were taken from different situations that had occurred as the role of DoS and from the publicly available NMC incidents detailed from their website. Using the NMC examples as a comparison to the misconduct issues from the university, before the vignettes were used, they were also discussed with the researcher's supervisors and censure checked with nurse tutors who did not participate in the final focus groups. The vignettes highlighted some of the different liabilities between the stakeholders where each stakeholder has a different reference of what constitutes potential safe or unsafe practice. The vignettes were applied in the focus group meetings.

To maintain anonymity, a variety of scenarios were utilised ranging from honesty, professional behaviour, and clinical ability. Each vignette was developed to explore the participant's thoughts and feelings around professional, clinical, and potential criminal issues and were valuable for prompting topic discussion (Appendix 4). Several vignettes were specific to either a student's personal conduct including students who have committed a drink driving offence or failure to maintain professionalism, while further vignettes focused on nursing competency. For example, driving with excess alcohol contrary to the Road Traffic Act 1988 in vignette 3 focuses on the potential conviction element with vignettes 1 and 2 focusing on clinical competence and professionalism.

Furthermore, considerations around compassion, duty of care and dignity which are all key principles of nursing, were utilised. The vignettes were also loosely based on the growing number of cases presented to the NMC with the same fitness issues and difficulties with professionalism experienced by nursing students. Therefore, to devise the scenarios similar in nature to the reality of actual fitness cases or issues experienced, the vignettes allowed for some degree of reality but connected to the

principal foundations of nursing care. This allowed the participants opportunity to explore and consider fitness overall.

The vignettes reflect several student situations that have occurred in the clinical setting. These were then compiled into three manageable vignette scenarios to elicit discussion from the participants. The relevance to the study is that they are based on real-life situations replicated to enhance conversation and are an attempt to represent real world which can help disentangle the complexities and conflicts present in the clinical and academic management of student matters.

Hence the vignettes and open-ended semi-structured questions were focused on insider knowledge and as Unluer (2015, p.5), offers knowing "*local values, knowledge and taboos*" and this was instrumental in developing the open-ended questions to prompt myself and promote discussion. The vignettes were approved by the supervisory team and deemed suitable to reduce any chance of participants feeling professionally compromised.

4.8 Data analysis: Focus Groups

This is the stage when the process of linking, conceptualising, and making sense begins by processing the data into meaningful themes or categories. To render an account that stays close to the data as originally recorded and hence interpretation of the categories can be established. My focus of the analysis is the account taken from the transcription and categorised leading to the formal inductive process of interpreting the meaning derived from the participant's data. This may take into account understanding gained "*from formal analysis but more emphasis is placed in retaining the holistic nature of the data through intuitive processes*" (Simons, 2009,p.117). The challenge however was to move beyond the basic description to the next level of analysis through the construct of coding subthemes, then themes that capture some recurring patterns (Merriam, 1998).

This process was utilised to organise the data by employing a commonly adopted process for analysing data by breaking down data into segments and categorizing all the data until the theme was saturated to help make sense of the data (Simons, 2009). The process used to explore the data was Braun and Clarke's thematic analysis (2006). Braun and Clarke's thematic analysis (2006) is a method for identifying, analysing, and reporting patterns, themes, within data. Thematic analysis organises and describes data in rich detail and the term "'*data item' is used to refer to each individual piece of data collected, which together makes up the data set or corpus"* (Braun and Clarke, 2006,p.79). Braun and Clarke (2006) define the terms of '*data corpus'* referring to all data collected while '*data set'* refers to all the data from the corpus that are being used for a particular analysis.

For example, a data item includes all the documentation (historical, educational, and contemporary) and interview focus group data. A data item would relate to the individual interview transcription and hence coded quantity of data (Braun and Clarke, 2006). As a result, thematic analysis reports patterns (themes) within data and it minimally organises and describes data in (rich) detail (Braun and Clarke, 2006). This approach was preferred as thematic analysis is not wedded to any pre-existing theoretical framework, and therefore can be used within different theoretical frameworks. In this instance, a single exploratory case study. Furthermore, capturing the participants (peoples) everyday experience of reality to gain understanding would be best appropriated in Braun and Clarkes thematic analysis as considerable attention through the '*keyness*' of a theme emerged (Braun and Clarke, p.82). Importantly, the refinement of analysis will often result in overall themes, and sub themes within those. Furthermore, the researcher preferred the term themes over categories and felt it best suited the study topic.

However, caution must be taken as '*there is only interpretation'* and analysing qualitative inquiry is an' *analytical pendulum constantly in motion'* (Denzin, 1994,p.500), (Gubrium and Holstein, 2013,p.214). Simply presenting "*quotations from interviews without thematic structure, analysis or interpretation is unlikely to convey the meaning of the case*" (Simons, 2009,p.118). Notably the collection and analysing of data leads to a description, and qualitative interpretations are constructed and chronicled from all the raw data from transcription, reading through and coding was an essential part of the analysis for the findings (Denzin and Lincoln, 2013).

4.9 Coding & Theming: Focus Groups

Coding at such a very general level is a first step towards organising the data into meaningful categories to be themed. The process of coding is debated in the methodology of case study and according to Yin (2009, p127) analysing case study evidence is "*one of the least developed and most difficult aspects of doing case studies*". Merriam (1998,p.155) supports this notion by suggesting that data analysis in qualitative research has been like a "*mysterious metamorphosis"* but according to Coffey and Atkinson (1996,p.35) the analytic procedures that underpin coding procedures "*establish links of various sorts*". However, Yin (2009) suggests that much depends on the investigator's own style of rigorous empirical thinking along with sufficient presentation of evidence and this was achieved through using Braun and Clarke's thematic analysis (2006).

Thematic analysis was identified by Braun and Clarke (2006) as having 6 phases:

- Phase 1, Familiarising Yourself with Your Data:
- Phase 2, Generating Initial Codes
- Phase 3, Searching for Themes

- Phase 4, Reviewing Themes
- Phase 5, Defining and Naming Themes
- Phase 6, Producing the Report

(Braun And Clarke, 2006).

Phase 2 relates to generating initial codes which involves the production of initial codes from the data to identify interesting features in a systematic fashion across the entire data set. This was achieved following transcription from each coded individual participant with every focus group being transcribed but was then broken down into codes. Codes according to Braun and Clarke (2006) identify a feature of the data as it was organised, the data was then placed into meaningful groups so data was coded by breaking down the participant's thoughts, feelings, assumptions, language and spoken word manually (by transcribing the verbal data into written form) and then coding '*keyness*' extracts with a highlighter pen of words and commonly used phrases to indicate potential patterns (Braun and Clarke, 2006, p.89) (Appendix 5). This visual representation of consistent words began to show patterns and regularities within the conversations which were collated and placed into subthemes. Working systematically meant full attention needed to be given to all the data to form the basis of the final themes.

Fundamentally working through to phase 5 the researcher was able to define and name the subthemes and a satisfactory thematic map of the data identified the essence of what each theme described. This helped determine what aspect of the data each theme captured by compiling the sub-themes (essentially themes within themes). This was useful as there were large themes to write the final report, phase 6. Producing the sub-themes and themes visually ascribed discussive consistencies thus tracing them to emergent discussion. For example, every time the students'

practice assessment book was mentioned it was placed this in a '*documentation*' section. Thus, sub-themes and themes were developed which in some part relates to Merriam (1998,p.179) unit of data that any meaningful segment can be *"as small as a word a participant uses to describe a feeling or as large as several pages of field notes describing a particular incident".*

Through the application of highlighting and colour-coding common words and phrases into sub-themes and drawing them together into three main themes allowed for an in-depth examination of context, comments, commonly used language that could relate directly to sections of the transcribed interviews. Essentially enabling the coding of data into "*descriptive segments categorising in a systematic manner to build understanding and offer explanation*" (Yin, 2009,p.128). Although initially my internal debate with themes and categories did begin to lean towards Merriam's (1998) suggestion that subcategories and categories can be commonly constructed through the constant comparative method through sorting out groups of words and phrases.

Assigning the themes can only be established after an initial sub-theme may be considered as "*'distinct' activities and transfers bits of data from one context to another context the original data to another the data assigned to the theme*" (Dey, 1993,p.113). Using Braun and Clarke (2006) thematic analysis can help extract data into an individual coded description that has been identified within and extracted from a data item, featuring in the final analysis. Braun and Clarke's (2006) thematic analysis framework were an ideal method for identifying, analysing, and reporting patterns or themes within the data.

To offer that explanation using Braun and Clarke (2006) enabled the capture of something important about the data in relation to the research question and a *"theme might even be considerable space in some data items, and little or none in others, or*

it might appear in relatively little of the data set" (Braun and Clarke, 2006,p.82). Whilst a researcher's judgment is necessary for deciding on the themes, it is also essential that a researcher recognises their own interpretations of that data.

Sub-themes were re-organised from smaller units of data that were amassed into one of three assigned themes from the transcribed notes. Also, it was easier to collate with the simultaneous and ongoing analysis of the immediate transcribed notes for recall of events that reduced the sheer impact of an overwhelming sense of data. The starting point for extrapolating the data was by highlighting word repetition and key words in context from each separate focus group. For example, the Education Champions and mentors frequently referred to *'time'* and this was identified as a commonly used phrase or word that created a sub-theme specific to their focus group data.

This data was then cross-referenced with the complete transcribed notes that made it easier to create sub-themes and themes. From this data, further de-coding of the data commonalities of the three focus groups, produced eight sub-themes: record keeping, contact, process, professional boundary, role, proprietorship, clinical academe, and clinical proficiency. These represent an amalgamation of the common words and phrases produced from the data. Findings from the coding and theming finally created three main themes: 'Process & Procedure', 'Professional Affiliation & Association' and 'Clinical Aptness' (Table 2).

4.10 Chapter Summary

This chapter detailed the chosen methods of sampling of 3 different nursing groups consisting of academics (EC and PT) and registered mentors across three focus groups. Through semi-structured focus groups, recruitment, purposive sampling and data collection data from a variety of professional, clinical and university documents,

the "*iterative path that the data has produced*" in this study can be its strength and this chapter aimed to rationalize and justify the chosen method of data collection (Hartley, 2004,p.329). The focus groups in the study may have influential benefits for nurse education, policy, and fitness to practice whilst being able to generate rich description and understanding of processes through enquiry.

Through purposive sampling of locally recruited academic and clinical participant s into focus groups, the researcher argues that the choice of participants would provide valuable perspectives in the understanding of fitness to practice responsibility bounded in the partnership. To conduct the study, the rationale for using semi-structured focus group interviews with a generalised academic and clinical population, was the most relevant to facilitate discussion for meaning and understanding with those closely involved with student nurses and of who have association with fitness to practice matters. The focus groups also acted as the means to uncover thoughts and feelings around local and national documentation for FtP used between the partners and their sense of application.

All interviews were conducted in the participant's respective workplaces to put them at ease. Within case study the small collection of focus group conversations is quite typical for inquiry using this approach and my chosen participate numbers consisting of no more than six within each group gained adequate insight.

The framework suggested by Braun and Clarke's (2006) of thematic analysis, was adopted to seek meaning and to understand contextual differences between the HEI and practice: procedural ownership and management of fitness to practice. Data extrapolated from the transcribed notes, by cross matching the narratives to knit key words and phrases into sub-themes, were re-analysed and recoded into three main themes 'Process & Procedure', 'Professional Affiliation & Association' and 'Clinical

Aptness'. As a result, Braun and Clarke's (2006) thematic analysis methodology allowed me to prepare the narratives for rich description in the process of seeking meaning.

Chapter Five – Findings

5.1 Introduction

In the previous chapter a rationale was provided for the use of local and national documentation and focus group interviews with academic and clinical participants. Focus groups have been used by researchers worldwide to explore a range of phenomena for more than 80 years and is an opportunity to study ways in which members of the group collectively make sense of a topic and the purpose is to understand rather than just infer (Doody et al., 2013).

Through purposive sampling of academic and clinical participants, the group interview data collected provided an account of the participants' thoughts and feelings. The voices have been captured through transcription and represented through Braun and Clarkes (2006) thematic analysis. Braun and Clarkes (2006) thematic analysis produced 8 sub-themes and 3 key themes, and these are presented in a narrative format to render an accurate account of the discussions. The narrative provides an account of their beliefs and perceptions of fitness to practice and was chosen as the method of collecting their voices. This is essential to make sense of the data and in the final account the underlying premise was that the data would speak for itself (Wolcott, 1994).

To make meaning of the participant's accounts, an interview guide, prompt sheet and vignette scenarios were used within each of the three focus groups; one focus group consisted of academic Education Champions (EC); one focus group of Personal Tutors (PT); and one focus group of mentors' inclusive of sign-off mentors (M). All the participants' voices are represented. Prior to each '*voice*' is their focus group denomination: **EC**- Education Champion, **PT** - Personal Tutor and **M**- mentor followed by the participants group denomination numerical anonymous code for example **EC1**.

Each key theme is narrated with its respective sub-theme in the following sections which has built a picture of the participant's perceptions. This is organised into three key themes: '*Process & Procedure'*, '*Professional Affiliation & Association'* and '*Clinical Aptness' and* eight sub-themes: record keeping, contact, process; professional boundary, role, and professional charge; clinical academe and clinical proficiency.

This will be depicted in Table 2 (page 243) to illustrate each sub-theme and key from the coded data of the participants.

5.2 Theme 1: Process & Procedure

5.2.1 Introduction

The heading of this theme was developed from the commonly used phrases and words of the participant's sub-texts. These were identified into three sub-themes emerging from the thematic analysis of: '*record keeping', 'contact',* and *'process'.*

This theme is pivotal to the participant's perspectives around documentation, university fitness to practice process and the communication processes between partners, thus the heading is reflective of the context of their beliefs. This theme provides a narrative account of the sub-themes from the participant's story.

5.2.2 Record Keeping

The keeping of records between the academic and clinical setting demonstrated a rather confused but essential element of practice documentation. The PAD was immediately identified as a university document and was viewed as the document to record concerns as well as being a document of angst for time taken for its completion. For detailing and record keeping aspects the relevance for monitoring

and recording fitness to practice progress and evaluation of student achievement issues was significant. The PAD was also seen as a vital tool in maintaining communication between partners.

A variety of partnership perspectives with the mentors commenting that the PAD was a university-based text document that bore no correlation to practice or clinical competency:

> **M***...and the book just doesn't just doesn't meet requirements for me, you know, it doesn't... it has no idea, it just goes to show how much the university doesn't kind of get what's going on in practice. It feels that the book has a gap that there is, it doesn't... What do you think?* …(M1)

This seemed to establish the disconnect between the professional body setting standards, the mentor attempting to address the standards through the PAD. There was a mismatch of what the mentors believe to be a university created document.

The PAD while considered by the mentors as a university 'document' which was wieldy in nature, was seen in a positive light by the personal tutors:

> **PT***…they are fantastic books, but they are very heavy, they're overloaded with information and they don't get any smaller because as new initiatives come on, they don't take things out, we just add them on…*PT1

This was balanced with the PAD's feature of being totally inclusive of all documented information:

> **PT**…*I think one of the concerns is that - this is a very subjective point- is that the practice books that our students have which are realistically their bibles as they go into practice and should contain everything*... (PT2)

The notion that everything about the student and noting of issues within the book received different reviews. Of the contested reviews was of the recording of competencies and character of record keeping with findings suggesting that mentors and academic staff place a lot of procedural emphasis on the PAD. Participants focused on the administrative element rather than the PAD acting as the means of reporting student progress, ability, and character. Documentation within the PAD is meant to be inclusive of all information as suggested by PT2.

This was expressed by the mentors in their beliefs that the formative was a separate (assessment) stage and did not connect it to the summative stage for progress:

> **M**…*we'd of course have the formative assessment, meet initially with them, this is what we expect of you, this is what you expect of us, and then we'd formatively say, well, if we'd noticed at that point, oh, you're not very good at… you don't have particularly good teamwork, this is what I want you to do to try and achieve this… I'm going to help you do this by doing this, and then you come to the summative assessment…then we raise cause for concerns if they're still not pulling their weight, you know, or not doing what we expect them to do*...(M1)

This finding is suggestive of a lack of progress reporting in an action plan format, or learning contract, as a means of the nursing student meeting the expectations of the mentors. The formative assessment process can be a useful action planning approach for student development alongside nursing students who are experiencing practice learning difficulties. The formative assessment (action plan) can identify gaps in knowledge at a relevant mid-point of the placement to help focus the student, and mentor, on the necessary objectives that need to be met. The mentor can provide support, development, and monitor nursing students at this stage. The PAD appeared

to remain a university document that does not wholly connect to the mentors which is evident within the last sentence.

M "*then we raise cause for concerns if they're still not pulling their weight, you know, or not doing what we expect them to do".* M2

This demonstrates immediate referral to the university CfC process and the lack of connection to NMC standards which represents a disconnect (of ownership) for the purpose of record keeping. Essentially, there is a connection demonstrated by the participants of university documentation and its purpose in reporting processes. However, limited university documentation is explicit within the PAD and is not easily accessible to the mentors unless requested, for example, the university FtP policy.

Record keeping is a valuable activity to clearly identify outcomes the student to meet to achieve summative assessment. Summative is the pass/fail element of the learning outcomes, but this comment elicited disconnect namely related to a university document and not one of meeting standards. This suggests that participants do not clearly perceive the natural progression order, from formative action planning as a measure of progress monitoring and achievement, to the summative assessment contained in the PAD's learning outcomes. This is taught however, in the mentorship updates but appeared to remain an issue for the university to manage.

One academic participant concurred that in the mentor updates, monitoring progress between the formative and summative stages, and therefore fulfilling the PAD requirements and professional development, was not seen as key for documenting and noting progress. This is also evident within the participant's conversation when a lack of noting, as an aide memoir for the next mentor, to continue with adequate and

necessary ongoing action planning if required. To enhance certain elements of a student's practice. From the findings, the mentors did not consider this.

> **M**…*I think the first bit would be, I think, you know, the initial formative meeting you have a concern, I probably wouldn't even think about contacting the university at that point. It depends on what the issue is…But, you know, I'd set them targets…giving them constructive criticism…they all want to take on board constructive criticism…so I think for the formative bit I wouldn't even consider, it would be then if they didn't achieve*...(M1)

This mentor's viewpoint is opposite to the previous mentor's understanding and perception of the use PAD, and formative section, with their immediate need to call upon the university to address issues through the university CfC process. M1 seemed happy to continue supporting the student through their responsibility as a mentor and use the PAD accordingly. Also, M1 has shown the adherence to university process and for accurate monitoring.

The timing of and process for '*filling it out'* (completing the PAD) was key for all participants but seemed especially pertinent to the Personal Tutors. They expressed concerns around the timing and completion of the formative and summative assessment. One participant concurred that in the mentor updates, the completing and fulfilling of the formative and summative assessment was key for either documenting and noting progress, or noting a lack of progress, as an aide memoir for the next mentor or for the continual operational review of action plans. Responsibility and ownership appeared to be '*shifting*' to the next mentor from this suggestive comment.

However, the question of influence for the completion of, decision making skills and responsibility within these situations was wholly influenced by the mentors and university processes with one response being elicited that:

> **PT**…*I would try and speak to the mentor and get some indication of why process wasn't followed. If you've got any difficulties don't let it get as far as the summative stage because that means that the students have a right to appeal because you haven't followed process properly*…(PT2)

This is a demonstration of how academics and clinical partners view the need to both complete and adhere to process but only the Personal Tutor's understand university process (appeal) and why this is more important. The mentors and Personal Tutor's did recognise the formative assessment as a distinct indication of the student's progress but not from the same perspective. Not all the mentors considered the formative as another sense of action planning, and therefore more documenting, but the Personal Tutor's viewed this as clear process to possibly avoid appeal, and not just about failure or even recognition that the student maybe dangerous and an omission deficit in practice. This is also suggestive of possibly wishing to avoid, or navigate around, the university regulatory systems which can be relatively time resourceful.

This stage of the assessing process provided opportunity for clinical staff to directly liaise with the student and academic staff if issues are identified. However, as an opportunity to address such concerns the views expressed by the participants demonstrated some degree of insecurity.

> **EC**…*We often say why haven't you followed process and it's pretty clear they [the mentor] are in a difficult situation. We have lots of anecdotal stuff and you just can't do anything with that*…(EC2)

The concern that involvement from the academic staff's point of view was that they really expressed concern with full inclusion of the support process network:

> **PT**…*we much rather be involved earlier to actually iron out difficulties before it gets to that stage*…(PT3)

This finding was key in the support and understanding of a students' workload and life balance recognised by both clinical and academic staff. '*Life events*' can often hinder a student's progress but without knowing the student (this is addressed in more detail within the contact theme) if an Education Champion had dealt with the matter, they may not be aware of the students personal or home circumstances within that situation. Therefore, if an incident occurs and is recorded within the PAD, the focus groups felt that it may not be a true reflection of that student's ability:

> **PT**…*If it a one-off incident, you know, or if it's been going on over a period of time, so you might be able to link that with the students, not only whether they're stressed due to the amount of practical work or theoretical work, but if home life balance is having an effect on that, so everything to do with context is important in this situation*…(PT2)

Another interesting point raised was that whilst all relevant learning contracts are focused on the clinical experience, not all were recorded. Incompletion of record keeping led to a disparity in communication and clinical needs purposes. However, through the interviews it became apparent that not all participants were able to directly review the learning contracts or action plans. Learning contracts and action plans are standard documents within the student's PAD and are useful for the formative process of addressing any outstanding learning goals. However, it transpired that

often any action plans were not attached or appeared to have fallen out. This was considered as poor record keeping by all participants with one participant stating that:

> **PT**…*A concern should be an action plan and be stapled into the assessment book*…(PT3)

Additionally, commenting that:

> **PT**…*cause for concern was written but had never been processed and he added that it's not actually a case for concern but it's a formative type issue*... (PT3)

The Personal Tutor participants indicated agreement to this comment and suggested that often-additional documents or supportive evidence were not attached. More importantly they knew that this was a regular occurrence and were unable to fully address matters with students due to the action plans not being attached. The point of record keeping for formative and summative purposes was felt by the Personal Tutors to be strictly adhered too and this was exampled by the participants that (they) must:

> **PT**…*to advise their students with the university appeal system when process had broken down (from the mentor side). If the formative stage had not been completed and hence issues addressed*…(PT3)

This was coupled with a concern for the difference between learning contracts, action plans in relation to the formative stage of assessment. One participant appeared quite confused as to whose responsibility it was to complete such a plan and raised the concern that her student had an action plan and was a '*problematic student*'.

> **PT**…*My student is quite animated verbally in the classroom and when she's out in practice, would we expect the Personal Tutor to do an*

*action plan, would we expect one of the PEF's to do it or who do we expect to do the action plans for a struggling student...(*PT4)

Misunderstanding concerns were raised regarding recording student performance (*and potentially recording their fitness for practice*) were expressed by the academics that.

PT…*I think there is confusion between learning settings contracts for students, what's that about responsibility it is and what they should be like, there's confusion between learning contracts linked to skills and performance criteria or even if they do*…(PT2)

This raised another concern with the effectiveness of recording directly into the PAD that should an action plan be stapled into the document; the Personal Tutors would examine the issue with the student during the 1:1 session. The timing of and *'end of placement'* review of the PAD felt to the Personal Tutors as a kind of *'mop up'* operation to review the PAD as pass/fail elements for that module.

This led to another aspect expectation around the timing of the review. The Personal Tutors considered their part in the review timing suggesting that their role in this process was:

PT…*if I had seen any documented concerns within (my) students book I would use the 1:1 tutorial session as an ideal opportunity to discuss the matter directly with the student...* (PT2)

Timing and reviewing the PAD was key for these participants with their attention drawn towards the submission date (to record the pass/fail mark). They expressed their concern with the presentation of *'new'* information that may have been included in the document outside of this timed period. One participant commented that:

> **PT**…*I'm sorry to say that I had one cause for concern form submitted to me at the same time as the PAD and I wasn't aware of the cause for concern until that time*... (PT1)

However, they all noted that this tutorial session is timetabled at the end of each module for the pass/fail result and one participant expressed an example of missing a Cause for Concern.

5.2.3 Contact

Contact between partners was key but contacting the relevant person within the university when dealing with fitness to practice processes lacked clarity. Whilst the Education Champions appear to receive most communications from the clinical setting the Personal Tutors were not always contacted.

Even though the details of the Personal Tutors are identified on the front page of the PAD, it soon transpired that not every Personal Tutors' details were accurately recorded. This seemingly simple administrative omission seemed to result in the Personal Tutor being excluded from the communication loop. This may cause potential conflict for ownership as the mentors relied on the Education Champions and their link lecturing team for support rather than contact the Personal Tutors.

Through the narratives, the mode of communication to the university was established in two different areas, firstly the Education Champion contact details (phone and email) were posted across the Trust site and secondly Personal Tutors details were on the PAD front page. However, the use of email was the key mode of contact.

> **PT**... *wasn't that unusual to be contacted via email*…(PT1)

However, should the student or practice area require support or advice from the Personal Tutor if fitness issues arise, the omission of their details becomes significant and undermine the role the tutors' role-plays within the support network. From the mentor's perspective, the point of contact was more focused on the Education Champion and their team. However, without the Personal Tutor details they cannot expect to be contacted and this could either be due to the transparency of the '*role*' the Education Champions were exposed to within the clinical setting with their identified 'academic linkage' to a hospital site or clinical area. This then reduced communications across the Trust to a single point of contact when an issue occurs.

An example of reduced communication was the triggering of a fitness concern, but one of the academic participants seemed unsure of the communication route when and who should be contacted should an issue arise:

> **PT**…*it depends how this cause for concern is triggered and whom it comes to and how it's managed…(*PT3)

It appeared that this participant felt that should a matter arise, not all academics communicated with each other which triggered debate about how Personal Tutors receive information regarding their personal student. There was a sense of disparity extending to in-house communications between faculty staff that may all stem from the Personal Tutors name being missed off the students' front page. This suggests that Education Champions and mentors have access to each other for communication purposes but that the Personal Tutor details in the PAD seems purposeless. Hence a gap has appeared for the Personal Tutor to get involved.

5.2.4 Process

Highlighted in the narratives was a sense of confusion surrounding the procedural management of fitness. It was evident that influences appeared to affect fitness facilitation and management between partners, with academic and clinical staff appearing unable to explicitly differentiate, or correlate, university systems for decision-making purposes. The conceptualised feelings of the institutional bond from the academic or clinical perspective linked to practice, lacked cohesion. Thus, understanding the process had more of a connection to their work-related realm. For the purposes of clarification within this theme, HCA relates to a Health Care Assistant (HCA) who works under the guidance of a qualified nurse and help with the day-to-day care of patients without nursing qualifications.

An example of this was sending students home following a clinical incident:

> **M**…*I think that's so severe (namely the incident may constitute gross misconduct or involve patient safety issues) that I'd probably, if that did happen, I'd send them home*…(M2)

Another mentor commented on a similar situation with the suggestion that.

> **M**…*I've had that situation with two members of staff, so the accused member of staff was actually suspended until... whilst the investigation was carried out, so, you know…I think that shift though I'd send them home*…(M1)

The Education Champions demonstrated unease about decision-making should an event occur and one Education Champion, upon receiving a phone call over the weekend, felt that the removal of a student from placement was an important decision to make. They expressed concern that their level of authority was insufficient as exampled by one participant who stated that:

EC…*the ward wanted to dismiss a student, but I wanted advice from the faculty...* (EC3)

This sense of '*authority*' for student removal with university '*approval*' placed the education champion in a professional predicament thus appearing to enhance their insecurity:

EC…*Oh God I tried to find a manager and couldn't find one, but I did remove the student*…(EC3)

The Education Champion's response to the removal of the student from placement:

EC…*I took the action out of safety for the patient, but the Trust wanted the student removed immediately from the area. We also have a duty of care to the students*…(EC3)

This elicited mutual consent and the conversation that followed was whether they (the Education Champions) could remove a student without asking any permission from someone at the university. They felt their actions were merited to respond swiftly to clinical staff including mentors, students and for patient safety. The university was subsequently informed after the event but comment from the Personal Tutor regarding removal of students from placement was highlighted by:

PT... *It would not be for a minor reason but for a gross incident. Mostly related to unsafe practice... (*PT1)

One rationale offered by the Education Champion regarding the dismissal of a student, unless the matter was considered a gross misconduct issue or threatened patient safety, was given by one participant:

> **EC**…*no guidelines to the removal of students from practice and that we make the decision based on our own judgment*…(EC3)

These terms were intricately linked with the removal of students from the clinical area and investigation with one Education Champion commenting that:

> **EC**…*They may need to be moved from the situation whilst you found out if there was a problem and the Health Care Assistant (HCA) and between both parties, sometimes they may need to go to another placement, you know, whilst that was sorted out*…(EC1)

The narratives are evident of the major concerns related to gross incidents and patient safety compared to any other lower-level matters. This maybe suggestive that removal is only necessary when a major incident occurs and that any other matter can be dealt with within the clinical setting. Importantly it is the decision of the university Vice Chancellor to suspend a student at the request of the DoS. However, this was not at the forefront of knowing for the mentor participants.

The Personal Tutors also exemplified the subject of authority and role. There was an opaque connection to discipline in-so-far that when discussion regarded a student as being deemed as '*unfit'*, or if there was a gross misconduct issue, the Personal Tutors were concerned with which disciplinary process the student would go through:

> **PT**…*I think it would be the University's*…(PT4)

The mentors felt that:

> **M**…*I've not had a failing student, but yeah, I would get in touch with the university for support for me and the student as well, so probably we'd discuss it between us as well*…(M2)

In respect of discipline, both the Personal Tutor and mentor participants seemed to struggle with the concept of responsibility when a student demonstrated gross misconduct concerns.

> **M**…*That's not happened to me with a student nurse, I've had it with a member of staff, and I have sent a member of staff home, so*...(M1)

Also, the difference of opinion for managing difficult situations mentors voiced their support for a student within that kind of difficult situation:

> **M**…*Yeah, I'd probably scream at them to get out…(*M1)

In this instance the mentor advised the researcher that this was a metaphorical example.
Further thoughts, by the mentors were:

> **M**…*I think it would be a good idea to get them [the student] away from a situation (removing the student from the area) ...because you don't know what has precipitated this, whether it's...(*M3)

> **M**…*so, you know, even if they'd done something like that (potentially something considered as dangerous or patient safety is at risk) , you know, they can just get out for the day and I'd probably tell them that I'd ring them and that I'd be in contact with the university and tell them that we'll ring them and say when they can come back*…(M1)

However, all agreed that should such an incident occur the Personal Tutor would not be contacted but the Education Champion would be. What is more suggestive of this commentary is the lack of transparency for the mentors to understand how university systems for disciplinary purposes operate as they simply *'refer'* the matter on. Fundamentally though they do not have ready access to hard copy university documentation and would have to request copies of the relevant information.

Whilst this is understandable for mentors, there does appear to be a gap in the knowledge base of Personal Tutors to the university Secretary & Clerks Office who have overall authority into student suspension. However, the DoS does act as the information conduit for disciplinary processes, but this was not mentioned in the narrative. It is essential though that the Education Champions are aware of the impact of gross misconduct can have on patient, and student, safety and that the appropriate university regulations are applied. These were again not mentioned.

This led the discussion from personal tutors towards the matter of being '*out of the loop'* should a student demonstrate misconduct issues. This only set to enhance their level of disconnect with practice issues and academic processes and discussion within the Personal Tutor participants consistently reverted their understanding of process back to the university's academic regulatory Academic Appeal process. The Personal Tutors felt that students had the right to appeal if they needed to be guided by the Academic Regulations (when investigating a fitness to practice issue):

> **PT**…*There's two differences between investigatory process and disciplinary process, isn't there?* (PT4)

Within all the narratives the Personal Tutors only questioned the topic of the university Academic Appeal regulation process with consistent referral that student disciplinary matters could be subject to the university process but answered with:

PT- *"it's the appeals process".* (PT3).

This constant reference to the university appeal system reflected their perspective to be entangled, and entrenched, with this university regulation. They were unable to differentiate academic appeals from an investigation of fitness to practice matters and

the subsequent disciplinary process. The academic regulations of ARU are subject to the *Academic Registry* department whilst the *Rules, Regulations and Procedures for Students* are subject to the Secretary & Clerk's office, two very separate and distinct departments. However, one Personal Tutor did say:

> **PT**…*In terms of disciplinary processes, that comes after the investigation, doesn't it, and in my eyes, we are responsible for the disciplinary processes of the student*…(PT3)

Similarly, the mentors seemed slightly perplexed by disciplinary processes and investigation responsibilities commenting that:

> **M**…*No, I think it would need to be resolved… in the university*…(M1)

The mentors, however, were not overtly aware of how the appeal process works or indeed its regulatory impact. Furthermore, mentors do not have access to the university regulations or the fitness procedures. They never referred to the actual policy document other than commenting of '*fitness to practice'* as a generic term. This demonstrates connection to the NMC but not for university fitness conduct matters and process. Furthermore, the regulations, whether academic or disciplinary, are not readily available to the Practice Learning Partners, mentors would therefore need to be guided towards them.

