Surviving and thriving in practice placements: A qualitative exploration of student nurses' practice placement learning experiences

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Summary of thesis

There are currently numerous concerns about the quality of pre-registration nurse training in the United Kingdom, particularly regarding the fifty per cent of that training spent in practice placement settings. If pre-registration nurse training is to be as effective as possible, it is essential to create practice placement learning environments where all student nurses are empowered to be caring, confident, competent and resilient, where students feel able to survive and thrive and, hence, where they can maximise their learning experiences. When undertaking nurse training in the United Kingdom every applicant has to decide which field of nursing they wish to enter – adult, mental health, child, or learning disability – the majority choosing adult nursing. The aim of this study was to gain a deeper understanding of the practice placement learning experiences' of those students who had chosen the adult nursing field, with a view to improving those experiences.

This qualitative study drew on interpretive description, narrative inquiry and used Framework as the basis for the data analysis and interpretation.

The findings of this study suggest that in order to ensure that student nurses have the best possible practice placement learning experiences attention needs to be paid to the following areas:

- The preparation of individual student nurses for their practice placements.

- The selection and preparation of individual mentors for their mentorship role.

- The design and development of humanistic and transformative pre-registration nursing and mentorship preparation curricula.

- The development of effective practice placement learning environments, including consideration of how both students and mentors are supported and valued in those practice placement settings.

This study proposes that if the practice placement learning experiences of student nurses are to be improved, changes are required at the professional and regulatory levels within nursing, at the practice placement-university level of nurse training and at the individual student nurse-mentor level. Such changes, however, must be underpinned by evidence and not based solely on expert opinion, political ideology, or economic expediency, as has so often been the case in the past.

Chapter 1 Introduction

Things fall apart; the centre cannot hold;

The Second Coming (W B Yeats)

Pre-registration nurse training in the United Kingdom currently demands that all student nurses spend a substantial part of their training, at least fifty percent, in a practice placement setting (NMC 2008a, NMC 2010). It is acknowledged that this is where the clinical skills and professional values, which enable students to become competent, caring, and compassionate nurses, are learned (Benner et al 2010, Willis 2015). It can also be the deciding factor in whether, or not, students become, and remain, committed to a career in nursing (Bradbury-Jones et al 2007, Taylor 2009). The quality of the practice placement experience is then of fundamental importance in ensuring that pre-registration nurse training is of the highest quality and as effective as possible. There are, however, challenges and tensions associated with practice placement learning, with the recognition of the need for change acknowledged (Field 2004, Bray and Nettleton 2007, Carnwell et al 2007, Hyatt et al 2008, Willis 2012) and recently this has become one of the most pressing concerns about nurse training in the United Kingdom, with urgent action being demanded (Willis 2015, RCN 2016).

The reason for undertaking this research study was to gain a greater understanding of the learning experiences' of adult student nurses while they were in their practice placements. The study was undertaken with the acknowledgement that the wider social, political and economic climate

surrounding nurse education cannot be ignored, but it primarily focused on the

individual learning experiences of a number of adult student nurses, with

particular reference to the role of the mentor in this process. The study also

mirrors my own personal interests and concerns. When I commenced the study

I was a nurse educator involved in the training of student nurses and mentors.

At that time I had some anxieties regarding both the quality of practice

placement learning and the main practice placement learning strategy – a

dyadic mentorship model. I also had a desire to ensure that student nurses'

learning was maximised in the practice placement setting. In addition to my

own personal interest, the study was also envisaged as contributing to the

current empirical data on this topic, because, as Kelly and McAllister (2013)

point out, there is a lack of nursing research into nurse education, which has

led, historically, to an inadequate evidence base, and an overreliance on

tradition and expert opinion when considering change.

In terms of methodology, the study is qualitative in approach, drawing on

interpretive description (Thorne 2008) and narrative inquiry (Clandinin and

Connelly 2000, Riessman 2008) and using Framework (Ritchie et al 2003) as a

basis for the data analysis and interpretation. The participants were adult

student nurses undertaking a master's level pre-registration programme and

were half way through their training at the time of the study. They all completed

reflective diaries during two of their practice placements (n=40 completed

diaries) and a smaller number of the students were subsequently interviewed

individually (n=9). It was hoped that new insights or knowledge generated from

the study would help to inform and maybe lead to changes in the practice

placement setting. Following an initial literature review, the intended learning outcomes of this study were as follows:

- To gain a better understanding of what student nurses learn in practice and how they learn it.
- To gain a better understanding of what student nurses are taught in practice, how they are taught and by whom.
- To gain a better understanding of how student nurses perceive the role of the mentor in this process.
- To identify examples of good practice, and to produce suggestions of how things could be.

After data collection, analysis and interpretation the following findings were identified:

- In order to ensure that students have positive practice placement experiences, they need to be prepared for those placements with an emphasis on the development of their social and emotional literacy, their self-efficacy, their emotional resilience and their ability to be confident, self-directed learners.

- Individual mentors who have been selected for the mentorship role based on their values, knowledge and skills, also need to be trained for this role. This preparation requires a focus on the development of their facilitation and coaching skills, their ability to articulate a clear

professional identity and a personal pedagogy, and the skills to utilize teaching strategies such as experiential learning, scaffolding and role modelling.

- The collaborative design and development of effective pre-registration and mentor programme curricula that utilise humanistic and transformative learning strategies, ideally within a sympathetic philosophical, regulatory and professional framework, is also essential to ensure that students can maximize their practice placement learning experiences.

- The collaborative development of effective, well managed interprofessional practice placement learning environments, within learning organisations, where both students and mentors feel that they belong and that they are well supported and valued, are also a fundamental part of pre-registration nurse training. The development and maintenance of such environments, however, requires strong nursing leadership from ward to board, robust governance processes within practice placement providers, and excellent communication and collaboration with the education providers.

Preparation of individual students for their practice placements

Development of effective practice placement learning environment

Caring, confident, competent, and resilient student nurses who feel able to survive and thrive in their practice placements

Selection and preparation of individual mentors for their mentorship role

Development of curricula to support transformational learning

Figure 1

Essential components of student nurses' practice placement learning experiences, as identified in this study

The current situation in nurse education has brought us to, as W B Yeats would say, a '*gyre*', or a paradigm shift. At times like this, Yeats would argue that "*Things fall apart; the centre cannot hold;*" so at this time of great challenge for nursing and nurse education a fundamental change is required in how we train nurses, with the current system being unsustainable. This offers an exciting opportunity for real and major change in the future. I would argue, however, that whilst the current situation offers great possibilities, it also calls for a position of head in the clouds, with feet on the ground, or as Dingwall et al (1998:229) suggest

'*Professional ambitions must be reconciled with economic realities*'

1.1 Structure of the thesis

Chapter One

This chapter starts with a discussion of why the research topic, the practice placement learning experiences' of student nurses, is important and why it was selected. This will be followed by an exploration of the historical development of nurse education and nurse training in the United Kingdom and a discussion of current nurse training, including the mentorship role.

Chapter Two

This chapter consists of a literature review of the relevant empirical research and grey literature on this topic. From these findings and my a priori knowledge and interest, the research aim and objectives for the study were developed and are outlined.

Chapter Three

This chapter starts with a discussion of the research methodology underpinning the study. The data collection and analysis methods are then reviewed, plus an exploration of what makes high quality qualitative research, including a personal reflection on this.

Chapter Four

This chapter outlines the main findings from the study, in vivo, or in the students' own words and stories.

Chapter Five

This chapter returns to the wider literature to identify relevant concepts and theories, in order to produce a new interpretive description of the students' experiences of practice placement learning and begins to make suggestions for possible changes in practice.

Chapter Six

This chapter concludes the study by exploring how the findings from this study are located within and extend the existing literature, including a discussion of the limitations of this study. Based on the findings of this study several changes in nurse education, policy, and practice have been suggested and, finally, related topics for further research are identified.

1.2 Historical context of nurse training in the United Kingdom

The debates and disagreements regarding the best way to train nurses are not new. Modern nursing in the United Kingdom is commonly thought to have emerged in the 1800s, mainly due to the vision and political skills of Florence Nightingale (Dingwall et al 1988). She believed that all nurses should be trained for their role and therefore established the Nightingale Training School for Nurses at St. Thomas's Hospital, London, in 1860. She also believed that although nurses were born, not made, training would improve their work; she recruited for values and trained for skills (Dingwall et al 1988). She did not, however, believe in nurse registration, as she thought that the skills and values required by nurses could not be tested through examinations and it is interesting to note that many of her ideas and values are still evident in current discussions.

In 1916 the precursor of the Royal College of Nursing, the College of Nursing, was established in order to promote nursing as a profession, with a distinct body of knowledge and skills, for which all nurses should be trained (McGann et al 2009). This body was, initially, unashamedly elitist and saw its primary role as protecting the status of trained nurses, (who were the minority of nurses at that time), from other untrained nursing aides. They did, however, fear the effect of too much theoretical education, which they believed would create unskilled and insubordinate nurses (McGann et al 2009). Again, it can, be seen that many of the current tensions and discussions are recurring themes in nursing.

Nurse registration in the UK commenced in 1919 (McGann et al 2009). This was a significant move and created a two-tier system in nursing – those nurses who were trained and registered and those who were not, which has survived up until today, in one form, or another. The debate about exactly who can call themselves nurses has always been controversial and a recent call by Ian Cumming Chief Executive at Health Education England for the introduction of nurse associates, to take on a role similar to that undertaken by enrolled nurses in the past (Guardian 2nd June 2015), has met with mixed responses.

Pre-registration nurse training in the UK continued from its beginnings, using an apprenticeship-style method for many years and whilst there may have been periods spent away from the clinical setting, to study theoretical knowledge, the majority of the learning took place in the clinical setting (Dingwall et al 1988). Whilst students were in clinical settings, experienced nurses, and latterly, clinical teachers, or tutors, supervised the students and assessed their clinical skills, either informally, or formally. Initially students were salaried and part of the workforce. Increasingly, however, there was an acknowledgement that a change was required in the nature of nurse education (Quinn and Hughes 2007). This was considered necessary due to the increased complexity of healthcare provision and the acceptance of the fact that if nurses were to continue to deliver safe, competent care, they needed a higher level of theoretical knowledge, critical thinking and problem solving skills (Quinn and Hughes 2007). This, plus political imperatives to increase access to higher education, underpinned the move of nurse training from hospitals into higher education and the introduction of the Diploma of Higher Education in Nursing.

The introduction of Project 2000 in 1986, however, led to much criticism over the direction in which nursing was moving from many quarters, including doctors, trades unions and nurses themselves; it was perceived as becoming too academic and there was a call for a move back to the previous training system (Dingwall et al 1998, Rafferty et al 2015). There was also a lack of planning and investment in up skilling the teaching workforce prior to the move to higher education, which made it difficult for nurse educators to thrive in the university environment (Rafferty et al 2015).

The next major curriculum shift for pre-registration nurse training came in the form of the Making A Difference, or Partnership Curriculum (DH 1999), which was underpinned by Fitness for Practice (UKCC 1999). This attempted to address some of the criticisms of Project 2000, which was increasingly perceived as being too academic, with its emphasis on subjects such as sociology and psychology. During this time there was real concern about the teaching and assessing of essential clinical skills; it was argued that some students successfully completed their nurse training, whilst still having many gaps in their clinical competence (Gopee 2007). This was thought to be due to the fact that such skills were being taught neither by the university, or in the clinical setting; it had become unclear who was responsible for such learning. In July 2004, an evaluation of this curriculum was undertaken, which identified numerous difficulties with the curriculum and its delivery, including the quality of the practice learning experience. This led to the establishment of a more formal mentorship role and 2004 saw the publication of the Essential Skills Clusters by the NMC (NMC 2004), standards designed to ensure that all newly qualified

nurses were clinically competent. It was at this point that mentors became responsible for teaching and assessing student nurses, in the practice placement areas (Quinn and Hughes 2007), making the mentorship role central to pre-registration nurse training (Gray and Smith 2000, Nettleton and Bray 2008, Jonsen et al 2013, Foster et al 2015).

1.2 Mentorship role

A mentor is defined as "*an experienced and trusted adviser…who takes on responsibility for advising or training someone*."

(Oxford Dictionary of English 2005)

The term originated with Homer's Odyssey, in which Mentor, a wise and trusted friend of Odysseus took on the upbringing of his son in his absence; the older, wiser male taking responsibility for the learning and development of a younger individual (Andrews and Wallis 1999). The English National Board and Department of Health ENB/DH (2001) defined the mentorship role in nursing and midwifery in the United Kingdom, as being one that included: the facilitation of learning, supervision and assessment of practice in the clinical area and the Nursing Midwifery Council (2008:3) clearly stipulated the requirements for mentors of pre-registration nursing students:

> *"Students on NMC approved pre-registration nursing education programmes, leading to registration on the nurses' part of the register, must be supported and assessed by mentors."*

The current mentorship model in the UK is then a dyadic one where every

student has a named mentor and possibly a co-mentor, with whom they should

spend at least forty percent of their time whilst in the practice placement setting.

The mentors are also responsible for assessing the students' performance

within the practice setting (NMC 2006, 2008). There are, however, increasing

concerns in the UK, and globally, that this dyadic model is not the best way to

structure practice-based learning, and that other models need to be considered

(Luhanga et al 2010, Branson 2014, Turnbull et al 2014, RCN 2016). The

issues with this model of mentorship include the fact that in 2006 when the

current NMC standards regarding mentorship were first introduced, economic

constraints were much less stringent than today making the one to one

approach of mentorship financially viable, but, currently, although it is the dyadic

mentorship model that is still being used predominantly in the United Kingdom,

it is no longer economically sustainable (Turnbull et al 2014). This model can

also be viewed as one predicated on a traditional view of teaching and learning,

where the teacher is the expert, who transmits their knowledge to a passive

learner and many would argue, that this is not a desirable approach to learning,

if you wish to develop confident, questioning, self-directed learners (Dewey

1938, Freire 1993, Freshwater 2000, Knowles et al 2015). There is also a clear

and sometimes unhelpful power relationship between the mentor and the

student – the mentor alone is responsible for passing or failing the student

(Ghaye and Lillyman 2008). Furthermore, the model discourages

interprofessional learning and assessment in the practice placement setting

(RCN 2016).

During the time when nurse training followed an apprenticeship model and students were members of the ward team, there was a heavy reliance on opportunistic observation, as the main learning strategy (Wilkes 2006, Hyatt et al 2008), and in the 1980s, the assessment of clinical practice comprised four summative assessments, undertaken by a clinical teacher, or the ward sister. Even at this point, however, there were concerns about the inconsistent quality of practice-based learning, claiming that is was dependent on the ward culture and the ward sister (Orton 1981, Ogier 1982, Fretwell 1983, Melia 1987).

The introduction of Project 2000, in 1986, however, meant that students became supernumerary in the practice placement setting, theory was taught in universities and continuous assessment was introduced on the wards (Stuart 2003). The concept of nurse mentorship began, with named mentors teaching, supervising and supporting students in practice, but not always assessing. Initially, however, the mentorship role was very variable in respect of how it was undertaken and in how nurses were prepared to carry out the role, so concern continued that some student nurses were still completing their training, without the necessary clinical skills to practice safely. In order to address these issues, in 2006/2008, the NMC introduced the NMC Standards to Support Learning and Assessment in Practice (SLAiP). These standards put the responsibility and accountability, for the teaching **and** assessing of clinical skills firmly in the court of practice-based mentors and sign-off mentors. These standards succeeded in raising the profile of mentors, and the importance of mentorship in nurse training, but did not necessarily improve the quality of practice based learning in a consistent manner (Willis 2015, RCN 2016). On the positive side, this

framework defined and described the knowledge and skills mentors required in order to competently teach and assess student nurses in practice settings. It also made clear that all registered nurses were either Stage One, or Stage Two mentors. Stage One mentors were all registered nurses, but in order to become a Stage Two mentor, an NMC approved mentorship training programme had to be undertaken, following at least one years experience as a registered nurse. Stage One mentors, although unable to summatively assess students in practice, were, and still are, however, answerable to the NMC Code (2008b, 2015)

> "*You must facilitate students and others to develop their competence…You must make sure that everyone you are responsible for is supervised and supported.*" (NMC 2008b)

And more recently in the NMC Code (2015)

> "*Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues*"
> *To achieve this, you must:*
> "*…support students' and colleagues' learning to help them develop their professional competence and confidence.*"

In the current mentorship framework then, all registered nurses are expected to be mentors. Furthermore, the teaching, support and assessment of student nurses is regarded as primarily the responsibility of other registered nurses working in the same field of practice as the student.

More specifically, the SLAiP framework identifies eight domains for which mentors are responsible (NMC 2008):

1. Establishing effective working relationships

2. Facilitation of learning

3. Assessment and accountability

4. Evaluation of learning

5. Creating an environment for learning

6. Context of practice

7. Evidence-based practice

8. Leadership

It also lists exactly what mentors are responsible and accountable for:

- Organising and coordinating student learning activities in practice

- Supervising students in learning situations and providing them with constructive feedback on their achievements

- Setting and monitoring achievement of realistic learning objectives

- Assessing total performance, including skills, attitudes and behaviours

- Providing evidence as required by programme providers of student achievement, or lack of achievement

- Liaising with others to provide feedback, identify any concerns about student's performance and agree action as appropriate

- Providing evidence for, or acting as, sign-off mentor with regard to decision-making about achievement of proficiency at the end of a programme

The framework was, however, problematic from the outset and, due to difficulties with interpretation and practical application, it was amended in 2008, with numerous further minor amendments being made over the years. The framework is now acknowledged as being outdated and, hopefully, the current review of the NMC education standards will lead to fundamental changes in this quality assurance framework (Willis 2015, RCN 2016).

When teaching, supervising and making assessment decisions, mentors are also required to consider the NMC (2004) Essential Skills Clusters, the student's practice assessment documents (PADs) and more recently in England, the NHS Constitution (DH 2013) and the 6C's - care, communication, compassion, commitment, courage and competence (DH 2012a). It can be seen then that mentorship is a complex concept, demanding much from individual mentors, whilst at the same time being one which is regarded as pivotal in nurse training. The significance given to this role was clearly demonstrated by the introduction of 'sign-off mentors' from 2007, when some mentors became responsible for signing off the whole of the student's clinical practice, throughout their training, by making the declaration that they were fit to qualify as registered practitioners (NMC 2008:3).

> *"From September 2007 a sign-off mentor, who has met additional criteria, must make the final assessment of practice and confirm that the required proficiencies for entry to the register have been achieved."*

The sign-off mentor role has, however, been fraught with difficulties from its inception, due to a number of reasons, including a shortage of sign-off mentors, the process to become a sign-off mentor being unnecessarily bureaucratic, an overreliance on sign-off mentors by other mentors who fail to fail students, and mentors being unwilling to become sign-off mentors, due to perceived higher level of responsibility (Rooke 2014, Turnbull et al 2014, RCN 2016). Furthermore, in some universities, practice assessment was graded, rather than just pass/fail and this mark influenced the student's final degree classification. So, as Paterson and Burns (2007) note, practice placement learning and assessment became extremely important in nurse training, with mentorship being the preferred way of delivering this aspect of the pre-registration nursing programmes.

1.3 Current nurse training in the UK

Registered adult nurses are presently trained in the United Kingdom by undertaking a degree level nurse training programme, comprising 2,300 study hours in a higher education institution (HEI) and 2,300 practice hours in a practice placement setting (NMC 2010). This training has, however, been widely criticised in various ways and from diverse sources. Firstly, nursing, as a profession, has been under very close scrutiny during the past few years, following a barrage of criticism from patients, patients' families, carers, the media, and from nurses themselves, about the poor quality of nursing care being delivered in the current healthcare system (Age Concern 2006, Patients Association 2011, Cavendish 2013, Francis 2013, Keogh 2013). In the wake of

these criticisms, there has been a, sometimes, emotional debate regarding the root of the problem, with many laying the blame at the door of contemporary nurse training

> "*Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard*"
> (Francis 2013:6)

Furthermore, it has been alleged that nurse training, since its move to an all-graduate profession in 2010, has become too academic and, as such, attracts the wrong sort of person into nursing (Gallagher 2005, Cavendish 2013,). The argument is that student nurses do not possess the values and attitudes compatible with the delivery of compassionate nursing care; but rather, they become nurses who see themselves as being 'too clever to care' and 'too posh to wash'. This move to an all graduate profession led to an outcry, often from nurses themselves, that such a change would adversely affect the quality of nursing care, as it would belittle the importance of essential nursing care, delivered by caring and compassionate practitioners. This highly charged debate led to the establishment of an independent inquiry to look at pre-registration nursing education, commissioned by the Royal College of Nursing (RCN), namely, the Willis Inquiry (2012). The findings of this inquiry were of great interest to all of those involved in nurse education, (but less so the media, it has to be said), and asserted that there was no evidence to support a fundamental problem with a degree-based nursing profession, per se. This was good news for nurse educators, but there were other aspects of the report that

did not make such reassuring reading. One such issue was a concern about the quality of student nurses' practice placements; some were excellent, but many were not – Willis noted a worrying lack of consistency in the students' experiences. As nurses spend fifty percent of their time in placement, it is a crucial component of nurse training and, if problematic, the ability to produce nurses with the necessary values, clinical skills and theoretical knowledge base, would be severely undermined. Subsequently, two further reviews of nurse training were commissioned by Health Education England (HEE), the Shape of Caring Review (2014), supported by the NMC, and Health Education East of England (HEEOE) A Fundamental Review of Nurse Education (2013), to investigate the efficacy of current pre-registration nurse training. These two reviews culminated in the publication of the Raising the Bar Shape of Caring Review Report (Willis 2015). This last report identified eight themes in its recommendations, with the fifth one being the need to assure '*a high quality learning environment for pre-registration nurses'* as many issues had been identified with this aspect of nurse training. Such concerns regarding nurse training have also prompted the Nursing and Midwifery Council (NMC) to evaluate their nurse education standards and indeed Willis urged the NMC to change their current preferred mentorship model and standards (NMC 2008), particularly relating to the requirements for one-to-one mentorship.