There was quite a palpable sense of responsibility when leading an investigation into a student conduct with participants seeming to be apprehensive when discussing whose ultimate responsibility would be to lead the initial investigation for fitness to practice. This comment elicits disconnect of how university system is perceived by the clinical setting and was reiterated by a Personal Tutors comment that:

> **PT**…*I don't think it's about giving them, you know, it's your problem, you deal with it, that not what I'm saying, we have to be part of that, but I think they should take the lead in the investigation and give us the information*…(PT1)

However, another participant who argued that considered dispute for responsibility:

> **PT**…*I think I'd agree with that entirely (*saying it direct to participant *PT3) but I think the Trust, once they've investigated, would then put the action back to the university*…(PT1)

> **PT**…*There's a responsibility on the Trust or independent sector. They have in place a process to investigate that matter. They'll either want our involvement or they don't, but they should, realistically, we should be aware of that, and be supportive of it. In my eyes, we are responsible for the disciplinary processes of the student…(*PT3)

All participants unanimously agreed that the mentor should investigate initially and inform the university of their findings in readiness for the university to continue with the investigation. When asked to elaborate on the responsibility issue, one participant said:

> **PT**…*I have to agree with [participant PT1] as a token but I think there's responsibility on the, let's call it placement, the students there, they are covered by the organisations processes for investigating things and I think, you know, the normal process for investigating that we should be informed and should know what they're doing, that they should follow, probably exactly what PT1 has just said, that, you know, they should follow that process, because, as they will do with one of their members of staff. But I think it should be their responsibility*... (PT3)

> **PT**…*But we take on a responsibility for them and we are held absolutely accountable for them from the university's perspective and from the Trusts perspective*…(PT3)

Another participant's views were:

> **PT**…*the initial investigation has got to be done there and then*… (by practice) (PT1)

For the Education Champions, fact-finding was considered as *"collating evidence from clinical staff for any "fitness to practice matter"* with the group associating fitness to practice with evidence:

> **EC**…*I should imagine that they're a bit woolly, you know, no evidence, no you know, so what can be done to support the student who didn't do this or didn't do that, you know, we'll actually have the education champion in, they work with them for, you know, a whole shift, half a shift*…(EC1)

However, there appeared to be a sense of reticence about asking for the evidence and this alluded to this being sufficient when discussing a difficult student *'with the university'* as all participants nodded on agreement. One Education Champion mentioned that often anecdotal mentor evidence superseded the reporting of incidents and issues with:

> **EC**…*I don't want to cause any trouble, she's a nice girl but rather useless*…(EC4)

However, processes were resolutely clear between partners and that was the university driven CfC response strategy process:

> **EC**…*there's a flowchart, isn't there, in the back of the students' documentation, there's a flowchart about cause for concern*…(EC1)

5.2.5 Process & Procedure summary

The findings identified within this theme have shown that the participant's viewpoints are interwoven with university process and clinical perceptions for the procedure of fitness to practice. Evidence from the focus groups demonstrates that Process & Procedure is confused with perceived processes compared to actual process. For example, completing the CfC response strategy or initiating a fitness to practice investigation such as when a gross misconduct matter occurs. Discussion focused on the sub-themes of record keeping, contact and process did not reflect clarity of processes between partners for fitness to practice and thus role responsibility.

Essentially record keeping and contact was mainly allied to Education Champions and they were contacted first. However, the findings demonstrated that Education Champions felt a great sense of both attachment and burden to record keeping in association to fitness to practice and considered it more as a professional apprehension than a procedural one. Alternatively, the mentors demonstrated complicity with the universities CfC response strategy acknowledging this to the use of the HEI documentation. They did not however appear to fully integrate the CfC response strategy with their own mentoring.

However, the sub-themes have demonstrated the mentor's views for Process & Procedure with importance but expressed thoughts and feelings more associated with managing students in the clinical area. The mentors did not place an overarching emphasis on university process. For example, contact for mentors was important but not in a procedural way, the mentors just wanted to contact someone without any

emphasis, or prejudice, being placed on a specific academic role, but rather on a role that was easily contactable and available from the HEI.

Further participants comments demonstrated that the conduct of university process proved more problematic for academic staff than the mentors. Two distinct perceptions to process were identified between academic and clinical staff: academic appeal and discipline. The Personal Tutor's perceptions focused uppermost on the student being able to *'appeal'* a decision, but the mentors were not concerned with the appeal process at all, rather their focus was on discipline labelled as fitness concerns.

Additionally, the findings produced evidence around the interactions of Personal Tutors and their association to the student journey. It was shown that they have limited perceived attachment to contact and were disconnected from record keeping and process even though they are clearly identified on the PAD. This produced a sense of dis-involvement for Personal Tutors who perceive de-attachment to student matters in practice directly to this process. This also appeared to produce professional and academic disconnect.

For the Education Champions process and procedure was torn between professional commitment as gatekeepers and authority. Their role produced a uniqueness in the academic and clinical relationship, but often left them in a confused state between university process and good professional practice. Credence appeared to be paid to them from the mentors in their preparedness to visit ward areas, receive phone-calls at weekends, which added to their sense of needing to manage the requirements of the clinical setting for student challenges, whilst adhering to university process. They were always attempting to promote professionalism and process but at the expense of their academic role within the academic environment. Therefore, all these

influences have been identified as having an impact on the management of fitness to practice, communication and process between the university and practice.

This section has produced evidence of disconnect between '*higher level'* university documentation and processes and proceedings with the PAD, CfC, and appeal. Each stakeholder distinguishes clearly how they used the documentation in relation to their role but without full understanding to the wider sense of the document's origin and the connection to the sense of ownership. The CfC process does act as the conduit for recording purposes and preparation, should it be required, for FtP and while not known by the participates was further endorsed by the Secretary & Clerk's office as part of the regulatory process.

5.3 Theme 2: Professional Affiliation & Association

5.3.1 Introduction

The pivotal area of this theme was about professional boundary surrounding conflict and insecurity regarding role and responsibility. The participants focused their thoughts and feelings around a sense of professional self that from the academic participant's viewpoint appeared to be in question compared to the mentors' clinical (professional) self-perspective.

Common words and phrases such as '*workload', 'role', 'time'* and '*responsibility'* appear in this theme. These frequently used phrases appeared embedded within the participant's perceptions of their work-related functionality for fitness to practice, professionalism and the working partnership. This reflection of being their association to the profession has been reflected in the heading.

Underlying this theme are three sub-themes concerned with: ‘professional boundary’, ‘role’ and ‘professional charge’. The narratives demonstrated the interlinking connectedness between partners but there was confusion with academic and clinical participant positions in the partnering of student nurses.

5.3.2 Professional Boundary

This sub-theme relates to the findings associated with the participant’s often-difficult ability to distinguish perceived professional boundaries between the academic and clinical setting. The border of their academic involvement as university lecturers seemed to blur with the clinical needs of the hospital. The findings suggest maligned boundary demarcation lines.

One participant demonstrated an example of this.

> **PT**…*responsibility was in that situation* (a serious incident within the clinical setting*) I was being a nurse and not an academic*…(PT2)

This comment infers a reference to the participant’s own nursing background being at the forefront of their mind when managing a student situation. This belief highlighted the difference between the academic and clinical world they attend thus the gatekeeping aspect of student support became clouded within their sense of professional boundary. This demonstrates disconnect between local documentation and national standards of pre-registration nurse education.

In essence, this milieu on the one hand enabled the academics to assist with student matters, but on the other hand was a source of interference and confusion for university process. Failure to disconnect the clinical aspects from the academic one

suggested that the academic staff were unable, or perhaps unwilling, to disassociate with it resulting in a professional, clinical, and academic world conflict.

Other participants did not demonstrate this expression of conflict, but the perception of support was clear across all. The Education Champions perceptions of student and mentor support were viewed as essential, but the Personal Tutors expressed a sense of decohesion. The perceived professional expectations for clinical support when dealing with student matters were undermined by the notion of their lack of position within the working clinical relationship.

This was illustrated by one participant who suggested that their involvement was minimal compared to the Education Champions, by suggesting that they often felt recipients of:

> **PT**… '*second-hand' information*…(PT3)

However, they did recognise their boundary as an academic when dealing with their personal students but seemed uncomfortable with the weakened links to practice and reduced clinical working relationship. This may in some part provide a rationale to their feelings and sense of being '*left out'* of the working relationship with the clinical area and faced exacerbation that:

> **PT** …*we have no Personal Tutor responsibility for them, so the link with the Personal Tutor wouldn't necessarily be the first thing I would think about*…(PT3)

From the narratives, participants considered boundaries, based on their academic position, when dealing with student matters. This boundary issue seemed to be

affirmation of the Personal Tutors' perceptions of partial involvement in the working clinical relationship, expressed by one participant:

> **PT** …*There's another dynamic here which is about the relationship with the Practice Educator Facilitator (PEF), and I think particularity in my area…I have one PEF who's home grown really and spent the majority if her working life in or around this Trust and is very well known…I think the way that a PEF would handle something is not necessarily how we hear either Personal Tutor or Educational Champions might handle it*…(PT2)

Overall, the narrative suggests that participants clearly recognise the clinical partnership and wanted to be a part of it. However, the importance of this relationship depends on the (perceived) boundaries that can affect that working relationship.

This further suggests an important element of focus for the academic role. The Education Champions were able to focus their role on the Trust led PEF role, whilst recognising academic and clinical role boundaries. This recognition of PEF responsibility focused on the responsibility they held for the clinical learning environment and for supporting mentors. One participant however, stated that their PEF worked very closely with the students and mentors in devising action plans, providing support for both and worked closely with the link team and champions. This was exceptional.

Overall, most of the Education Champion participants concurred that their Trust PEF's did not facilitate that method of institutional working but rather focused solely on the mentors but that they would receive communications from the PEF regarding student issues direct to the Education Champions. This suggested that an academic had to work very closely with the clinical area to be kept up to date on their students.

Interestingly, evidence from the participants demonstrated that the boundary issue for all the academic staff was not perceived equally. The Education Champions held a much clearer boundary belief system of their role between the faculty and clinical setting compared to the Personal Tutors. However, clarity of that belief system was only demonstrable when dealing with student matters and was depicted by the Education Champions who continued to display elements of disconnection from their academic ties by swapping them with their clinical and professional background. The Education Champion participants seemed to gravitate towards a clinical point of view but did display awareness of role demarcation. However, this boundary did seem to affect their own work ethical boundary as they were on the periphery of clinical practice but had a close relationship with the hospital staff which could also be a blurring of the boundary.

Another demonstration of this boundary facet was through conversation of membership to the professional code of conduct:

> **EC**…*we are all having to work within a professional code of conduct or being reported to our governing body. But this is a very separate in terms of employer and employee. They don't sit comfortably with each other*…(EC1)

Discussion around the NMC Code of Conduct once again allied the academics to their nursing professional ties as opposed to a professional academic tie.

However, whilst the perceived expectation is for students to adhere to the NMC Code of Conduct for students, they are subject to the university disciplinary procedures. The extra level of responsibility for academic staff confuses its association to the hospital in the management of fitness to practice. But they did reinforce the element of accountability for students with one suggestion that:

> **PT**…*But we are accountable for them from the University's perspective and from the Trust's perspective*... (PT2)

However, full comprehension of the Code of Conduct and university regulations are opaque between the partners and a lack of reference to the specific documents shows a lack of knowledge and understanding between the academic and Practice Learning Partner.

5.3.3 Role

The matter of time management for supporting and mentoring of students produced a valuable insight into the participant's perspectives of support mechanisms in the clinical setting. This was evident from the narratives where a sense of reminisce from the mentors about their own training days and time spent with their own mentors:

> **M**…*Yeah, my mentors didn't have time; they didn't have any time set aside when I was a student*…(M1)

> **M**…*the mentor didn't seem to have time, and again we are...I mean specifically time to do the paperwork*…(M2)

It was found that their historical perspectives of being mentored produced a fair reflection of their ability to mentor students today. The indication from the focus groups that time management was the focus of this historical reflection was supported by comment that:

> ***M****…I wasn't... I would say no, because I don't think they were given time to spend time with us as a student...* (M3)

Time was also connected to role in terms of attending to matters in the clinical placement. Actual face to face time with the clinical staff when dealing with a student

issue was important, but the Education Champions considered this at odds with their academic work hours. They expressed concern that student matters do not fall within the 9-5pm hours of faculty life. This was expressed by one participant who voiced their concern that:

> **EC**…*But because we need to show that we're actually supporting the students and supporting the mentors in practice, if we can't be there then there's the need for us to be there, and for the time constraints*…(EC3)

The point to this conversation was the sense of frustration that the Education Champions felt about being able to go out into practice. The transcriptions produced evidence that when an Education Champion was called into practice by the mentors because a clinical area had asked for assistance, they did not seem concerned at the actual calling out but of the time constraints hindering them going.

A sense of powerlessness and restrictions of office related hours was obstructing attendance to the clinical area, and this appeared to produce a sense of annoyance. The frustration that they could not go out and help their colleagues and students was demonstrated by the Education Champions stating they should see the students at the best available opportunity and not just between the university hours of Monday to Friday office hours. This was voiced by one participant who commented that they (the mentors):

> **EC**…*Wanted the tutors there to actually go into practice, particularly when failing a student, because of staff, staffing issues and time constraints to actually do some teaching like one to one*…(EC2)

Another participant who discussed their visitation timings reinforced attending the clinical areas. This was not an unusual occurrence from the Education Champions who demonstrated going into ward areas outside faculty hours:

> **EC**…*I mean I come in, when someone's on an early shift, I've come in at seven to catch them before I come to work*…(EC3)

Similarly, **EC1** commented that they attend the clinical areas in their own time when there is an exceptional event:

> **EC**…*In my own time and, you know, when there are issues with students working shifts, if they're on a night shift we can't go in and help because technically it's out of hours, you know, but I know some of my team have actually been there on night shift to sort out problems*…(EC1)

Another participant who felt strongly about support measures supported this:

> **EC**…*and myself, if there are clinical issues, I go in at the weekend*…(EC3)

This is significant in what appears to be their sense of urgency to attend and assist with any perceived or actual clinical issues or major concerns. They appear to have clear supportive intentions towards the student and mentor (and for public safety). Therefore, attending to a sizeable issue when a serious incident occurred at unusual times (outside of business hours) was not considered to be of huge concern. Their sense of professional responsibility surpassed their office hour's work ethic, as they were quite adamant about supporting 'outside' of university hours. An example of this was:

> **EC**…*Its Saturday morning but actually there's a problem here that can't wait until Monday, so I've gone in purely out of professional responsibility, obligation, in my own head*…(EC3)

An element of control for the '*instantaneous*' addressing of issues was paramount. Nothing seemed able to wait until Monday during faculty hours. This narrative shows the sense of urgency to both support student and mentors along with a sense of professional earnestness to get out into the clinical area.

The participants were unable to clearly rationalise why they should attend with a sense of immediacy other than:

> **EC**…*felt out of control in situations like this but could only think of their pin numbers when dealing with it*…(EC3)

This perspective seems to demonstrate the academics feeling of being at odds with their sense of attachment to their clinical background. It seemed to clash with their academic world, hence affecting their decision-making. This is illustrated by a comment that:

> **EC**…*I think in those situations as a nurse…as a nurse, you know? Because you just couldn't leave it*…(EC1)

Workload and administration were also another perceived barrier to the support of student matters. This was evidenced for the Education Champions and the mentors who expressed that the time it took to complete 'paperwork' related specifically to their ability to fit it into the day and an example of an issue by one participant:

> **EC**…*I think, I know where, as a sign off mentor you have an hour a week and I find I've got a timetable, I've got to be very strict to say, no,*

> *I'm going off now, because otherwise I think what is going off out there, you don't have time set aside...(*EC2)

It was clear from the narrative that the primary role of the Education Champions is one of supporting the students, but the issue of workload was exampled by one of the Education Champions who commented that the role:

> **EC**…*role was bolted onto their existing academic workload... (*EC2)

Not only did they feel it had been bolted on but that some of the tasks were rather more administrative than academic. One Education Champion felt that:

> **EC**…*the amount of administration, including attendance, presence and note taking at the monthly audit meetings set within the Trust was a high expectation from the university perspective and from the placement provider*…(EC2)

Thereby maintaining a collaborative working partnership and managing the link team was considered as administrative task:

> **EC**…*The role at the moment is a paper pushing exercise. And the role should be the facilitation between the two areas* (clinical and academic) …(EC2)

Other participants agreed and commented that they already have:

> **EC***…full-time jobs and are under time constraints to visit weekly*…(EC4)

The participant's view that they must attend weekly visit to satisfy the ward area seems to be confused with their previous perceptions that they must attend the clinical area because of their accountability. This thereby confuses the academics muddling

their clinical attachment and relationship to the clinical setting to professional obligations. The findings suggest that the academics are clouded in their sense of accountability in relation to their clinical attachment. And one participant spoke an example of this:

> **EC**…*NMC pin numbers so you still have accountability*…(EC3)

5.3.4 Professional Charge

The evidence suggests that the participants place great importance on the maintenance of the clinical working relationship. This importance can be linked to the academic's professional attachment to the clinical setting, but the evidence also suggests a visible division in the management of student matters between partners. This was highlighted when the academic participants attempted to link clinical matters to their (own) clinical credibility.

The issue of clinical credibility appeared to be intertwined in the academics historical nursing past and was coupled with purpose and responsibility. They perceive themselves as nurses foremost, but despite this recognise the mentors' contemporary nursing skills and this was exampled by one academic:

> **EC**…*I think there is a divide in the way we're perceived by practice and I think what would probably help to smooth the waters is if they considered us to be clinically credible. I think there is a perception that we come, we, you know, we come from the university up in there and we say all this, but what do we know... (*EC1)

This was an interesting aspect demonstrating a sense of separateness between the HEI and clinical setting both in terms of credibility (the academics are still registered

nurses) compared to their academic role. However, the academics seem acutely aware of their role within the clinical setting to offer advice to mentors and students, but this perceived lack of clinical credibility led to an element of insecurity for the academic staff. This commentary is suggestive of the Education Champion role which acts as a factor in their powerlessness to manage certain situations directly. They felt that the level of (professional) job responsibility was overwhelmed by their work commitment. It was found that there appeared to be a dichotomy between being an academic in comparison to being able to facilitate clinical judgment and process.

One champion demonstrated this conflict:

> **EC**…*probably wouldn't challenge a mentor's assessment*…(EC4)

However, one Personal Tutor suggested that if a concern had been raised, they:

> **PT**…*Don't know what the learning environment is like* (PT1)

And continued the theme expressing that they would be:

> **PT**…*going with a fact-finding mission, but we're actually also going to check about the safety of that environment*" …(PT1)

Adding that:

> **PT**…*I think for me it depends on how it arrives, if this issue has gone to the link team, then it will probably, and I could be part of that link team, I could be dealing with it with that hat on, if I'm contacted by the mentor, because my names on the front of the PAD as their Personal Tutor, then I, it depends, I could, I may have to approach it with three different hats on*…(PT2)

The '*hat*' wearing remark seemed to provide a clue as to their position and the disparity they felt as academics from being academics as well as nurses. They seem torn between roles and their desire to go out into practice to deal with matters

complicated their work role. What must be considered within this context that the position is not solely about '*hat wearing'* and officiating their role, rather while not being their job, it was seen to be about a sense of responsibility to the needs of the student. The implementation and application of local policy and documentation alongside the NMC guided standards act as the measure of meeting all criteria for success, and safety. So, the connection to the origin of the documents has been lost on the sense of ownership for their application to the student.

This was evidenced through a Personal Tutors association to practice incidents linked directly to their students:

> **PT**…*I'd want to speak with the student to see if that's what happened, or even speak with the patient, you know, sort of go out there as, again, either link, champion or Personal Tutor, to actually try and find out, how did that occur, what context was it in and if it's a genuine conflict or personality clash between HCA and the student*... (PT2)

This was interesting in so far that whilst the Personal Tutors displayed feelings of loss within the managerial process of student matters, they were quite demonstrative in wanting to know what the situation was. The expressed wish to visit the ward was a clear example of the desire to be involved with the managerial process. However, an alternative perception from another tutor showed that they would not visit the ward but would expect to have a direct pastoral talk with the student:

> **PT**…*I think in the first instance the Personal Tutor should be able to have a pastoral talk with them, talking about professional behaviour, the fact that they have joined a profession and that their language that they would use in personal life can't be used. They are representing both the university and the Trust out there in practice…(*PT1)

The position from the mentor's perspective was quite the opposite. They held a sense of assurance with their role and belief in managing the clinical side of the student was quite clear.

> **M**…*I think a lot of, especially in the first year when they first come in... they don't know what they need to do to learn, they're just here and they, you know, they rock up and crack on and sometimes it's the ones that they, you know, they'll answer the bells, they'll do anything, but they don't try and do anything more, they don't recognise their own learning needs*…(M1)

Mentors appear to like students who engage straight away and was equally matched with the mentors suggesting that should anything untoward occur, their thoughts were primarily for the patient and student. This concern was insightful from the narrative of one participant that:

> **M**…*that's our first concern, isn't it? It's also one of the first things I say to the student nurses, they are important to me, I would do my utmost to teach them, but they are not my main priority, the patients will always come first*...(M2)

Possessing the notion that they, the academics, should question mentors was quite evident and intriguing in the narrative. However, one Personal Tutor was perfunctory that the student in vignette 1 required supervision. The tutor recognised the importance of appropriate delegation to clinical tasks and of their status level, but one participant followed the comment about going back to their (the students) Personal Tutor:

> **PT**…*I'd want to separate the two issues because they're quite different. The first one about the observations would be, for me, a reasonable expectation of a student nurse. If the student…why had*

this not been undertaken, that's why I'd want to go to visit and find out …(PT3)

This finding demonstrates the academic's historical link to nursing, but all Personal Tutors appeared comfortable enough to challenge their students if faced with professional concerns. This was corroborated by a comment that:

PT…*asking why the student didn't go and check, especially if there was anything with regards to abnormal vital signs, you know, for this patient, that because we're not given any indication of that we can really can't tell, so you want to go out there and speak with the mentor, speak with the student and maybe even have a three-way meeting*...(PT1)

This appeared to be an exhibition of pastoral and professional care, rather than as an academic issue, tinged with nursing concern. Being unable to disentangle the nursing context when wanting to discuss the student's situation with the mentor was exposed. This was exampled by:

PT…*Definitely a fact find mission. Because from the mentor I would want to know whether the mentor explained the consequences to the student of not undertaking the hourly observations, especially if the patient was poorly enough to have a central line put in, you know*…(PT3)

However, the narrative clearly shows a perceived barrier to visiting the ward to review a student's progress is connected to work constraints. Combine this with the work placed responsibility of the Education Champions being the actual first point of contact when observing difficult matters in practice, this appeared to leave Personal Tutors bereft of responsibility.

Therefore, the evidence from the narratives provides a direct correlation to work placed responsibilities, which do not link with clinical accountability, or responsibility. Within this context Personal Tutors are academic's and provide pastoral care and not the link to clinical practice. The administration of their names on the front page is a misnomer of responsibility. Fundamentally, the university has awarded the Education Champion as the first point of contact between the academic and clinical setting. Therefore, the Personal Tutor may become redundant in their role to the student in the clinical setting. The NMC do not have a written policy of Personal Tutors visiting the clinical area so this is a university assigned role. The NMC do have standards of achievement that mentors must adhere to for assessing and managing nursing students. This demonstrates disconnect.

Furthermore, whilst it could be argued that the Personal Tutors feel a sense of loss at the managerial level of dealing with students directly in the clinical area, they clearly want involvement. Moreover, there was agreement and recognition between the Personal Tutors of their role within student support and that going back to the Education Champion was key. Even though one participant mentioned that they would go back to the Personal Tutor in most cases each of the participants within the group concurred that involving the Education Champion was essentially more important.

Another dichotomy evident through the findings was the expression of reservations by the academics in connection to the university relationship with the sign-off phase process. An element of displeasure was shown regarding the sense of responsibility and professional charge between the clinical and university partnership. The mentors displayed a cohesive and unabashed focus to their sign-off charge exampled by mentors stating that:

> **M**…*The sign off mentor is making a judgment of (*a student's*) competence and their documents (PAD) getting them to reflect back on the 17 dimensions, I think, isn't it, it's only the management competency*…(M1)

The mentors also realized their accountability within that 12-week process:

> **M**…*We are the ones finalising everything had been met and we sign off their declaration of good character alongside a practice sign off, and we have that final decision, we can do that...* (M2)

Further evidence connected their sense of attachment to the profession by suggesting that:

> **M**…*Sign off mentors aren't making competence decisions; they are making decisions on what has gone before, and we are getting conflict at that point if we feel a student hasn't met the criteria...(*M1)

Personal tutors do not view this equally:

> **PT**…*what's the point of competencies and sign off then. They can look at all the formatives and summative sign off at the very end. That's where is falls down, if we have a sign-off mentor refusing to sign that person off because of competency, yet, that's student has passed every module in practice to that point, that's just insane*…(PT3)

Process clearly has order and the issue for the academics was the question of this sequential timing. The review asks for the university to sign off, but the issue is the dichotomy of clinical skills and competencies versus the university signed-off good character for the student. The findings can evidence this dichotomy:

> **PT**…*the sign off is a here and now decision…that's a process. With the student over the period of three years in practice there should be, as my understanding, there is another point for that student to develop*

> *on those after that. If after that time, the sign off mentor won't sign off the student, well, they're different issues to me*... (PT3)

This issue produced a mixture of ownership contention for the sign-off process. This resulted in confusion for the Personal Tutors' professional facets, patient safety, concern for the student and university process. The uneasiness stemmed from the three-year course amalgamating into the finality of a 12-week period.

The NMC produces essential standards for good character but the final sign-off signature is the sole responsibility of the mentor for the practice element of conduct and competence (NMC,2008). This is a key aspect for the Personal Tutors whom despite fully recognising that students must meet the NMC standard and criterion for registration, they expressed that:

> **PT**…*It's about understanding why they aren't signing them off and show that decision is made. Is a safety gap, it is that gatekeeper and somebody has picked up on those issues? Going on in their first year or have they been ignored?* (PT2)

However, another participant disagreed:

> **PT**…*I disagree. The sign off mentor is signing to say that from a student perspective is fit to go onto the register. So that sign off has to trawl through the practice book. The sign off is a bit like an MOT, you're as good as you are on that day, but then after that I'm not responsible*…(PT1)

What followed was debate about responsibility and the frustration that should a student not be signed off the result was a sense of academic powerlessness to intervene. However, this powerlessness was also coupled with the realisation that the students probably should not be signed off. Sign-off is a clear requirement of mentors

through the NMC standards but appears to have been lost in translation for application to their students. The PAD and consequent sign-off is the measure of FtP for the mentors guided through a 'university' document.

A general lack of power consistency produced this dichotomy of power and professional balances. The power balance seemed relatively clear to the mentors, however. They were able to facilitate a student learning with some degree of ease and did not consider any university processes at all that would or could interfere with their student mentoring. Indeed, they were quite focused on their position of mentoring and expectations of students. This was exampled by one mentor who established and clear line of mentorship and understanding of their role and professional standing in relation to the students' year and level abilities was evident:

> **M**…*well, it is, I mean you can teach people sort of strategies for doing it, but unless they can take those on board, unless they're confident enough to do that, and that comes with experience, doesn't it?* (M3)

The mentor was also quite clear about student expectations, however. This was exampled by the feeling that:

> **M**…*student's wanting to do it right, they all want to take on board constructive criticism, some better than others, and it's the way you put it, and they do mostly take it on board and try and improve...(*M2)

This demonstrated expectations from the mentor the student's need to actively participate in the clinical setting whilst understanding the student's level of ability.

However, this was also a point of contention for the academics that expressed some reluctance in the sign-off phase, process, and professional charge. More intriguingly comments from a Personal Tutor that:

> **PT**…*The key roles of being a mentor, aside from a sign off mentor, the key role is to, you know, to guide them in the right direction? Because that's what it means, doesn't it, you know, being a mentor, you're sort of... you're the example that you want them to follow…(PT4)*
>
> ***PT**…And they don't, you know, their skills books however are really quite good…But I don't think their PAD should be all about that*…(PT4)

5.3.5 Professional Affiliation & Association Summary

The three sub-themes discussed within this theme have identified a connection to professional relationships and professional boundaries. The findings have shown that the participant's sense of attachment for the EC and PT to professionalism remains bound to nursing rather than academia. This was evident from the narratives around workload, responsibility, and time.

Time was an important factor for all participants with different viewpoints. The Education Champions felt their practice visitation role was bolted on to their academic life, producing a sense of disconnect to academia through administrative workload. Mentors felt that their allocated 40% mentoring time and responsibility was affected through their beliefs of administration for '*completing*' the PAD but mentoring remained important. The Personal Tutors felt caught between their historical nursing beliefs as opposed to their current academic life and this blighted their connection to students.

This was suggestive that the concept of role whether academic or clinical, has a focus around what needs to be done rather than what is a monitoring, teaching and facilitation process for student learning. Factors such as time interfere with offering a trainee their full attention. This was however, contradicted by the need of the academic participants to get involved, albeit with some degree of antipathy, but needing to make sure the student and mentor were supported in difficult or serious times. I felt this to be an academic issue rather than for the mentors as they were quite happy to call the EC into assist. In essence the mentors can step back, and perhaps review the situation more objectively, or it could be argued that they step back to allow the EC to manage the situation thus avoiding conflict.

This was especially pertinent for the Cause for Concern response strategy as transparency of fitness to practice process was far less obvious for the mentor participants and yet the anecdotal evidence produced for the EC's suggests that some matters were worse in the clinical setting than documented. Moreover, it was quite difficult to finitely establish or separate out the contextual differences between '*professional boundary'* and '*professional charge'*. I kept them within their respective headings, but I do consider them to be juxtaposition within the sub-theme and consequent theme as the data suggests that there was difficulty for the academic participants to position themselves solely within pre-registration nurse education, rather they wanted to have access to their students in the clinical area.

The mentors, however, were far more assured of their position and in summary of this theme, facilitation of the PAD, clinical relationship and university documents were not perceived as a professionally defined requirement but an administrative, university one. For the mentors, there is a clearly defined element to their involvedness, both as clinical mentors and role models, in comparison to the academic's perspectives. Alternatively, academic staff appeared to grapple with the

duality of their academic role against their nursing background. Albeit whether working as a clinician or as a faculty based academic member the perceived role of the nurse was vanguard. Whilst clear ties to the clinical environment were evident this feeling had not been diminished since entering the academic environment.

Whilst the participants understood their role within the teaching, assessing and management of students, there did appear to be a lack of connection to the origin of documentation. Mentors could happily assess students, but the academics seemed only to have '*bit parts'* of the process and once again a lack of transparency affected the sense of responsibility and ownership.

5.4 Theme 3: Clinical Aptness

5.4.1 Introduction

Being competent in the practice setting is the pivotal concept of this theme. Analysis of the narratives produced key words and phrases such as *'clinical ability', 'clinical matters'* and *'credibility'.* The participant's focus was around clinical ability, supervision and credibility interjected with academia.

From this narrative inference to the participant's thoughts and feelings relating to the students' acquisition of clinical skills and supervision produced several sub-themes. However, the overarching story emerging was that of delivery and attainment of clinical skills. The narratives demonstrated disconnect of clinical ability with academia inferring that academics and mentors display attachment and purpose to the facilitation and development of clinical skills from different supervisory angles.

This theme provides an account of the sub-themes identified from participant's story. By illuminating these contextual beliefs this section will reveal that through a

combination of taught skills delivered by each partner, that had a different impact on the notion of competence for all participants.

Two sub-themes were derived from the narratives, the first being '*clinical academe'*. This is the participants' interpretation of the academic approach to skills curriculum and how this methodology of learning is perceived. The second, '*clinical proficiency'* relates to participant's notions of responsibility, supervision, and competence.

5.4.2 Clinical Academe

The teaching and learning of clinical skills encapsulate the shared element of knowledge between the academic environment and clinical area. However, perceptions within the different participants indicated that mentors did not necessarily perceive the acquisition of skills as a shared objective. The mentors would surmise that a student is failing to perform their duties that:

> **M**…*Your students can't take hourly observation's; your students didn't use an aseptic technique when taking out this central line*…(M1)

The Education Champions commented that the student's deficiency for taking blood pressure was a commonly discussed theme within the clinical setting:

> **EC**…*your students go out into practice and do not have the skill to take blood pressure*…(EC4)

The use of the expression '*your student'* by mentors was one of the commonly used phrases by mentors to Education Champions indicating a lack of ownership. Furthermore, this perception was exemplified with comment from the academic focus group that a common behaviour from the mentors when dealing with a *'difficult'* student matter was that the student was *"not 'his or her' student'"* it was the *'Education*

Champion's/universities'. The Education Champions felt this to be a commonplace intimation that the '*university was to blame'.* What is also apparent is the lack of reference to any university documents; Secretary & Clerks Office, university regulations or NMC standards in terms of following process through role responsibility. For example, one of the responsibility perceptions for clinical skill achievement held by an Education Champion was exampled by comment that:

> **EC**…*well I think our students, OK, and therefore the 'our' means that we, we do a bit, they do a bit, but we're not with them in practice, so I do…I think that the responsibility for practice is ultimately theirs*…(EC1)

The Education Champion articulated their perceptions of the mentors' duty of responsibility with a clearly defined certainty that mentors govern, and therefore, have ownership for nursing students' skills:

> **EC**…*Ultimately, it's the practice responsibility for practice*…(EC3)

However, the focus of responsibility from the Education Champions perspective was tangled with a sense of '*apprehensive'* confidence towards the mentors. This perspective was highlighted by one Education Champion that:

> **EC**…*I think it's our responsibility to make sure that practice is suitable for the student, and if I was to see a registered nurse mentor telling a student to go and do hourly observations and they hadn't been done, I might have a chat with the mentor*...(EC1)

The level of confidence awarded to mentor appeared to be an uncomfortable precedence for the delegation of clinical skills, leading to student capability, through the academic's continual desire to check out the practice area. A demonstration of this apprehension was a comment offered by an Education Champion:

> **EC**…*I find most of the time when you go out it is to deal with student issues. I'd love to go and visits and say 'Hi, I'm here' you know, just having a catch up... (*EC4)

This facet of insecurity seemed connected to responsibility and the narrative showed that the procurement of clinical skills was mainly concentrated towards the mentors. This apprehension demonstrated how important the sense of responsibility is perceived from the Education Champions' '*outside*' view of how the working relationship between student and mentor works. This aspect of the relationship is a vital component for the academics in assurance that the students are learning and being taught clinical skills properly. However, as previously mentioned, the Education Champion is a university assigned role (developed locally) and not an NMC requirement therefore may not be expected to have a higher level of engagement.