There are real concerns then about the quality of the fifty percent of student nurse training undertaken in the practice setting, (RCN 2016), which is worrying because as Benner at el (2010) argue, practice-based learning, albeit 'high stakes learning', is the only way that student nurses can learn how to become

competent practitioners. Furthermore, supporting learners in practice placement settings in the United Kingdom, is currently taking place in a difficult political context of financial austerity (DH 2011, Robinson et al 2012), skill mix austerity (Glasper 2012, RCN 2014), and health and social care reorganization, following the implementation of the Health and Social Care Act 2012 (DH 2012), which makes it a very complex issue.

1.4 Conclusion

The debates regarding nursing and nurse training are not new, with many of the same themes emerging repeatedly throughout history, particularly regarding the level of skills and knowledge required by nurses, and how they can be best taught and assessed. How we ensure that all nurses are, and remain, caring and competent, have been, and still are, contentious issues – are nurses born, or made? These discussions are often, however, ideological and politically motivated, lacking any real discussion of basic philosophical questions, including what is the best way to educate nurses and for what role they should be educated (Edwards 2007). The current framework for learning in the practice placement setting is well established and closely monitored, but despite this, there are still concerns about the quality of student nurses' experiences in their placements; some students have excellent experiences, but some do not. This might be due to the fact that the SLAiP Standards (NMC 2008) were written in a very different political and economic time and may no longer be fit for purpose, or, some would argue, they were always fundamentally flawed (Turnbull et al 2014, RCN 2016). Furthermore, the framework is predicated on a

very traditional view of teaching and learning, where the teacher, or mentor is the expert and the student is a passive learner and there is a lack of acknowledgement of the importance of the learning environment as an interprofessional community of practice. These concerns and challenges with both student nurses and mentors, with particular reference to the student nurses' practice placement learning experiences are explored in more detail in this research study.

Chapter 2 Literature review

In order to identify the existing evidence base regarding student nurses' practice placement learning experiences, with particular reference to the mentorship role, a review of the literature was undertaken. The review, which was a traditional narrative one, helped to identify gaps in the research, to identify the issues and debates surrounding practice placement learning and mentorship, and to identify relevant theories and concepts (Jesson et al 2011, Moule and Goodman 2014) and is summarized in **Appendix 1**.

2.1 Methodology

The following databases were accessed:

Cumulative Index to Nursing and Allied Health Literature (CINAHL)

British Nursing Index (BNI)

Medline

Scopus

Using these search terms:

1. Student nurs* AND practice placement learning OR clinical learning

2. Student nurs* AND mentor* OR preceptor* OR clinical supervisor OR clinical educator OR clinical facilitator

3. Student nurs*AND learning environment

4. Mentor* OR precept* OR practice educator OR clinical facilitator and nurse education

This was enhanced by hand searching relevant journals, cross checking references from relevant articles and making comparisons with relevant literature reviews.

The following inclusion criteria were applied:

Primary research relating to student nurses' experiences in their practice placements

Literature reviews

Grey literature

Relevant terms/concepts/keywords

Published in peer-reviewed journals

Pre-registration student nurses

English language

Studies from UK, Australia, New Zealand, USA, Canada, Scandinavia (all these countries have similar nurse training models, including an emphasis on practice-based learning)

1986 onwards, as this is when the current UK mentorship model was initially established, although some earlier seminal literature was included

Papers concerning the following were excluded:

Post registration nursing education

Preceptorship / supervision

Other healthcare professions

Opinion pieces

All relevant articles were identified and critically evaluated using a critical framework (Critical Appraisal Skills Programme CASP 2008). However, as the main purpose of the literature review was to identify the current knowledge about practice placement learning, even though not all the included papers met all of the requirements of the framework, they were incorporated into the literature review (Gould 1994). Furthermore, all the studies in this review resonated with my own personal experience, were credible and have, therefore, been included in the review.

2.2. Findings

The selected papers were read, coded, and thematically analysed (Aveyard 2014), which resulted in the following themes:

1. **Mentor-student relationship**

2. **Conflicts in the mentorship role**

3. **Preparation and support for mentors**

4. **Alternative practice-based learning models**

5. **Characteristics of a good learning environment**

6. **Student belongingness**

7. **Characteristics of a good mentor**

2.2.1 Mentor-student relationship

The research literature is very clear that often the students' practice placement experiences are shaped by the relationship that they have with their mentor and, in particular, the mentor's interpersonal skills (Earnshaw 1995, Gray and Smith 2000, Luhanga et al 2010, Courtney-Pratt et al 2011, Jokelainen et al 2011a, Kelly and McAllister 2013).   The characteristics of these effective mentor-student relationships include mutual attraction and mutual respect between student and mentor (Darling 1984), warmth and nurturing (Spouse 2001) compassion, acceptance and support (Koontz et al 2010) and nurturing and reciprocity (Vallant and Neville 2006). To make these relationships work, however, requires emotional labour from both mentor and student (Webb and Shakespeare 2008) and, both mentor and student, need to assume some responsibility for establishing and maintaining the relationship (Gidman et al 2011, Thomas et al 2012, Crombie et al 2013). Students and mentors, therefore, need to come to practice placements with the necessary skills to establish and maintain such relationships (Houghton et al 2012, Lewallen and DeBrew 2012).

Practice placements can be stressful environments and a student's ability to cope with this again often depends on the relationship that they have with their mentor (O'Mara et al 2014). Students need to develop practice placement 'survival' skills including reflexivity, self-care, conflict resolution and emotional resilience and mentors can help students to develop these skills (O'Mara et al 2014). However, some mentors argue that the realities of nursing need to be

accepted by students and they need to 'toughen up', hence the use of strategies such as 'throwing students in at the deep end' (Thomas et al 2012). Interestingly, Jokelainen et al (2013) found that Finnish mentors valued individuality and the emotional aspects of their relationships with students more highly than British mentors.

It is also clear from the literature that whilst an effective mentor-student relationship can clearly benefit students, it can also benefit mentors, it can be an enjoyable experience for them (Courtney-Pratt et al 2011, Turnbull et al 2014) and it can also increase the motivation of staff who mentor, thus creating a more dynamic working environment (RCN 2016).

2.2.2 Characteristics of a 'good' mentor

As mentors are commonly regarded as gatekeepers to the profession and thus help to protect the public (RCN 2016), it is essential that they are effective mentors. The personal attributes of individual mentors are frequently cited when students and mentors are asked about the characteristics of a 'good' mentor (Gray and Smith 2000). They are described as being approachable, confident, professional and well organized (Gray and Smith 2000). They are enthusiastic about their job, about passing on their knowledge, and they give regular feedback, both positive and negative, to their students (Webb and Shakespeare 2008). Good mentors are also described as being friendly and enthusiastic, self-aware, and as having good teaching skills (Courtney-Pratt et al 2011, Jokelainen et al 2013) and being committed to student education

(Robinson et al 2012). Crombie et al (2013) note that kindness and an ability to make students feel cared for were also highly rated by students, but that this attitude often emanates from the ward manager, rather than just the individual mentor.

Another important characteristic of a good mentor is the ability to support students to make links between theory and practice and assist the student to understand the theory underpinning their practice (Field 2004, Wigens 2006, Taylor 2009). In order to be able to facilitate this learning, however, mentors need to have a clear personal teaching philosophy (Hegenbarth et al 2015) and to be skilled teachers (Rassool and Rawaf 2007). Furthermore, this characteristic depends on the individual mentor being a knowledgeable practitioner (Moseley and Davies 2008).

A good mentor can also promote the professional socialization of student nurses, particularly through role modelling (Earnshaw 1995, Papp et al 2003, Murray and Main 2005, Koontz et al 2010, RCN 2016) and enhance the credibility of the profession (RCN 2016). Whilst this is normally a positive process, if mentors are not competent practitioners, then students may learn poor practice and inappropriate values and attitudes from these mentors (Papp et al 2003, Thomas et al 2012).

Support from good mentors for their students can also increase student motivation and hence reduce student attrition (Pearcey and Elliott 2004, Pellatt 2006, Taylor 2009). In fact Crombie et al (2013) note that the quality of

mentorship can be the deciding factor in whether students stay, or leave their nurse training. Furthermore, 'good' mentors can enhance student empowerment and self-esteem, which in turn improves student learning. This also has a direct bearing on student retention, both in terms of students successfully completing their placements and in maintaining their desire to remain in the nursing profession (Bradbury-Jones et al 2007).

Although it is clear that mentors have a vital role to play in the students' practice placement learning experiences, not all nurses are effective mentors and some would argue that mentors should only take on the role if they are keen to do so (Gidman et al 2011, Turnbull et al 2014), as toxic mentors (Darling 1985) can be extremely destructive. Others, however, regard mentorship as a part of every registered nurse's responsibility (Dunn and Hansford 1997).   Some nurses undertake the mentorship training because the qualification is required for promotion to a higher grade, or is a requisite of their current post (Watson 2004, Turnbull et al 2014, RCN 2016), but such coerced mentors may be far less concerned with being a mentor than being promoted, or meeting the requirements of their current post. Similarly, others argue that a formalised selection process for mentorship would be preferable, whereby nurses are selected to be mentors, rather than the current system in which all nurses are expected to become mentors (Andrews and Wallis 1999, Turnbull et al 2014, RCN 2016). It is also argued that the completion of a mentorship programme should not be regarded as the sole gateway to further continuous professional development (CPD) opportunities (Turnbull et al 2014).

2.2.3 Conflicts in the mentorship role

The literature highlights that whereas this is a very important role, there are many areas of tension within the mentorship role. Although the NMC (2008) are very clear about the role of a mentor, the literature would suggest that, in reality, the role is full of confusion and conflict (Carnwell et al 2007). One of the specific tensions within the role is that of teacher versus assessor (Wilson 1994, Neary 2000, Bray and Nettleton 2007). Neary (2000) suggests that it would be preferable to separate out these two aspects of mentorship, as was done previously, because it is unrealistic to expect one person to be both teacher and assessor. Duffy (2003) also notes tensions in the mentorship role, leading to students who are not clinically competent passing their placements; mentors being guilty of 'failing to fail' under performing students. These tensions include the idea that failing a student is incongruent with the perception of nurses as being caring professionals. This is a very powerful perception amongst nurses and can make failing a student very problematic for some. Duffy (2003) also found that practical reasons such as time pressure on mentors, or not understanding the assessment process and documentation, discourage mentors from failing, failing students. The answer, Neary (2000) argues is to have a named, supernumerary practitioner to supervise and assess students in practice and to separate out the teaching and assessing roles. Assessment is then probably one of the most important roles of the mentor in the current mentorship framework, but it is also one of the most problematic (Duffy 2003)

There is also a perceived tension between the delivery of patient care and having enough time to teach and assess a student (Pulsford et al 2000, Duffy 2003, Murray and Main 2005, Wilkes 2006, Gleeson 2008, Jokelainen et al 2011b, Jokelainen et al 2013). This may, however, be a false divide, as Cahill (1996) notes that if teaching and learning activities are seen as separate from patient care and can only be undertaken once the work is done, then teaching is being perceived in a very traditional, didactic and formal manner, whilst the reality is that much learning is informal and situational. According to Field (2004) this perception of how students learn in practice, could be due to the fact that mentors do not explicitly connect nursing knowledge with academic knowledge, theories, or research.

2.2.4 Preparation and support for mentors

The research literature suggests that good preparation for the mentorship role is essential (Jinks and Williams 1994, Duffy 2003, Vallant and Neville 2006, Wilkes 2006, Bray and Nettleton 2007, Gleeson 2008, Jokelainen et al 2011b, Jokelainen et al 2013, Turnbull et al 2014). In 2003 Duffy argued that improvements in pre-registration nurse training, particularly regarding the acquisition of clinical skills, could be achieved by focusing on improving the skills and knowledge of individual mentors. Her proposed solution was then to enhance the initial training of mentors, make it mandatory, and to improve subsequent mentorship continuing professional development. This work was funded by the UKCC (precursor to the NMC) and led to the development of the NMC Standards to Support Learning and Assessment in Practice in 2006

(SLAiP), which made mentorship preparation programmes and annual updates mandatory for all mentors. Although appropriate preparation for mentors is important, there is a lack of evidence in the research literature, regarding the best pedagogical approach to such programmes, apart from Clemow (2007) who suggested that a good learning strategy for mentorship is that of skills rehearsal, so again there is great variation in the approach adopted by different programme providers.

In terms of provision of the necessary ongoing support and supervision for mentors, many mentors report feeling poorly supported by both universities and practice placement providers, which clearly can adversely affect the quality of teaching and assessment in practice (Pulsford et al 2000, Watson 2000, Turnbull et al 2014, RCN 2016). Furthermore, the mentorship role is a complex and demanding one and this is not always acknowledged, nor is good mentorship always valued and rewarded (Bray and Nettleton 2007, Jokelainen et al 2011b, Turnbull et al 2014, RCN 2016).

2.2.5 Alternative practice-based learning models

According to Andrews and Chilton (2000), it is important to look not only at the individual characteristics of good mentors, and good student-mentor relationships, but also at alternative mentorship models. In recent years in the UK, the predominant mentorship model has been a one to one, dyadic model, and this has been regarded as the gold standard of mentorship models (NMC 2008). Increasingly, however, this model is perceived as being unsustainable

for a number of reasons - too few mentors in some areas, increasing work pressures on existing mentors, an increasing emphasis on interprofessional learning in the workplace (Turnbull et al 2014, RCN 2016). Furthermore, Andrews and Wallis (1999:207) argue that maybe, in reality, no one person can fulfill all the properties of a '*good mentor*' and a better approach would be to use a mentoring team. Others argue that new practice placement frameworks, based on coaching and mentorship may also be a viable alternative to the current system (Turnbull et al 2014, Bazian 2015, RCN 2016).

According to Nielsen et al (2013) clinical education models are a possible alternative and Grealish and Rance (2009) found that the use of a dedicated education unit, which focuses the development of a community of practice and on the individual learner and their sense of belonging, improves practice learning. Killam and Heerschap (2012) argue that to maximize student learning, a systems approach is required, including an exploration of placement organisation, impact of workload, stress and tiredness levels, which again does not just focus on the individual mentor. Gidman et al (2011) also note that personal issues such as finance, working shifts and travel have a bearing on practice placement experiences and therefore need to be taken into account when planning student placements. Peer learning should also be considered as an alternative model of practice-based learning, according to Mamhidir et al (2014), as it can help to increase student confidence and competence and to decrease student anxiety in the practice placement setting. This model also encourages students to take responsibility for their own learning and is therefore empowering and encourages critical thinking.

Interprofessional education in practice is also crucial, in order to ensure high quality care delivery, but more research is required according to Barr et al (2014), as there is a lack of understanding of how practice-based interprofessional education is best implemented. There are also many health care assistants involved in the training of student nurses (Hasson et al 2012), both formally and informally and as such these members of staff should be trained and supported, as they can be a very important aspect of student nurse training (RCN 2016). This is, however, a contentious issue, with some arguing that this should not be part of the health care assistants role (Turnbull et al 2014).

The underpinning similarities in these alternative models include the fact that the sole responsibility for student learning does not rely exclusively on the individual mentor, rather, there is a general emphasis on the importance of learning and education in the setting, and that someone within the setting takes responsibility for creating a positive learning environment. Luhanga et al (2010), however, suggest that a diversity of models should be explored, including the dyadic mentorship model.

2.2.6 Characteristics of a good learning environment

It is clear from the literature that practice placement settings can be effective learning environments, despite the variable qualities of individual mentors, and which mentorship model is utilised. These effective learning environments are a vital part of nurse training and can provide rich learning opportunities (O'Mara

et al 2014). They are characterized by civility, productivity, good relationships, high staff morale, and happiness (Kelly and McAllister 2013). They can also help to build social capital, which in turn, leads to the retention of students both within their training and within nursing (Taylor 2009). Furthermore, they assist with the delivery of high quality safe patient care and offer the opportunity for interprofessional learning (Allan et al 2008, Henderson et al 2011, Hood et al 2014). It is clear, however, that an effective learning environment does not just happen by chance, it requires inspirational leadership at both strategic and ward level, and effective management (Carnwell et al 2007, Allan et al 2008, Webb and Shakespeare 2008, O'Driscoll 2010, Henderson et al 2009, Henderson et al 2011, RCN 2016). Congdon et al (2013) note that roles such as learning environment managers can help with this process and Turnbull et al (2014) suggest that it is essential to have a named person in each practice placement setting to take responsibility for the students' practice placement learning experiences.

According to the literature, one of the key characteristics of a high quality learning environment is a close collaboration between practice and university (Dunn and Hansford 1997, Duffy et al 2000, Carnwell et al 2007, Congdon et al 2013). Similarly, Andrews and Wallis (1999) note that if mentorship is to be delivered successfully, good communication between the university and the practice placement provider is essential, but that this does not always happen. O'Driscoll et al (2010) note that here has been an '*uncoupling*' of education and practice, with the main responsibility for practice learning now falling to individual mentors, despite not having the support, training, or capacity to

individually shoulder this responsibility and they claim that this has led to a decline in practice placement learning. Likewise, Foster et al (2015) note that universities need to strengthen links between themselves and the practice placement settings, particularly regarding support for mentors. Papp et al (2003) note that good learning environments are typified by a clear alignment between the values and views of faculty and clinical staff, which again will only result from close collaboration. Henderson et al (2009) suggest that one way to maintain the links between practice and university is though the deployment of an experienced researcher, or educator who undertakes the facilitation of capacity building sessions in practice. This can improve the student experience, particularly if such changes are embedded within leadership practices, and then become the accepted values, norms and behaviours in the clinical setting. Jonsen et al (2013) also note that a tool for bridging the gap between theory, research and practice is needed, to ensure high quality learning environments.

2.2.7 Student belongingness

It is clear from the research literature that one of the most important aspects of a positive practice placement is whether or not the students feel that they belong in the setting (Cope et al 2000, Spouse 2001, Papp et al 2003, Levett-Jones and Lathleen 2007, Thrysoe et al 2010, Roxburgh 2014). When students feel that they belong in a practice placement setting, their learning and motivation is enhanced. Spouse (2001) notes that mentors are well placed to enable students, through their personal sponsorship, to ensure that students

gain entry to the ward environment and Jones et al (2001) note that without a

mentor, the students just '*hang about'*, or '*tag along*', rather than becoming a

fully functioning member of the team and hence their learning is limited. Del

Prato (2013) noted that for women especially, confirmation and community are

pre-requisites to adult learning and development, so when female students are

treated badly in placement, this impedes their learning and professional

socialization. Del Prato (2013) also talks about the fact that students often have

to deal with uncivil experiences and even horizontal violence and bullying in

their placements. If students feel alienated in a practice placement this can

lead to distress and disengagement and again impede their learning in the

clinical setting (Levett-Jones and Lathlean 2007, Moscaritolo 2009). Some

groups of students may find 'belonging' more difficult to achieve than others, as

noted by Stacey et al (2010) who found fear, resistance and intimidation from

colleagues towards master's level students, mirroring an anti-intellectualism

within nursing, where such students are seen as 'too clever to care'.

2.3 Conclusion

This literature review confirms the importance of practice placement learning in

nurse training and the importance of the mentorship role in that process. The

personal characteristics of a 'good mentor' are very clear in the literature and

this often emphasizes the intrapersonal and interpersonal skills of the mentor.

In particular, the individual relationship between a student and their mentor is

clearly fundamental in ensuring that the students' practice placement

experiences are as effective as possible. Although there is sometimes an

assumption that it is the mentor's responsibility to form and maintain the relationship between mentor and student, there is an increasing acknowledgement that students also have to take some responsibility for their relationship with their mentor, and for their practice placement learning experiences more generally. The mentorship role is complex and can be demanding, and many mentors would argue that this responsibility is unfair, as they have no time to carry out the role effectively, they are ill-prepared for the role, they have minimal support and minimal acknowledgement from their employers or the universities, and some, simply do not want the added responsibility of being a mentor.