The mentors however, perceived teaching clinical skills with time management:

> **M**…*I have gathered the students before to come and do drug calculations, I've gathered them to talk about other things…unfortunately with our staffing the way it is, we have a period now between half past one and three o'clock where there's two shifts on duty…even if it's half an hour informal…teach about MRSA (Methicillin-resistant Staphylococcus aureus) care pathways or whatever…because we had good staff* in…(M1)

The mentor's perspective appeared to imply that learning and teaching was directly connected to staffing levels. Alternatively, the viewpoint from academics was their perspective of the inclusivity of skills within the curriculum. It was a positive from the Education Champion's perspective that students are taught clinical skills in the university skills laboratory before placement. The context and timing of teaching of clinical skills posed an issue for the Education Champions with comment that:

> **EC**…*Certain skills run through different modules and they still currently are, as they go out into practice and are in practice when they haven't actually been trained in the skills lab*…(EC1)

Evidence from the data suggested that the teaching of skills in the laboratory was associated with responsibility:

> **EC**…*We've got responsibility to ensure that what they learned in practice we teach skills to the best we can*…(EC1)

This comment insinuates that the academic environment leads to the development of skills for students with academic perception being that the successful achievement of clinical skills (in the university lab) has direct correlation to the course. The student's development of skills was an essential component of curriculum supporting the notion that clinical skills are a fundamental aspect of the curriculum that relates to the notion of the university student rather than as a shared learning objective for the profession.

5.4.3 Clinical Proficiency

Foremost in the participant's views was the achievement of clinical skills connected to competency. However, the mentors held differing views to the academics in so far that they felt clinical skill achievement were tied to the PAD's learning outcomes. This was a directly opposing view to those held by the academics that appeared more concerned with the areas of professionalism and duty of responsibility.

The level of responsibility awarded to students appeared to ebb and flow between participant's viewpoints with the findings suggesting that the timing of and the clinical ability appeared to correlate with the students' placement and year level as an indicator of ability. Student's ability and clinical aptness was considered within this example from one Personal Tutor:

> **PT**…*then I'd want to look at the student's ability to do the observations and link back with what had happened in the skills lab so far up to that point of student training*…(PT4)

> **PT**…*the student must have known she wasn't fulfilling the delegated task and clearly hadn't sought support or guidance back with the mentor to recognise that she was either falling behind*…(PT3)

The mentor's perspective differed slightly in the doing ability of the student and they wished to be assured that students:

> **M**…*what I want to know is the skills…can they bed bath, can they speak to someone's relatives about something difficult…do they understand... the fluid balance ones and things are all good, but there's fluid balance and there's nutrition and then like every other concept of nursing is gone, they don't consider anything else than can they communicate, can they do fluid balance, can they nutrition... infection control*…(M2)

Additionally, mentors seemed concerned with ability linked to year. This was exampled by a comment that:

> **M**…*It doesn't always work because of course some third-year students need an awful lot of input, so sometimes we're kicking ourselves down*…(M1)

Alternatively, they were quite comfortable at placing students from any year:

> **M**…*But either give us first year students or third*…(M1)

Whilst there seemed to be a preference for first and third years the data did suggest that second year students:

> **M**…*and then, you know, the third years are easier for us as well. But second years, they need an awful lot of... but OK, they don't all fit into that slot, do they?* (M2)

There was, however, recognition of the subject of proficiency and the findings displayed feelings and thoughts that a struggling or failing student may be unfit. This was exampled by one academic who stated that.

> **PT**…*And I suppose it's debatable about whether checking that at the end of the shift is good enough for a student or whether she should be checking that during the shift*…(PT2)

Another facet to the level of competency and clinical ability was concerned with management students. The perspectives altered slightly possibly since all the mentors were sign-off mentors. This may have given them differing set of beliefs around third year. For example:

> **M**…*in the last part of their third year I'd be expecting a student to be able to run a bay* (managing patients in a six-bedded ward bay) …(M1)

This expression of competency specifically around third years yielded from the interviews suggesting that the expected levels of competency should easily be demonstrated. For example:

> **M**…*But I would expect them to know everything about those 4 to 6 patients, but not expect them to go and answer the bells elsewhere, you know, they are still, you know, if the bell is ringing and they're able to answer it, they answer it… But they should know everything about those patients, be able to hand them over, be able to participate in the drug round for those patients, be able to prepare them for theatre or whatever's going on with them, that kind of thing*…(M1)

However, discourse from the mentor's narratives suggests that leaving students to manage a bay of patients was fraught with some degree of concern even though this is a requirement of clinical practice within their nursing course. Additionally, the NMC set the required competency levels which are facilitated, and assessed, through the PAD. They are not the requirement of the university and therefore appear lost between the professional body and Practice Learning Partner. The university appeared to get caught in the middle here.

Within the student's management phase at the end of the third year, specific competencies related to the management of four to six patients and management competency is identified within the PAD. However, to complete the competencies mentors expressed a sense of hesitancy in procuring this. They expressed some diffidence around expectations of either their supervisory role or the practice PAD requirements and was exampled as:

> **M**…*Yeah, those, yeah, their final... they've got to manage..." colleague interrupts, "A group of 4 to 6, I'm sure it says". Other colleague, "...a group of 4 to 6 patients it says, so...(*M1) and (M2)

Essentially once the mentors had agreed the requirements of the management phase, they added their own sense of caution:

> **M**…*So, you know, they would only be expected to manage a group of like... we always say 4 to 6, don't we, because that's what's in the university documentation but of course our template isn't that at all, it's more like 15 patients at the moment. So, there might be a jump where, as a student nurse, we'd be expecting them to manage a bay*…(M1)

There seemed an indirect correlation to management through PAD outcomes that did not correlate with the student's actual ability or the mentor's confidence in allowing

the students to manage four to six patients. Furthermore, the PAD could be misconstrued as the representation of clinically task-orientated requirements. This documented evidence could skew the mentor's perspective of nursing student's managing a ward. This may be due to the mentors expressing concern that their expectations for a newly qualified nurse are related to the management phase of a nursing course. For example, one mentors stated that:

> **M**…*I suppose the difference is though, you wouldn't as a new qualified Registered Mentor be expected to run a whole ward, it would just be a bay or two bays hopefully [laughs] it doesn't happen on occasion... and then when they qualify…we try and make sure that they were supported but it does happen, or preceptor, but it does happen that, you know, they have got 15 patients all on their own because of our staffing levels*... (M1)

Hence confidence for the mentors in allowing students to *'run'* wards is professionally self-limiting. This can also be supported by findings from the mentor's perspectives of their past '*mentoring*' experiences when they were nursing students:

> **M**... *because when I trained there was a ward sister and possibly two or three trained nurses and the rest were students, and a third-year student could run the ward, because that's what you had to do to get your... pass your practical but things were quite different then, you know, there was a different level of care*…(M3)

This was a reflective and interesting historical viewpoint reminiscent of their nursing days. This association with the mentor's perspective of expectations of management students was supported in the findings from the mentor's perspective to allow the student to manage a ward. This seemed to skew the mentors' beliefs in leaving students alone on the ward:

> **M…***Not in charge of the ward*… (all mentors nodded in agreement) (M1)

Role expectations were quite clear for the academics in terms of clinical responsibility and a dichotomy in the findings was shown through the academics discussing the matter of incidents. Should an incident occur, or a student show poor clinical judgment, especially during their management placement, most of the Education Champion group would not directly challenge the mentor commenting that:

> **EC**…*Failing a student …almost imperceptible could possibly be subjective*…(EC4)

This was in direct contradiction of the level awarded to the student for sympathy and again demonstrated that mentors probably would not actually be challenged but they '*want to'* in their nursing minds. They even stressed that even if inappropriate supervision had occurred the Education Champion would not particularly question him or her even if their student had "*overstepped the mark".*

This displayed an un-balanced perspective relating to the matter of student conduct. Each focus group viewed conduct similarly, but the Personal Tutors considered that the students are seen in a *"snapshot of time"* and that they would want to know the context of the situation. Likewise, one Education Champion suggested that should a student "*overstep the mark*" this would still be viewed in a (the) snapshot of time:

> **EC**…*Often it's a very reactive thing from students and that's what's been happening, and it does affect the way the student works*…(EC3)

This was followed by another comment from the Personal Tutors that:

> **PT**…*It shouldn't do but it does...* (PT3)

The Personal Tutors felt that within that '*snapshot*' of time they would want to know more and noted that:

> **PT**…*want to separate the two issues because they're quite different. The first one about the observations would, for me, a reasonable expectation of a student nurse. If the student hadn't done them, I'd want to know why. I wouldn't want to approach it with bias as the student would be very frightened to have found out that he or she has taken the central line out unsupervised*…(PT3)

and

> **PT**…*I would say there's a desensitisation really about and a disengagement from mentors because of the resource issues and because they don't have time and it's not a priority, as we spend a lot of time trying to bring the importance back of making sure that they are NMC compliant and that's about…that's not necessarily just about understanding their role, but they actually have to be active participants with the students*… (PT3)

The original comment by personal tutors of wanting to go and visit the ward area that was noted earlier resulted in the majority agreeing that they would not expect to visit the ward area, but they did expect to be informed by the link tutor if there had been a problem with their personal student.

The narrative suggests that the Education Champions would explain to the student that the work allocation of the mentor to student is 40% direct contact so their contact hours can incorporate working with an HCA and other clinical staff. Furthermore, if they changed their off duty without permission, they could lose valuable learning time. An example of this:

> **PT**…*If a student says no to helping the HCA with chores because they want to read the patients notes or do the drug round, the HCA's don't like it*…(PT2)

This was especially pertinent to one Personal tutor who stated that their student didn't like working with HCA's and commented that:

> **PT**…*I'm not going to study a degree at university to wipe backsides*... (PT4)

This elicited a jokey comment from one participant about being 'too posh to wash' regarding nursing students who felt that essential nursing care was the responsibility of health care assistants (Olesen,2004).

Clinical proficiency was also connected to student attitude. An example of this was from the vignette scenario whereby an Education Champion suggested that students could manipulate their shift patterns and would change off duty without permission. Following this point if a student is off-duty and this did become an issue then the ward area would contact the Education Champion with an expectation that they would discuss the matter with the student.

The mentors commented:

> **M**…*the next time I see their mentor or, you know, I haven't seen them in a week, sometimes that does happen, their mentors, that they can change their shifts if necessary, as long as they're spending the majority of the time with their mentors, and that is down to their mentors to, you know, sort out*…(M1)

The mixed reviews and working practices across the hospital sites was disparate for students working with HCA's as a means to settle into the ward area. One participant

suggested that within her Trust area students are encouraged to work with HCA's initially:

> **EC**…*I tell my personal students to work with the HCA's in their first year but there does seem to be a hierarchical barrier when students don't work with them*…(EC3)

This comment was negated against another Education Champion who said:

> **EC**…*HCA's think students are there as a pair of hands and don't seem to understand their supernumerary status*…(EC2)

Mentors are required to supervise students for 40% of their time together but for the remaining 60% this time was interpreted as the need to fulfil the student's clinical experience to other areas with allocations to all multi-disciplinary staff members. These include:

> **EC**…*they get allocated someone else or somewhere else, if they're in their first year, OT [occupational Therapist], physio [physiotherapist], that kind of thing*…(EC2)

Furthermore:

> **EC**…*because first year students are very much better off paired up with the HCA, especially in their first placement…second placement, different matter. But first placement it doesn't matter if they've been an HCA before it's better to just crack on and do that bit in a different environment*…(EC3)

This provided an interesting perspective of the un-mentored time with an expectation that the remaining time be allocated as usefully as possible with all staff, especially HCA's. This perspective appeared to relate to the student being able to learn other valuable skills with

the mentor's consideration towards the students' clinical experience. Fundamentally, the requirements are set by the professional body, not the HEI and therefore should not be questioned in terms of needing to be achieved or completed.

5.4.4 Clinical Aptness Summary

Through the focus groups interviews valuable insights have been gained for ownership perspectives of fitness management. Each partner recognises the importance of clinical proficiency and competency for achievement of learning outcomes but that the association between partners is detached.

This display of detachment was evidenced through the narratives that academics and clinical staff, and factors such as practice skill, proficiencies seem to have a perceived 'miss-placed' foot in each partner's sector. The findings have shown that the attainment of skills from both perspectives is essential but that the delivery and responsibility aspect has become lost in mentoring time and university curriculum. Clinical skills responsibility was connected to written documentation and clinical academe was rooted in curriculum and of skills teaching in the faculty led skills laboratories.

The participants expressed consternation that whilst there was academic provision for taught clinical skills occurring in the skills laboratory, the timing was sometimes at odds with the practice area. The intimation was that taught clinical skills on a modular curriculum did not always match the needs of a clinically focused profession who are immersed in skills daily. It would appear from the findings that there is a sense of disconnect between the two areas of learning with the findings suggesting that responsibility of teaching clinical skills is inequitable.

This disconnect was apparent from the practice area perspective with mentors demonstrating role disassociation to the teaching of clinical skills. They displayed elements of wanting to teach through '*protected*' time that they seemed to feel was not inclusive in their mentorship allocation time. Mentorship allocation time did not appear to be the prime reason for teaching clinical skills and was often characterised by their perception that students were unable to do skills when they arrived on the ward.

Academic staff also perceived that the attainment of clinical skills was through university teaching in the clinical skills lab and expressed the normalization of teaching skills in this manner. However, skill sessions did not always match the expectation, and this was transmitted to the university in a manner that deferred ownership as exampled by the mentor's suggestion of '*your student'*. Similarly, the academics perception resulted in dissociation of the clinical partner's responsibility in skills coaching and the daily delivery of skills in the clinical environment. This produced an element of disconnection between mentor and student.

Another aspect to the element of clinical academe and proficiency relates to the disconnected phenomenon that a specific clinical skill has not been achieved. This became an issue that the university was failing to deliver clinical skills in a timely fashion prior to the students' arrival on placement. The mentors expected the university to ensure clinical skill attainment but the timing of clinical skill delivery, rather than the mode of delivery, had direct association to ownership values. This was evidenced by the theme that '*Clinical Aptness*' did have one clear distinct feature for all participants that for mentor's viewpoint clinical proficiency is associated with the PAD, but academic staff associate proficiency to professionalism.

Therefore, a dichotomy exists evidenced by the findings that both partners wanted assurance of clinical safety but without agreement within their own role as how best to

achieve this. From the mentors' view their perspective to the practicing of skills, and management, has a direct connection and correlation to the students PAD. However, the academics felt that the attainment of clinical skill is the remit of clinical staff, but that their expectations focused on the professional aspect of the student's ability. Furthermore, an internal professional dichotomy between the mentor's desire to '*teach*' compared to professional development of students, education, and the profession per se and also worked as a constraint to the expected 40% mentoring time. As a result, expectations and responsibility are not succinct between partners in terms of responsibility. The PAD is the vehicle for assurance of skill attainment and achievement, but each partner still expected the other to provide the actual teaching and coaching of skills.

The sense of detachment maybe attributed to the role that each local stakeholder applies to their position and related sense of responsibility to the student in connection to their own attachment to their workplace and hence role. Ultimately, competency is very much connected to the mentor through the NMC standards and competency guidelines which are not negotiable for any partner. However, the academic staff appeared to act as the channel for affecting and processing the university needs which affirms the concept of the HEI being the conduit for communication and process.

Furthermore, the use of local and national documentation was segregated from practice and the academic environment. Examples given of the PAD and the mention of appeals clearly demonstrated disconnect between how and why the local and national polices and documents which affect a nursing students' progression and management. This also highlights the partner's disassociation to each other's understanding of documentation and subsequent application within each world. There was a divide of responsibility and ownership using documentation which acted as barrier to factors that exist when there is a fitness to practice issue. Also, here was a lack of transparency between the academic and Practice Learning partner.

5.5 Chapter summary

In this chapter, the applied research questions ask what enables or constrains fitness management was examined through focus group interviews, by exploring vignettes. Using semi-structured interviews consisting of local academic Education Champions, Personal Tutors and local Practice Learning registered nurses as mentors as participants, the findings suggest that several factors affect the tripartite partnership and their perceived responsibilities between stakeholders.

To seek understanding of the participants accounts, the interviews were supported by vignettes to aid discussion within each focus group. The vignettes were based on scenarios experienced by the DoS and examples taken from NMC cases to explore different perceptions to fitness, for example, drink driving.

Braun and Clarke's thematic analysis (2006) was a process of knitting together key words and common phrases from the narratives and the analysis produced three distinct themes 1) Process & Procedure, 2) Professional Affiliation & Association and 3) Clinical Academe (see Table2). The themes captured the focus groups' perceptions associated to responsibility and ownership supported using local and national documentation in the exploration of the tensions and factors between the partnership.

Fundamentally, role and responsibility appeared imbalanced within the university itself and its subsequent use of policy and documentation between the Education Champions, Personal Tutors and Practice Learning area. Critical points producing disconnect around reporting systems, process, and the management of fitness to practice were sectionalised and appeared to be undertaken in silos. One of the fundamental findings was around record-keeping which became a constraint to partnering in relation to PAD requirements. The focus of this to record progress and competency was mostly viewed as a university document and was lost on NMC standards of achievement. This belief may have elicited

from the mentor focus group, the comment '*your student'*, which is suggestive that responsibility and ownership can be delegated easily to the university thus negating decision making requirements and is indicative of not wishing to '*own*' the student. The mentors did not appear to actively conceptualise connection with the NMC standards, and their role in upholding the standards. Furthermore, the PAD appeared to become an administrative task by both the mentors and similarly for the Personal Tutors.

The narratives uncovered key constraints to partnering related to time, workload, role, documentation, record keeping and processes with a key enabler being partnership communication. This was especially evident with the focus group participant's demonstration of professional collaboration and professional-self association to the support and management of students.

The relationship between the academic and Practice Learning Partner was evident and appeared quite strong. Themes from the focus groups were reflective of the academic and practice learning relationship which appeared to have an impact in the support, management and mentoring of students. Clear practice learning relationships had been forged between the Education Champions and mentors with evidence suggesting these participants felt a close connection to each other for support. This close relationship was not mirrored with the Personal Tutors whose link to the practice setting was more tenuous.

This was reflected in the narratives of the academics by expressing a sense of feeling '*left out'* of the communication loop, namely Personal Tutors. Mentors appeared to continue without too much role confusion but relied on the university to complete process for FtP or CfC, via the Education Champions. Alternatively, the narratives revealed responsibility, for some academics, to be a heavy burden on their sense of role and professional self. Academic participants seemed torn between being '*academic*' alongside the duality of being a registered nurse.

The participants' self-reflections, and recount of their own nursing actions, was evident throughout the interviews and became a key theme in the findings of Professional Affiliation & Association to each partner's workplace setting. This demonstrated each focus group's perceptions of the management of students and their role within the practice and academic environment and the pivotal complexities that contextualised the actions pertinent to their own setting, namely the procedural management of fitness.

The focus and emphasis given to role in correlation to time and professionalism was paramount. The participant's focus around the amount of time dedicated to their role had a clear connection to their conceptual beliefs and misunderstanding of their *'job'* whilst being responsible for student learning. Fundamentally, perceptions of responsibility, and therefore ownership, were affected by the participant's position as an academic or registered nurse with each local stakeholder displaying different views of what documentation meant to their role.

Such personal and professional influences have been identified as having an impact on recording the student's ability whilst adhering to and understanding process. However, the findings suggest these are not solely attached to fitness, but participants' perspectives produced an insightful view of their professional '*world'* whilst grappling with their own sense of position within pre-registration education.

However, it seemed the participant's sense of responsibility within process, policy, documentation, and management of fitness was skewed by their beliefs on individual level set within the complexities of university process for clinical assurance, quality of student ability and competency achievement. This sense of responsibility had been diluted to the point where the partners, whilst recognising the need for each other, were unable to clearly establish or define their role within process. Documentation was not cohesively applied between the partners and did not feature greatly within the narratives.

However, each theme has demonstrated application of how documentation, local and national, is perceived between each focus group and their perceptions of usage whether by mention or omission alone. For example, the PAD was a commonly debated subject by all participants but the use of the document itself was considered as a university tool and not a professional, educative standard professional standard setting learning tool.

244beliefs that it was a university document for local application, misappropriated to the national NMC standards to monitor and assess nursing students. Observations from the academic's narratives suggest that critical application of the PAD for each partner is enmeshed in university process. The Education Champion felt they had a responsibility to help complete it, the Personal Tutor needed to '*mark*' it compared to the mentor who had to '*fill it out'* yet no one participant expressed the thought or feeling that they owned it. The greatest finding was the lack of cohesion between the documentation, their roles, and the tripartite partnership. This is examined in greater detail in the synthesis of documentation section.

Table 2 - Braun and Clarkes (2006) Thematic Analysis - Participant Focus Group Theme and Sub-Themes

*This works in conjunction with Table 1 in the background chapter.

Participant Focus Groups- Themes & Sub-Themes					Key Documentation Numbers *
Themes	Sub-Themes	Education Champions	Mentors	Personal Tutors	
1. Process & Procedure	Record Keeping	CfC Response Strategy	Documentation	Practice Assessment Document (Pad)	21, 22, 23, 18, 17, 16,12,11,9,8,7, 6, 1
	Contact	Investigation	Communication	HEI Processes	21, 22, 23, 18,16,13,12,11,9,8
	Process	HEI Processes	Process and Procedure	CfC Response Strategy	21, 22, 23, 19,17,16,15,13,12, 11,8,7,5, 4, 3, 2, 1
		Hat Wearing			16,10,8
		Nurses Role	Mentor Role	Academic Role	16,12,11,10, 6, 4, 3, 1
		Academic Role	Mentoring		18, 17,12, 7, 4
		Clinical Relationships			21, 11,10, 8,7, 6
2. Professional Affiliation & Association	Professional Boundary	Workload	Workload	Professional Boundary	19, 16,15,10,9, 7, 6, 4
	Role	Time	Time		21, 11,10, 3, 2
	Professional Charge	Responsibility			22, 18, 13,12, 11,10, 7
					19, 16
3. Clinical Aptness	Clinical Academe Clinical Proficiency	Professional Charge	Clinical Expectations	Competency	21, 22, 23, 19, 16, 14,13,12,11,10,9, 7, 6,5, 4, 3 ,2

5.6 Synthesis of Participant Focus Groups and Documentation

Braun and Clarks Thematic Analysis represented responsibilities which relate to each stakeholder for their perceptions of local (university) and national documentation (regulatory body). For the partners to establish process, and to facilitate management of practice matters, key aspects to the academic and clinical use of documentation need to be explored. In terms of enabling, the findings yielded a clear demonstration of interconnectedness in communication, but tensions did exist, between usage and understanding of the connection between the stake holders. There appeared a sectionalised approach in-turn creating devolved responsibility with each partner displaying some degree of confusion in his or her exact position in the management of fitness.

University process is connected to the professional nursing regulatory standards, but this was not wholly evident between the professional body and Practice Learning partner. Competency, charge, and responsibility were foremost within their remit for securing patient safety (through completing the PAD) but did not act as co-owners with the university. Fundamentally, the narrative reflected an accurate representation of the participant's connectedness to the nursing profession from whichever side they represented but the connection to academia was more tenuous.

By collating the findings of the focus group participants and reviewing local university and generic professional documentation as part of the multiple sources of documentation used within this case study, the development of an original perspective was tabulated to illustrate responsibility and ownership; Table 3 '*Participant Focus Groups themes and application of National & Government, Regulatory Nursing Body, Local University & Practice Learning partner documentation'* (page 250).

Table 3 represents and identifies local and national documentation, policy, and procedure gaps between the local academic and local Practice Learning partner. Each theme has

demonstrated application of how documentation, local and national, is perceived between each focus group and their perceptions of usage; responsibility and delivery of professional body standards have been separated into the four distinct categories: National & Government, Regulatory Nursing Body, Local University and Local Practice Learning Partner and their application to each focus group.

Whilst the use of local documentation provided the means for communication between the partners, the mode to use it was tinged with confusion in terms of FtP perspectives. There was a clear sense of bonding to each other through the lens of professionalism of being '*nurses'* from the participants, whether academic or clinical, but they became subsumed in silos for role and perceived responsibility. This facilitated discord for ownership. The academics felt like '*nurses first'* and academic *'second'* which may affect how one processes the evidence for potential investigation for the DoS.

This has been explored in-depth in the background chapter, literature review which also conceded that as a case study and through historical and contemporary aspects of pre-registration nurse education which are embedded clinically in-patient care and educationally in higher education. The synthesis of patient safety and education has affected the delivery of curriculum and therefore has led to how the participant's view their world.

The National & Government category applies to the participant's perspectives to the greater mandate of nursing education and standards in general. For example, the themes identify the participant's view of policy with regards to the application of locally used documentation. This is evident mostly with the Education Champions and mentors who use on a regular basis the PAD, FtP, and government driven health care standards. It is visibly notable that Education Champions and Personal Tutors are primarily academics in this category but that mentors hold a duality of patient care (safety) and mentorship of peers.

However, mentors must adhere to NMC teaching and learning standards as part of their professional registration, but they are not subject to act as mediums for university 'process'. Mentors apply the NMC requisites as required to address local directives, but this table and study has demonstrated a sense of disconnection between the categories exists. This could also be argued that the same difference exists for the academics; Education Champions and Personal Tutors in the local category, as they are key stakeholders, and act as mediums of process for the university and professional body, as they need to ensure the placement area meets the student's education needs.

Education, training, conduct, and performance standards are set by the NMC for nurses and midwives in the UK, but they do not.

- **Set curricula**. This is done by the AEIs and practice partners in line with our standards.
- **Do not regulate students**. If there are concerns about a student, this is dealt with by the AEI.
- **Do not assess** the ability of practice settings to support students' learning. This is done by AEIs.

(Nursing Midwifery Council, 2019).

Delivering professional body expectations appeared to be filtered down into role with individual expectations between university process and professional requirements becoming two different methodologies. One methodology was the actual employment of documentation compared to a second methodology of NMC mandates being applied to local authority.

For example, actual employment of the PAD documentation, could be evidenced from the findings that mentors consider the PAD to be a locally produced document. They understood it had to be used as the tool to teach and assess to authenticate student attainment of learning outcomes. Furthermore, through association to the NMC Standards

of Mentorship, the PAD was a key driver for appropriate completion for the Education Champions. The appropriate completion, including CfC would negate an academic appeal. Vice-versa, Personal Tutors saw record keeping, to '*marking*' the PAD to meet the University Awards Board deadline. The mentor straightforwardly met the mentorship requirements, whilst also ensuring patient safety.

The PAD acts as the objective record to verify clinical attainment for the necessary competency skills set. However, it remains an interesting point that whilst they use the PAD as a tool for teaching and assessing students, the document was still referred to as a university one and not as the recording document for a potential registrant.

Not only is mentoring a national NMC requirement to teach and assess within the clinical setting, but mentors were also not associating local to national NMC requirements for record-keeping. This was highlighted by the notion of '*your*' document, referring to the university, which displays a reduced sense of connection to how local '*process*' was applicable to the NMC Standards. There was also mention of *'your'* student which further imposes disconnect. The mentors did recognise however the CfC being a university process. However, the merits of the CfC to monitor and address failings the student maybe experiencing or to provide an action plan to meet those failings, alongside acting as a record of incidents or events within the Practice Learning environment, appeared detached. Mentors are aware that all practice assessments, formative and summative, and the recording of incidents, are their responsibility for national requirement of NMC Standards. However, within the findings, the discharge of responsibility was given to the Education Champion who would essentially manage the CfC process. Local and national Stakeholder Reference Source had been weakened at this point for ownership. Furthermore, whilst FtP is an exceptional matter, a CfC can be the predecessor to identifying greater misconduct issues that may arise and therefore had a significant potential to foresee and act on problems early together within the partnership.

Mentors are key to the clinical proficiency element of a nursing student's knowledge base which is evident within Table 3. Clinical Proficiency has national connection to the mentors, through the NMC, but it has been observed that local policy, the PAD and CfC are not considered in the same context. Academics have no connection to the local or national section for this theme as they are aware of their boundaries between the academic and practice setting. This can be demonstrated as the Education Champion acting as the facilitated academic-clinical link, the Personal Tutor considers the results for the awards board, but clinical practice elements are subject to the Practice Learning Partners. It could be argued that this is their domain but that reference to local policy requires clarity.

The stakeholders should have clear understanding of process between each other, but mentors have already disassociated themselves from the HEI. There is no impact or university obligation upon them to initiate any FtP referral. Recording difficulties of nursing students results in direct referral to the university representative to facilitate misconduct matters. This is the role of the Education Champion.

In this context the university usurps the Practice Learning Partner which produces a gap in ownership between the Practice Learning partner, professional body, and university. This however should not be the case but from the review of documentation, the mentors felt affiliated to the NMC Standards section but did not fully integrate themselves to the partnership in its purest sense. It appeared that they were attached to the university but not correlating local and national as a key stakeholder and thus not enhancing their sense of responsibility. The key academic however, was the Education Champion who is mostly associated to the local category but who also appears to have a dissolved sense of responsibility to delivering NMC Standards. Mentors primarily manage students within the Practice Learning area, but this study has shown that Education Champions are key to the partnership.

Thus, how each focus group has expressed and distinguished how they apply local and national strategy to their role, exposes how far the connection and co-ownership between delivery and perception has diminished. The highlights inequalities between the academic and local Practice Learning partner's application and understanding of documentation thus weakening responsibility.

Clear disassociation between the professional body, university and the mentors own practice learning environment is evident in Table 3 with mentors appearing to separate their own HEI training experience, and relationship, to their professional world. This suggests that as nursing students enter the register, they immediately adopted the professional domain of the NMC, as mandatory, but leave behind their affiliation to the HEI. This affiliation is only reconnected if they embark on the mentorship course delivered by the HEI. Their main single point of contact to the university though is through the academic link but as a sense of responsibility, the mentors have shown to distinguish the use of local and national documentation, policy, and procedure differently to the academics.

Table 3 Participant Focus Groups themes and application of National & Government, Regulatory Nursing Body, Local university & Practice Learning Partner documentation

Participant Focus Groups themes and Government, Regulatory Nursing body and Local university and Practice Learning Partner documentation													
Themes	Sub themes	National & Government			Regulatory Nursing Body - NMC			Local- University			Local- Practice Learning Partner		
		Ed.C	M	PT	Ed.C	M	PT	Ed.C	M	PT	Ed.C	M	PT
Process & Procedure	Record keeping				FtP Curriculum NMC-Standards	FtP Curriculum NMC-Standards	FtP	FtP CfC PAD University guidelines; Rules, regulations & procedures for students	PAD CfC	FtP CfC PAD Academic regulations	Local Policy	Local policy. Disciplinary	
	Contact				Link tutor role	PAD Ed.C		Mentor	Ed.C CfC		Mentor	Education Champion	
	Process				FtP NMC-standards	NMC - Standards	NMC - Standards	FtP CfC Academic Regulations	CfC	Academic Regulations	CfC PAD		
Professional Affiliation & Association	Professional boundary		Mentor ship			Mentorship NMC-standards		CfC FtP Academic regulations					
	Role		Mentor ship		Link tutor	Mentor/teacher /assessor/sign-off		Link tutor					
	Professional charge				Link tutor	Mentorship Teaching & Assessment NMC–Standards		Link tutor	PAD				
Clinical Aptness	Clinical academe		FtP Duty of care			PAD Clinical competence NMC - Standards Mentorship Teaching & assessment				PAD Academic regulations		Disciplinary processes Escalation – DATIX NMC-Standards	
	Clinical proficiency		Patient safety NMC-Standards NICE guidelines CQC			Duty of care Code of Conduct							

Chapter Six - Discussion

6.1 Introduction

From the findings of the three focus groups, commonly spoken words and phrases were coded using Braun and Clarks (2006) thematic analysis, and respectively complied into three main themes; *Process & Procedure; Professional Affiliation & Association and Clinical Aptness* - Table 2.

Further synthesis of these themes identified that there was a connectivity between the academic, professional and Practice Learning Partner world which identified an incoherent use of documentation between the stakeholders. This disjointed approach, related to their role, resulted in disconnect in the application of documentation across the worlds. This culminated in the creation of Table 3 (page 250) the *'Participant Focus Groups themes and application of National & Government, Regulatory Nursing body, Local university & Practice Learning partner documentation'* to represent documents used, associated to each stakeholder's world.

Reality and knowledge of reality according to Berger and Luckmann (1991), has shown that each participant's world has an interconnected sense of existence but also has distinguishing traits of their reality. These reality traits were evidenced within this case study of how local and national documentation is interpreted between the three stakeholders. This interpretation, from the participant's narrative, supports the notion that their beliefs and understanding of their world are connected but that responsibility dissonances are evident. This reality and use of documentation were highlighted through Table 1 (page 23) to highlight the respective policy changes of the time and the following discussion, specific to actual policy implementation, will be discussed in this chapter.

This chapter will discuss how the use of local university and national, regulatory, and governmental documentation has reorganised responsibility and ownership for FtP management between the academic, professional and Practice Learning Partner.

6.2 The Documentation & Communication Ownership Index: University, Practice Learning Partner and Professional Body; Education Champion, Personal Tutors and Mentors.

Representation from the use of documentation, Table 3, tabulates how the three-focus groups, identified, applied, and associated with documentation. Application of local and national documents and polices by the stakeholders within the researchers own university, is key to understanding how and why dissonance in responsibility can be explained.

To build upon the concept of responsibility and ownership, each section demonstrates, from each local stakeholders' perceived sense of responsibility and ownership, connections in the use of documentation and how application influences understanding on process. Therefore, to illustrate and contextualise how the participants as stakeholders, access and associate themselves to process and documentation, a tabular structure 'Documentation & Communication Ownership Index' - Table 4, catalogues documentation to illustrate the connection to role and responsibility in the distribution and relationship of policy, process and communication used between the partnership when managing nursing students.

Management of FtP within pre-registration nurse education within this study has been amalgamation of analysis from Key Documents Table 1; Table 2 Braun and Clarkes thematic analysis and Table 3 to create Table 4 '*The Documentation & Communication Ownership Index'* page 255 with discussion around responsibility and ownership consistent throughout the study with Table 4 a consolidation of the perceptions and actual usage of current documentation by the participants, analysed via local usage by the participants in relation to the worlds and from origination.

The dictionary definition of own, ownership and responsibility were taken from the Oxford English dictionary in its simplest form with greater understanding of responsibility and ownership referred to in chapter 2, represented by The Ownership Matrix (Diagram 2). Therefore, the analysis and application to this study has resulted in Table 4 which provides a picture of how documentation is applied and communicated between the partners in a local and national way.

Each column represents the group using the actual document; Education Champion, Mentor and Personal Tutor compared to the wider association to the professional body, Practice Learning partner and the university and has been coded and assigned a colour for ease of representation.

The blank cells highlight the documentation and communication elements missing within the working partnership and demonstrates how across the worlds, certain aspects are not communicated or shared when used. The table provides detail of how each stakeholder has been assigned use of a document and therefore has been assigned an 'ownership' term in respect of their position to the world of FtP.

An important finding within the table is the discovery of how important the Education Champion is within the partnership. Their role is key to the partnership to assist, support and facilitate mentor, student, and university interconnection between the professional regulatory body and the partnership. Shown in the Education Champion column there appears to be, compared to the mentor, responsibility assigned to them for record keeping, appeal, FtP action planning and referral process on behalf of the university. This is in part due to the processes required by the university when investigating claims of misconduct. The mentor however, appeared to own many of these elements but did not through the focus group findings, appear to consider this to be their responsibility but would refer to the university with reliance on the Education Champion. This was transparent within the mentor

focus group analysis and appears as a dichotomy to the mentor's sense of 'own' through the PAD but not through the FtP section 'Office of Secretary & Clerk'.

The Documentation & Communication Ownership Index:

University, Practice Learning Partner and NMC: Education Champions, Personal Tutors and Mentors

Key:

- Own = O - used with a possessive to emphasis belongs or relates to someone or something to the person mentioned
- Ownership = OS - the act, state or right of possessing something
- Responsibility = R- the state, or fact of having a duty to deal with someone or something or having control over someone.

Documentation Themes	University	Education Champion	Personal Tutor	Practice Learning Partner	Mentor	NMC
Practice Assessment Document						
Learning contract	O			R	O	
Proficiency	O		R	O	O	O
Action plan	O			O	O	
Record keeping	O	R		O	O	
Academic Regulations						
Appeal	O	R	R			
Office of Secretary & Clerk						
Fitness to Practice	O	R		O	O	
Referral process	O	O		OS	OS	
Action	OS	O		R		
Process	OS	O				
NMC						
Standards	O			OS	O	O
Mentor	O			OS	O	O
Sign-off mentor	O			OS	OS	O
Cause for Concern (CfC)						
Action plan		R			O	
Referral process	O	R			O	
Communication						
Contact	OS	O		R	R	
Sub themes						
Completion of skills and attainment	O			O	O	O
Pass/fail			R		O	
Proficiency not attributed to progress	OS			O	O	
Immediate action/gross misconduct	OS			O	O	

Table 4. The Documentation & Communication Ownership Index.

6.3 Education

6.3.1 Academic Environment & Role Dislocation

A study conducted by Rhodes and Jinks (2005) focused on the role of nurse teachers who act as personal tutors. Through purposive sampling of 10 personal tutors in one UK university, Rhodes and Jinks (2005) presented an interesting counter-finding from their original aim of exploring the role personal tutors play for student retention with findings suggestive of conflict for the personal tutor between process and product for specific university deadlines. This has resonance with the current study of academic nurse teacher respondents, albeit Rhodes and Jinks (2005) intended to illuminate the role of personal tutor, the similarity of the duality of academic tutorship and deadlines.

An insight offered by Rhodes and Jinks (2005) into the role of personal tutor as one of a commitment to pastoral care with the word '*support*' used 102 times. They found this indicative of personal tutors (nurse teachers) having a caring background and in keeping with a nurse philosophy. Nurse academics employed to support students clearly has an impact on their sense of '*academia*' when dealing with student matters. Importantly their study indicated, although noted as small-scale, a representation of the example group for pre-registration nurse education tutorship's, but similarities can be drawn. For example, the retrograde perception of nursing (labelled as caring) was evident within my academic participants through role dislocation between the academic environment and the clinical setting. Their nursing backgrounds supplanted their academic role and appeared a pivotal aspect of their academic and tutorship positioning. The context of '*support'* appeared to be supplanted with '*responsibility'* within this study but support perceptions within the respondents of Rhodes and Jinks (2005) study, personal tutors did focus on their (the personal tutors) willingness to offer pastoral care (labelled as support). This encompassed element of care such as dealing with student anxiety, listening, and talking to clinical staff.

This was also evidenced within the '*Professional Affiliation & Association'* theme. This theme related to the academic and mentor's role in fitness to practice management with academics appearing to display complex feelings around professional obligation and duty associated with their nursing background. From the narratives, the academics expressed feelings that they were nurses first and academics second. The commentary evidence suggests that expressions used such as '*torn*' suggested a sense of caught between the academic and clinical side and was one of the factors that disabled the partnering of students.

The academic participants, and especially the Education Champions were concerned for the student and mentors' welfare and of patient safety. This was evidenced through the narrative findings with their willingness, if not apprehension of adding to their perceived workload, to attend the clinical area to assist with the tripartite meetings between student and mentor. They would attend when called upon by the clinical setting and did not appear to question the immediate practice needs of the student and mentor albeit for their own need to ensure support mechanisms were in place. Evidence of this was direct from the academic narratives with key commentary voicing their desire to visit their clinical areas in time of need, to support students and mentors alike.

One of the key phrases expressed by the Education Champions was the explicit mention of multi '*hat wearing'*. Whilst this phrase seemed associated to workload and time factors, when attending the clinical setting they went in with the perception of having their '*nursing*' hat on. The use of this terminology supports the claim of role dislocation mainly for the Education Champions. In the need to visit the clinical setting, the Education Champions perceived themselves as nurses first and academics second. This is suggestive that the close links they maintain with the practice areas keeps their relationship to their mentor counterparts strong.

However, '*hat wearing'* as part of the link lecturer role does not mirror the feelings expressed by the Education Champions in the context suggested by Rhodes and Jinks (2005). The mentor participants within their study commented that "*you're expected to wear more than one hat, you are expected to be this supportive counsellor, but you are also their manager and a disciplinarian…"* (Rhodes and Jinks, 2005,p.394). However, concession can be applied that the academic participants had a caring attitude that was a reminiscent feeling of being a nurse (Rhodes and Jinks, 2005).

The Personal Tutors, however, did appear to feel a sense of disconnect to the Practice Learning area. Whilst this did not constrain the partnering of students, role dislocation for the Personal tutors was evidenced by their need for accurate documentation for the academic recording of student's PAD results. They did display a caring attitude towards students who were struggling, evidenced by the desire to visit students in practice, but felt compelled to review the students' progression through the PAD. Personal Tutors facilitate and collate PAD results for presentation at the awards board for student progression.

For process, the PAD's are formatively reviewed at the inter-semester period and assessed at the summative stage of the semester. According to Watts (2011) personal tutors review the student's portfolio, for the study the PAD, and are key in the professional development of that student nurses' progress. Watts (2011) suggested that personal tutors are a core component of the academics '*moral career'* within UK universities. Personal tutoring places a boundary between the student and the academic but as recognised by Watts (2011) these elements are ill-defined and thus subject to interpretation. Indeed, tutorial support in the UK pre-registration nurse education programmes is not optional, the NMC require the system to be structured and embedded in curriculum (Watts, 2011). Personal tutoring is built into curriculum and detailed as taught sessions within the timetable but not as the philosophy of pre-registration nurse education. The constraints are workload, timetabling and university

academic regulations. Thus, disconnect has been created between university and pre-registration nurse education documentation.

This is a suggestion offered by Watts (2011) that the tutoring system creates confusion since the NMC stipulated the personal tutoring requirements within the course, but this works against the notion of personal tutoring within a HEI. She suggests that pastoral care of the student, the essential role of the personal tutor is in direct conflict with the actual requirements of a nursing student. This dichotomy, as demonstrated within the study, constrains the partnering of students, and has facilitated difficulty with responsibility and ownership. Role dislocation remains evident and was evident within the researcher's case study.

However, the connection between Watts (2011) and the current study can be related to the findings which were suggestive of the PAD documentation being viewed as a means not for personal tutoring, in terms Watt's (2011) findings for monitoring student progress, but for the recording of marks of practice achievement. This would relate more to Rhodes and Jinks (2005) study. Conversely the findings suggest that the sense of tutorship, and thus sense of academia, was stronger than their sense of nursing for participants (Watts, 2011).

Ultimately this is in direct conflict with the Personal Tutor's names being on the front of each students PAD and it could be argued that this is unnecessary unless they are expected to attend the practice area or indeed contribute directly to any fitness to practice matter. At present they do not and this is in direct contravention of Hughes (2004) suggestion that the fundamental academic role of the personal tutor is in developing the students' understanding and perception of clinical practice.

Another conflict disposition for personal tutors was explored by Gidman et al. (2000) who described role conflict as an attempt to align with organisational culture. Providing academic

guidance is part of the role of the personal tutor but is a complex balance of personal tutorship, teaching, research, clinical practice, course management and professional development (Gidman et al., 2000). This was evident with the need for results to be processed as opposed to monitoring a student's progress. Again, the profession remains at a point of disconnect and this finding cements the beliefs that Personal Tutors act as the processors of results but are not part of FtP ownership. This role was bequeathed to the Education Champion and their link lecturing team.

The role of monitoring student progression within the clinical setting was fundamentally obliged to the Education champion. The findings suggest that this was the academic, but also a professional role for collaborating directly with the clinical setting. They had a perceived belief that the role was an addition to their academic responsibilities with the role, and its associated responsibilities, running concurrent to their academic position with the description that it was '*bolted on'*. O'Driscoll et al. (2010) found link lecturers expressed uncertainly about their role in leadership for learning which the researcher deems as evident within the current study. The study conducted by O'Driscoll et al. (2010) was an ethnographic case study consisting of a literature study and consultation with a stakeholder to produce a conceptual framework to shape the data collection. Four case studies in four NHS trusts in England were undertaken with ethnographic fieldwork.

The findings by O'Driscoll et al. (2010) illuminated the clinical link concept by suggesting that the context of learning is spread across several roles thus weakening links between link lecturers and practice. They suggest this weakened link is due to the uncoupling between practice and academia and was as a result of the diminished presence of link lecturers in the clinical areas (O'Driscoll et al., 2010). However, their participants ranged from student nurses to senior trust nurse leadership and management so therefore whilst some comparison can be made to the present study, the lack of purposive sampling has affected the outcomes. It is important however, as resonates with this study, the Education

Champions role was essential in the mediation of student and mentor relationships and is the closest partnership link. This was instrumental in bringing together the academic and clinical side and was in direct comparison to the Personal Tutors who sit on the periphery of process, appearing to watch from the inside out. Lastly. O'Driscoll et al. (2010) do allude to the notion that an '*uncoupling*' of academic links with the clinical setting has created a deficit in leadership of practice learning. This suggests that the two areas are very separate-academic and clinical. Working towards *'coupling'* is therefore needed as offered by O'Driscoll et al. (2010) which again does have strong similarities to the finding of the current study.

This transition of academic to nurse was the critical finding from this theme with a key feature exposing the academic's inability to leave their historical nursing roots behind. However, there is a dichotomy of their role within the processing of results and without the closer communications with the Education Champions, the results may simply become a means of processing rather than as a means of monitoring student's progress, and indeed being documented. This will not enable partnering.

Maybe it is provident to match the Education Champion to the student. Role responsibilities at this conjecture suggest that the Education Champion and their team are more likely have a greater knowledge of the student's ability and progress and record matters compared to the Personal Tutors. This is a fundamental concern that the academic, professional, and clinical setting needs to address.

6.3.2 Competency, Progress & University Documentation

Conveyance of curriculum has been a key factor in the beliefs system between partners. Mentors associated curriculum as competency because that is predominantly what they can view to achieve the NMC's standards of assessment. The NMC standards for

competence identify knowledge, skills and attitudes the student must acquire by the end of the course. This is visually represented within the students PAD. Access to university policy and documentation is more on request via the university staff through the Education Champions rather than the mentors accessing the documentation direct.

The setting of competency-based outcomes legitimised nurse education. Learning contracts endorsed the teacher and student to identify what the student will learn, how it will be achieved and the time span and criteria for measuring it (Hughes, 2004). Even though the origins of the PAD stem from the profession's competency-based agenda to nurse education, outlining competencies were needed for registration but these seem affected by external factors (Kenny, 2004). However strengthening nurse education according to Scott (2008) was an investment, and the trend towards competency standards which must be achieved for practice entry certification, and ongoing registration and was evidence of collaboration between education and service providers can be seen as successful achievement.

The clinical setting remains key to the assessment of student's proficiency, but the mentors did display an element of hesitation about the process and called upon the Education Champions to facilitate student meetings. Education Champions felt they were being called to such meetings on a regular occurrence and for a variety of issues highlighted by the mentor. Whilst this does not constrain the partnering of students, it does wedge open gap in responsibility and ownership when the mentors feel the need to call upon the university to assist on a frequent basis. This added to the mentor's sense of disconnect and ownership of FtP. Local communication was essential but application to consider the NMC standards, and therefore manage the situation, was handed over quite quickly to the HEI.

Evidence of this was the immediate call for assistance by the mentors to the Education Champions when a CfC response strategy form had been completed. Procedurally this was

correct, but the Education Champions did express consternation about attendance for several matters that they felt could have been dealt with by the mentors. However, there was an expectation by clinical staff that the university be in attendance.

The study demonstrated critical findings focusing on university process, procedure and professional charge conveyed through the PAD. While skills attainment and fitness to practice were confused with responsibility. Should a student demonstrate competency related issues, mentors felt compelled to contact the university for assistance and this assistance was predominantly facilitated through the Education Champion.

The study showed that mentors expressed clear thoughts that the university are to be contacted to assist in practice matters thus responsibility appeared to be decentralised to university process rather than as a shared partnership process. Filling out of the formative and summative stages were frequently mediated with the Education Champions and perhaps this serves as a means for the mentors to avoid conflict and thus constrain ownership.

Completing formative and summative results means that all partners needed to follow the university regulations to meet submission deadlines, i.e., at the end of the assessment period. However, the focus for the mentors was not on the need to get the document signed and completed for recording purposes, but to achieve the students' submission date whether pass or fail. There is an obvious disconnect to the timeline of summative assessment with clinical staff having to titrate learning and teaching to the student's timetable of submission deadlines. This is a driver for university process rather than a need to meet the NMC education standards for competency.

Ownership appears to fail through the simple process of reviewing documentation causing disconnect for clinical development and is some part disconnected between education and

service providers as addressed by Scott (2008). Who reflected on the notion of work-based competency with a notion that work-based competencies are designed to strengthen the service link with academia? Whilst Scott's thoughts were within the context of work-based learning, they were not within the context of the current study.

The learning and assessment of students is procured through the PAD and is a dynamic positive means to show that a student is developing knowledge and competence (Hughes, 2004). However, the HEI translates the competencies into the PAD, thereby the procedural element of recording competence has by default been adapted and applied through the curriculum. This worked against the mentor's beliefs of being driven by their professional expectations and rather than fully comprehend the document as an achievement of clinical competence, the result of a pass or fail 'mark' has become encompassed in process. The study shows certain beliefs from the clinical setting that connect the PAD to the university but are not considered as the professional learning document as ascribed by the profession itself.

Competency has been shown to be a key aspect of the mentor's perception within the study, and this element has also been viewed as a key component of clinical proficiency. This belief had more association to the mentors compared to the academics, so the study has shown that competency is related to clinical ability within the clinical setting. This connection between clinical ability and competency created the theme of Clinical Aptness as clinical ability was comparable to achievement of a pass or fail mark for the Personal Tutors (for progression to the university awards board). The Education Champions engage in and have the belief of role duality by being the facilitator of clinical issues, with mentors and students, alongside needing to complete university processes.

The findings suggested an opaqueness of the competency of the student which appears to lack transparency of shared definition for mentors and academics alike. Since inception of

competency led outcomes, the mentor participants appeared convinced that clinical skills identified in the PAD were university-developed outcomes and the clinical motivation to complete them, to assign and assure a student's clinical ability, and achievement of fitness, appeared to be disassociated, rather than linked to the NMC standards. The PAD appeared to dissolve responsibility for the mentors and Personal Tutors.

Alternatively, the mentors maybe exacting university process but competency in terms of achieving learning outcomes remained as a clerical, administrative task, rather than a learning opportunity. Competency therefore does appear to relate to curriculum in the minds of the mentors even though documenting progress is a matter of recording progress and clinical proficiency and attainment for preparedness to the register. There was a disconnect to '*owning'* the PAD which was viewed a bureaucratic task for the awards board rather than as a tool for documenting CfC or incidents for potential fitness to practice matters. Therefore, the PAD seemed to exacerbate each participant's viewpoint of procedure and progress but held different accounts for its use. The focus of documentation may need a full review from the mentor's perspective and their mentorship training.

6.3.3 Academic Award & Appeal

Fundamentally should a student struggle to meet the competency outcomes then under the university academic regulations they may be entitled to a further second attempt at theory and/or practice. For the academic participants, what was crucial was the need for students to meet the regulation deadlines as failure to do so would obstruct student progression. This was especially pertinent for both academic groups, but the significance of meeting university regulations was not as apparent for the mentors.

Progression for the student is often time critical and is a key in the fostering of the academic and clinical partnering of students. The Education Champion acts as the mediator in the

clinical partnership to facilitate student progression should the student not meet the practice requirements and who may require an extended period of clinical practice. Therefore, they play a fundamental role in supporting the academic and clinical partnership where the Personal Tutor does not appear to.

If a student cannot meet the assessment deadline, they can be subjected to the escalation of other more severe progression outcome delays. This has potential consequences for the students' continuation on the course. All results are subject to assessment periods dependent on the HEI's Awards' Board dates and this places pressure on the academics to complete the marking process for all summative assessments. The mentors were not aware of awards board dates or submission deadlines but were guided by their students, when knowing that '*the book had to be completed'*. To award ratified results in readiness for the awards board, the academics understand the academic regulations to give additional support, where required, but where the mentors are not aware of such processes. This demonstrates a lack of shared knowledge between all partners. This disconnects the Practice Learning Partner from the HEI which can be considered as a partnering constraint as students are expected by the mentors to meet the profession's standards and the set competencies but not university deadlines.

6.3.4 Laboratories, Teaching & Clinical Skills

One of the critical findings in the study was the mentor's perception of educators teaching students in the clinical setting. This is similar to Kenny (2004) notion that service providers would like to see nurse educators physically present on the ward teaching skills. The academics on the other hand articulated feelings of a shared responsibility.

The paper produced by Kenny (2004) argues that the political discourse of Higher Education had an ideological preference rather than that of the needs of the NHS. The curriculum of pre-registration nurse education was thus embedded within political discourse

of Higher Education, Project 2000 onwards rather than for the economics of the NHS. Academic staff did not have the same ideals of those of the NHS and thus responsibility and ownership widened. Nurse educators as suggested by Kenny (2004 p 89) were '*unable to be powerful social actors who could advocate for holism in the nurse education curriculum'*. This is suggestive of the conflict academics could face thus affecting their role with a HEI.

Therefore, Kenny (2004) argued that nurse educators cannot afford to be passive deliverers of education and that this must remain active in setting the curriculum. However, to fulfil this integral part of care delivery, educators would need to refresh forgotten practical skills for clinical credibility (Kenny, 2004). However, nurse educators (academics) were no longer expected to work in the clinical setting as responsibility had been assigned to the mentors for teaching including clinical skills and assessing nursing students. Therefore, it could be argued that disconnect occurred at this stage as academics felt clinical responsibility was the remit of the practice setting.

Foremost, service providers would like to see nurse educators present on the wards, but the university is highly unlikely to relinquish them. This transformation of the tutor role means that a sense of clinical connect is lost within nurse education and this in part must influences, and may widen, the stakeholder's sense of responsibility and ownership.

This was highlighted from the findings which emphasized the conceptual belief that the skills lab is a contributory factor constraining fitness to practice ownership. Perceptions that responsibility of skills teaching remains within the academic realm was uncovered through the findings, when participants expressed the notion that it was university responsibility to ensure that students learnt in practice with what was taught in the skills lab. Furthermore, student proficiency focused on the timing of the skill sessions with merits of the simulated

area being appreciated for the provision of a safe environment, the purpose, timing and understanding of simulated learning in the lab has produced another level to HEI ownership.

Simulated learning was an aspect examined by Ricketts (2011) who explored the concept of simulated learning. Seventy-four full text journal articles were selected with six primary studies offering evaluation of current nursing simulation studies identified and the findings demonstrated the purpose of simulation to replicate real life scenarios for students to explore. In conclusion, simulation is an educational tool and opportunity for students to rehearse clinical practice skills. Ricketts (2011) also suggests that this teaching method calls for careful planning and organisation in accordance with the background and expectations of the students, before they start placement.

An alternative viewpoint offered by Berragan (2011,p.661) that "*the 'wholesale' and uncritical adoption of this pedagogical approach may take over from or replace reality*". So much emphasis is placed on the attainment of skills in the simulated arena this this seems to produce disconnect that official and timetabled teaching and learning in an academic setting will meet all clinical expectations before the student starts a placement. This also appoints expectation to '*being able to do'* upon the student's arrival to the ward. If the engagement of learning has been established in the skills lab, participation in the clinical setting should work as the arena to hone those skills and may allow mentors to, gently, disconnect from the initial teaching of the skill. Furthermore, supplanting skills to the lab means that a potential reduction in engagement in practice may occur.

If the belief has been forged that the mentor has a reduced responsibility to teach skills competencies because it has already been taught, the skills lab must be a constraint to ownership. Ricketts (2011) supports this notion in his paper that simulated learning will meet all learners needs and this requires further research to support or disprove this notion. It is essential, as the study has identified learning to be condensed into set times and

compartmentalised into academic and clinical sectors, rather than a fluid process which flows between the two settings.

In order to ensure effective learning, the environment for teaching clinical skills needs to be realistic with effective communication between partners to ensure a smooth transfer and transition of skill proficiency (Houghton et al., 2012). Within the study the transfer and transition of skills was not transparent between the partners. Perceptions from the mentors were suggestive of skills being a university led responsibility, but academic perception was that clinical skill sessions should precipitate the student's clinical experience. Conversely the articulated expectations of academics that skills learnt in practice should be taught in the skills lab were the alternative perspective to the mentor's viewpoint. The mentor's perception was that students should be able to have a certain level of proficiency prior to practice placements and these perceptions suggest that skill practice in the lab can enhance competency but the responsibility, delivery and teaching of clinical skill expectation was indiscernible. This supports the notion of Houghton et al. (2012) that the transferability of skills needs to be consistent between partners (Houghton et al., 2012).

The Education Champions felt that the disjointed continuity for constant observation of student's overall progress was affected by the Personal Tutor's attending their own student sessions and not communicating any issues to the Education Champions. This centred on the clinical skills laboratory and timing of taught clinical skills but no actual case reference to any student was given. However, one participant suggested that mentors noted the ability of the student's clinical skills through '*anecdotal conversations'* only.

However, the narratives explicitly detailed findings from the mentors of their equation to the pedagogy of learning being causally related to staffing levels. For learning to occur, the findings suggested that staffing levels were instrumental in teaching time. Mentors' wish was to have protected time to teach was another caveat to being able to achieve successful

mentoring. If they had full staffing levels, time could then be specifically allocated thereby producing an association of learning to specific times and staffing levels. This depicts a perception that teaching was meant to occur at an identified time-period only rather than as an ongoing process. This perception appeared to devolve the learning of clinical skills to a teaching session rather than be in conjunction with the students learning outcomes identified within the PAD. This seemed to create further disconnect to the NMC requirements working against the notion of student's clinical development through working 40% of their time with their mentor.

If the teaching of skills is limited to percentages and delivery through 'blocked out' time, we need to question how the process of mentoring and supporting students is managed. Learning clinical skills and the profession cannot be dissected into compartments to suit the workplace. Mentors within this study continued to focus on historical aspects of teaching at certain times rather than mentoring students as an ongoing monitoring and developmental process to produce a nurse fit for entry to the register.

This is a constraint to ownership and that the gap was very evident in their long-term view of fitness to practice. The professional body since Project 2000 has set limits to roles but a review is required to re-establish the balance of the needs of the learner compared to the needs of mentor's as this was a prominent hindrance in partnering. Mentors according direct students to care while learning Cassidy (2009,p.43) "*natural and insightful care situations while fostering a partnership model of learning and assessment can strengthen the connections between formal theory underpinning practice and informally acquired clinical knowledge*". Moreover, the Hunter discussed the student's enjoyment associated with the development of practical nursing skills with a theme that for a student a major aim for practice placements is to undertake different skills; "*I got to do loads of things. Loads of drug administration*" (Hunter, 2010,p.34).

On the contrary, the mentors expressed reservations about leaving management students alone with fewer than six patients. Even though they were happy to leave the student with the Health Care Assistant (HCA), discussions elicited from the vignettes were suggestive that it was quite reasonable to leave the students with non- qualified staff. This scenario questions whether workload or the mentors' conceptual beliefs of the academic environment having already taught skills in the lab advocates that supervision can be dissipated. Furthermore, if mentoring is holistic the question of whether 60% unsupervised time can be an enhancement to skill development seems reasonable to consider. The mentors within the study seemed able to detach holism by expressing reservation about students not being able to perform their clinical duties such as taking blood pressure, a first-year skill to the removal of central lines, often seen to be a qualified nurse's role only. But how often the student is likely to see such a technical skill as removal of central lines is debatable.

Certainly if a central line requires removal the HCA would not be expected to perform this, conversely blood pressure is a key first year skill quite easily taught in the lab, thus creating a relatively easy transferable clinical skill to the clinical setting (Bland et al., 2011). Bland et al. (2011) suggest that blood pressure measurement is considered an essential skill for student nurses to achieve prior to commencing the second year of their pre-registration course (Bland et al., 2011). Other skills may not be quite so easily transferable.

Mentors are key to providing validity to the proficiency of clinical skills, but the study has identified from the mentor's perspective that their focus on clinical ability is tinged with devolved responsibility. They seemed to lack full ownership of the important part they undertake in the instrumentation of being the clinical vehicle to facilitate a student journey towards registered status. This is disconnecting the mentors from their responsibility as to gatekeepers to the profession.

The mentor's belief system appeared to focus on skills being an integral aspect of university teaching via the written learning outcomes and competencies identified in the PAD, but their position is signatory of proficiency. Responsibility seemed to be detached from the mentor's perceptions and while the PAD represented skill attainment their sense of responsibility did not have a clearly defined demarcation line. The mentors kept to the practice of completing the PAD or using the CfC response strategy, if competency issues were raised, thereby requiring intervention from the university. They seemed to display disconnect in imparting valued clinical knowledge, and judgment, to their future peers thus creating a fissure in ownership.

Furthermore, the Personal Tutors supported this claim with their evidence that often the PAD was incomplete or if a CfC response strategy form had been completed, it had often not been reviewed by academic staff namely by the Education Champions. Furthermore, the completing of and mediation of the CfC response strategy was illustrated by the Education Champions that they would receive anecdotal evidence of a struggling student and yet when the PAD was reviewed, no evidence was produced or documented of such matters. Ownership at this point becomes confused, in an un-reviewed PAD and the opportunity for student development, record keeping and instructions between partners is lost.

Pre-registration nurse education remains constant within those worlds, but it appears that the stagnation of ownership since HEI involvement between the academic and clinical setting for fitness to practice is unmoving and unidirectional. The partnering of students and significance of the evolutionary shift for the clinical and academic relationship has affected ownership stakes.

6.4 Clinical Practice

6.4.1 Mentoring for Record Keeping ~ A Misnomer?

Competencies determine that the standards of proficiency have been met for entry onto the register (Nursing & Midwifery Council, 2008). However, the study has shown that for the purposes of fitness to practice monitoring, role responsibilities lacked transparency both academically and clinically between the partners.

Scott (2008) associates work-based competency to service delivery, and therefore professional development, which provides a similarity to the ownership aspect of the study. However, whilst learning is in a practice-based profession, this has difficulties for ownership due to the university leading process through its educational programmes and procedures.

This presented a challenge for practice as the need to monitor and assess competency has been confused with the mentor's perspectives around the attainment of skills and the process of record keeping through the PAD. Recording PAD outcomes appeared to bear no connection or transparency to fitness to practice between partners as alongside the perception of completing the PAD as an administrative task. This aspect was key for ownership as each participant group viewed recording as different elements of a student's progression rather than as a vital record of a student progress for fitness to practice.

However, the study has shown that monitoring is associated with time management, workload and the 40% required mentorship time. Whilst each clinical component of the module system has specific outcomes, mentors only view learning and competence at that point in time and this was exampled by the mentor's hesitancy about management students. Through the mentors' narratives it was evident that the competency of students in the management phase could not (in their view) be trusted. This was attributed to the time mentors had spent with the students but having to *'trust'* they were capable. Therefore, mentors have in some respects to assume that a student is capable at points in their training

that is an ownership anomaly because students have achieved the competencies to reach that stage. There was an element of distrust however from the mentors' narrative as suggested previously.

This may in part be ascribed to the modularised snapshot of a student's proficiency. Accurate record keeping of attained skills is a necessary professional reliance on previous mentors to provide accurate information in the PAD. However, from the findings of anecdotal conversations between Education Champions and mentors, this is not professionally assured. Thus, the PAD has become a compartmentalised process of recording progress in a secular state and this singularity of process has altered how mentors view record keeping.

Fundamentally meeting the needs of the university appeared to usurp the clinical arena. The PAD appeared to be central to being university '*process*' and was a university document. The mentor's perceptions focused on this rather than the PAD being reviewed as an essential part of record keeping for competency. Mentors can only assume a students' proficiency through the PAD and, in some respect, to make a professional assumption that a student is capable at this point to enter the register. However, from the findings, this does not appear to be a transparent, assimilated document connected directly to the professional body standards. The PAD does not seem to be a document that the mentor can consider to be used as a holistic progression indicator nor is it considered as a key document to record such findings. The PAD is a clear indicator of achievement as a document to monitor progress in an evaluative manner.

The study has shown that the PAD was viewed as a process for completion, and a means for getting it filled in for the student, but this seemed more as a side-line for student evaluation progression, rather than for university process of recording the pass or fail mark. Furthermore, for the academics completing the PAD was paramount and the association

as a fact-finding documentation key, they needed an audit trail of documentation to address and adhere to university policy, mentors did not appear to understand this. Mentors were more obligated to complete the book therefore managing student's competency skills through learning outcomes produced a teaching *'at'* rather than as a holistic *'learning'* approach. Whilst there did seem to be a connection of clinical competency to the learning outcomes the monitoring and progressive state of the student was not seen as a holistic process for FtP. Helminen et al. (2016,p.308) concluded in their study that the purpose of assessment is to "*describe student nurses' ability to perform the required skills based on the job description, that is 'fitness to practice'*".