Mentorship, however, occurs within the context of a learning environment and the characteristics of effective learning environments are clear from the literature. This includes an emphasis on the importance of inspirational and transformational leadership, and efficient management, both at a strategic and ward level. It is also clear that there must be a close and collaborative relationship between practice and the university. These characteristics are always required in a good learning environment, irrespective of which practice-based learning model is used, from the more traditional dyadic model, to alternative models, including dedicated education units, clinical educational units, peer learning and the use of coaching. The most important factor from the student's point of view, however, is whatever model is used the students need to feel that they belong in that setting; that they are welcome and valued, and that they have a meaningful role to play in the healthcare team.

The issues of practice placement learning, and in particular mentorship, have been explored previously in the literature, but as Jinks (2007) points out, there is a lack of rigour and transferability in many of these studies; many of them are small scale qualitative studies only, set in very specific geographical areas. Also much of the earlier research in this literature review explores the practice placement learning experience from the mentor, or university perspective, with a particular emphasis on how mentors and lecturers can enhance student learning, with less emphasis on the student perspective and Foster et al (2015) argue that the student voice is still under represented on this topic. Furthermore, much of the earlier empirical research was undertaken using the Clinical Learning Environment Inventory developed by Chan (2002), an adaptation of this inventory, or pre-set questionnaires, (Chan 2002, Saarikoski et al 2006, Murphy et al 2012), but as O'Mara et al (2014) point out, standardized data collection methods limit the ability to capture the nuances of the practice placement setting. Later research has tended to rely on questionnaires (often with low response rates) and focus groups, but with an increasing move towards the use of individual interviews. The use of a narrative methodology is however, rare, with two exceptions, Grealish and Rance (2009) and Stacy et al (2010). This study, therefore, wished to explore the individual students' practice placement learning experiences form their perspective and in their own words.

More specifically the intended outcomes of this study were:

- To gain a better understanding of what student nurses learn in practice and how they learn it.

- To gain a better understanding of what student nurses are taught in practice, how they are taught and by whom.

- To gain a better understanding of how student nurses perceive the role of the mentor in this process.

- To identify examples of good practice, and to produce suggestions of how things could be.

Whilst undertaking this study I was involved in two other related research projects. The first project was funded by Health Education England - *An exploration of the influences on developing and maintaining a successful mentorship process: An investigation of mentorship from multiple perspectives* (Turnbull et al 2014). The participants in this study were mentors, student mentors, and educational managers in Trusts. The participants for this study were all recruited from the same geographical area as the participants for my study. My role in this project included, with three other researchers, study design, data collection and analysis and writing final report. The second research project was an exploration of the mentorship role in the United Kingdom commissioned by the Royal College of Nursing – The *RCN mentorship project 2015 From today's support in practice to tomorrow's vision for excellence* (RCN 2016). My role in this project was to help analyse the data and co-author the final report. This study included data from mentors, practice development facilitators, directors of nursing, a small number of students and

the Bazian literature review of alternative mentorship models being used

internationally (2015). Both these pieces of work explored practice-based

learning and mentorship in student nurse training, but from a different

perspective to my own study; from the mentor, student mentor and practice

placement provider perspectives. My involvement as a researcher in both these

other studies, whilst undertaking my own study, therefore, afforded me the

opportunity to partially redress one of the limitations of my own study – that it

only considered the student perspective on this issue.

Chapter 3 Methodology

This chapter describes the philosophical approach and the methodological theories underpinning this study, starting with an explanation of why a qualitative paradigm was selected. The decision to use interpretive description and, more specifically, narrative inquiry, as the methodological framework for this study, is then considered. The choices regarding sampling, the choice of sample population and the decision to use purposive sampling, are then explored. Next, the selection of data collection methods, namely, reflective diaries and semi-structured interviews, are reviewed. As there are many frameworks that could be used for data analysis, but none specifically related to either interpretive description, or narrative inquiry, the decision to use Framework for the data analysis is justified. As qualitative research studies require a high level of reflexivity, there is an analysis of this concept and an explanation of how this was achieved in the study. Finally, the chapter explores how rigour and trustworthiness can be achieved in qualitative research; generally, and how this was done within this particular study, including an explanation of how research governance and ethical issues were addressed. The chapter ends with a personal reflection on some of the issues and challenges I experienced as a researcher, during this part of the research project; this section is based on the notes I made at that time about my personal experiences, and discussions I had with my supervisors.

3.1 Research paradigm

When designing a research project, there are philosophical and theoretical decisions to be made prior to undertaking any actual research. These philosophical and theoretical decisions are fundamental to any project, as they underpin all further practical decisions regarding the design of the research project; and thus, they will ultimately determine the quality, or otherwise, of the project (Blaikie 2007, Thorne 2008). The first major decision for most researchers is whether or not to utilise a quantitative, or qualitative approach. Qualitative research can be viewed as research that aims to provide an in-depth and interpreted understanding of the social world (Snape and Spencer 2003), or as Denzin and Lincoln (2000) state, it attempts to make the world of the participants visible to others. As I wished to understand and explain the placement practice learning experiences' of student nurses, I decided to use a qualitative research paradigm, a research paradigm being a philosophical and theoretical framework, or a metatheory, constructed to help facilitate an understanding of the social world (Kuhn 1962, Alvesson and Skoldberg 2009).

3.2 Qualitative methodology

There is, however, more than one way to carry out qualitative research and the exact nature of any qualitative research project, depends on several factors. The first factor is the researcher's personal beliefs about the nature of the social world and how knowledge of the social world can be acquired. It also depends on the purpose of the research and the nature of the research project.

Transparency about the philosophical and theoretical beliefs underpinning any research is essential and is expressed in terms of ontology, epistemology and personal axiology (Snape and Spencer 2003, Blaikie 2007, Thorne 2008, Alvesson and Skoldberg 2009).

3.3 Ontology

The underpinning ontological assumption for this project could be described as subtle realism; this acknowledges that whilst there is a shared understanding of social reality, it is accessible only through human construction (Snape and Spencer 2003). Unlike the physical world, there are no universal laws to explain the social world; an individual's experience will be shaped by the context of the social phenomenon being investigated (Snape and Spencer 2003). This approach is closely aligned theoretically to social constructionism, which claims that an interaction between society (social order, social institutions, socialization) and the individual does exist (Alvesson and Skoldberg 2009).

3.4 Epistemology

Interpretivist epistemology was used to underpin the study, which, according to Bryman (2008) is an attempt by the researcher to understand the social world of the participants, through an examination of the interpretation of that world by the participants. This examination, in turn, requires analysis and interpretation by

the researcher. In terms of epistemology, or how we learn about the social world Snape and Spencer (2003) identify three issues. Firstly, there is the nature of the relationship between the researcher and the participants. Natural science research regards the phenomenon under investigation to be independent of the researcher, who is objective and unbiased, whereas, many social scientists would argue that the relationship between themselves and the social world is interactive (Holloway and Freshwater 2007). Within this research study there was an underpinning assumption that all researchers and their participants do have an impact on each other. Secondly, theories about the nature of 'truth' vary and in this study there was an acceptance that if a participant confirms a statement, then it can be regarded as a faithful representation of their socially constructed reality. As objective, value-free research is considered impossible in this project, I will declare and be as transparent as possible about my personal beliefs, values and assumptions as they apply to this study. Thirdly, the methods of natural science are not appropriate for this study as the social world is not ruled by universal rules, and so needs to be mediated through my analysis and interpretation, and through the particular meanings given by the participants (Bryman 2008). This approach to research then attempts to produce ideographic knowledge, which according to Swinton and Mowat (2006), means that as no two people experience the same event in exactly the same way, multiple truths are possible. This is in contrast to nomothetic knowledge, gained through the use of scientific method and meeting the criteria of falsifiability, replicability and generalizability (Swinton and Mowat 2006).

3.5 Abductive logic

Blaikie (2007) suggests that it is essential for a researcher to clearly state their chosen logic of inquiry, so this study was underpinned by abductive logic. This approach requires that the concepts and theories of social life are derived from the research participants' conceptualizations and understanding of their social worlds, through an iterative research process (Blaikie 2007; Alvesson and Skoldberg 2009). Furthermore, according to Alvesson and Skoldberg (2009), during this abductive process, the researcher starts from the empirical data, but they do not reject the importance of theory, indeed, theoretical preconceptions and the data are combined, with the data and theory being reinterpreted in the light of each other. This iterative process is then one of interpretation and explanation, acknowledging that 'facts' are theory-laden (Alvesson and Skoldberg 2009). Researchers coming from this perspective, attempt to socially (re)construct their research participant's knowledge of their social reality. The researcher is then, at most, attempting to construct ideal types, or examples of how a typical person may behave in certain situations (Blaikie 2007). The aim in this study is, through abductive logic, to generalize and maybe create new knowledge about the students' experiences. This requires a systematic analysis and interpretation of that social phenomenon, viewed within its wider context (Morse et al 2001). The role of theory then, in this study, is to help structure the research and to inform the findings, but not to restrict it, by trying to make the data fit the theory (Ely et al 1997). According to Ely et al (1997) this is particularly important in nursing research, as they argue that there tends to be an anti-intellectual mindset in nursing, which is unconcerned with theory.

Furthermore, they argue that this disempowers nursing in public debates and denies the opportunity for theory to illuminate practice, indeed, they go so far as to suggest that when theory is used, it is merely to ask, 'what works', not 'what if' (Ely et al 1997).

3.6 Reflexivity

According to Thorne (2008) it is important for a researcher to identify their particular theoretical and experiential field and to be transparent about this, prior to starting their research. The researcher needs to declare what they represent, and what they are trying to achieve through their research. The researcher's personal values, assumptions, beliefs – axiology needs to be explored. Roulston (2010) points out that all researchers bring their own assumptions, previous knowledge and experience to a research project, but that a high level of reflexivity will temper this subjectivity, or potential bias, or even embrace it. She suggests several ways of dealing with this including a subjectivity statement, in the form of a biographical life history and researcher journals, including memos, ideas, reflections recorded as a project progresses, both of which I used during this project. As Gadamer (1989) points out, in order to understand others, you need to understand yourself first. According to Dowling (2006) reflexivity operates on multiple levels, at the individual level, a researcher needs to be self-aware and reflective. There is also epistemological reflexivity, which requires the researcher to be transparent about decisions made during the research process, including, how has the research question been defined, what can be 'found' and how could such research questions be

investigated differently. Although the knowledge generated from such research is tentative, it can be rigorous, if transparency and reflexivity are maintained (Spencer 2011). Similarly, as Denzin and Lincoln (2000) note, all social enquiry is influenced by theories and will reflect the beliefs, assumptions and experience of the researcher, again emphasizing that reflexivity is crucial in social research projects. Following on from personal reflexivity and epistemological reflexivity, Alvesson and Skoldberg (2009) discuss the need for methodological reflexivity, particularly during data analysis and interpretation. They claim that this happens at several levels. Firstly, the researcher interacts with the empirical data and at this stage makes many decisions on how to proceed with the analysis of the data, for example, not just cherry picking the data, or data dredging, to fit researcher's pre-conceived ideas. Next, there is a first level of interpretation to discover underlying meanings in the data; this includes organizing and deconstructing the data. This is followed by critical interpretation of the data, including acknowledgement of the political, professional and social context of the research. Finally, reflection is required within the final text, regarding claims to authority and whose voices are represented in the text. This process requires reflection and reflexivity on the part of the researcher at every stage (Holloway and Freshwater 2007, Alvesson and Skoldberg 2009). As there are no set rules, or procedures to guide these processes, unlike research in the natural sciences, the researcher's judgment and their ability to see something beneath the explicit data are vital. This process requires being aware of relevant theories, but not being completely tied to them, a healthy scepticism is required, plus the ability to shut out common sense pre-conceptions. This requires an excellent memory and intellectual

flexibility on the part of the researcher, '*good qualitative research is not a technical project; it is an intellectual one*…' (Alvesson and Skoldberg 2009:317) and, as Wright Mills (2000) suggests, a good sociological imagination. If this study is to be a credible and trustworthy piece of work the importance of reflection and reflexivity cannot be overstated and this includes personal, epistemological and methodological.