Reporting of failed learning outcomes that may be considered as competency issues were not considered as a need to ask for university support. Process through the PAD and the expectation that the Education Champion would attend the practice setting did appear to suffice the mentor's need to discuss a student's behaviour. However, Personal Tutors were never invited or ever expected to visit, and mentors could neither facilitate misconduct processes or disciplinary matters and this was evident from the findings.

Whilst there did appear to be consistent communications between the partners, the CfC response strategy did seem to be a transparent and clearly identified process for all, but responsibility was devolved purely to the academic environment. The CfC response strategy form is completed by mentors but processed by the university. Immediate disengagement of disciplinary process was executed from this moment. The mentors do not need to do any more than complete the form as they held no power over process other than orchestrate a meeting with the Education Champion and student to discuss the CfC. Furthermore, any meeting that may require the student's union, an independent service of any university student, is hindered by their inability to attend meetings off campus grounds.

There was evidence that having the CfC response strategy form included in the PAD provided accessibility to sharing concerns with the university but whilst considered useful as an enhancement of attaining clinical competency, this accessibility also affected the mentor's opportunity to invite and '*expect*' the Education Champion to attend. This reinforced the notion of trying to keep the '*clinical setting happy'*. This is not too dissimilar from Huybrecht et al. (2011) study of mentoring and their findings of the value academic support provides to clinical practice

A questionnaire supported by semi-structured interviews was used to investigate perceived characteristics of mentorship with a response rate of 112/181 (62%) from mentors (Huybrecht et al., 2011). As a Dutch study this has comparable findings, although more associated to their research topic of mentoring, their findings suggested that the '*link lecturer'* could be a source of support. However, upon further examination of their research they referred to the link lecturer as the personal tutor but in the present study, it is the Education Champion and their team. They found that with the assistance of a link lecturer if problems had occurred, they were invaluable especially with written evaluations (Huybrecht et al., 2011). Moreover, as Huybrecht et al. (2011) state appropriate conflict resolving support must be offered, preferably by the link. This places emphasis on the academic side to resolve matters allowing the clinical side to step back and away from direct resolution which has similar issues as explored by Huybrecht et al. (2011) study therefore having relevance within my discussion.

Their study also aimed to examine the mentor's perspective of documenting the student's progress for record keeping purposes with the suggestion that writing PAD reports were considered as time consuming for the participants (Huybrecht et al., 2011). Furthermore, time to provide feedback to students was lacking in almost half of the mentors (Huybrecht et al., 2011b). Time was an important factor in the mentor participants of the current study and the sub-themes demonstrate that the student's PAD provided the essential link to the

partners. This documentation linkage was evident throughout the interviews demonstrated through the academic and clinical staffs' interpretation and beliefs of the purpose of the practice book in its record keeping capacity. These record-keeping details included key aspects such as action planning, formative and summative assessments.

However, completing, detailing, and reviewing the document to assess for fitness to practice hosted three sub-themes; record keeping, contact and procedural management (Huybrecht et al., 2011). All sub-themes were entwined within the student practice assessment book and are the established link between the partnerships. This was one of the themes that can span across two components in the ownership model of professionalism debated later in this chapter. This highlights the criticality of time for a mentor's workload to be reduced to a level that allows appropriate feedback to students. Whilst the PAD connected the academic (Education Champion) and Practice Learning Partner together, it also created an ownership wedge in terms of handing over marrying local and national aspects of documentation.

6.4.2 The Equality of Role Modelling

Whilst HEI's provide preparatory programmes the clinical area is required to demonstrate procedures which ensure students are of good health and character (Tee and Jowett, 2008). For mentors, clinical proficiency was an element of professionalism, but the academics appeared more concerned with professionalism being demonstrated in attitude and manner and conduct.

Pre-registration nurse education still holds the belief that role modelling is associated with skills development and clinical competence. Felstead (2013) questions whether role models establish the accepted norm of nursing or adoption of the professional qualities associated with professional socialisation with defined values, attitudes, and knowledge.

The study findings demonstrate a dichotomy of beliefs toward clinical skill attainment, proficiency, role modelling and professionalism between partners. The beliefs of the mentors internalised the concept of role modelling as a component of their mentoring, but the academics focused role modelling on professionalism. This was suggestive of a displaced sense of responsibility or misplaced cohesive partnering.

The notion of role modelling and mentorship was apparent from the perspective of the clinical staff, but the concept of professionalism and modelling from the academic participants exposed elements of partial disassociation and disconnectedness. The academic staff displayed elements of '*role confusion'* when considering students clinical placement experiences and practice matters compared to the clinical staff by explaining throughout that they '*wanted to go into practice'* to aid the student and support mentors. The mentors however were keen to be role models in a clinical sense. However, the clinical staff that felt that they only needed to call in the university '*when necessary'* which demonstrated the opposition view of not requiring academic staff to visit practice. More importantly, as Peters et al. (2013) suggests clinical experience has been cited as shaping students attitude to learning, clinical practice and professional development.

Fundamentally, whilst responsibility for the attainment of clinical skills was clearly important to the mentors, working with the HCA to gain knowledge of essential nursing skills was ward '*routine*'. This was deemed as valuable experience for students to gain clinical skills. Written as a paper following a preparation day for HCA's in supporting student nurses, Wright (2006) considered that HCA's have a close working relationship with the students albeit not in an assessing capacity. Wright (2006) evaluated an HCA study-day which was set up to develop their understanding of the needs of students in placement and one key realisation of the HCA's was that support from the university is available. This was endorsed by a comment from one HCA that "*I have learnt who to contact in case we need to*…" (Wright, 2006, p.35). This is an interesting finding that HCA's understood the system of

clinical placements which created a sense of awareness of how they *'fitted'* into the students' course, but they were made aware of who to contact from the university. The paper however does not detail whether an HCA would contact the university, but they (the HCA's) found it beneficial to know.

This still does not address the fundamental aspect that the HCAs are there to provide a different style of learning in the pedagogy of care compared to a registered person. Whilst HCA's provide clinical skills as care givers, and thus may be merited to teach skills to students, students are subject to a more complex demand of professionalism. Wright (2006) is correct in her beliefs that HCA's play an important part in the student's lives, however, professional clinical skill development could be at risk with the over reliance of HCA's to support students in the clinical setting. The HCA vignette was key to explore thoughts and feelings from the mentor's perspective as to the merits of their use with students as a learning experience. They could use HCA's as the alternative to not have '*enough time'* to spend with students. Wright's (2006) study acknowledged that students are often unhappy to receive supervision from the HCA. This is an anomaly within the profession and the issue of working directly with your mentor within the UK system appears to affect the student experience according to O'Driscoll et al. (2010).

O'Driscoll et al. (2010) identified the issue of mentoring and student satisfaction by examining altered affects the ward sister's role played for supporting student nurses in the 1990's. According to O'Driscoll et al. (2010) prior to changes in the changes in the 1990's, ward sisters played a pivotal role in facilitating student nurses learning. However, the subsequent shift of workload, curriculum design and fitness to practice commission reports. O'Driscoll's et al. (2010) findings suggested that 56% of students agreed that mentors taught regularly seemed low considering mentors were with the students daily. In their study, it was not the effect of the ward sister's role that shaped the experience, it was simply time spent with a mentor regardless of position.

This may be considered as one of the constraints to ownership. The use of HCA's within the teaching and learning responsibilities of a student's journey, may only set to confuse matters. Developing proficiency through the medium of unqualified staff has similarities to the findings of Swain et al. (2003). Student nurses were surveyed for moving and handling practices and according to Swain et al. (2003) the experience of training students in manual handling suggested that they did not practice the techniques they had been taught, when in the clinical setting. Therefore, if students are denied access to such learning of skills, proficiency may not be fully facilitated.

6.5 Professionalism

6.5.1 Workload & Time

Workload and time management was central to all participants. Three aspects of teaching, protected time and role were merged within this theme. Through the academic narratives, the need to visit ward areas regularly was key especially with Education Champions but less so for the Personal Tutors, though if they had time they would visit if a student needed them. However, the Education Champions had full access to students, mentors, and Trust sites with the focus on the importance of integrating their academic tasks with supporting the clinical setting.

There was evidence from the mentor's narrative that teaching skills was not an addendum to the clinical mentorship role but that it required protected time to facilitate. From the findings, teaching was meant to occur at an identified time-period rather than as an ongoing process. This perception appeared to devolve the learning of clinical skills to a teaching session rather than be in conjunction with the students learning outcomes identified within the PAD. This seemed to create disconnect to the NMC requirements.

Teaching skills appear to have been reduced to achieving clinical skills within that moment of mentoring time with a student. Furthermore, the pedagogy of learning causally related to

staffing levels was also the perception that skills are not equated to progression. For learning to occur the findings suggested that staffing levels were instrumental in teaching time. If they had full staffing levels, time could then be specifically allocated thereby producing an association of learning to specific times and staffing levels. Thus, protected time with sufficient staffing levels was another ownership caveat. Furthermore, perceived time constraints equated with allowances needed for the teaching and assessing required to meet the standards for entry to the register. NMC documentation and application to the greater profession was lost in local time management issues.

One other caveat to ownership was the participant's beliefs and expectations accentuated by the teaching of clinical skills from a simulated arena as a constraint. This was elicited from the mentors' narrative that when students' go into practice, they do not have the skill to take blood pressure when they arrive on the ward. Furthermore, the academics emphasised skills to process and record keeping whilst the mentors attached skill attainment to signatures and protected time. In conclusion, this study has demonstrated that time-specific notions suggesting that all delivery, teaching, and timing of skills add to the constraint of partnering and the management of fitness to practice.

Time management, protected time for teaching and learning and the document being a '*university*' document hindered the connection to ownership with these considerations appearing to decrease the PAD's importance to be an established and valued document for assuring professionalism. This produces a sense of disconnect as the mentors expressed several challenges to completing the book and it appeared to be viewed as an administrative task associated mostly to time issues. Mentors expressed the need to want to teach but seemed compelled to cite issues with time management as a means preventing accomplishment.

Alternatively, teaching clinical skills in the lab appeared to create confusion for mentors between their expectations of the student's ability in the practice setting and their own sense of responsibility for imparting practice-based skills. The findings emphasised the conceptual belief that the skills lab is a contributory factor that constrains ownership.

6.5.2 The Difference Between Partnership & Ownership

Another facet to the sense of disconnectedness was the participants' beliefs around professionalism within nurse education. The academic's viewpoint appeared to focus on the dissemination of knowledge and the development of professional values whilst the mentors focused on the attainment of clinical skills, this is more likely to be in relation to a professional's role, it has to be of value to the organisation (Andrew et al., 2008). This sense of value should be demonstrated by the academic and clinical setting equally.

This illustrates opinion that theory taught in the HEI emphasises professionalism as opposed to skills competence of the practice arena (Felstead, 2013). Felstead (2013) debated within her article on role modelling within pre-registration nurse education, that literature of role modelling focuses on the belief that students must learn professionalism from mentors set in the practice setting and she argues that this occurs when students work in practice (Felstead, 2013). The student nurse begins to identify with their practice colleagues, mentors, thus a slight decrease in seeing the academics as role models. What may be offered here is that the students only need the personal tutor to sign off the book, yet the Education Champion remains a key collaborator with practice for both student and mentor. The current study has shown that personal tutors do have expectations which corroborates Felstead (2013), that personal tutors set expectations of work patterns and behaviours. This will potentially influence the dependence of the student's professionalism, but that they (personal tutors) found it hard to teach professional behaviours compared to actual behaviours in the clinical setting.

The notion of the complex duality of delivery between partners, and that professionalism cannot be learnt in the one environment alone was discovered in this study and Felstead (2013) does provide food for thought and connects to the present study. Furthermore, as Felstead (2013) suggests for students to learn nursing both partners are responsible for half of the student education and development as professionals. Therefore, relevancy is applicable between Felstead (2013) study and the current study.

Learning however, has been considered in several pedagogical manners and in several different communities. If, as argued by Andrew et al. (2008), individuals wish to develop a professional identity through the workplace and fit in with their peers. Swain et al. (2003) is clearly demonstrative of this, their study surveyed 148 student nurses on an adult branch UK programme. Questionnaires were specifically designed to assess the students' knowledge of recommended techniques for manual handling through diagrams of five techniques. Through self-reporting of the questionnaires, a mismatch was found between their knowledge and their reported practice. They remembered learning correct techniques through simulation but the power of auxiliaries, powerlessness and saying no diplomatically (*amongst other factors*) impeded their ability to complete manual handling tasks safely. Swain et al. (2003) did offer recommendations from their findings but overall, susceptibility to follow others had a greater tendency.

However, if the desire is to learn arising from the individual's motivation continues to develop as the result of ongoing work centred engagement, and collaboration, the profession still remains confused in its state of ownership (Tee and Jowett, 2008). I think this comment is key. If professionalism is about being in a partnership and belonging is part of that ownership, then as a profession working in a team is provident. This providence has already been addressed by The NMC Code "*to work collaboratively*" (Nursing & Midwifery Council, 2015,p.8). Therefore, it seems that responsibility belongs to the clinical area to

identify students unfit to practice and for the academic environment to work with practice to action it.

Principally, with studentship came university status and one clear example from the findings focused on academic appeals with the Personal Tutors showing more concern with this process than the Education Champions. They were better able to identify issues for an academic appeal compared to the Education Champions even though the Education Champions have the same access to the academic regulations. The Education Champions seemed more integrated with practice support and not around regulations. Through the narratives, it became clear that regulations played a key role in decision-making. It seemed that one partner may blamed the other and continue to swap allegiances between worlds. Blaming the university for the appeals system should a student's appeal be upheld for another attempt to pass the PAD in practice. Documentation has produced a key disconnect between the worlds.

Academics tended to blame mentors for failing to spend quality time with the student or incorrectly completing documentation. Mentoring is seen as the formal partnership and clinical vehicle to facilitate a student towards registered status. However, the display by the mentor participants in the study appear to detach their role, and sense of responsibility, from university process thus being guided by the HEI. This is a factor that appeared to widen responsibility and ownership.

Clinical proficiency was an element of professionalism from the mentor's perspective, but the academics wanted the students to *'show'* professionalism in attitude and manner. However, it is essential for students to learn the mastery of the profession, but the mentors' comments demonstrate the dichotomy of beliefs between clinical skill attainment and professionalism. The findings provided indication that practitioners believe clinical skills are the responsibility of the academic setting. This was elicited from the mentors' comments

that when students' go into practice, they do not have the skill to take blood pressure when they arrive on the ward.

This created a further sense of flux for ownership with the mentor's displaying disconnect with clinical skills whilst academics articulated feelings of a shared responsibility. Through the findings, they expressed the notion that it was university responsibility to ensure what they learn in the practice is taught firstly in the skills lab. In essence with studentship the reform of education uncoupled learning from practice and the HEI became the purveyor of clinical proficiency. Essentially, the Ownership Framework conceptualises the disconnect documentation has affected the partnership for ownership responsibilities. The framework highlights gaps between local and national policy for the management of fitness to practice between the partnership.

6.5.3 A Policy for Partnering Fitness to Practice

The NMC clarified their position of FtP by stating that all education providers must have a fitness to practice committee (NMC, 2009). This rather belated addressing of FtP policy between the partners was an attempt to enhance ownership of process. However, throughout this study whilst mentors highlight concerns, process falls to the HEI thus reducing the Practice Learning Partners sense of ownership. Mentors did not comprehend FtP university regulations compared to their academic counterparts.

This disconnect has meant that the HEI has fulfilled the professional body's' statement of a fitness to practice committee but has added to ownership disconnect.

Students being fit for practice has been revisited with a focus on HEI's needing to provide robust procedures which have the confidence of all stakeholders for any potential disciplinary action (Tee and Jowett, 2008). Being FtP has therefore been officiated within HEI procedure through reform of policy stakeholder. Thus, this suggests that the practice

area should highlight '*at risk'* students but that the university instigates the fitness to practice hearing.

The study has shown that students at risk are managed through the CfC response strategy, which may lead to fitness to practice, but has become a process for mentors handing over documentation for university review. The fitness to practice process was not transparent to the clinical setting, but the CfC response strategy clearly was. The mentors did not demonstrate or feel the need to demonstrate understanding of a process that did not affect them. The concern therefore is that by the HEI investigating or convening a fitness to practice hearing, or even investigating, a procedural synapse in communication and transparency remains.

The separation of process devolved to the university from the clinical setting has meant that procedure is not evident to the mentors on a day-to-day basis. It could be argued that the clinical area is no longer expected to act on or implement process through practice but hand over responsibility to the HEI for this. The study has made a connection of ownership disconnect through university systems thus separating responsibility from the clinical setting. This expectation has been shown as a presentation of inequitable ownership with the transfer of responsibility being opaque.

The mentors need not do any more than complete the CfC form, as they hold no power over process other than orchestrate a meeting with the Education Champion, and student, to discuss the concern. Furthermore, any meeting that may require the student's union, an independent service of any university student, is hindered by their inability to attend meetings off campus grounds.

The university led CfC response strategy can address potentially serious issues or document general concerns. The process has proved to be a particularly useful tool for the documentation of a noted student concern and subsequent action planning. However,

discrepancies between student's clinical reports and the academic assessment weaken the process of clear ownership.

The visible effect of this devolvement of responsibility from the NMC itself inadvertently cut professional charge. The devolvement of responsibility through professional requirements from the clinical setting to the HEI shows a remarkably clear sense that responsibility and professional charge are attached to university procedure. The findings have shown that mentors were indifferent to fitness to practice through academic processes but that the academics needed to complete university process.

It could be argued that the lack of transparent responsibility has affected the collaborative processes between partners when a student exhibits fitness concerns and that effective communication must be fostered to ensure parity of fitness to practice (Reid, 2010). However, for a student to be considered fit for practice Reid (2010, p89) impresses the importance robust systems require to document concerns, identify problem students, and manage them in a way that places equal value on both "*academic and non-academic aspects of fitness to practise*".

Such importance for recording is documenting evidence and actions within the PAD. However, the PAD appears to be a baton to pass responsibility from one partner to another even though it was developed as a quality monitoring system to ensure validity and reliability of clinical assessment. This is a professionally defining suitability to the NMC register for practice, but between the partners was suggestive of an inability to own the issue.

The indication elicited by the study was that the PAD did not seem to be a shared responsibility for academic and clinical processes. The Education Champions expressed the feeling that the element of ownership was often blighted by mentors surmising that if

students were failing in their duties, the expression of '*your student'* was most certainly aimed at the academic element for responsibility. Furthermore, the Personal Tutors appeared to review the PAD as a document that needed to be marked for awards board purposes and not for the monitoring, review and recording of a student's practice progress. There did not appear to be a continual flow for the recording of practice achievements as a holistic assessment of the student. The PAD appeared to be a segregated indication of the student's modular practice assessment outcomes and like the thoughts of the mentors, it had to be done.

Thus, the passing of clinical knowledge from partner to partner has been recognised as a key component for *'removed'* obligation amplifying the disconnection but the word '*removed*' can be explained in the study as *'disconnect'*. Perceptions of delegated responsibility may possibly add to the concept of distanced responsibility towards the profession and these feelings were quite clearly articulated by the Education Champions.

According to Jokelainen et al. (2013) the role of the respective educational institution in providing educational support was considered important. Within their study, the difference between Finnish and British mentors was feeling at ease with which information could be accessed from the university, such as curricula (Jokelainen et al., 2013).

This notion of role must be rebalanced and the favours for clinical fitness to practice awarded back to the clinical setting. The university need only convene a panel hearing, but the clinical setting must supply the evidence and engage with the professional standards set for future peers. The Education Champions were essential for process and thus are key to ownership partnerships between the academic and clinical setting. Through the data collected, their attention to supporting students and mentors alike with the access they have to the Trust sites, are suggestive of being the essential component of the academic/clinical partnership.

6.6 The Ownership Gap.

Building upon the findings from the discussion chapter around responsibility and ownership, the findings were condensed into three key domains: *Education, Clinical Practice* and *Professionalism*. A further nine sub-headings of these three domains within this case study, considered all aspects of documentation to articulate the meaning of ownership between the three stakeholders. These three domains and nine sub-domains were Education: academic environment and role dislocation; competency, progress, and university documentation; award and appeal and laboratories, teaching and clinical skills. Clinical Practice: mentoring for record keeping- a misnomer; the Equity of role modelling. Professionalism: workload and time; the difference between partnership and ownership; a policy for partnering fitness to practice.

Deconstruction and synthesis to demonstrate the association between the three domains and their relevancy to ownership from the interpretation of multiple sources of documentation, is represented in a Venn Diagram titled The Ownership Gap Diagram 3 page 293. Analysis from Table 3, '*Participant Focus Groups themes and application of National & Government, Regulatory Nursing Body, Local University & Practice Learning partner documentation'* (page 250) and Table 4 *'The Documentation & Communication Ownership Index'* (page 255) the tables charted documentation is applied locally and communicated between the partnership and The Ownership Gap presents the reorganised sense of responsibility to visually symbolize how disconnect has been created. Blank cells within Table 4 highlighted these gaps of ownership and were evidenced through the process of synthesizing literature, The Ownership Matrix, Thematic Analysis and the Participant Focus Groups themes and application of National and Government, Regulatory Nursing body and Local University and Local Practice Learning Partner charting of documentation the diagram will show co-ownership aspects of FtP.

Thus, three domains, captured in The Ownership Gap Diagram 3, provides a visual representation of relations between a finite collection of different relationship sets (domains) and sub-domains; *Education: Higher Education beliefs, Personal Tutor, Professionalism: Professional body; Clinical practice: Clinical aptness, Mentor.*

Portrayal through the inter-lapping sections identify a gap in ownership between the academic, professional, and '*clinical*' world. The fundamental finding was the lack of correlation between Professionalism and Clinical Practice. Their own professional understanding of process and requirement was not lost within the focus groups, but the blank overlapping section highlights segregation from the professional body (Professionalism) and the Practice Learning partner (Clinical Practice) which displayed disconnect to themselves.

The overlapping sub-domains reveal how each domain co-owns responsibility and in simplistic terms, the Venn diagram represents the documents each world associate and apply within their own perceived boundaries. The claim, therefore, within this study, is that responsibility and ownership is behest to usage, perception, and association to reality and knowledge of individual professional worlds. Furthermore, The Ownership Gap represents, in the overlapping sections, the sub-domains of ownership to highlight key co-used, and therefore co-owned, elements between the worlds.

For example, co-ownership between Education and Professionalism has a distinct association and is labelled as academia, process, policy and procedure and misconduct & FtP. This association is clear within the literature review and from the discussions of the participants, the integrated use of local and national documentation. The academic Personal Tutor has a clear role in the domain of Education but does not have co-ownership rights within the sub-domain overlapping co-ownership section between Professionalism

and Clinical practice. The Education Champion however does, and this role has a co-ownership role with all three domains and sub-domains.

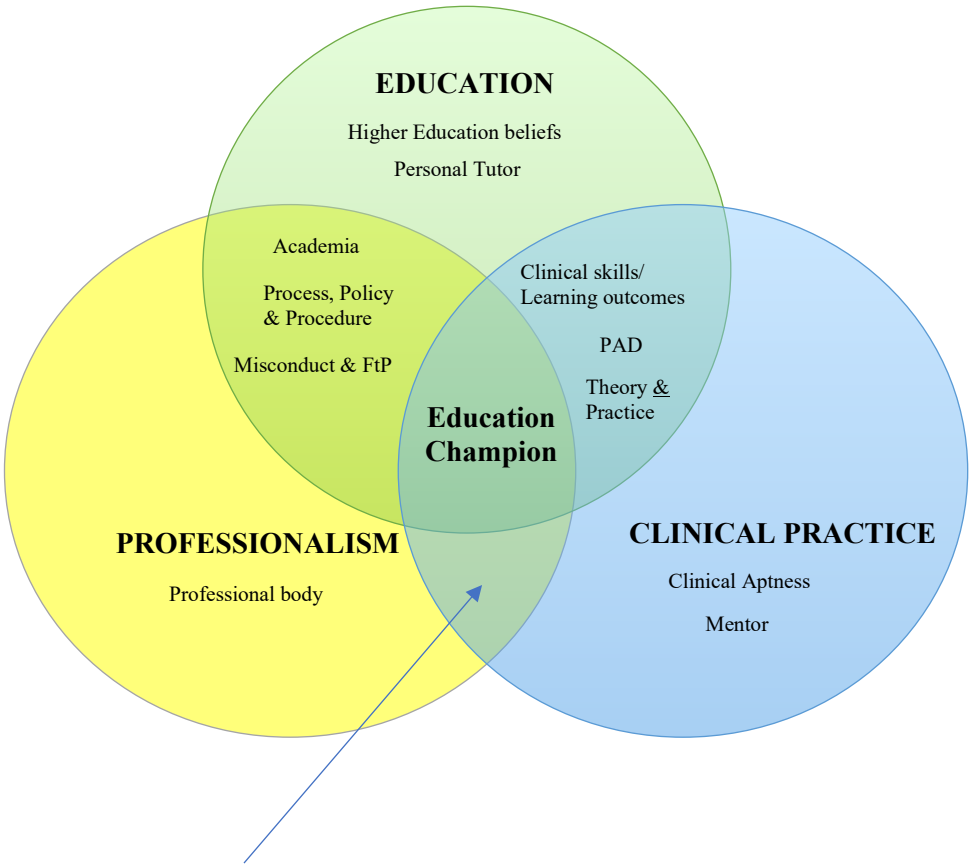
There is also clear co-ownership between Clinical Practice and Education for clinical skills and learning outcomes, PAD and Theory & Practice. Principally however, the sub-domain between Professionalism and Clinical Practice remains vacant. Clinical Practice co-own the concept of managing, completing, and fulfilling the PAD and the required learning outcomes for Education. This was also evidenced in the findings of needing to '*getting it done and signed*' but does not demonstrate in the diagram a clear relation to the beliefs of ownership responsibility. If you examine the sub-domain however between Clinical practice and Professionalism, the overlapping sections remains vacant. This blank section suggests that co-ownership is not evident, and that requirement does not correlate to their own professional body. They simply equate documentation to another stakeholder's educational requirement for completion and not theirs and is therefore perceived as set by the university. This perspective evidenced in the participant narratives.

There was, however, clear evidence that while the mentors were aware of NMC teaching and learning standards requirements, but this sectional gap between Clinical practice and Professionalism suggests that they do not apply a cohesive sense of responsibility between themselves and their own professional body. It appears to be a university requisite.

The sub-domains revealed in the overlapping sections, highlight how documentation of local and national standards, does not extend across all three worlds. A reciprocal relationship exists between Education and Professionalism and between Education and Clinical Practice but not between Clinical Practice and Professionalism. Fundamentally these two domains do not have a connection and therefore a gap has emerged. Fundamentally the Education Champion remains as co-owner to all three worlds.

Therefore, as a point of ownership and co-ownership, the Education Champion overlaps all areas. This overlapping represents the pivotal role they play for local and national application of documentation. National documentation it would appear have not extended the boundaries between Professionalism and Clinical practice. This section does not even consider local documentation either. Thus, discrepancies exist between the professional body and the Practice Learning partner and without the Education Champion to act as the mediator between the three worlds, dissonance of ownership will remain.

Fundamentally, as a registrant, mentors must adhere to their Code of Conduct (NMC,2018) which is inclusive of their own fitness accountability, but fundamentally nursing students are not registrants and therefore not '*accountable*'. The connection to Clinical Practice and Professionalism is not lost on the mentors but that the lack of an FtP process for nursing students is not something they are required to initiate or adhere to in their own Code as decreed by the professional body. Their role is to teach nursing students, not manage process thus this section remains empty. All concerns are immediate referred to the university thus negating the need to act or assume responsibility.



The Ownership Gap - Venn Diagram 3.

6.7 Section summary

The purpose of this chapter was to discuss the findings of the study in comparison to other studies with a focus on FtP responsibilities and ownership of process. Furthermore, through the methodology of a single exploratory case study approach, collection of data from academic and clinical mentor focus groups, contemporary literature and archival documentation as suggested by Yin (2009) case study which has shown that the assessment of a student's clinical competence remains a fundamental aspect of pre-registration nurse education to establish FtP in readiness for entry to the professional register.

The then professional nursing body UKCC, bade requirements from HEIs to enable FtP based on health needs and readiness at the point of entry to the professional register through curriculum. As a result, clinical performance was facilitated and assessed through clinical mentorship assessment. However, a commissioned report for The UKCC, Fitness for Practice Commission for Nursing and Midwifery Education scrutinised pre-registration nurse education with thirty three recommendations to affect change between the academic and clinical partnership to ensure organisations work together (United Kingdom Central Council, 1999). Responsibility for the working partnership, was equally apportioned to the HEI and Practice Learning partner (United Kingdom Central Council, 1999).

However, it was not until 2009 that the NMC strengthened processes to ensure that HEIs produce a standard FtP operation procedure. However, following the current study findings, the *'Participant Focus Groups themes and application of National & Government, Regulatory Nursing body, Local university & Practice Learning partner documentation'* (Table 3) has illuminated inconsistency within the usage of documentation associated to each partner and the fortification of HEI management.

The Ownership Matrix (Diagram 2) offered a visual framework of historical, procedural, and methodological beliefs of FtP from the Pre-Project 2000 period to current management strategies adopted by the academic and professional body stakeholders. Designed as a flowing and consistent commentary of national, local, and archival literature, study findings and themes founded throughout the study, The Ownership Matrix encompasses the perceptible key themes the relationship and responsibilities of FtP is associated to each partner. This resulted in the breakdown of three key areas within FTP management between the stakeholders: HEI, Practice Learning partner and Professional body inclusive.

The Ownership Matrix helped signpost how responsibilities devolved around the key domains of Education, Professionalism and Clinical practice and through Braun and Clarks

(2006) thematic analysis three key themes were identified from twenty-six sub-themes; twelve Education Champions sub-themes; eight Mentor sub-themes and six for Personal Tutors. This culminated in the breakdown of how local and national documentation is affiliated to each stakeholder resulting in the Participant Focus Groups themes and Government, NMC, Regulatory Nursing Body, Local University & Practice Learning partner documentation table, Table 3.

From inception of The Ownership Matrix, thematic analysis, and breakdown of documentation as per the study methodology, the consistent element between the three stakeholders is the Education Champion. This is suggestive of being the key advocating link between the academic environment and Practice Learning environment. Their academic role has created, and maintains, an open and often critical network system between student, mentor, professional body, and the faculty. Not only does their connection facilitate communications between the tripartite partnership, but they also act as intermediaries for the student and mentor relationship, assigning university process to the clinical setting and provide a cohesive link between pre-registration nurse education and clinical needs.

As a collation of themes and findings, this has led to the development of a process of how documentation is used between the tripartite stakeholders titled ‘The Documentation & Communication Ownership Index’ - Table 4. The Index tables and catalogues documentation and communication habitually used by each local partner for responsibility and ownership. This led to the amalgamation, from the finding’s, perceptions of local and national documentation used in their respective worlds and their connection to each other.

Common themes within this case study have been consistent to three domains academia, professionalism, and practice placement which can be classified as: Education, Professionalism and Clinical Practice. The consequences affecting professionalism, has

been determined by interaction and association between Higher Education and the Practice Learning partner. This has influenced the procedural aspects of FtP management between the three worlds that for Clinical Practice, which encompasses activities with and on behalf of patients and clients, has needed to adapt its relationship to itself (professional body) and the university as represented in the ‘The Ownership Gap’ Venn Diagram 3.

For the HEI within this case study, fortification of FtP has been bestowed to the university and thus by default university staff. This appears as a reality within each partners world and as part of this case study, understanding the usage of local and national documentation (some of which were Key Documents from Table 1) between the stakeholders is key to ownership. If whoever is the author and therefore owner of the document, this has an impact on process.

6.8 Chapter Summary

The partnership has been assigned their own responsibilities, for example the NHS (Practice Learning Partner) has sign-off mentors, the HEI for programme delivery and the NMC holds authority for standard setting. The duality of academic and clinical delivery was meant to produce a nurse fit for practice, but the study has shown that both stakeholders cannot adjoin a collaborative decision for FtP.

However, in summary, this case study has shown that FtP was bound in university process. This entwinement of academic and clinical stressors has transferred, and detached, fitness to practice ownership obligations with the clinical assessment of student's becoming embodied in academic process and the management of fitness to practice being administrated by the HEI. Thus, dissolving clinical responsibility. The dismantlement of responsibility between the academic and clinical setting that occurred during the change in the educational model since Project 2000 has been identified as one of the factors that constrains the partnering of students.

Through examination of the findings, the factors that enable or constrained the partnering of students between the academic and clinical setting have shown that the unique relationship between the partners within the study revolves around university process and that fitness to practice at the point of entry to the register belongs to the sign-off mentor but is subsumed within academic award. Furthermore, the sense of obligation to documentation is often lost between the partners and resulted in a silo approach to FtP. Application of local and national documentation also lacked fluidity.

This itself was not the issue but what has been found is that the sense of ownership between the clinical setting and professional body lacks transparency. However, the relationship to the clinical setting and the academic body is evident. The focus group of

mentors failed in the study to observe the NMC their professional body as part of the driver for education and for the development of producing nurses fit for practice. They felt the university *'owned'* the student with comment that the student was '*yours*'. This disconnect was demonstrated throughout the mentor narratives.

The chapter provided the basis for the discussion, and a unique contribution to research, a visual representation of the inter-connected academic and clinical partnership concepts for fitness to practice management (Diagram 1). In the model, it is shown that a sense of disconnect has appeared, creating The Ownership Gap. That pre-registration nurse education: fitness to practice management and ownership between partners revolves around three constituent parts; '*Education', 'Clinical Practice' and 'Professionalism',* entwined in academic, competence and fitness to practice beliefs and properties for ownership. These constituent parts were evidenced in The Ownership Gap Venn diagram.

The Ownership Matrix demonstrates disconnect between the professional body and clinical setting but highlights the partnership strengths of the academic alliance. The main association however was the clinical settings alliance with the academic Education Champion. This interconnectedness stresses the dependability that pre-registration nurse education has on each partner's role and according to Scott (2008) evidence of collaboration between education and service is required for certification and registration. Entry onto the register is an important epitome of collaborative partnerships and strengthening nurse education was an investment the trend towards competency standards, must be achieved for registration (Scott, 2008).

However, throughout the study factors were observed affecting the partnerships sense of shared responsibility and the research findings have found a sizeable ownership gap between the clinical setting and academic arena remains. The narratives suggested that academics felt mentors devolve responsibility to the university, mostly towards the

Education Champions, thus lessening their responsibility. Through their clinical visitations, and assistance with university documentation and process, the study has shown the Education Champions to be the key academics providing the link to academia and the practice setting.

The Education Champions were called upon by the practice setting for the facilitation and mediation of student and mentor negotiations. All processes of managing issues were conducted by, and communicated with, this academic role. However, mentors are key to providing validity to the proficiency of clinical skills and this study has identified role modelling from the mentor's perspective as the focus on clinical ability tinged with devolved responsibility.

Throughout the findings, mentors' associated credence to clinical ability and clinical competency. What was evident was the mentors' focus was on clinical ability was not correlating with the beliefs of the academics. However, to facilitate the principles of achieving competency, lacked transparency to the assessing and evaluation of achieved skill through the students' PAD. The PAD, although observed as a necessary objective, presented difficulties for all participants, and was considered as unwieldy by the mentors.

The findings suggested that the mentors were overwhelmed with the sheer amount of documentation, learning contracts and competencies requiring evaluation and this impacted with mentoring time of the student. Mentoring, time, and workload were consistent themes within the study and may explain the continued disconnect my model has shown between the professional body requirements of fitness to practice compared to the clinical settings understanding of monitoring learning through the association of competency.

The thoughts and beliefs of the mentors that the delivery and acquisition of clinical skills should be a university led responsibility facilitates the belief that achievement of

competency is through curriculum. As a profession, it is expected that the clinical area passes or fail the student on their merits of competency to the register. This is after all a future signature for the profession itself. Responsibility and therefore ownership could be devolved simply through process to the university, but this fracturing of charge effects the partnering. Curriculum development and implementation, however, is a shared process between the NMC, HEI and the Practice Learning Partner but seemed to be diluted down to the mentors. Mentors had to face their own day to day patient care alongside managing the potential FtP of nursing students.

Each academic group remained true to their historical nursing backgrounds of wishing to care for and nurture both student and mentor. The narratives demonstrated that their professional nursing background was more prominent when dealing with student matters of a clinical nature. They were acutely aware however, of the need to adhere to the academic regulations but it was felt that nursing was their initial profession with being an academic second. Their thoughts and beliefs focused on their historical professional role simultaneously regressing their actions to university process and procedure. This created role confusion.

A comment offered by Kenny (2004) that fitness to practice needed to close the gap between service and education, remains key. The mentors lacked understanding of the academics needs to complete process for fitness to practice and this produced a lack of ownership cohesiveness. The Personal Tutors also seemed to feel the same, as they were not involved in fitness matters but were attempting to try applying rules and regulations. Education Champions are at the forefront of the education and clinical partnership.

The three connective constituent parts appear to show that each partner considers the other responsible and that this disconnect has been achieved through curriculum delivery of the HEI. The model clearly shows that the NMC and HEI have close links, but the clinical setting

has little involvement on the FtP process. This suggests that they may not need to own the student as all matters are progressed through Higher Education and professional body legalisation, while Personal Tutors may feel they are on the outside of the clinical world looking in.

This weakness may produce unfit nurses and one example of this is how the academic environment considers its sense of ownership of students. Curriculum is bound in Higher Education and while the professional body continues to allow the HEI to develop competencies without input from the clinical setting, then The Ownership Gap will remain. Conversely if given a higher priority towards professionalism beliefs and expectation through responsibility, our understanding of what constitutes achieving fitness can be altered. It seems loops of responsibility need to be affirmed and this could be associated to, and part of, communication and process transparency between partners. However, being a university-registered student suggests that clinical issues of fitness to practice will always fall under the jurisdiction of university procedure. Absolution of the training model to HEI curriculum post Project 2000 has shown the HEI to be gatekeepers, investigators, and instigators of fitness to practice.

If as Watkins (2000, p.338) suggests, *"the benefits of a college or university-based education were perceived in various ways, but if 'individuals' are to be given academic awards in nursing then by definition they should be fit for both award and registration concurrently*" is key then fitness to practice has to remain with the HEI. The relationship between Higher Education, professional body and the clinical setting need to agree that if a nurse is to be given a dual award then one partner must preside process.

This remains essential to the procurement of fitness to practice aside from ownership and indeed process. Thus, perspectives of responsibility and ownership between the

partnership and the cultivation of productive collaborative working relationships, are essential so that one partner is not the finite decision-making partner.

Therefore, the findings have produced insight as to how participants perceive their role and their use of the documentation conceptualised and illustrated within the framework. Together these are suggestive of the university acting as the conduit for the NMC to design curriculum for implementation of the professional body standards for application within the clinical setting. However, the Practice Learning Partner represents the professional need to fulfil the requirements of the NMC but has no clear sense of conceptual ownership to the university. The mentors may also be considered as '*clinical bystanders'* like the Personal Tutors to the process of ownership. This original framework demonstrates that each partner, whilst having a 50/50 stake in the education of pre-registration nurse education, utilise and understand documentation in silos.

Furthermore, across the whole framework the Practice Learning Partners have 48% Own and the University 39% Own in regards the holistic process. OS is 12% university and 14% Practice Learning Partner with 20% responsibility attributed to the university and 8% to the Practice Learning Partners. The Professional Body Owns 12% but with no OS or R evidenced within the findings section.

The framework has evidenced the gaps with many aspects shared between the partners. For example, the Practice Learning Partner and mentor share many elements but there are visible gaps between them and the university. An example of this within the framework is the high-level strategy for nursing standards produced by the professional body seen in the PAD and NMC section. These however bear little authority over local delivery. An example of this is processes between the two partners and the professional body for owning fitness management which is placed solely with the university Secretary & Clerks section. The Practice Learning Partners however are shared owners of the CfC process, and

documentation, with the university but the focus group findings suggested that often referrals are sent straight away to the Education Champion. This demonstrates a reluctance by the practice setting to own the issue.

The gaps and coding represent the differences perceived around the use of each document and where they originate from. For example, the PAD has a clear purpose for its use and a sense of who owns it, but not for the Personal Tutor who appears to be an '*academic bystander'* but provides academic and pastoral care for students when, and if, they are struggling. They seem only to be responsible for collating results to the university awards board.

Chapter Seven - Limitations of the study and recommendations

7.1 Introduction

This study has introduced and identified several fitness to practice responsibility issues between the three key stakeholders of pre-registration nurse education: academic environment, professional body, and clinical setting. The literature review captured the essence of historical and contemporary change between the HEI, NMC and the NHS over three decades which appeared to open the gap in ownership responsibility between the three partners. The responsibility issues were condensed and rationalized into an ownership model titled *'An Ownership Model of Pre-registration Nurse Education for Fitness to Practice'*. The model is a culmination of literature and focus group data analysis, demonstrative of the sense of responsibilities of managing fitness to practice between the stakeholders which appear to be in conflict.

As a result of the study, ownership of fitness to practice appears segregated and compartmentalised into academic operations guided by the professional body but with limited clinical input producing disconnect. For example, mentoring for face-to-face direct teaching within the clinical setting for competency assessment, and instituting professionalism to the student nurse, conflicted with Higher Education beliefs, professional body requirements and the needs of the clinical setting. This discord was conceptualised into the ownership model.

This chapter will discuss some of the limitations of the study and the beliefs around fitness to practice and the subsequent ownership gap founded between the three constituent parts of pre-registration nurse education. Recommendations for further study will be offered ending with reflection of myself as a researcher.

7.2 Limitations of the study

Simons (2009) suggested that concern around inferences drawn from a single case study and usefulness of the findings to inform policy can make the researcher think about the generalisability their claims from their study. These claims, and concerns, are in relation to Simons referring to a case study involving curriculum in which the researcher felt that three issues caused them to think again about their claims. One of the concerns reflected on the approach (case study), another related to the uncontrolled intervention that case study research is in the lives of others (unforeseen changes to practice) and the third focused on the distorted picture case study can give (one university and one health trust). However, Simons is very clear that case study is 'locked in time while the people have moved on' (Simons, 2009, p.24) but it is essential to reflect and consider one's own limitations of their study. Thus, looking back there are three aspects to the limitations within the study that merit review.

For this study, there are three key aspects to the limitations which are worthy of reflection: 1) literature review, 2) quantity and size of the focus groups and expanding the methodology to include quantitative approaches and 3) professional doctoral programme time.

Firstly, the scope and breadth of literature used while appropriate, however if time and resources had allowed using a wider pre-registration history base and the SoN perspective of FtP supported by policy making related to other UK based HEI's for FtP, this may have afforded a broader historical perspective. Furthermore, material connected to policy decision makers pre UKCC in use by local and UK Practice Learning partners and their application with HEI's processes may have deepened this study's findings.

On reflection that the literature could have spanned a different or more specific period, and reflected upon the UK HEI system, overall, appropriately used, and relevant material has provided key insights into the local management of FtP and the Practice Learning

partnership setting application to reinforce the findings considered in this study and has acted as the basis for other researchers. This remains key to a professional doctorate that local policy is changed within the researcher's location and therefore is meaningful.

Additionally, as suggested by O'Brien et al (2014), the SRQR standards may be useful for further investigation and research of the topic considered in this study. Key findings and aspects of ownership and responsibility to the management of FtP and a wider audience of stakeholders, may prove useful for the tool to carefully document processes and decisions of the topic. A narrower focus on the topic may have lent itself to the process and information the SRQR details in a qualitative research report for future research editions. This in turn as O'Brien suggests aims to 'keep track of procedures and decisions' in this instance not only related to how FtP is managed across UK pre-registration nursing programmes at a national and local level but how future research captures evolvement.

The second reflection of limitations relates to the number and participants recruited in the focus groups conducted. Engagement with more Practice Learning partners, other campus sites (across my own institution) and involvement with other UK HEI's as part of the examination of FtP processes, may have created a wider participant audience who may have broadened the scope of perceptions and therefore interpretation for the case study. This may have been extended to students in focus groups also. This may have given a counterbalance to the qualified nurse and tutors perspectives.

This study, however, was a small-scale study and essentially the exploratory case study approach of focus groups directly involved with FtP matters, whether from an academic or clinical level, was the direction of the study which felt applicable to understanding how the participants managed FtP locally. Principally, ward level nurses who act as mentors and role models to nursing students and who monitor and address the learning outcomes for the NMC standards were shown to be key within this study. Furthermore, the study

highlighted those who engage with the CfC process, which may lead to FtP, which were the key and remain as such. They are the link to FtP and the professional body NMC through their own professional registration and there is no denying that in this study, their application and connection to the topic was key.

One of the biggest impacts of the findings was the importance of the Educational Champion in connection with the mentors to whom concerns are escalated. This validates the value of their input from the focus groups and can, in turn, satisfy the professional body that the HEI does have a reporting process proceeding to an FtP hearing.

Additionally, if more time and resources were available a greater participant audience may have strengthened areas of discussion. Participants such as senior members of other universities who manage FtP policy and senior clinical staff across several health trusts may have allowed for a wider perspective of FtP in a local and broader reference. Furthermore, participation from a nursing student perspective would be complimentary to thoughts and feelings around FtP and the sense of ownership from their perspective. Therefore, these wider perspectives from a greater range of participants could enhance understanding of the players involved in FtP process and policy making, and therefore application in the HEI beyond this study. However, during the data collection and analysis, data striation was achieved for the focus investigated in the study.

On reflection of the data collection, from the perspective of using a quantitative approach to gain insight, this must be considered with caution. Detailed in the methodology chapter the argument was made to focus on the thoughts and feelings of an interpretative case study approach to seek meaning. However, the use of surveys or questionnaires may have objectivised certain areas connected to the topic and whilst they can be used to gather responses from a relatively large number of people scattered across the groups of academic, clinical, and senior staff and HEI policy across the UK, consideration is required

of who to include in the sample; are they individual or representative of their organization. This may have become unwieldy in a small-scale study.

All questionnaire data analysis of quantitative methods is based on the responses that a certain group of people gave to the questions on the questionnaire and developing those questionnaires may vary depending on how the questions are interpreted. Furthermore, the process to develop and administrate surveys or questionnaires was too extensive for the resource and time allocation devoted to this study. Nonetheless, using surveys or questionnaires to consider different aspects and components of FtP management may have been a useful tool to seek meaning behind this study.

This approach could be considered for further study into this topic. For example, this study has shown that there appears to be different views from different roles within the professional, academic, and clinical world and enhancement to these perspectives using survey or questionnaire and seeking a greater capture of data around the research questions, could have included senior decision-making participants both nationally (profession body and HEIs) and locally. The use of participants recruited from ward-based mentors may be different to senior clinical staff with greater decision-making authority for FtP policy. Moreover, from this study's findings, the mentors do not escalate within the hospital to senior staff but immediately refer to the Education Champion via the CfC rereferral process. However, we must remember whist it is a requirement in the CfC process, direct referral to the Education Champion has facilitated the responsibility gap on the ward with mentors and nursing students. In summary of this study, academics (Education Champions) have been shown in this study to implement and act on FtP matters at the very local ward level. Without this role or CfC there would be no process of escalation.

To address FtP, input from senior clinical staff and policy makers of HEI's, has potential to orchestrate clarity of decision making and process. This can also be extended to academic staff and the decision makers within the HEI. The ownership gap has been shown within this study to remain at a local level (mentors) fundamentally within the Practice Learning setting, with the Educational Champions acting as the connection to the clinical area and professional world. It would appear the 'process' stops there. Stoic management of FtP by the HEI is not seen by the clinical setting and the lack of transparency disconnected responsibility. The study has shown that procedure remains as an administrative task for 'completing the book' thus greater application for everyone to access and understand ownership accountability for FtP management as an effective safety tool for nursing students is needed. The impact of this study is knowing a gap exists and finding solutions to bridge the gap. This may only be achieved through a wider audience to examine as suggested above.

The use of the methods was applicable to the small-scale case study but nevertheless if resource had allowed for a greater geography of focus groups recruiting academics, clinical staff, nursing students and involvement with other HEI policy makers, may be a richer portrayal of a single setting to inform practice would have been invaluable. However, what was achieved within this study as Simons (2009, p.24) suggests 'the value of the case and/or add knowledge to a specific topic' was established. The reality of lived experiences creating as she states a 'partial nature of interpretation and the conditions of their construction so readers can make their own judgements and relevance and significance' (Simons, 2009, p.24.) was achieved with the participants recruited and is insightful of a rich portrayal of a single setting, the researchers own.

Thirdly, time and resources within the structure of the professional doctorate programme condenses into key two stages; developing research ideas, and the research proposal and ethical approval, progressing through to the second stage of Confirmation of Registration,

appraisals and completing the thesis whilst working in a demanding job, were a balancing act. Even though specific actions and outcomes were required at varying stages of the professional doctoral journey, these were managed in parallel to working fulltime. However, whilst time and resources added to the complexity of managing the programme, the decision for the topic, method and methodology for a practice led policy change was key. As the Director of Studies, the role is influential in HEI policy decision making. Through direct application to university processes, the aim to change and enhance FtP policy at a local level was achieved. Through the professional doctoral, this route offered the opportunity to examine a key aspect of the university processes in relation to the DoS and the relationship to the topic of FtP.

The doctoral route did uncover a unique insight to FtP from the participants involved and the size of the case study was compatible to the time constraints and resources of the programme. Using the DoS role meant greater access to and scope of examining current practice to consider changes to FtP management. This thought process led to the application of recruiting local Practice Learning partner colleagues and academics to seek understanding of how both their viewpoint towards current process of regulation allows for this study to make future changes.

Deliberation of inference for generalisability is argued by Thomas (2011) that as a form of interpretation what can come from case studies through the legitimacy of the knowledge produced. Thomas (2011) identifies that exacting expectations cannot be assured but that limiters of generalisability are negated by the credentials of the study findings. Above all, according to Simons (2009), telling the story of the evolution, development and experience of the case should be told. The case to be told for the study is one of the ways to best understand and locate the sense of ownership between the academic and clinical partnership. However, Simons (2009) discusses how the forms of report writing and presentations of the ‘story’ (as referred to by Simons herself) can be presented within a

case study. This story, or narrative, is communicated by Simons (2009) as the central story to engage the reader from different stakeholders.

My engagement with two key stakeholders through focus group interviews of academics and one group of mentors in the clinical setting, has provided a narrative of their 'story'. The advantages of focus groups are that they provide a valuable resource for documenting the complex and varying processes through which group norms and meanings are shaped (Andrew et al., 2008). However, in total three participants were interviewed in the one registered nurse mentor focus group conducted within the clinical environment. Bloor et al. (2001) ask the question *'does size matter'* within focus group numbers with a suggestion that the optimum of six to eight was a reasonable number of participants and discusses difficulties with access to venues as inevitable constraints to interviewing participants. This sadly befell the study as out of several NHS Trust partners written to for mentor participants, only one NHS Trust agreed to the interviews. Thus, the study concentrated on one clinical placement provider accessed through their R&D process. However, the process of purposive sampling for recruits, and on reflection, was an easier process to manage overall with a direct focus on attaining recruits from one large NHS Trust. However, by requesting participation from several NHS Trusts, hoped to increase the chances of recruits across different sites which might have offered a different insight from a mentor's perspective. This may have in turn increase data.

Contacting several NHS Trusts was not an attempt to over recruit but to find a reasonable numerical selection optimal sampling and according to Bloor et al. (2001), over recruitment is standard practice to anticipate that some participants will not turn up. From the experience of the poor response rate from the R&D requests, the greatest concern focused on recruited numbers of mentors but as suggested by Bloor et al., (2001), large groups can present problems and conversely small groups may produce limited conversation. Furthermore, the focus group is at risk of people not turning up and therefore cancelling but

fortuitously this did not occur but only three were able to participate. On reflection, I would consider sending the Participant Information Sheet (PIS) to mentors prior to their face-to-face update session to recruit participants as this may have augmented interest and perhaps offered opportunity to assure confidentiality and interest in the topic. Fitness to practice is part of the sign-off mentor update session and thus may have had a greater impact on recruits. This is a future consideration for future studies around fitness or ownership.

Fundamentally, the small group of mentors did provide insight into their perspectives of fitness to practice but the low numbers could be deemed as non-generalisable. Furthermore, as suggested by Bloor et al., (2001), they may not have been a good source since variations may be under reported within an intra-group. Certainly, the intra-group did consist of mentors but two were sign-off mentors and the other a non-sign-off mentor but to reduce the likelihood of under reporting within this focus group, all voices were transcribed, and equal attention paid to their narratives. On reflection however, a larger group perhaps consisting of one group of mentors and one of sign-off mentors may have been more useful to uncover perspectives of differences between the responsibilities of mentorship. This is a future study topic for fitness to practice as a wider focus on the differences between ownership of mentorship. Despite that limitation, overall, the narratives using the vignettes produced a wealth of data of the beliefs of mentors to fitness to practice ownership, differences between mentor and sign-off mentor and university (Higher Education) engagement and their perspectives on curriculum and professionalism. Their sense of responsibility was also examined with insight of university process.

Dynamics of participants must be considered in terms of group composition and the suggestion by Bloor et al., (2001) that every researcher is at the mercy of recruitment, attendees and their availability, and access to partake in the befell study. Whilst these participants were not complete strangers to each other, I did have to consider that

participants who belong to pre-existing social groups might bring to the interaction comments about shared experiences. Importantly as Bloor et al. (2001, p.22) state "*discrepancies between expressed beliefs and actual behaviour and generally promote discussion and debate".*

Telling the story did present some degree of challenge overall for the transcription of recordings. Codes were assigned to each participant to assure confidentiality but for the small mentor group consideration was needed to reflect upon the significance of the transcription to assure accurate attention to their voices for subsequent analysis. Body language and other oral communications need to be included into the narratives. As a construction of social meaning from the mentor's perspectives, Gubrium and Holstein (2013) suggests that the qualitative analytic pendulum is constantly in motion. The social worlds experienced by the participants may have been a weakness in this study as the focus was more on what they said with interpretation possibly against the fact of being within such a small group as the points notes above allude to. Fundamentally, as suggested by Simons (2009) the appropriateness for purpose, namely the predilection the researcher has for a particular style and data generated must bear in mind presenting the case as you *'craft'* the narrative. I think overall the presentation of the findings was a truthful account of the narratives and that they remained relevant to my research questions.

Traditionally, qualitative inquiry has concerned itself with '*what'* question types which as Gubrium and Holstein (2013) suggest is the hallmark of analytics of interpretative enquiry. The paradigm of the quantitative approach asks the '*why'* questions but this provides a limited basis for raising kinds of questions in the context of qualitative inquiry (Andrew et al., 2008). The study needed to seek meaning and why would have potentially been too broad a research question. The research questions:

- *What are the factors that exist between academia and practice that enable or constrain the partnering of nursing students if there is fitness to practice issue?*

- *What are the perceived understandings of fitness to practice between the partners?*
- *Are misconduct and disciplinary processes transparent between the academic and clinical setting?*

These '*what'* questions, however, can be reflective of the relevancy to my qualitative enquiry and therefore is a strength of the study as one needs to designate a domain of explanation for fitness to practice from the sought perspectives from the relevant stakeholder's accounts. Answering the question of what, I think, has been addressed in the discussion chapter through Braun and Clarks (2006) thematic analysis in a truthful representation of the participants' accounts.

Adopting Braun and Clark's (2006) thematic analysis was also an endeavour to reduce subjectivity. However, the move from coding to interpretation involves playing with and exploring the codes and categories that were created (Coffey and Atkinson, 1996). There has already been a demonstration of the need to code to uncover and categorize that data into meaningful findings, however simply having pure description is not enough. Wolcott (1994, p.9) heralds' interpretation as the threshold on thinking and writing "*at which the researcher transcends factual data and cautious analysis and begins to probe into what is to be made of them".* Therefore, the collection of narratives in qualitative research requires a start, middle and end but providing a logic to that narrative.

However, as Merriam (1998) suggests, theorising about data can also be hindered by thinking that it is linear rather than contextual. Furthermore, as suggested by Simons (2009) grasping the insight derived from the data may consider understandings gained from formal analysis but more emphasis is placed on retaining the holistic nature of the data. Preferring Wolcott's (1994) briefing that description is the fulcrum, or the pivotal base, but that

interpretation is more subtle analysis the findings presented balance, which neither fell too much towards description to falling too much on the side of speculation.

This is important, due to the small-scale exploratory study, where the findings may not be generalisable, but they can offer insight of pre-registration nurse education from the participant's views thereby providing analysis of the conceptual underpinnings of processes between partners, clinical aptness, and ownership. Thus to interpret the participant's views into a discussion to identify each partner's perspective toward ownership, when the claim is made that an interpretation derives from qualitative and descriptive enquiry, the link should be relevant and clear (Wolcott, 1994).

7.3 Chapter Summary and Recommendations

Academic input to the clinical setting is paramount in successful fitness to practice management. Through the academic role, a collegial relationship can be established and is essential and it is evident that mentor's value academic support. This support, from Education Champions, provides a vital networking relationship with practice partners when managing student matters of fitness to practice. However, the clinical staff do not get to be involved in the fitness matter, as they are cut off as soon as they have handed over to the HEI. For the fitness communication loop to be closed, and assurance of process and for public protection, working together on a dual process is needed. The clinical setting needs to take some charge.

This study has shown that process belongs to the HEI with the clinical setting acting as the key stakeholders of the profession to secure a student's competency. Whilst mentors are key to the identification, monitoring and evaluation of a student's competency, Education Champions are the allying ambassadors for university process with their mediation skills and willingness to attend to student maters swiftly. This academic position goes beyond a link lecturer role; they are the key connection between the professional body and the

university. Without them the practice setting would not be able to manage fitness to practice. The professional body have procured this to the HEI. Control over a student's ability, or failings, has become too engrossed in process and that they, the mentors, appear on the side lines even though it may be their registration at risk. Their signatures are ratification of a student's ability and cannot be underestimated.

It is, therefore, essential to understand the role; position and relationship academic and clinical colleagues have within the partnership and with each other. The practice setting assumes professionalism and clinical competence, but they are in fact bereft of ownership. There is clear evidence of a collegial working relationship between clinical staff and the academics, but the investigative role of the Education Champion has overtaken responsibility from clinical staff. University process has allowed this to occur and has been approved by the professional body. Control needs to be reasserted to the clinical setting and that Education Champions can participate in the support processes for students and mentors rather than leading the investigation. This must be practice led as they work with the students in the clinical setting for 50% of their course. The mentors also have a dedicated 40% time to monitor, action and facilitate their student's needs.

Fundamentally practice need to take the lead for clinical concerns and to complete a preliminary review and thorough investigation before the university is involved. This study has shown that clinical matters are immediately redirected to the university bypassing mentor involvement and therefore ownership and the researcher is confident that certain matters can be dealt with at the clinical setting. However, as a university awareness of process needs to be more transparent as currently it is only visible through the Education Champion or through the students PAD for the Personal Tutor to evaluate and record.

However, this can only occur if the PAD is correctly completed for recording purposes so that entry onto the register or for student progression is not hindered. Policy should match

Trust policy and the university and clinical setting should mirror each other. It is essential for future development that all matters clinical follow the university guidelines for the NMC Code of Conduct but is also reflected in the HEI disciplinary process. Therefore, my second recommendation is that the PAD is recognised as the vessel for monitoring, recording, and evaluating student progress for fitness to practice and not as simple competencies to be *'marked'*.

The concept of mentoring has become mixed with professional development and teaching, but the quality and amount of time devoted to mentoring is at odds with their perception of role modelling. This needs to be addressed with the professional bodies concept of mentoring. Mentoring should be role modelling but if there is conflict, such as needing the universities help with a fitness matter, the first mentor has already established a '*friendship*' role rather than act as a '*critical friend'* in the clinical setting.

Therefore, it could be suggested that a first and second mentor should provide different aspects of student support. The first should be a critical friend dealing with all matters clinical, professional, and developmental including assessment, the second should provide pastoral care and administrative support i.e., arranging placement experiences, date setting etc., and compiling learning contracts and actions plans as an objective observer and this is my recommendation. Mentors are the architects for future professional development but perceptions that completing the PAD is an administrative task, must be refocused on the student being the future professional and peer and should act as an encouragement for mentor's professional development for record keeping. Evidence has shown that '*filling the PAD out'* creates disconnect to valued record keeping. Additionally, team mentoring could be incorporated into the clinical setting.

The last recommendation is that the Personal Tutors remain impartial to outcomes of formative and summative assessment but are aware of process so they can offer objective

advice for their students. Whilst I appreciate this may create disconnect for their desire to provide clinical support, they must focus on academic tutoring rather than clinical management as the academic link-role Education Champion can provide support in an objective, disciplined fashion directly on the ward. The Education Champions and their team facilitate, mediate, and support the quality of the student practice learning experience, enhancing, developing, and promoting the efficient and effective delivery of education in practice. This was evident in the study and that they have clear collaborative relationships as part of their clinical link role responsibilities. Both parties valued this, and the Education Champion should be the lead of the link-lecturers, who could provide the day-to-day clinical visitations, but that the Education Champion is the strategic facilitator for the partnership. This should be a clearly established role recognised nationally and with the professional body.

Finally, any policy should involve direct mentor support and student dialogues with an academic advocate who should be the Education Champion. Fitness to Practice process within the HEI is simply the means to protect the public, but ownership before that stage needs to be owned by the clinical setting and this must be recognised by the professional body with policy curriculum amended reflecting this.

In conclusion, if given the fact that the HEI does own the student in terms of university registration, then by university standards the students are entitled to student rights. Academic regulations will invoke process for any academic or practice learning matters, and this has been demonstrated in this study by means of the university appeals system, PAD documentation, and through the manner that their competency is assessed and marked for fitness to practice. The partnership needs to be strengthened with clear protocols in place for each partner to be able to facilitate the investigation. This would assure process and uphold the standards expected by the NMC. Furthermore, whilst the pre-92 group did not register as expected, the balance of equal theory and practice did

ensure change for future working partnerships between the NHS, NMC and HEI. This therefore was an enhancement to improve, and share, responsibility more appositely.

7.4 Conclusions

According to Wisker (2012) a conclusion chapter serves two purposes; a) to summarise what has been; 1) researched; 2) discovered; 3) main argument; 4) challenged; 5) proved and 6) disproved and b) how it was done and to indicate both factual conclusions and conceptual conclusions. Therefore, under such indicative outlines I shall present my conclusions under each headed section to mirror Wisker (2012). More importantly as Trafford et al. (2014) state, the formal assessment for doctoral degrees are that candidates are required to evidence originality in the research that demonstrates the potential to make a significant contribution to knowledge and this originality is a characteristic of a doctoral degree. Simply expressed by Trafford et al. (2014) originality means that '*the study'* has not been done before. This study demonstrates originality in its application to the topic of ownership of fitness to practice in the arena of nurse academia.

7.4.1 Ownership of Fitness for Practice Between the Academic and Clinical Partnership

This study has examined ownership of fitness to practice within pre-registration nurse education between the academic and Practice Learning partner. By examining historical and contemporary professional body documentation, Government white papers, local university policy and pre-registration nurse education literature, I have explored the effect devolution of education from the traditional SoN to the HEI has altered ownership and how through professional body directions, a fissure of responsibility was produced between the academic and Practice Learning partner.

No longer under the influence of traditional SoN apprenticeship, Higher Education replaced ritual and routine with a curriculum of competency and mentorship under the model of Project 2000. Project 2000 was the construction of a new era of pre-registration nurse education and from Government intervention and professional body approval the HEI was the purveyor of producing a nurse fit for practice and was implemented across HEI's in the UK in 1989.

The educational change was instigated by the then professional body (UKCC) decreeing that students must achieve academic award and clinical proficiency to meet entry requirements of the nursing register. More recently orchestration by the NMC for the HEI to deliver the nursing programme with two parts of equal theory and practice. Curriculum was delivered in the academic environment with the Practice Learning Partner setting responsibility for the clinical assessment of students. This remains as the standard delivery pattern today. Principally, I think it was at this point in pre-registration history, the Practice Learning Partner appeared to contribute to the clinical education of nursing students but was unable to exert control over clinical assessment achievement as they appeared to be considered simply as the placement providers.

Devolution of pre-registration nurse education to the HEI was to assign competency standards, set by the then UKCC professional body, but were not the responsibility of nursing management or the regulatory council but of the individual nurse (Bradshaw, 2001c). Mentors were fundamental as assessors for competency to assure fitness for practice, but I think that this was when The Ownership Gap began to materialise. Evidenced by reports that Project 2000 student nurses had not entered the register as expected, thus initiated a review and the professional body commissioned The UKCC Fitness for practice, Commission for Nursing and Midwifery Education, (1999). This report highlighted deficiencies within Project 2000 and revisions were considered as essential to the education of nursing students.

7.4.2 Discovered

The study focused on the relationship between the academic environment, professional body requirements and Practice Learning partner. All three have been examined in terms of responsibility for fitness to practice and shared ownership of academic, professional, and clinical elements. These differing elements ranged from the role of the academic, mentor, policy, and the management of fitness to practice processes including my role as the DoS. Through the professional body and local university documentation, ownership of fitness to practice processes is maintained in the realm of the university and it appears that the Practice Learning Partner has limited involvement in the process.

This study has shown that ill-defined responsibilities of mentorship pre-2006 created a gap in what the professional body attempted to create as shared ownership of student learning. This, however, presented a dichotomy as the Practice Learning Partner were to produce a nurse fit for practice with responsibility being assigned to the mentor as assessor of student competency but the mentors role lacked clarity and this deficiency was not identified until the UKCC 1999 commissioned report.

Through the focus group narratives, valuable insight from the academic setting and Practice Learning Partner participants providing a unique and insightful account of their beliefs and perceptions to the inequitable partnership. Their narratives demonstrated demarcations of roles that have become confused and separated with the fissure of responsibility being widened since HEI delivery. This is in part due to a perceived loss in clinical management obligations for fitness to practice since the HEI now appear to *'own'* the process.