3.7 Interpretive Description

Moving on from a generally qualitative approach is complex for many researchers, including myself, as there are a plethora of qualitative research methodologies available, including ethnography, phenomenology and grounded theory, and, as Thorne (2008) points out, researchers must be cautious about becoming ensnared in 'methodolatry', which she describes as the tension between theoretical rigour and practicality. She suggests that to pursue an inductive, iterative and interpretive approach is sufficient: interpretive description. Thorne (2008) argues that this approach is particularly well suited to nursing research, as nursing knowledge is complex – a mix of theoretical and practical knowledge - and because nursing research should culminate in a plan of action, applicable to numerous different situations. This approach tries to bring together systematic observation, analysis and interpretation of a phenomenon, and then, putting that analysis back into the practice context, with the aim of producing an action plan. Thorne (2008:52) describes this as an attempt '*to shift the angle of vision with which one customarily considers that phenomenon*.' This study then will draw on interpretive description, with the

one caveat that inductive logic will be replaced by abductive logic. This general

methodological approach is particularly suited to my research in many ways. My

study is concerned with systematically documenting what is being observed and

heard, but is not about theory testing, or attempting to prove a causal

relationship, it values the subjective and experiential knowledge of the

participants and it assumes that social phenomena have a temporal element. I

believe that context is important and that human experience is socially

constructed, and this includes an acknowledgement of the importance of the

influence of the relationship between researcher and participants. The

challenge then, according to this approach, is to look beneath the self-evident,

to document identified themes through deconstruction and then to reconstruct

the findings, to provide a new understanding of the phenomenon (Thorne 2008).

In a previous research study I decided to use ethnography and often I felt that I

was forcing the data into the predefined categories as outlined by Spradley

(1979). I didn't want to repeat that experience, but I did decide that I needed a

more specific theoretical framework than interpretive description, for this study.

In order to make this decision I rehearsed the thought processes that had

initially led to my research topic; I have often listened to and read about student

nurses' placement experiences, through numerous different formats – written

placement evaluation forms, post placement discussion groups, individual

tutorials with students, case studies written for assessment purposes – but I

have only previously considered them through the lens of quality assurance

purposes, or as an assessor. These episodes were then guided and time-

framed by myself, limiting the students' freedom to explore the experiences they

wished to reflect on, and, in how much depth, due to time constraints. I was

aware, however, that they all had many more and longer stories to tell, if they had the opportunity. With this in mind, I decided to use narrative inquiry, in an attempt to capture the students' experiences in their entirety (Clandinin and Connelly 2000).

3.8 Narrative Inquiry

According to Holloway and Freshwater (2007), narrative inquiry is the contextual study of peoples' experiences and this fits well with an interpretive description methodological framework in several ways. Narratives are oral or written versions of experience; they are personal accounts of people's motives, actions, interpretations and meanings (Clandinin and Connelly 2000). This use of narratives, which can be seen as reflection on experience, can help the narrator to make sense of their experiences and the emotions created by them. This means that the use of narrative is potentially transformative by enhancing personal agency and it can perform a healing function (Holloway and Freshwater 2007). Freshwater and Holloway (2007), go on to suggest that such accounts produce a more holistic view of a social phenomenon, than would be achieved if the participants were just asked a list of questions, or asked to complete a questionnaire. Narrative inquiry regards the events described by participants as being temporal and contextualized, so that the knowledge created from such research cannot automatically be applied in all contexts, at all times (Clandinin and Connelly 2000), but although it is case-centred, it can generate concepts and prompt the reader to think beyond the text, allowing an insight into the participant's social world and how they make sense of that world

(Elliot 2005). In narrative inquiry, the knowledge produced is regarded as socially constructed, with the influence of the researcher on the research being undeniable (Clandinin and Connelly 2000; Thorne 2008), indeed, Holloway and Freshwater (2007) argue that in narrative inquiry the researchers should engage their emotions, be empathetic and not even try to be neutral, or distant. It has been argued that narrative inquiry works well as a research strategy when the researcher is interested in the experiences' of the participants, as it focuses on the way individuals assign meaning to their experiences, through the stories they tell (Elliot 2005) and as Clandinin and Connelly (2000) point out experience does happen narratively. It does not try to determine a 'true' picture, but rather to explore events from the participant's point of view; how they made sense of them, their attitude towards them, and the meanings that they have for them (Greenhalgh and Wengraf 2008). This can be achieved by collecting multiple stories about the same event, or comparable experiences, but there may be conflicting versions of one event and any 'final version' has to be carefully considered (Holloway and Freshwater 2007). This research methodology requires time and space to develop a caring relationship between the researcher and the participants (Elliot 2005). Before this research started I knew the participants fairly well and as the data collection period was several months, I ended up knowing the participants very well. I hoped that our relationship would be one of increasing equality and definitely be non-judgmental – important factors in narrative inquiry (Moen 2006; Holloway and Freshwater 2007). These aspects of narrative inquiry appeal to me, as I believe that as nurse educators we must treat our students in a caring, compassionate and non-judgmental manner.   Although a sense of complete equality may be

unrealistic in what is an essentially unbalanced power relationship, I do believe that during the course of a nurse training programme, this is what we should work towards (Ironside 2001). Furthermore, Holloway and Freshwater (2007) argue that such a research methodology is particularly suited to nursing research, as it emphasizes the individual person as being central to the research, making it more humanistic and holistic.

Narratives then consist of a story and a plot, with a beginning, middle, and end (McCance 2001, Elliot 2005). The story is, what happened, or a description of the events that occurred and the plot is concerned with how the events are linked (Gubrium and Holstein 2009). Equally important is how the story is told, and how the characters are represented. The narrative is a journey through time told by the narrator, it may be reflective, may clarify, or justify their behavior and will often link the past, to their present thinking and actions (Elliot 2005). The researcher will then retell their story (Riessman 2008; Elliot 2005). Similarly, Polkinghorne (1995) describes narrative as having three parts: the experience; the telling of the experience; and the interpretation of the experience by the researcher. The narrator and the listener then both depend on their background knowledge in their interpretation of the story. This aspect of narrative inquiry could be seen as both an advantage and disadvantage for me. I do know a great deal about student placements, which gives us a shared language and understanding, but I run the risk of making assumptions and jumping to premature conclusions about the students' experiences. Furthermore, the use of narrative inquiry is not without its dangers, as narratives

can be strategic and purposeful and such powerful stories can be used to justify, or even mislead (Elliot 2005; Riessman 2008).

According to Carson and Fairburn (2002), research often fails to present a strong case for change, as it is not answering practitioners' concerns; surveys, for example, may just ask the wrong questions, but with narrative inquiry, the participant has much more control over the process. As this is an applied research project, a methodology that leads to change is crucial. I am conscious that students often have negative experiences whilst on placement, hence another reason to use narrative inquiry, but I was concerned that the interviews might be unduly negative and so I drew on appreciative inquiry, particularly when designing the reflective diaries (Cooperrider and Witney 2005; Kowalski 2008).

The interest in narrative inquiry in nursing research generally can be regarded as a reaction to the dominant discourse of evidence–based practice, with its hierarchy of evidence, where randomized control trials are seen as the gold standard, and there is a disregard for personal, or experiential knowledge, whereas, according to Titchen and Higgs (2001), expert practitioners require theoretical and experiential knowledge. The personal wisdom and insight that expert nurses develop is not always grounded in theory, but rather, in an intuitive application of formal knowledge and protocols. This process has been described as phronesis or practical wisdom (Sellman 2011). Furthermore, it has been suggested that nursing has attempted to improve patient care and outcomes, by using scientific evidence, but patient care and outcomes are, by

their very nature, contextualized and particular, relying on individual judgments, made in particular contexts (Sellman 2011). In fact, a traditional evidence-based approach to nursing care delivery could lead to a dehumanizing of care, where the emphasis is on following procedure (Freshwater and Holloway 2007). According to Dunne (2007), good quality nursing care depends on individual judgment and the capacity to make decisions in complex situations; the expert nurse needs to be aware of protocols, but will also know that you sometimes have to deviate from them, for example, to accommodate patient choice. Nurses, therefore, need to develop evidence to underpin their practice, which includes experiential knowledge, as narrative inquiry does.

3.9 Sampling strategy

Clearly when investigating any social phenomenon affecting large numbers of people, or issues, for practical reasons, a sampling strategy has to be devised. In qualitative research, sampling is not about statistical representation, or random selection, rather it aims to ensure that the chosen sample is typical of a larger population, in terms of 'symbolic representation' (Ritchie et al 2003). Qualitative samples can be small in size for several reasons. Firstly, there comes a point in qualitative research where new data is unlikely to be generated, this is important because, unlike with quantitative data, issues need only be mentioned once (Ritchie et al 2003). Secondly, as incidence and prevalence are not important, the sample does not have to be of a size to provide statistically reliable information (Ritchie et al 2003). Finally, as the data

required needs to be rich in detail, 'thick description', this can be gained from small sample sizes, with good data collection methods (Geertz 1993, Ritchie et al 2003).