As a result, academic Education Champions are instrumental in the mediation of the student and mentor relationship for fitness to practice management. Personal Tutors commented and reflected upon their lack of engagement to the process and mentors were shown to refer issues immediately to the university rather than working through the CfC

first. This was reported from the narratives of mentors when expressing concerns over a student's competency by the comment '*your student'* when discussing a struggling student. This spoke volumes within the study and seemed highly suggestive of '*handing over'* responsibility to the academic arena.

The significance of Higher Education expectations throughout the study highlighted perceptions of the tutor role and the reality of its implementation within the Practice Learning partnership. This unique insight has mainly been due to the findings demonstrating role conflict from the academic perspective in conflict with their association to their profession practice and Practice Learning partner. Role conflict was significantly associated to the Education Champions role compared to the personal tutor's role.

7.4.3 Main Argument

The Nursing & Midwifery Council (2010,p.5) states that "…*The willingness of your university to sign the declaration of good health and good character for you to become a registered nurse or midwife".*

This willingness is not related to the clinical setting it is a direct ownership connection to the HEI. Mentors and sign-off mentors have the duty to declare the student's suitability as clinically competent, but this statement is reflective of the HEI's power as the awarding body. Mentors enforce the learning outcomes as a pass or fail but it must be remembered that the value of clinical judgment is essential. Whilst process must be adhered to for ensuring the smooth transition of results in readiness for upload to the professional register, it is still for debate whether the HEI should be the decider for a fitness case considering the clinical setting are inert within that process.

It is therefore important to view the subsequent processes and relationships in the light of the concurrent related changes and unintended consequences. Mentorship and the teaching and learning of nursing students were a key aspect of ownership. It was evident that there was a desire within the partnership to work in a cohesive manner, but it was clearly obvious from the narratives that process was identified as a factor that affected position and was a constraint.

7.4.4 Challenged

The element of blame for responsibility, and subsequently ownership, was deconstructed and represented in the ownership model. I made a unique connection of '*Education', 'Professionalism'* and *'Clinical Practice'* as the three-constituent parts to pre-registration nurse education with my model visually demonstrating The Ownership Gap. The gap is between '*Professionalism'* and *'Clinical Practice'* and is suggestive that the professional body and Practice Learning Partner are noticeably separated. This is a noticeable ownership gap and may be the reason for each partner to consider the other at fault for producing an unfit nurse. This element of the relationship between partners needs rebalancing.

This stems from evidence of the mentors calling upon the Education Champion to mediate student and mentor relationships suggesting that responsibility remains the responsibility of the academic arena and not the Practice Learning partner. More importantly the mentor role created another level to ownership in 2007 with instigation of the sign-off mentor role. This remains as standard for pre-registration nurse education, but the study has shown that mentors and sign-off mentors still display hesitancy about responsibility as evidenced in the findings.

7.4.5 Proved & Disproved- Answering the Research Questions

The mentor's role has diminished when managing difficult clinical student issues. Mentors did, however, value the academic support and found the CfC response strategy effective for managing both clinical issues and for the Education Champions mediation skills. Mentors expressing the need for university input expedited reporting such matters to the university. Uniquely to the study for the university the Education Champions provided the academic clinical link however the narratives were suggestive of mentors devolving responsibility to the Education Champions thus lessening their responsibility. The direct link to responsibility evidenced through mentor narrative of '*your student'* when the Education Champions were dealing with difficult situations students became university responsibility.

Moreover, the focus of managing clinical issues has concentrated on the university CfC response strategy, developed by myself as DoS to initiate, record and document any student matters in practice learning area.

The academics felt a sense of vulnerability and disconnect to clinical management, but the uniqueness of the study has shown that a lack of empowerment has been the by-product of university regulation and fitness to practice. This has kept the gap open, evidenced by the Practice Learning Partner expecting attendance of student matters by the Education Champion. Through the CfC response strategy, it is understandable that the mentor's hand over issues, and therefore responsibility, direct to the Education Champion when it is apparent that the HEI developed such a process to manage issues. This is suggestive therefore that ownership will continue to be disconnected between the partnership and may remain as a fissure in responsibility.

The academic focus groups expressed consternation about process and procedure with a focus on the PAD needing accurate recording of a student's achievements, record keeping and submission for university regulations and process.

Documentation was a notable aspect with conflict being demonstrated by participants for record keeping. Their viewpoints fluctuated between the PAD being used as a tool for monitoring purposes and not as a means for maintaining a progress record to be an administrative task needing to be completed in readiness for getting it done to meet university assessment submission deadlines. The most highlighting aspect of this was the use and belief system of the PAD as the key document for the recording of a student's competency and clinical proficiency through professional devised learning outcomes.

This documentation link was evident from the narratives with academic and clinical staffs' interpretation of the PAD and their beliefs of the PAD's purpose not being considered for action planning of formative needs in preparedness for the summative assessment. One new significant discovery was a lack of a holistic progression as the mentors sectionalised practice, and therefore fitness, into PAD component outcomes.

The mentors and sign-off mentor also displayed hesitancy in their assurance of a pass or fail result for a student. The mentors were reliant on previous clinical feedback to assure themselves that competency was being achieved. The narratives of the participants were noticeably clear on the need to complete this process, of marking the PAD and reviewing previous clinical placement outcomes, but it was the Education Champions who needed the process to be finalised accurately for recording purposes. The academics expressed a heightened sense of responsibility attached to professionalism whilst the mentors' focus was on completing the PAD outcomes. However, these thoughts and beliefs did not correlate with each other and affected the way the academic and the mentors would manage a struggling students' situation.

The expectation of role has been shown throughout literature to alter in context since HEI lead pre-registration nurse education, from Project 2000 onwards. Fundamentally my study showed that the mentors interviewed understand they mentor the students with academics

providing pastoral and academic care, but the two do not seem to be on common ground when monitoring a student's progress. It was evident that Personal Tutors wanted more involvement with the monitoring process rather than just being reviewers of the PAD outcomes at the end of the module.

This is an important problem for communication and process if there is a sense of reliance to one individual with the singular role of the Education Champion acting as the closest link between the partnership. Through their extensive collaborative support, Education Champions link academia to practice through regular visitations and assistance with university documentation and process and the resultant sub-themes demonstrate that the student's PAD and CfC response strategy provided the essential link between the partnership. However, throughout the study the findings suggested that each partner has certain thoughts and beliefs for how competency, and fitness to practice, is monitored, recorded, and actioned from the evidence presented. This is suggestive of established mentor beliefs and expectations associated to clinical ability awarding this with greater credence compared to the academics. However, the HEI process often overrode this.

7.4.6 Future study to inform education, clinical practice, and professional regulation

My study is the narrative of a moment in time in one university ending in 2017and has already been superseded in some situations due to the NMC reviewing and revising the roles of mentors and assessors in the Practice Learning environment and academic tutors in the HEI. It is therefore a challenge to replicate my research as the circumstances both in academia and practice continue to evolve with the change of how clinical assessment is processed with supervisors looking after students and assessors ensuring their competence. However, one thing that has not changed is the requirement that the nursing student be fit for practice at the end of their course, and for mentors (supervisors) to ensure

students are fit to practice during their education. However, it is also a key time to ensure that the process itself is fit for purpose.

In the very broadest sense, assurance that the FtP policy and process meets with the professional body standards, local Practice Learning partner application and HEIs rules and regulations. The implications of this study demonstrate that key players in the Practice Learning setting (mentors) and academics linked to practice from the HEI (Education Champions) oversee and facilitate the FtP process initially. Procedural obligation for the mentors to complete the CfC and for the Education Champions to escalate to the DoS has in some ways incumbered the process. Impeded by the completion of a CfC form, direct application of managing matters has become administrative and the Education Champions become the receivers of the forms often without immediate action from the mentors directly working with their allocated students.

The process of CfC places responsibility upon the mentor, and the sign-off mentor at the very last stage of a nursing students' course, but the HEI continues to lead at a procedural stage with their focus ensuring this is adhered too for the professional body. Process does need to be followed and the future for FtP management requires greater clarity of role and position of all parties within the process. The researcher calls for the ownership gap found within this study to widen the participation of the key decision makers to review policy both locally and nationally with all partners of the tripartite relationship.

This has been explored in detail within this study and a stronger message about the use, application and process of FtP remains cloudy. The Practice Learning partner does not appear to get involved in policy making and dissemination from the NMC to ward level, down to assessors, and this needs a greater focus on social and direct management. As the DoS, working with the Practice Learning partner in a long-arm capacity which is fundamental to objectivity of any specific case but there is still too much reliance on 'others'

to investigate initially. This requires change, which can only succeed if all parties are equal partners.

The professional doctorate has enhanced the topic and clearly defined roles and clarity of process will ensure that all key players have equal decision-making responsibilities and action as appropriate for the nursing student in question. Phrases such as ‘getting the book done’ and ‘it’s the universities problem’ are no longer valid arguments for managing difficult situations. The matter of FtP is not just administrative it is patient safety led but needs to span across all parties involved. There is no denying that FtP is an emotive subject but accountability and responsibility work hand in hand. The registered nurse needs distinct reporting processes and authority to monitor and action any professional concern. This could be achieved through the alignment of ‘near miss’s incidents local to the Practice Learning partner to mirror HEI process for parity of investigative and practical actions. Being awarded the authority to action and facilitate process will offer greater ownership to the mentors but with senior staff oversight and HEI process.

The NMC require the recording of achievements for nursing students and a portal to record and document as a patient safety measure has not appeared to have crossed over into the student world and their book. This was clear from the study and remains a task (to record and action) that seems to be avoided or referred on straight away.

Professional regulation is relatively straight forward. The NMC have offered through their standards of expectations with authority assigned to the HEI. From here a shift of accountability to use HEI processes as the means to address FtP matters is only one part of the action. The Practice Learning partner must begin to think about how they can own the process initially. This should come from a bottom-up approach, starting with nursing students and their mentors and then Practice Learning partners, academics and the HEI.

In many respects this was achieved by the NMC through the sign off mentor and by creating a person with greater responsibility and accountability is key to ensuring patient safety but there still appears a gap in reporting problems and managing them at first level and instance.

Moving forward from 2019 the NMC have suggested it is better to separate the role of supervision in practice, to permit more objective assessment of clinical competence. This change followed an NMC consultation, which found that named mentors did not always have the time to support students. Therefore, it is an expectation that all nurses and midwives should become supervisors or coaches. In the past there has been confusion over the difference between the role of mentor and sign off mentor, a lack of institutional support for the mentorship role, and a failure of mentors to manage failing students. Therefore, when supporting and assessing students, all registrants should be responsible for the supervision of students, and supervision and assessment are separate undertakings. This will include newly qualified nurse. The NMC will also no longer prescribe standards on the training of supervisors and assessors. Instead, there will be freedom for organisations to develop their own models, to allow for local circumstances, and utilise the skills of staff that are already experienced mentors.

From 2019 the NMC, after revisiting the requirements of nurse preregistration education by discussing the challenges with patients, nurses and employers have developed key components of the roles, responsibilities, and accountabilities of registered nurses. This includes the expects of the student when newly qualified, the requirements of the learning environment are also explored to ensure a safe and enhanced learning experience.

We believe that this approach provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate. These proficiencies will provide new graduates into the profession with the knowledge and

skills, they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills. For example, after they register with us registered nurses will already be equipped to progress to the completion of a prescribing qualification. (NMC 2018 b, p3)

Therefore, further research needs to be undertaken on the value of fitness to practice panels and whether student nurses are appropriately managed when they undergo the processes that are escalated.

The mentor participants within the study did positively endorse the CfC response strategy. With the revisions that separate supervisors from assessor's further interviews or focus groups need to be undertaken to review whether the current CfC approach is still pertinent to the management of professional issues. Now that the NMC require academics to be assessor this will also require farther investigation as this new role evolves.

There will still be a three-way bonding that may still have a complex arrangement due to the apparent rebalancing of the relationship between all three parts NMC, HEI and Practice Learning environment. Therefore, a further investigation needs to occur to see whether the gap increases or decreases as regard to the responsibility to students for fitness to practice. This needs to be undertaken at both a local, regional, and national level to ensure that lessons learnt can be rolled out thus ensuring parity and equality for students across the UK.

Other areas that research can be undertaken should include student nurse's experiences of FtP and their narratives regarding CfC processes and may even include FtP panels. This would enable developers of curriculum to acknowledge the students' needs when they are undertaking this potentially stressful process.

Whilst the NMC have gone a significant way with their recent review and revalidation of curriculum to balance the equity of power between the HEI and Practice Learning partners. It would be beneficial to investigate who and where the FtP process is best placed. This is not just about location it should also include balance of power and whether the Practice Learning Partner where the student was learning has ultimate say in the outcome of the students FtP panel. This could be undertaken as an action research study which would enable all participants to have a say in the final policy and procedures.

7.5 Reflections

Fundamentally I did not realise how differently I would feel as time progressed about the topic and often, I would worry that things appeared to be going in a different direction which was not in the original plan. However, you soon learn to '*go with the flow'* as the study developed.

As the DoS, the topic was truly relevant to my practice and an ongoing concern with regards to student experience which is a major part of my role within the faculty. One of the very first things I discovered was that the CfC form was not fit for purpose and therefore as part of my study this form evolved to fulfil the needs of both practices, the student, and the university.

My initial thoughts were focused on FtP being concerned with '*process'*, and therefore mechanical in its application between the clinical, academic, and professional body partnership, but through the participant narratives I soon realised the differences. The nuances of policy and its application to mentorship, academia, and implementation of fitness to practice was never dull and the connection to roles, between the working relationship, and the markedly different approaches between participants was quite astonishing.

A key finding was the sense of ownership and responsibility around the CfC policy developed. As the DoS, this local policy was adopted and utilised as a process to facilitate and manage concerns within the clinical setting. Ultimately it has been a useful process to address matters of competency and professionalism, but further developments are required. This requirement needs to focus on mentors and academics alike to produce a structured reporting process, essential to address any fitness concerns.

It is essential that assessment must remain with the mentor, but I found that one of the main challenges to this study was access to clinical participants. This presented as one of the greatest, time-consuming components and completing NHS ethical approval forms felt nothing short of tortuous and the process procedurally laborious. There were points where I was certain access to the practice area would not happen, leaving my research bereft of their essential involvement in student nurse education. Thankfully, access to academics was more straight forward. Access arrangements to participants will be exceptionally high on the list of to-dos in the future and a valuable lesson learnt. I think what worked well was using academic focus groups alongside clinical participants.

When exploring the new knowledge and insight I have gained in undertaking this qualitative case study I am gratified that both during and following data collection I have made significant improvement to both CfC processes and FtP procedures. Both by my direct involvement in reviewing and revising documentation but also being a significant lead in the working groups which will ultimately change experience both for nursing students and in the broader context of the university for all professional students including education and social work. Undertaking this study has significantly highlighted the relevance of my role and the impact it has on the student experience.

Where previously I was aware of my role it was while I undertook this study that it has crystallised the significant mediation element I have between all parties. This has enabled

the university to maintain a healthy balance between the needs of clinical placement and specially the vulnerable patients and the requirements of an academic course and the professional values of the NMC.

As I look forward to my developing role in the future and the continued requirements for open and transparent communication across the Practice Learning Partnership and the NMC, I am empowered by the findings to ensure that the CfC process is followed faithfully with shared responsibility and valid evidence so that the student receives both significant support and the appropriate outcome in line with the NMC four pillars of "*Prioritising people, Practising effectively, Preserving safety and Promoting professionalism and trust".* This also led me to co-authoring a chapter about fit to practice for new qualified staff, in a book to be published in 2019 on transitioning from student to qualified nurse.

References:

Abalos, E. E., Rivera, R. Y., Locsin, R. C. & Schoenhofer, S. O. 2016. Husserlain Phenomenology And Colaizzi's Method Of Data Analysis: Exemplar In Qualitative Nursing Inquiry Using Nursing As Caring Theory. *International Journal For Human Caring,* 20**,** 19-23.

Allen, D. 2009. The Legacy Of Project 2000. *Nursing Standard,* 23**,** 18-21.

Altheide, D. L. & Johnson, J. M. 2013. Criteria For Assessing Interpretive Validity In Qualitative Research. *In:* Denzin, N. K. & Lincoln, Y. S. (Eds.) *Handbook Of Qualitative Research.* Califronia: Sage Publications.

Andrew, N., Tolson, D. & Ferguson, D. 2008. Building On Wenger: Communities Of Practice In Nursing. *Nurse Education Today* [Online], 28. [Accessed November27, 2012].

Anglia Ruskin University 2013. A Students Guide To Our Personal Tutoring System. *Your Personal Tutor Will:.* Anglia Ruskin University.

Anon (n.d.) Oxford English Dictionary*.* Oxford University Press.

Anthony, S. & Jack, S. 2009. Qualitative Case Study Methodology In Nursing Resaerch: An Integrative Review. *Journal Of Advanced Nursing,* 65**,** 1171-1181.

Appleton, J. V. 1995. Analysing Qualitative Interview Data: Addressing Issues Of Validity And Reliability *Journal Of Advanced Nursing,* 22**,** 993-997.

Aveyard, H. 2002. Implied Consent Prior To Nursing Care Procedures. *Journal Of Advanced Nursing,* 39**,** 201-207.

Begley, C. 2008. Approaches To Research. *In:* Watson, R., Mckenna, H., Cowman, S. & Keady, J. (Eds.) Nursing Research Designs And Methods*.* USA: Churchill Livingstone Elsevier.

Bentley, H. 1996. The Need For Change In Nurse Education: A Literature Review. *Nurse Education Today,* 16**,** 131-136.

Berger, P. L. & Luckmann, T. 1967. The Social Construction Of Reality, A Treatise In The Sociology Of Knowledge*,* Great Britain, Penguin Books.

Berger, P. L. & Luckmann, T. 1991. The Social Construction Of Reality, A Treatise In The Sociology Of Knowledge, Great Britain, Penguin Books.

Berragan, L. 2011. Simulation: An Effective Pedagogical Approach For Nursing? *Nurse Education Today,* 31**,** 660-663.

Bland, A. J., Topping, A. & Wood, B. 2011. A Concept Analysis Of Simulation As A Learning Strategy In The Education Of Undergraduate Nursing Students *Nurse Education Today,* 31**,** 664-670.

Bloor, M., Frankland, J., Thomas, M. & Robson, K. 2001. *Focus Groups In Social Research,* London, Sage Publications Ltd.

Bradshaw, A. 2001a. The Autonomous Practitioner- Statutory And Educational Changes 1981-1986. *The Project 2000 Nurse.* London, Whurr Publishers.

Bradshaw, A. 2001b. Educating For Competence? Nurse Education 1985-1999. *The Project 2000 Nurse.* London: Whurr Publishers.

Bradshaw, A. 2001c. *The Project 2000 Nurse- The Remaking Of British General Nursing 1978-2000,* London, Whurr Publishers.

Bradshaw, A. & Merriman, C. 2007. Nursing Comptence 10 Years On: Fit For Practice And Purpose Yet? *Journal Of Clinical Nursing***,** 1263-1269.

Braun, V. & Clarke, V. 2006. Using Thematic Analysis In Psychology. *Qualitative Research In Psychology,* 3**,** 77-101.

Bray, L. & Nettleton, P. 2007. Assessor Or Mentor? Role Confusion In Professional Education. *Nurse Education Today,* 27**,** 848-855.

Bryman, A. (2015). *Social research methods* (5th ed.). OUP Oxford.

Burns,N. & Grove, S.K. 2011. Study guide for understanding nursing research, building and evidence-based practice. 5th edition, Saunders Elsevier.

Carney, M. 2016. Regulation Of Advanced Nurse Practice: Its Existence And Regulatory Dimensions From An International Perspective. *Journal Of Nursing Management,* 24**,** 105-114.

Cassidy, S. 2009. Interpretation Of Competence In Student Assessment. *Nursing Standard,* 23**,** 39-46.

Chadwick, G. (2008) Methods of data collection in qualitative research: interviews and focus groups. *British dental journal*. [Online] 204 (6), 291–295.

Chun-Heung, L. & French, P. 1997. Education In The Practicum: A Study Of The Ward Learning Climate In Hong Kong. *Journal Of Advanced Nursing,* 26**,** 455-462.

Clancy, J., McVicar,A., & Bird,D., 2000. Getting it right? An exploration of issues relating to the biological science in nurse education and nursing practice. Journal of Advanced Nursing, 32,6, 1522-1532.

Clark, L. & Casey, D. 2016. Support For Mentors-An Exploration Of The Issues. *British Journal Of Nursing,* 25**,** 1095-1100.

Coffey, A. & Atkinson, P. 1996. Making Sense Of Qualitative Data: complementary rsearch strategies*.* Thousand Oaks, California, Sage Publications.

Cohen, D. & Crabtree, B. 2006. Semi-Structured Interviews. *Qualitative Research Guidelines Project* [Online]. [Accessed 27 November 2020].

Cope, P., Cuthbertson, P. & Stoddart, B. 2000. Situated Learning In The Practice Placement. *Journal Of Advanced Nursing,* 31**,** 850-856.

Cousin, G. 2009. Researching Learning In Higher Education: An Introduction To Contemporary Methods And Approaches, New York, Routledge (online).

Creswell, J. W. 2009. Research Design. Qualitative, Quantitative, And Mixed Methods Approaches, Los Angeles, Sage Publications.

Crook, D. 2008. Some Historical Perspectives On Professionalism. *In:* Cunningham, B. (Ed.) *Exploring Professionalism* London: Institute Of Education,University Of London.

Cruz,E.V., Higginbottom,G. 2013. The use of ethnography in nursing research. Nurse Researcher, 20,4, 36-43.

Daniels, F. M. & Khanyile, T. D. 2013. A Framework For Effective Collaboration: A Case Study Of Collaboration In Nursing Education In The Western Cape, South Africa. *Nurse Education Today***,** 956-961.

Data Protection Act. 1998. http;//www.legislation.gov.uk.

David, T. J. & Lee-Wolf, E. 2010. Fitness To Practise For Student Nurses: Principles, Standards And Procedures. *Nursing Times,* 106**,** 23-26.

Denzin, N. K. 1994. The Art And Politics Of Interpretation. *In:* Denzin, N. K. & Lincoln, Y. S. (Eds.) *Handbook Of Quallitative Research.* London: Sage Publications Ltd.

Denzin, N. K. & Lincoln, Y. S. 2013. Strategies Of Qualitative Inquiry*,* California, Sage Publications.

Department Of Health 1999. Making A Difference*. In:* Department Of Health (Ed.). London: Department Of Health.

Dey, I. 1993. Qualitative Data Analysis*,* London, Routledge.

Doman, M., Prowse, M. & Webb, C. 2004. Exploring Nurses' Experiences Of Providing High Dependency Care In Children's Wards. *Journal Of Child Health Care,* 8**,** 180-197.

Doody, O., Slevin, E. & Taggart, L. 2013. Focus Group Interviews In Nursing Research: Part 1. *British Journal Of Nursing,* 22**,** 16-19.

Duffy, K. 2003. Failing Students: A Qualitative Study Of Factors That Influence The Decisions Regarding Assessment Of Students' Competence In Practice. Nursing And Midwifery Council.

Duffy, K., Hardicre, J. (2007) Supporting failing students in practice 1: assessment. Nursing Times; 103: 47, 28–29.

Durham, W., Sykes, C., Piper, S. & Stokes, P. 2015. Conceptual Frameworks and Terminology In Doctoral Nursing Research. *Nurse Researcher* [Online], 23(2):8-12. doi:10.7748/nr.23.2.8.s3.

Edwards, S. 1999. The Idea Of Nursing Science. *Journal Of Advanced Nursing* [Online], 29. [Accessed November 27,2012].

Edwardson, S. R. 2007. Conceptual Frameworks Used In Funded Nursing Health Services Research Projects. *Nursing Economics,* 25**,** 222-227.

Elcock,K. 2014. Protecting the public through collaboration and shared ownership. British Journal of Nursing, 23,9.

Elkan, R. & Robinson, J. 1995. Project 2000: A Review Of Published Research. *Journal Of Advanced Nursing,* 22**,** 386-392.

Ellis,J., Lee-Woolf,E., & David,T. 2011. Supporting nursing students during fitness to practise hearings. Nursing Standard, 25,32.

English National Board. 1987. (http://discovery.nationalarchives.gov.uk).

Farrand, P., Mcmullan, M., Jowett, R. & Humphreys, A. 2006. Implementing Competency Recommendations Into Pre-Registration Nursing Curricula: Effects Upon Levels Of Confidence In Clinical Skills. *Nurse Education Today,* 26**,** 97-103.

Felstead, I. 2013. Role Modelling And Students' Professional Development. *British Journal Of Nursing*.

Fisher, W. P. & Stenner, A. J. 2011. Integrating Qualitative And Quantitative Research Approaches Via The Phenomenological Method. *International Journal Of Multiple Research Approaches,* 5**,** 89-103.

Flyvberg, B. 2013. Case Study. *In:* Denzin, N. K. & Lincoln, Y. S. (Eds.) *The Sage Handbook Of Qualitative Research.* 4 Ed. Los Angeles: Sage.

Gainsbury, S. 2010. Mentors Passing Students Despite Doubts Over Ability. *Nursingtimes.Net* [Online]. Available: Http://Www.Nursingtimes.Net/Whats-New-In-Nursing/News-Topics/Health-Workforce/Mentors-Passing-Students-Despite-Doubts-Over-Ability/5013922.Article [Accessed 09.04.14].

Gardner, L. 2012. From Novice To Expert: Benner's Legacy For Nurse Education. *Nurse Education Today,* 32**,** 339-340.

Gidman, J., Humphreys, A. & Andrews, M. 2000. The Role Of The Personal Tutor In The Academic Context. *Nurse Education Today,* 20**,** 401-407.

Gosby, J. 2007. Ensuring Safe And Effective Practice: Fitness For Practice At The Point Of Registration. *JPP,* 17**,** 384-390.

Goudreau, J., Pepin, J., Dubois, S., Boyer, L., Larue, C. & Legault, A. 2009. A Second Generation Of The Competency-Based Approach To Nursing Education *International Journal Of Nursing Education Scholarship,* 6**,** 15.

Gray, M. A. & Smith, L. N. 2000. The Qualities Of An Effective Mentor From The Student Nurse's Perspective: Findings From A Longitudinal Qualitative Study. *Journal Of Advanced Nursing,* 32**,** 1542-1549.

Greaney, A.-M., Shhey, A., Heffernan, C., Murphy, J., Mhaolrunaigh, S. N., Heffernan, E. & Brown, G. 2012. Research Ethics Application: A Guide For The Novice Researcher. *British Journal Of Nursing,* 21**,** 38-43.

Green,H. 2014. Use of theoretical and conceptual frameworks in qualitative research. Nurse Researcher, 21,6.

Griffiths, P. 2006. Being A Research Participant: The Nurse's Ethical And Legal Rights. *British Journal Of Nursing,* 15**,** 386-390.

Gubrium, J. F. & Holstein, J. A. 2013. Analyzing Interpretive Practice. *In:* Denzin, N. K. & Lincoln, Y. S. (Eds.) *Strategies Of Qualitative Inquiry.* Second Ed. London: Sage Publications,Inc.

Hart, C. (1998) Doing a literature review : releasing the social science research imagination. London: SAGE.

Hartley, J. 2004. Case Study Research. *In:* Cassell, C. & Symon, G. (Eds.) *Essential* Guide To Qualitative Methods In Organizational Research. London: SAGE Publications Ltd.

Helminen, K., Coco, K., Johnson, M., Turunen, H. & Tossavainen, K. 2016. Summative Assessment Of Clinical Practice Of Student Nurses: A Review Of The Literature. *International Journal Of Nursing Studies,* 53**,** 308-319.

Holland, K., Roxburgh, M., Johnson, M., Topping, K., Watson, R., Lauder, W. & Porter, M. 2010. Fitness For Practice In Nurising And Midwifery Education In Scotland, United Kingdom. *Journal Of Clinical Nursing,* 19**,** 461-469.

Houghton, C., Casey, D., Shaw, D. & Murphy, K. 2012. Staff And Students' Perceptions And Experiences Of Teaching And Assessment In Clinical Skills Laboratories: Interview Findings From A Multiple Case Study. *Nurse Education Today,* 32**,** 29-34.

Hughes, R. & Huby, M. 2002. The Application Of Vignettes In Social And Nursing Research. *Journal Of Advanced Nursing,* 37**,** 382-386.

Hughes, S. J. 2004. The Mentoring Role Of The Personal Tutor In The 'Fitness For Practice' Curriculum: An All Wales Approach. *Nurse Education Today,* 4**,** 271-278.

Hunter, D. 2010. How Clinical Practice Placements Affect Professional Development. *Emergency Nurse,* 18**,** 30-34.

Huybrecht, S., Loeckx, W., Quaeyhaegens, Y., Tobel, D. D. & Mistiaen, W. 2011a. Mentoring In Nursing Education: Perceived Characteristics Of Mentors And The Consequences Of Mentorship. *Nurse Education Today,* 31**,** 274-278.

Jokelainen, M., Tossavainen, K., Jamookeeah, D. & Turunen, H. 2013. Seamless And Committed Collaboration As An Essential Factor In Effective Mentorship For Nursing Students: Conceptions Of Finnish And British Mentors. *Nurse Education Today,* 33**,** 437-443.

Kamberelis, G. & Dimitriadis, G. 2011. Focus Groups. *In:* Denzin, N. K. & Lincoln, Y. S. (Eds.) The SAGE Handbook Of Qualitative Research. 4 Ed. California: Sage.

Kenny, G. 2004. The Origins Of Current Nurse Education Policy And Its Implications For Nurse Educators. *Nurse Education Today,* 24**,** 84-90.

Keogh, K. 2013. Transgressing The Code- Why Fitness To Practise Is An Undergraduate Issue. *Nursing Standard,* 28**,** 14-15.

Killam, L. A., Montgomery, P., Luhanga, F. L., Adamic, P. & Carter, L. M. 2010. Views On Unsafe Nursing Students In Clinical Learning. *International Journal Of Nursing Education Scholarship,* 7**,** 17.

King's College London 2009. Nursing Competence: What Are We Assessing And How Should It Be Measured? *Policy+ National Nursing Research Unit.*

Lincoln, Y. S. & Guba, E. G. 1985a. Lincoln And Guba's Evaluative Criteria. *Qualitative Research Guidelines Project* [Online]. Available: Http://Www.Qualres.Org/Homelinc-3684.Html [Accessed 20/05/2015].

Lincoln, Y. S. & Guba, E. G. 1985b. *Naturalistic Inquiry,* London, SAGE Publications Inc.

Litosseliti, L. 2003. Using Focus Groups In Research*,* London, Continuum.

Lloyd-Jones, M., Walters, S. & Akehurst, R. 2001. The Implications Of Contact With The Mentor For Preregistration Nursing And Midwifery. *Journal Of Advanced Nursing,* 32**,** 151-160.

Longhurst, R. 2016. Semi-Structured Interviews And Focus Groups. *In:* Clifford, N., Cope, M., Gillespie, T. & French, S. (Eds.) *Key Methods In Geography.* London: Sage.

Maclaren, J., Haycock-Stuart, E., Mclachlan, A. & James, C. 2016. Understanding Pre-Registration Nursing Fitness To Practise Processes. *Nurse Education Today***,** 412-418.

Macleod-Clark, J., Maben, J. & Jones, K. 1997. Project 2000. Perceptions Of The Philosophy And Practice Of Nursing: Preparation For Practice. *Journal Of Advanced Nursing,* 26**,** 246-256.

Merriam, S. B. 1988. Case Study Research In Education A Qualitative Approach*,* San Francisco, Jossey-Bass Inc.

Merriam, S. B. 1998. Qualitative Research And Case Study Applications In Education*,* San Francisco, Jossey-Bass Publishers.

Miles, M. B. & Huberman, A. M. 1994. *Qualitative Data Analysis An Expanded Sourcebook,* California, Sage Publications.

Moule, P. and Goodman, M. 2009. Nursing Research. An introduction. SAGE.

National Health Service, Health Research Authority. accessed 2012 https://www.hra.nhs.uk

National Nursing Research Unit 2009. Nursing Competence: What Are We Assessing And How Should It Be Measured? *Policy+*.

Noble, H. & Mitchell, G. 2016. What Is Grounded Theory? *Evidenced Based Nursing,* 19**,** 34-35.

Nurses, Midwives and Health Visitors Act 1979. 1983, The English National Board (http://www.legislation.gov.uk/ukpga/1979/36/contents accessed August 2017).

Nursing & Midwifery Council 2006. Standards To Support Learning And Assessment In Practice. London: Nursing & Midwifery Council.

Nursing & Midwifery Council 2008. Standards To Support Learning And Assessment In Practice. London: NMC.

Nursing & Midwifery Council (2008) Nursing And Midwifery Council Standards For Mentors,Practice Teachers And Teachers. *2.1 NMC Mentor Standard.* London.

Nursing & Midwifery Council 2009a. Guidance On Professional Conduct. *What Does The NMC Do?* London: NMC.

Nursing & Midwifery Council. 2009b. *Guidance On Professional Conduct For Nursing And Midwifery Students* [Online]. London: NMC. Available: Http://Www.Nmc-Uk.Org/Students/Guidance-For-Students/ [Accessed 31.03.14 2014].

Nursing & Midwifery Council 2009c. Guidance On Professional Conduct For Nursing And Midwifery Students. London: NMC.