3.10 Study population

The first task then is to identify the study population – who, or what, is to be sampled and then a sample frame (Ritchie et al 2003). The study population needs to be close to the research question, so that rich and relevant data can be identified (Ritchie et al 2003). The study population for this study, therefore, needed to be adult student nurses. The sample frame for this study is potentially extremely large - there are numerous student adult nurses undertaking nurse training in the UK, but I decided to ask my own students to participate in the study. I felt that they would be suitable as they had already discussed their placement experiences with me in other contexts and had some very interesting points to make. This was, however, a very small sample population, with little room for attrition, but I felt that this would not be an issue, as I had a close working relationship with the group. This was also a particularly pertinent group to investigate, due to the fact that they were on an accelerated pre-registration nurse training programme, which intensified their learning needs whilst in placement. At the start of this research study in fact, these students were part of a unique pre-registration nursing programme in the United Kingdom; a two-year master's level training programme. The findings then from this study could then never be completely generalized to other cohorts, but if I wished to understand the experiences of these particular students, then they

were the only truly relevant participants for this study. I went on to select a cohort of 20 adult nursing students, in their second year of training, which meant that they had all undertaken several placements before the study started. I asked them to complete reflective diaries over two placements, which they all did and then invited ten students to be individually interviewed. These ten were selected as they had all undertaken the majority of their placements in the same acute hospital. Nine students agreed to be interviewed.

3.11 Purposive sampling

The sampling was purposive which Bryman (2008) describes as the selection of participants who are known to be relevant to the research question and Ritchie et al (2003) suggest that in purposive sampling the participants are selected on the basis of their ability to provide a detailed exploration of the phenomenon being studied. The sample was homogeneous, in that I was looking at a specific group; they were all student adult nurses, on the same pre-registration nursing programme, who had experienced placements in the same acute Trust and so were close to the research issue (Ritchie et al 2003). Patton (2002) argues that such homogeneous samples allow for the detailed investigation of a social process, in a specific context, which is what I required for this project. Although a homogeneous group, there was some diversity within the group, including age, previous levels of nursing experience, gender (one male), cultural heritage and religious beliefs, this is important as it ensures that no important information is missed (Ritchie et al 2003).

3.12 Data collection methods

I decided to use a two-stage data collection strategy, starting with reflective diaries and then moving to semi-structured interviews.

3.12.1 Reflective diaries

Reflective diaries have been found to be an effective way of collecting data and as being, potentially, beneficial to both researcher and participant (Nicholls 2010, Bedwell et al 2012, Hayman et al 2012, Moule and Goodman 2014). They sit well with narrative inquiry as a data collection method, as they allow the participants an opportunity to tell their stories, in their own way. The advantages of diaries as a data collection method include the fact that they are written whilst the participants are engaged in the experience being explored, which may make them more accurate (Moule and Goodman 2014). They are also recorded in the natural context and are free from the direct influence of the researcher, although admittedly not the indirect influence. But there are challenges associated with this data collection method, including poor participation, the participants feeling very exposed, and the ability to maintain the diary entries (Hayman et al 2012). There is also the need to consider that the participants may change their behaviour, due to increased awareness, or that they may complete the diaries very selectively (Moule and Goodman 2014). For the first stage of my data collection I asked the students (n=20) to complete a reflective diary for the duration of a four-week placement. Giving the participants a time limit is considered good practice, as it increases compliance, lessening the

possibility of participant fatigue (Moule and Goodman 2014). Before the students went on this placement, I spent time with them exploring the potential professional and ethical issues associated with keeping a reflective diary (NMC 2008), to ensure that they understood the purpose of the diary, how to complete the diary, and what would happen to the information from the diary. According to Nicholls (2010) these activities are essential to ensure participant engagement. The students were given a template to use (see **Appendix 2)** and I collected in the diaries at the end of the placement – twenty were returned. I did discuss with the students whether or not a template would be helpful and the consensus was yes. On return from that placement four weeks later, again we discussed the diaries and, following this discussion with the students, I amended the template slightly (they said I needed to ask more directly about learning, so I added this in) and asked them to complete the diary again during their next five-week placement, which they all did. Many students were very keen to complete the diaries again, commenting on the fact that they found them useful in that it gave them a focus for reflection about their placements and they asked me at this point could they use them as evidence of reflection, for their own portfolios to which I agreed. Some students, however, noted that the process of diary writing did not come easily and some were filled in very briefly! Through coaching the participants on how to write the diaries and following up with them, however, helped to maximize participation (Hayman et al 2012). I collected the diaries after the second placement and used them to inform an interview topic guide (again I received twenty). I re-visited the diaries later on as part of the data analysis process. The use of reflective diaries in this study proved to be a useful data collection tool, despite their limitations. They

also sit well with narrative research where respect for people must be central (Carson and Fairburn 2002), particularly in this instance where the diaries were co-designed by the participants and myself. In order to improve the quality of the diary data, in terms of depth, an alternative approach could have been to offer the option of audio diaries for those who did not find diary writing an easy task.

3.12.2 Semi-structured interviews

The second stage of my data collection strategy consisted of nine semi-structured interviews. I selected ten students to interview – all having had their placements in the same acute Trust – of which, nine, agreed to be interviewed. Interviewing can be regarded as a craft, requiring skills, training and personal judgment, which can only be learned through practice, as there are no set rules (Kvale and Brinkmann 2009). The purpose of the interviews was to try to understand the experiences' of the students from their point of view and to explore the meaning for them of these experiences. Interviews are, and always have been, one of the main methods of data collection in qualitative research and are a '*conversation with a purpose*' (Webb and Webb 1932:130), Hermanowicz (2002) goes on to describe them as an intimate exchange, in which the interviewee reveals their thoughts and experiences, whilst possibly at the same time, discovering things about themselves. It has to be remembered, however, that although there may be a desire for empathy and equality, the partners are not equal, and the researcher defines and controls the interview (Kvale and Brinkmann 2009). Also, as we live in an interview society (Silverman

2000) and people are very familiar with the interview format, researchers may not realize just how difficult they are to do well. For me, a particular challenge was to avoid slipping into a therapeutic interview, which aims to change the emotional personal reactions of the participants, particularly when the students discussed events that they had found distressing (Kvale and Brinkmann 2009).

Interviews as a data collection method are congruent with narrative inquiry, but as Mishler (1986) points out, whilst stories are common in everyday conversation, interviews can suppress them, for example, when the interviewer interrupts that narrative. Elliott (2005) suggests that to avoid this, the interviewer needs to ask the right open-ended questions in everyday language, that are broad and then the interviewer needs to really listen to the answers, without interruption. The specific wording of interview questions is less important than emotional attentiveness and the level of reciprocity offered (Riessman 2008). It is also better to have repeated conversations, rather than just one interview (Riessman 2008). Furthermore, according to Holstein and Gubrium (1995), unlike in traditional interviews where the interviewees are regarded as passive, there is a need to stimulate the interviewee's interpretive capacities. The goal is to create detailed accounts, through a conversation, but to allow for this possibility, the investigator must give up control and although this can lead to anxiety, on the part of the researcher, it will also lead to greater equality (Riessman 2008). They should be structured to allow the participants an opportunity to tell their stories according to Kvale and Brinkmann (2009), as interview knowledge is socially constructed and actively created through questions and answers; the product is co-authored by the interviewer and

interviewee. As the knowledge is contextual and has a temporal dimension, it will not be automatically transferable; hopefully, though, inferences can be made from it, regarding its applicability to other settings (Kvale and Brinkman 2009). Again these aspects of interviewing sit well with narrative inquiry. As these were in-depth interviews they comprised a mixture of structure and flexibility; although I encouraged the participants to tell their stories, I guided the interviews to ensure that I did elicit the information I was hoping to analyze. My topic guide (see **Appendix 3)** offered me a reminder of the key objectives of my research; it allowed for a degree of comparability; and was a starting point for my analysis (Ritchie et al 2003). Although narrative methodology begins with no preconceived questions and no particular theory to orientate questions – there is a topic, but the focus is on the participant's story, this avoids asking the 'wrong questions', based on erroneous assumptions. This coupled with a high level of reflexivity, helps to produce research that is more useful, rather than creating grand narratives (Carson and Fairbourn 2002).

A mixture of types of questions, were used, starting with very general 'what' questions and then moving on to more probing 'how' and 'why' questions (Ritchie and Lewis 2003). As these were narrative interviews, I did try not to impose temporal categories, but rather allow the participants to determine the sequence of events. I tried to use questions that elicit stories such as 'tell me what happened' 'and then what happened' (Riessman 2008). Furthermore, as I was hoping to develop solutions and to help improve other students' experiences in placement, I tried to encourage new ideas and explanations from the participants, in the spirit of appreciative inquiry (Kowalski 2008).

The interviews lasted between forty-five minutes and an hour and a half. They took place in my office at the university and I used Quick Time computer software on my MacBook Pro to record them. Technically this worked well and I managed to obtain nine high quality recordings, which was a relief.

There is a real skill to be being to good interviewer and a good interviewee, so we were learning together and the students often made comments such as '*am I giving you the information you need*' (Berg 2003). The audio recordings were transcribed verbatim. Kvale and Brinkmann (2009) claim that the interviewer can be seen as either a miner, concerned with knowledge collection, or a traveller, concerned with knowledge construction. I was definitely striving to be a traveller and through asking questions I hoped that new knowledge might emerge through analysis and interpretation, or that a new understanding of taken-for-granted ideas and values might be reached (Thorne 2008).

According to Kvale and Brinkmann (2009) there are particular ethical issues associated with interviews. They rely on the interviewer's ability to create the opportunity for the participants to talk freely of private events, recorded for later public use. Therefore, there needs to be a balance between the interviewer's desire for interesting knowledge, with the need to respect the integrity of each interviewee.

3.13 Data analysis

The data from the diaries and the interviews was thematically analyzed. Thematic analysis in narrative inquiry is concerned with 'what' is said, or written, with a view to uncovering and categorizing experiences thematically (Riessman 2008). The data is then interpreted in the light of the themes developed by the researcher, which have been influenced by prior and emergent theory, and the purpose of study (Riessman 2008). According to Polkinghorne (1995) narrative analysis can be used to tie together individual experiences, in order to create a context for understanding meaning. Overcash (2004) asserts that nurses are skilled at interpreting the voice of the patient and so the analysis of narrative inquiry relies on skills intrinsic to nursing, which was very reassuring for me. The data resulting from the diaries and the interviews, although rich and voluminous was not systematically organized. It was, therefore, necessary to find a means of sorting the data, identifying themes, coding the data, and then looking for patterns of association, or explanations. Ultimately, it was hoped that some general inferences could be made from the data (Ritchie and Spencer 1994). The data was analyzed using Framework, a data analysis process developed by the national Centre for Social Research (Ritchie and Spencer 1994), designed specifically for qualitative applied research projects. This Framework comprises six stages:

Stage 1.	Familiarization with, and immersion in, the data. This was achieved through repeated listening to the audio recordings and reading of the transcribed tapes.
Stage 2.	Creation of a list of key ideas and recurrent themes; a deconstruction of the data.
Stage 3.	Establishing a thematic framework by going back to the aim of the research, looking at the emergent issues from the participants and identifying any analytical themes. This stage involves a mixture of logical and intuitive thinking.
Stage 4.	The data was then coded; all the data was annotated manually, according to the emergent framework.
Stage 5.	The next stage was charting – having applied the framework to the individual transcripts, then the data was considered as a whole, by considering a range of experiences for each theme. The data was lifted from the original context and re-arranged thematically.
Stage 6.	Mapping and interpretation – all the data was then organized according to the core themes. This part of the process required: Defining identified concepts and theories Mapping range and nature of phenomena, to map polarities Creating typologies – having identified key dimensions of phenomena, typologies can be developed, giving a range of types of cases Finding associations – clusters of types of responses Possibly providing explanations, as well as illuminating people's experiences Developing strategies – by identifying underlying motivations and patterns, hopefully, possible to develop strategies for change.