Nursing & Midwifery Council 2010. Good Health And Good Character:
Guidance For Approved Education Institutions. *In:* NMC (Ed.). London: NMC.

Nursing & Midwifery Council 2015. The Code Professional Standards Of Practice And Behaviour For Nurses And Midwives. *Work Cooperatively.* London: Nuring & Midwifery Council.

Nursing & Midwifery Council 2007. Guidance For The Introduction Of The Essential Skills Clusters For Pre-Registration Nursing Programmes. Why Is The NMC Introducing Essential Skills Clusters. Nursing Midwifery Council.

Nursing & Midwifery Council 2008. Standards To Support Learning And Assessment In Practice. *3.2.3* Allocated Learning Time For Mentor Activity. London: Nursing Midwifery Council.

Nursing & Midwifery Council 2010. Standards For Pre-Registration Nursing Education. Section 1: Introduction. London: Nursing Midwifery Council.

Nursing & Midwifery Council, 2018. Ensuring public safety, enabling professionalism London: Nursing Midwfiery Council.
Nursing Standard 2013. NMC Report Reveals Fall In Ftp Referrals. *Nursing Standard,* 28**,** 10.

O'Brien,B.C.,Harris,I.B.,Beckman,T.J.Reed,&D.A.,Cook,D.A. 2014. Standards for Reporting Qualitative Research: A Synthesis of Recommendations. Academic Medicine,Vol.89,No.9.

O'Driscoll, M. F., Allan, H. T. & Smith, P. A. 2010. Still Looking For Leadership - Who Is Responsible For Student Nurses' Learning In Practice? *Nurse Education Today,* 30**,** 212-217.
O'Mara, L., Mcdonald, J., Gillespie, M., Brown, H. & Miles, L. 2014. Challenging Clinical Learning Evironments: Experiences Of Undergraduate Nursing Students. *Nurse Education In Practice,* 14**,** 208-213.

Ousey, K. 2011. The Changing Face Of Student Education And Training Programmes. *Wounds UK,* 7**,** 70-76.

Palamar,M., Doan,T.Le., & Friedman,O. 2012. Acquring ownership and the attribution of responsibility. Elsevier Acquiring ownership and the attribution of responsibility - ScienceDirect (doi.org)

Papastavrou,E., Lambrinou,E., Tsangari,H., & Saarikoski,M. 2010. Student nurses experience of learning in the clinical environment. Nurse Education in Practice, 10,176-182.

Peters, K., Halcomb, E. J. & Mcinnes, S. 2013. Clinical Placements In General Practice: Relationships Between Practice Nurses And Tertiary Institutions. *Nurse Education In Practice,* 13**,** 186-191.

Proctor, S. 2010. Independent Inquiry Into The Colin Norris Incidents At Leeds Teaching Hospitals NHS Trust In 2002. Yorkshire And The Humber Strategic Health Authority: Yorkshire And The Humber Strategic Health Authority.

Rafferty, D. 1992. Implications Of The Theory/Practice Gap For Project 2000 Students. *British Journal Of Nursing,* 1**,** 507-513.

Redmond, R. & Curtis, E. 2009. Focus Groups: Principles And Process. *Nurse Researcher,* 16**,** 57-69.

Reid, A. 2010. Identifying Medical Students At Risk Of Subsequent Misconduct. *BMJ,* 340**,** 1041.

Rhodes, S. & Jinks, A. 2005. Personal Tutors' Views Of Their Role With Pre-Registration Nursing Students: An Exploratory Study. *Nurse Education Today,* 25**,** 390-397.

Ricketts,B. 2011. The role of simulation for learning within pre-registration nursing education- A literature review. Nurse Education Today,31.

Rixon, J. & Brooks, C. 2012. Bridging The Skills Gap. *Nursing Standard,* 26**,** 60.

Robert Francis QC 2013. Report Of The Mid Staffordshire NHS Foundation Trust Public Inquiry. Commons, Home. Office. (Ed.). London: The Stationery Office.

Robert Wood Johnson Foundation 2008. Focus Groups. *Qualitative Research Guidelines Project.*

Rooke, N. 2014. An Evaluation Of Nursing And Midwifery Sign-Off Mentors, New Mentors And Nurse Lecturers' Understanding Of The Sign-Off Mentor Role. *Nurse Education In Practice,* 14**,** 43-48.

Royal College Of Nursing 2007. Guidance For Mentors Of Nursing Students And Midwives. London: Royal College Of Nursing.

Scott, S. D. 2008. 'New Professionalism' - Shifting Relationships Between Nursing Education And Nursing Practice. *Nurse Education Today***,** 240-245.

Sharples, K. 2007. Sign For Success. *Nursing Standard,* 21**,** 64.

Simons, H. 2009. Case Study Research In Practice, London, Sage.

Sprinks, J. 2012. Audit Exposes A Lack Of Progress In Addressing Problems At NMC. *Nursing Standard,* 27**,** 11.

Stake, R. E. 1995. The Art Of Case Study Research*,* California, Sage Publications.

Stokes, P. 2008. Colin Norris: From Student To Deadly Abuser. *The Telegraph*, 2 March.

Stuart, C. C. 2007. Assessment, Supervision And Support In Clinical Practice. A Guide For Nurses, Midwives And Other Health Professionals, Edinburgh, London, Churchill Livingstone Elsevier.

Sturgeon, D. 2012. Higher education reform: conflict of interest or enhanced experience? British Journal of Nursing, 21, 1.

Swain, J., Pufahl, E. & Williamson, G. R. 2003. Do They Practise What We Teach? A Survey Of Manual Handling Practice Among Student Nurses. *Journal Of Clinical Nursing,* 12**,** 297-306.

Teatheredge, J. 2010. Interviewing Student And Qualified Nurses To Find Out What Makes An Effective Mentor. *Nursing Times,* 106**,** 19-21.

Tee, S. R. & Jowett, R. M. 2008. Achieving Fitness To Practice: Contributing To Public And Patient Protection In Nurse Education. *Nurse Education Today***,** 9.

Thomas, G. 2011. How to do your case study. SAGE.

Trafford, V., Lesham, S. & Bitzer, E. 2014. Conclusion Chapters In Doctoral Theses: Some International Findings. *Higher Education Review,* 46**,** 52-81.

United Kingdom Central Council 1986. Project 2000 UKCC A New Preparation For Practice. London: United Kingdom Central Council For Nursing, Midwifery And Health Visiting.

United Kingdom Central Council 1999. Fitness For Practice. London: The UKCC Commission For Nursing And Midwifery Education.

Unluer,S. 2012. Being an insider researcher while conducting case study research. Qualitative report 17 (29), 1-.

Vaughn, S., Shay, J. & Singagub, J. 1996. Preparing For The Focus Group. Thousand Oaks: Sage.

Velasco, E. 2012. Inclusion Criteria. Encyclopaedia of Research Design. SAGE Publications online access https://dx.doi.org/10.4135/9781412961288

Velasco, E. 2012. Exclusion Criteria. Encyclopaedia of Research Design. SAGE Publications online access http://dx.doi.org/10.4135/9781412961288

Watkins, M. J. 2000. Competency For Nursing Practice. *Journal Of Clinical Nursing,* 9**,** 338-346.

Watson, N. A. 1999. Mentoring Today-The Students' Views. An Investigative Case Study Of Pre-Registration Nursing Students' Experiences And Perceptions Of Mentoring In One Theory/Practice Module Of The Common Foundation Programme On A Project 2000 Course. *Journal Of Advanced Nursing,* 29**,** 254-262.

Watson, R. 2006. Is There A Role For Higher Education In Preparing Nurses? *Nurse Education Today,* 26**,** 622-626.

Watson, R., Mckenna, H., Cowman, S. & Keady, J. 2008. Nursing Research Designs And Methods, Churchill Livingstone.

Watson, S. 2004. Mentor Preparation: Reasons For Undertaking The Course And Expectations Of The Candidates. *Nurse Education Today,* 24**,** 30-40.

Watts, T. E. 2011. Supporting Undergraduate Nursing Studnets Through Structured Personal Tutoring: Some Reflections. *Nurse Education Today,* 31**,** 214-218.

Wells, L. & Mcloughlin, M. 2014. Fitness To Practice And Feedback To Students: A Literature Review. *Nurse Education In Practice,* 14**,** 137-141.

Whitty, G. 2008. Changing Modes Of Teacher Professionalism: Traditional, Managerial, Collaborative And Democratic. *In:* Cunningham, B. (Ed.) Exploring Professionalism. London: Institute Of Education,University Of London.

Williams, A. 2008. Ethnography. *In:* Watson, R., Mckenna, H., Cowman, S. & Keady, J. (Eds.) Nursing Research Designs And Methods. USA: Churchill Livingstone Elsevier.

Wilson-Barnett, J., Butterworth,T., White,E,. Twinn,S., Davies,S & Riley,L., 1995. Clinical support and the Project 2000 nursing student: factors influencing this process. Journal of Advacned Nursing, 21, 1152-1158.

Wisker, G. 2012. The Good Supervisor, Hampshire, Palgrave Macmillan.

Wolcott, H. F. 1994. Transforming Qualitative Dat*a,* California, Sage Publications.

Woodcock, J. 2009. Supporting Students Who May Fail. *Emergency Nurse,* 16**,** 18-21.

Wright,K. 2006. The role of health-care assistants in supporting student nurses. Nursing & Residential Care, 8,1.

Yin,R.K. 1993. Applications of case study research. SAGE.

Yin,R.K. 1999. Enhancing the Quality of Case Studies in Health Services Research. HSR:Health Services Research 34:5 Part II.

Yin, R. K. 2009. Case Study Research Design And Methods*,* California, Sage.

Appendix 1.

Appendix [redacted] Cause for Concern response strategy

[redacted]

Cause for Concern Process

Urgent issues related to student progress

Student is struggling with elements of practice/professionalism.
This needs to be identified early.
This may be 2nd or 3rd week of placement or at any time prior to a formative/summative assessment.

↓

Mentor to discuss with student.
Develop an action plan and agree a date for review.
Document in student's practice book.
If required, arrange tripartite meeting for student/mentor/link lecturer

↓

Mentor and student review action plan.

OBJECTIVES MET NO FURTHER ACTION ←

↓ OBJECTIVES NOT MET

Mentor completes a Cause for Concern form and documents the following in student's practice book:
- Identify clearly the failed practice outcomes
- Complete formative feedback
- Complete summative feedback, clarifying the reasons for failure.

↓

Mentor to discuss the action plan required with Education Champion/link team.

↓

Within 2 working days, Education Champion/Link Team to:
- Collect photocopy of cause for concern form
- Check student practice document has been completed
- Inform personal tutor.

For examples of action plans, please visit the mentor portal at [redacted]
All action plans should relate to the practice outcomes that need further development.

Revised May 2016

[redacted]

Cause for Concern Process

Urgent student concerns which impact on patient safety

Serious concerns/complaint about the student's professional behaviour and/or there is a risk to patient & colleague safety.

OR

A serious incident occurs.(Mentors must always follow SUI policy)

↓

Mentor to discuss with student and complete either one or both of the following **immediately following the discussion**:

- Incident form in accordance with local policy
- Cause for Concern form.

↓

Mentor to contact Placement Education Lead & Education Champion within 24 hours to inform them Cause for Concern form completed.

↓

Education Champion to:

- Inform Course Lead
- Collect photocopy of Cause for Concern form within 24 hrs
- In liaison with Placement Education Lead, gather all supporting evidence within 5 working days of receipt of form (See mentor portal for Supporting Evidence template www.anglia.ac.uk/mentors)

↓

Course Lead presents evidence to Director of Studies within 5 working days of receipt of Cause for Concern form.

↓

Director of Studies:

- Send holding email to student, Education Champion, Course Lead and Placement Education Lead
- Review evidence
- Decide on appropriate course of action
- Inform Placement Education Lead of outcome within 5 working days of receiving evidence.

For examples of action plans, please visit the mentor portal at [redacted]
All action plans should relate to the practice outcomes that need further development.

Revised May 2016

[redacted]

Cause for Concern form (Professional behaviour / Competency issues)

Trust / Organisation Details	
Trust / Organisation Name:	
Clinical Area:	

Mentor Details		Student Details	
Name:		Name:	
Email:		Cohort:	

Education Champion [redacted]	
Trust/Organisation Placement Education Lead:	

Key Issues: ***Please list in the form of bullet points below:***

Actions taken to date: ***Please mark responses below:***

An action plan is completed in the Practice Document and directly relates to student performance:	YES	NO
Written formative feedback for Interpersonal Skills/Practice outcome assessment is evident in the Practice document, directly relating to the action plan/student performance:	YES	NO
Summative feedback for Interpersonal Skills/Practice outcome assessment is evident in the Practice document, directly relating to student performance:	YES	NO
Verbal feedback given:	YES	NO

MENTOR ACTION

On completion please photocopy this form with supporting evidence, if required, and submit to the Education Champion/Link team.

Date Education Champion / Link team contacted:

EDUCATION CHAMPION ACTION

On receiving the photocopy of this form, please check if supporting evidence is required and forward to the Course Lead.

Name of Course Lead:	
Date Course Lead contacted:	

MENTOR: Please see mentor portal: [redacted] for template for additional supporting evidence

Please do not remove this form from the Practice Assessment Document

Updated May 2016

[redacted]

Statement of Event or Incident

Evidence to support concerns related to a student

Placement details	
Trust/Organisation name:	
Clinical Area:	
Date of Event:	
Student Involved:	

Statements of event / incident:

Please provide a chronological summary with factual information / data

Summary of actions taken:

Please provide details of actions taken and persons involved. Please attach any/all supportive evidence

Date statement completed: _____

Completed by (Name): _____

Signature: _____

Date forwarded to Education Champion ARU: _____

Version 1 May 2016

Appendix 2.

Appendix 4 Ethical Approval documentation

22 August 2012

[redacted]

Martella Chambers

[redacted]

Dear Martella,

Re: Application for Ethical Approval

Project Number: 11/090

Project Title: Fitness for practice within pre-registration nurse education, whose responsibility? An exploration of ownership tensions between academia and practice

Principal Investigator: Martella Chambers

Thank you for resubmitting your documentation in respect of your application for ethical approval. This has been reviewed by the Chair of the Faculty [redacted] Research Ethics Panel (FREP) in advance of the next scheduled meeting in September.

I am pleased to inform you that your research proposal has been approved by the Faculty Research Ethics Panel under the terms of [redacted] *Policy and Code of Practice for the Conduct of Research with Human Participants.* Approval is for a period of one year from 22 August 2012.

It is your responsibility to ensure that you comply with [redacted] Policy and Code of Practice for Research with Human Participants and specifically:

- The procedure for submitting substantial amendments to the Panel, should there be any changes to your research. You cannot implement these changes until you have received approval from FREP for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the FREP Secretary copies of this documentation.

- Any laws of the country where you are carrying the research out (if these conflict with any aspects of the ethical approval given, please notify FREP prior to starting the research).
- Any professional codes of conduct relating to research or research or requirements from your funding body (please note that for externally funded research, a project risk assessment must have been carried out prior to starting the research).
- Notifying the FREP Secretary when your study has ended.

Information about the above can be obtained on our website at:

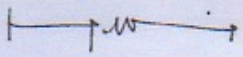
[redacted]

Please also note that your research may be subject to random monitoring by the Panel.

Please be advised that, if your research has not been completed within one year, you will need to apply to our Faculty Research Ethics Panel for an extension of ethics approval prior to the date your approval expires. The procedure for this can also be found on the above website.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely



Dr Leslie Gelling
For the Faculty ([redacted] Research Ethics Panel

T: 0845 196 2529
E: leslie.gelling@[redacted]

cc:

Prof. Sharon Andrew (Supervisor)
Beverley Pascoe (RESC Secretary)

R&D Reference: 2013/034		REC Reference: 11/090			
NIHR ID: N/A		IRAS NO: 129860			Target Recruitment: 6
Study: Fitness for Practice: Partnership Perspectives – Academic & Practice.					
Document	**Required**	**Dated**	**Signed**	**Version**	**Date Received by R&D**
NHS REC form parts A,B	Yes	21/05/2013	Yes		02/09/2013
SSI Form	Yes	29/05/2013	No		02/09/2013
REC letter of approval [redacted]	Yes	22/10/2012	Yes		11/09/2013
Participant Information Sheet	Yes	30/05/2013		1.0	02/09/2013
Consent Form	Yes	30/05/2013		1.0	02/09/2013
Interview schedule	Yes	30/05/2013		1.0	02/09/2013
Focus group trigger questions	Yes	30/05/2013		1.0	02/09/2013
Letter of confirmation from Sponsor	Yes	18/05/2013	Yes		02/09/2013
Insurance / Indemnity statement	Yes	09/07/2012	Yes		02/09/2013
Authorisation – Service Support Manager	Yes	04/03/2013	Yes		02/09/2013
CV of Chief Investigator/Principal Investigator	Yes	20/06/2013	No		02/09/2013
Peer review or scientific critique	N/A				
Risk Assessment Tool	Yes	02/09/2013	Yes		02/09/2013
Letter of Access	Yes	11/07/2014	Yes		11/07/2014

[redacted] Hospital University NHS Foundation Trust

Summary of conditions of approval for all Research studies

Your study has been given Trust approval to proceed by the Trust's R&D Steering Group.
Any conditions of this approval, which are specific to your individual study, will be outlined on the front page of this document.
In addition, there are a number of common conditions of approval for all studies conducted within the Trust. These are outlined below:

1) All medical research involving human subjects should undergo ethical review by an independent ethics committee, visit http://www.nres.ncsa.nhs.uk/ Local contact: [redacted]. Tel: [redacted]

2) All research must comply with current law, good practice guidelines and standards of conduct (all as amended from time to time). In particular, all people and organisations involved in research should be aware of their responsibilities under the following:
   - *'Research Governance Framework for Health and Social Care', Second edition 2005*
   - *Trust current R&D policy*
   - *International Conference on the Harmonisation of Good Clinical Practice Guidelines (ICH-GCP)*
   - *Declaration of Helsinki*
   - *Data Protection Act and Caldicott Principles*
   - *Health & Safety Act*
   - *Medicines for Human Use (Clinical Trial) Regulations 2004*
   - *EU Directive on Clinical Trials (Directive 2001/20/EC)*
   - *The Medicine for Human Use (Clinical Trials) Regulations 2004*
   - *The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006*

3) Researchers are required to provide the R&D Steering Group with all information requirements for the NHS Executive.

4) Researchers will be expected to comply with all monitoring arrangements, as required by the 'Research Governance Framework for Health and Social Care'.

5) A Central Investigator File must be maintained. The R&D office is able to provide an empty file with dividers and lists of appropriate contents for retention.

6) Any gaps in Directorate or clinical arrangements or practice identified by the study should be notified to the Directorate Manager for inclusion on the Directorate Risk Register as appropriate.

7) Local researchers must ensure that the medical records of subjects recruited to Clinical Trials of Investigational Medicinal Products are clearly labelled, to allow the records to be retained by the Trust for data audit purposes.

WHERE APPLICABLE:

8) All costs for studies are to be agreed by all Parties (Investigator, Pharmacy, other Trust departments involved e.g. Laboratories, the R&D Office and the Company) before the study commences.

9) Trust approval is not complete until all costings have been agreed and contracts and indemnities have been negotiated and signed. Potential participants must not be approached until all relevant documents are signed by all parties.

10) The Chief Executive or a nominated Trust signatory must sign all indemnity agreements and contracts. In instances where unauthorised persons sign contracts on behalf of the Trust, any contractual liabilities and obligations may not be accepted and will then remain the responsibility of the signatory.

11) All R&D income (for both commercially and non-commercially sponsored R&D) should be invoiced by the Trust's Finance Dept via the R&D Manager. All income for R&D activity should be received into Colchester Hospital University NHS Foundation Trust R&D Revenue accounts, as per the 'Standing Financial Instructions', section 6.2.3 (April 2005 version). Income should not be received into Trust Funds.

12) Income for Commercial research is subject to VAT.

13) Income for Commercial research is subject to the Trust's 15% levy, which will be top-sliced from all income.

[redacted] NHS
NHS Foundation Trust

[redacted]
Research and Development Department
[redacted]

Tel: [redacted]
Fax: [redacted]

Date: 11 July 2014

Mrs Martella Chambers
Director of Studies
[redacted]

REC ref: [redacted]
R&D ref: [redacted]

Dear Mrs Chambers,

Re: Fitness for Practice: partnership perspectives - Academic & Practice

Thank you for your application for Trust Research and Development (R&D) approval

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from a Research Ethics Committee (REC) within the UK Health Departments Research Ethics Service, if applicable and approval from the R&D Department prior to commencement.

A REC review is not required as this research project involves healthcare staff by virtue of their professional role and presents no material ethical issues. Researchers in Higher Education Institutions (HEIs) are advised to check whether, under their institution's policy and internal arrangements, ethical review is required by their HEI research ethics committee.

R&D have reviewed the documentation for this project, undertaken a site specific assessment based on the information provided and submitted a report to The Director of R&D for final review.

The Director of R&D, on behalf of the R&D Steering Group has further considered the proposal and has no objection to the research proceeding within [redacted] Hospital University NHS Foundation Trust

Sponsor: [redacted]

Protocol: 16/07/2012

Conditions of Trust Approval

- The project must follow the agreed protocol and be conducted in accordance with all Trust policies and procedures especially those relating to research and data management.
- You and your research team must ensure that you understand and comply with the requirements of NHS Confidentiality Code of Practice and the Data Protections Act 1998 and are aware of your responsibilities in relation to the Human Tissue ACT 2004, Good Clinical Practice, the NHS Research Governance Framework for Health and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.
- Under ICH – GCP (International Conference of Harmonisation of Good Clinical Practice), a Central Investigator File, containing essential study documents should be set up for this study. Such a file is available from the R&D Office upon request.
- Members of the research team must have appropriate substantive contract or a letter of access with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold suitable HR documentation.

Amendments

Please ensure that you submit a copy of any amendments made to this study to the R&D Department for review and approval prior to being implemented.

PLEASE NOTE THAT THIS RESEARCH IS SUBJECT TO STANDARD CONDITIONS OF APPROVAL, WHICH ARE ON PAGE FOUR OF THIS LETTER.

Should you require any further information please do not hesitate to contact the R&D Department

May I take this opportunity to wish you every success with this research.

Yours sincerely

[redacted]
Director of R&D

Cc (by e-mail)
Professo[redacted], Sponsor Representative
[redacted] Practice Development Nurse

Appendix 3.

Anglia Ruskin University
Cambridge & Chelmsford

Chelmsford Campus
Bishop Hall Lane
Chelmsford
CM1 1SQ

T: 0845 271 3333
Int: +44 (0)1245 493131
www.anglia.ac.uk

Participant Consent Form for [redacted]

Fitness for practice within pre-registration nurse education, whose responsibility? An exploration of ownership tensions between academia and practice.

Main investigator and contact details: Marty Chambers 0845 196 4117
Email: martella.chambers@student.anglia.ac.uk
Members of the research team: Marty Chambers, Prof. Sharon Andrew and Dr Chris Thurston.

1. I agree to take part in the above research. I have read the Participant Information Sheet that is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.
2. I understand that I am free to withdraw from the research up until the data is aggregated into themes.
3. I have been informed that the confidentiality of the information I provide will be secured on university grounds and will be anonymous.
4. I am free to ask any questions at any time before and during the study.
5. I have been provided with a copy of this form and the Participant Information Sheet.
6. All focus groups/interviews will be audio-recorded.

Data Protection: I agree to the University[1] processing personal data, which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me*

***Note to researchers:** please amend or add to this clause as necessary to ensure that it conforms to the relevant data protection legislation in your country*

Name of participant [redacted]……Signed…[redacted]……Date [redacted]..

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

Title of Project: Fitness for practice within pre-registration nurse education, whose responsibility?

I WISH TO WITHDRAW FROM THIS STUDY

Signed: _____ Date: _____

[1] "The University" includes Anglia Ruskin University and its partner colleges

Stonewall DIVERSITY CHAMPION · INVESTORS IN PEOPLE · POSITIVE ABOUT DISABLED PEOPLE · 1 CUSTOMER SERVICE EXCELLENCE UK

PARTICIPANT INFORMATION SHEET

Section A: The Research Project

1. **Title of Project:** Fitness for Practice within pre-registration nurse education, whose responsibility? An exploration of ownership tensions between academia and practice.

2. **Purpose and value of study:** The primary aim of this research is to explore the perceptions of fitness to practice between clinical and academic staff. Specifically, the focus of the study will be about perceptions of fitness to practice within clinical practice and the university setting and to explore further the understanding of processes used to discipline students whose fitness to practice is being questioned. It is anticipated that the research findings will identify the factors, or tensions, between the clinical and academic settings, in order to cultivate and mediate partnerships.

3. **Invitation to participate:** Your views and experiences are important for understanding the perceptions of fitness for practice, process and its application to nurse education to mediate partnerships.

4. **Who is organising the research:** Marty Chambers

5. **What will happen to the results of the study:** The results of the study will be published in scholarly journals and may be presented at conferences.

6. **Source of funding for the research:** Funded by the FHSCE research body.

7. **Contact for further information:** Marty Chambers 0845 196 4117 Email: martella.chambers@student.anglia.ac.uk

Section B: Your Participation in the Research Project

1. **Why you have been invited to take part?** As a provider of nurse education within the clinical setting, your opinions are important to this study.

2. **Whether you can refuse to take part?** You can refuse and all participation is voluntary.

3. **Whether you can withdraw from the research?** Up until the data is aggregated into themes using the signed consent form/withdrawal section.

4. **What will happen if you agree to take part?** Participants will be required to take part in one small focus group consisting of approx. 6 registered mentors. The focus group will last approximately one to one and a half hours within an agreed clinical setting and hypothetical vignettes will provide the basis for discussion for the group and will give a trenchant impression of fitness examples for the participants to explore.

5. **Whether there are any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety?** It is anticipated that the emotional risk is minimal. Sources of counselling will be

provided by the Universities counselling service if participants experience any emotional impact from the interview.

6. **Agreement to participate in this research should not compromise your legal rights should something go wrong?** Your legal rights are not affected.

7. **What will happen to any information/data/samples that are collected from you?** All written publications will assume a pseudonym. All data will be computer coded and stored away on secure university, password protected computers. Also any information given will be decoded to protect individual's confidentiality.

8. **Whether there are any benefits from taking part?** For the development of nurse education.

9. **How your participation in the project will be kept confidential?** By the use of pseudonyms or anonymous data details.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix 4.

1

Vignettes for Fitness for Practice

These are the 3 trigger discussions and questions for the focus groups;

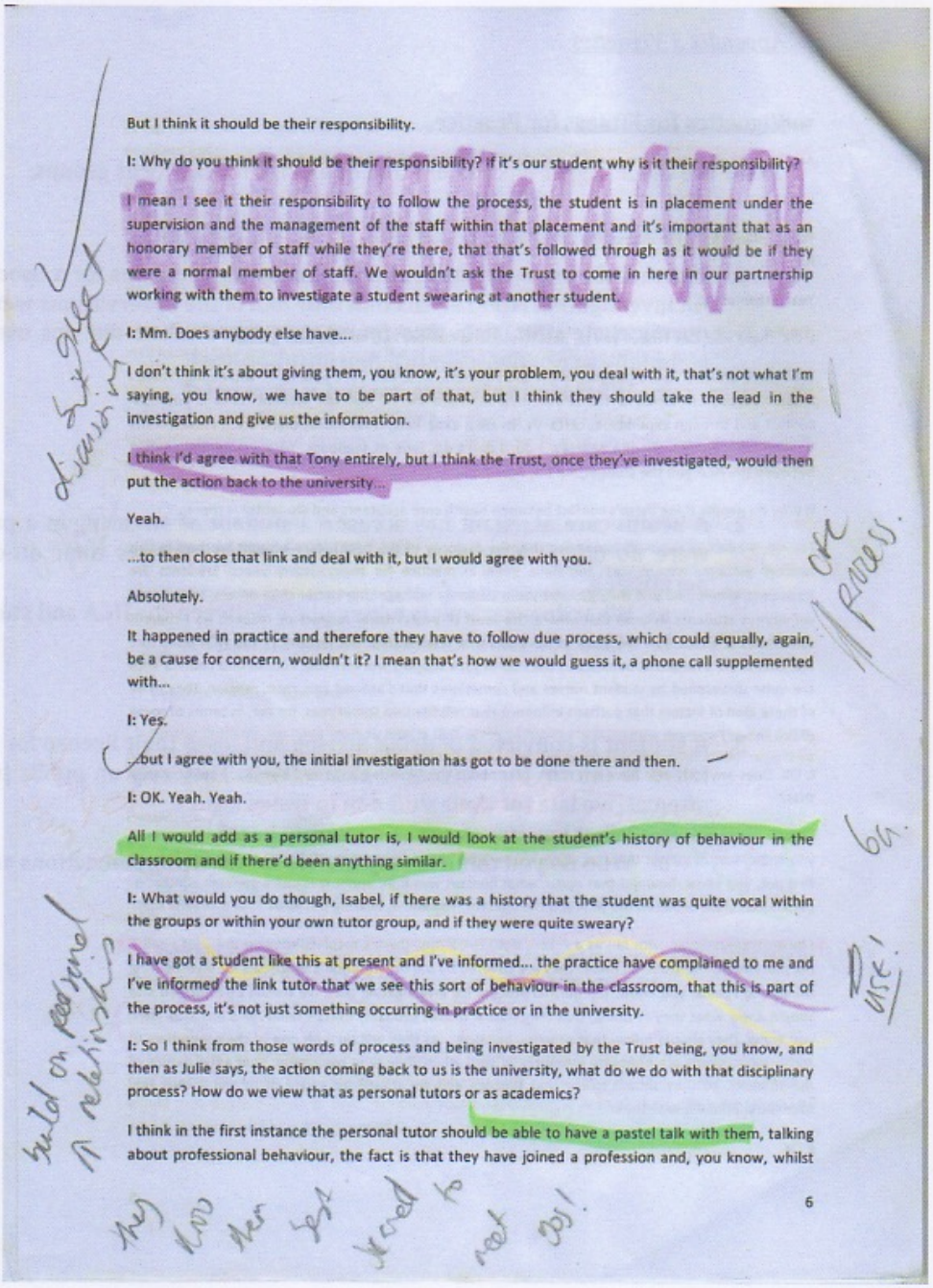
1. The mentor tasks the student with hourly observations for a specified patient. An investigation later reveals that only half of the observations were completed during their shift. It is also found that the student did not use the aseptic technique to remove a central line unsupervised.
    a. What kinds of issues are in question here?
    b. How do you regard their behavior?

2. A health care assistant has accused a student of swearing at a patient. There were no other witnesses. The student often changes their off-duty without permission.
    a. What do you think is taking place between the HCA and student?
    b. Have you experienced anything similar?

3. A student is convicted of drink driving and loses their license for one year but failed to inform the university or the trust. They rely on public transport and often arrive late for their shift due to travel issues.
    a. What key issues can you identify here?
    b. Who do you think is responsible for ensuring convictions are detailed?

Appendix 5.

Appendix Coding sample



But I think it should be their responsibility.

I: Why do you think it should be their responsibility? If it's our student why is it their responsibility?

I mean I see it their responsibility to follow the process, the student is in placement under the supervision and the management of the staff within that placement and it's important that as an honorary member of staff while they're there, that that's followed through as it would be if they were a normal member of staff. We wouldn't ask the Trust to come in here in our partnership working with them to investigate a student swearing at another student.

I: Mm. Does anybody else have...

I don't think it's about giving them, you know, it's your problem, you deal with it, that's not what I'm saying, you know, we have to be part of that, but I think they should take the lead in the investigation and give us the information.

I think I'd agree with that Tony entirely, but I think the Trust, once they've investigated, would then put the action back to the university...

Yeah.

...to then close that link and deal with it, but I would agree with you.

Absolutely.

It happened in practice and therefore they have to follow due process, which could equally, again, be a cause for concern, wouldn't it? I mean that's how we would guess it, a phone call supplemented with...

I: Yes.

...but I agree with you, the initial investigation has got to be done there and then.

I: OK. Yeah. Yeah.

All I would add as a personal tutor is, I would look at the student's history of behaviour in the classroom and if there'd been anything similar.

I: What would you do though, Isabel, if there was a history that the student was quite vocal within the groups or within your own tutor group, and if they were quite sweary?

I have got a student like this at present and I've informed... the practice have complained to me and I've informed the link tutor that we see this sort of behaviour in the classroom, that this is part of the process, it's not just something occurring in practice or in the university.

I: So I think from those words of process and being investigated by the Trust being, you know, and then as Julie says, the action coming back to us is the university, what do we do with that disciplinary process? How do we view that as personal tutors or as academics?

I think in the first instance the personal tutor should be able to have a pastel talk with them, talking about professional behaviour, the fact is that they have joined a profession and, you know, whilst

6

Appendix 6.

Transition to Registered Practice: From Student to Qualified Nurse

C. Thurston and N. Wrycraft

Sage Publications (To be published January 2020)

Chapter 6 *(sections of)*

Responsibilities Regarding Fitness to Practice

Dr Chris Thurston and Marty Chambers

[REDACTED IN THIS VERSION DUE TO COPYRIGHT AND ACCESSIBILITY]