Stage 1 – immersion in the data

Once the semi-structured interviews were completed and transcribed and the diaries returned, the first stage in the analysis of the data commenced. This entailed reading through the diaries, the transcribed interview data and listening to the audiotapes several times, to achieve immersion in the data.

Stage 2 – list of key ideas and recurrent themes

Following this, the key issues identified by the students were noted:

- Confidence and assertiveness can enhance a student's ability to access learning opportunities, but students must not be too pushy

- Good placements increase confidence levels - students aspire to feel confident and comfortable in the placement areas and this can be cumulative, increasing with each placement

- Mentors and other students often perceive Master's level students negatively in practice, so this has to be managed sensitively by the students.

- Supportive environments enhance learning, if a student feels comfortable and not too anxious they will learn more

- Practice is very busy, sometimes chaotic, and mentors do not always have time for students

- Good teamwork = good mentorship, as people more likely to be willing to teach, even in very busy areas

- Working things out for yourself, in a safe environment is a very good way to learn

- Being given responsibility is essential for learning to be maximized, rather than just shadowing/observing

- Constructive criticism is necessary for improvement; feedback from mentors and patients is useful

- Mentors who set tasks are highly regarded by students, for example, asking students to look up the liver and then asking them about what they have learned and how it relates to specific patients, similarly with medication, are highly regarded

- Learning by imitation and role modelling is important, including, how not to do it

- Learning by observing and listening, particularly with sensitive topics, can be very helpful

- Learning from other students can be helpful (although there is a tension between students in this study and students from another University, particularly around the master's level training issue)

- Learning from other professions is good, when it happens

- Many different mentoring styles - from shadowing to being thrown in at the deep end – were identified by the students

- Mentors are very important, but the students can also learn from others

- Skills booklets have positive aspects - can focus learning in a placement

- Skills booklets have negative aspects - too big and difficult to complete, mentors don't understand them - student needs to explain

- The grading system can be disheartening

- The grading system can be motivating

- There are 'HCA' skills to learn and there are 'nursing' skills to learn and these are seen as different

- Students must have a positive attitude, as you can always get something

out of a placement

- Students need to prepare themselves for a placement, but this is not always easy, as placements change at the last minute

- Students must have good negotiating and interpersonal skills - need to manage the mentor, in order to get what you want from the placement, particularly a less enthusiastic mentor. Some students reported good experiences on wards and with mentors they had been 'warned about'

- Learning from making mistakes is possible, but it depends on how it is handled - several student had been involved in drug errors, with very different learning outcomes

- Some placements are much more enjoyable than others

- It is good to be able to talk to some one about the experience in detail, enjoyed being interviewed, makes you realize how much you have changed

- Many mentors have no idea about what is being taught in the university, so students like it when they meet someone who has qualified recently, particularly from same programme, as they are more aware of the pressures the students are under e.g. essays

> - Mentors can actually get something from a student, it is not a one-way process; the students provide an extra pair of hands, when the ward is busy. Mentors can also learn new skills and knowledge from the students

Stage 3 – establishing a thematic framework

The next step was to establish a thematic framework, based on relevant a priori issues. This included the original aim of the research (to gain a greater understanding of the students' learning experiences), the important issues relating to this overarching aim, as identified by the students in their reflective diaries and the interview transcripts, and the literature review.

Following this analysis the following themes were identified:

1. **What the student brings to the placement experience**
2. **Learning from others**
3. **Different ways of learning**
4. **Ward culture**
5. **Role of the university**

Stage 4

The data was then coded and manually annotated, according to this thematic framework.

Stage 5 – charting all the data

The next stage was charting – having applied the framework to the individual reflective diaries and the transcripts, the data was considered as a whole. The data was lifted from the original context and re-arranged thematically. Following this process, the following core themes and sub themes were identified:

5.1. What the student brings to the placement

5.1.1 Confidence

5.1.2 Positive attitude

5.1.3 Mentors' perceptions

5.1.4 Taking responsibility

5.1.5 Benefits to mentors

5.1.6 Motivation to learn

5.2. Learning from others

5.2.1 Learning from mentors

5.2.2 Learning from other nurses

5.2.3 Learning from doctors

5.2.4 Learning from allied healthcare professionals

5.2.5 Learning from patients

5.3. Different ways of learning

5.3.1 Learning by doing

5.3.2 Feedback

5.3.3 Questioning

5.3.4 Role modelling

5.3.5 Demonstration

5.3.6 Interpersonal relationship with mentor

5.3.7 Making mistakes

5.3.8 Reflection

5.4. Ward culture

5.4.1 Teamwork

5.4.2 Mutual respect

5.4.3 Everyone teaches

5.4.4 Barriers to learning

5.5. Role of university

5.5.1 Practice assessment documents

5.5.2 Alignment of theory and practice

Stage 6.1a – mapping and interpretation, providing explanations

The next stage was to further refine the identified themes, to identify relevant

concepts and theories and to offer some explanations for the students'

experiences. This was completed under the following themes:

- **The preparation of individual students for their practice placements**

- **The preparation of individual mentors for their mentorship role**

- **The design and development of effective nursing curricula**

- **The development of effective practice placement learning environments**

Stage 6.1b Strategies for change

The final stage was the development of strategies and principles to improve the students' practice placement learning experiences, at the individual student and mentor level, at the practice placement provider-university level and at the philosophical, regulatory and professional level.

3.14 Rigour and trustworthiness

Hammersley (2008) argues that although the quality of some qualitative research has been challenged, there are actually no specific criteria by which to judge it. On the one hand, he perceives this lack of criteria problematic, but on the other hand, argues that there is no substitute for practical judgment. Similarly, Greenhalgh and Wengraf (2008) argue that there is very little consensus on what makes good narrative research. This means that an individual researcher undertaking a qualitative and more specifically narrative inquiry, needs to make their work as transparent as possible, in order to reassure others that their research is high quality and thus credible.

In qualitative research quality is usually discussed in terms of rigour and trustworthiness and Moule and Goodman (2014) suggest that rigour and trustworthiness are comprised of the following concepts: credibility, dependability, confirmability and transferability. In terms of the transferability, sometimes known as generalization, of qualitative research findings, Lewis and Ritchie (2003) argue that this is possible, and they talk about three types of generalizability, starting with representational. This is when the findings from the research sample can be generalized to the parent population from which sample has been drawn, but, in order to do so, the researcher needs to feel confident that the experiences described by the sample population would be the same as the parent population; symbolic representation. Qualitative research cannot be generalized on a statistical basis, inference can only be made from the content of the range of views, and experiences expressed by the participants (Lewis and Ritchie 2003). I would like to think that in my research, the experiences' of the participants would resonate with the other adult nursing students. Lewis and Ritchie (2003) assert that in order to achieve high quality representational generalization, accuracy and transparency in data collection are essential and that this depends on the quality of the fieldwork. This is also essential in the analysis and interpretation of the data, where the same principles also apply to ensuring the credibility and trustworthiness of qualitative data, namely, accuracy, transparency and thick contextual descriptions. Inferential generalization, when research findings are generalized to other contexts, also requires thick description, of both the sending and receiving contexts, to decide whether or not this is possible (Geertz 1993). Although qualitative research can contribute to the generation of social theory, theoretical

generalization, this is not a primary concern in this study. The degree to which

the data from this study supports existing theories can, however, be assessed

and, maybe, new theories can be developed, or older ones refined (Lewis and

Ritchie 2003). I was, hopeful however, that, at the very least, I could move from

the students' individual accounts, to a more collective descriptive and

explanatory analysis. In order to do this, in a credible manner, however,

requires a clear account of the logical and conceptual links and evidence on

which such claims are based. The credibility and confirmability of qualitative

research similarly depends on the quality of the original data, how it was

collected, how it was analyzed and interpreted, and whether or not the language

of the participants is clear and accurate. All this must be transparent in the

reporting of the data (Kvale and Brinkmann 2009).

3.15 Research ethics and governance

Ethical problems can arise in qualitative research, due to the complexities of

'…*researching private lives and placing accounts in the public arena*.' (Birch et

al 2002:1 cited in Kvale and Brinkmann 2009). Kvale and Brinkmann (2009)

identify possible ethical issues at all stages of the research process. This starts

with the purpose of the study, which should be concerned with the value of the

knowledge produced, and also with its ability to improve the situation being

investigated.

3.15.1 Informed consent

Ethical research requires the informed consent of all participants (NHS Health Research Authority 2015). This means that they need to understand the purpose of the study, design of the study, if it is funded, who the funder is, who will be in the research team, how the data will be used, what participants will be required to do - how much time and what are subjects likely to be covered. They also need to know whether they will be identified, or comments attributed to them and that the results will be published (NHS HRA 2015). I made it clear to the students that I wished to use the findings to make changes in practice and they were very supportive of this aim. They were also aware that the results would be published. It is, however, important not to give too much information at this stage, as this might curtail the participant's responses. It must be clear that participation is voluntary and that the participants have the right to withdraw at any time (**Appendix 4**). When people who have a professional relationship with the participants conduct research, they might feel obliged to take part (Ritchie and Lewis 2003). As I was their teacher, I was conscious that the students might feel under pressure to take part, but they seemed very keen to take part and to genuinely want their voices heard on this issue, as they felt very strongly about it. I did, however, make sure that I was not marking their work, or teaching them during the period of the research study.

3.15.2 Anonymity and Confidentiality

Anonymity and confidentiality are also crucial elements of ethical research
(NHS Health Research Authority 2015). The identity of those taking part should
not, therefore, be evident to those not known outside of the research team.
This is not always possible, but it should be attempted. More specifically,
confidentiality requires the avoidance of attributing comments to individuals
(NHS HRA 2015). This may be direct, or indirect attribution and to avoid
indirect may need to limit contextual data, or to make minor changes in order to
disguise identity. I did slightly alter the quotes from the students to maintain
their anonymity and to preserve confidentiality of specific contexts. Although I
could reassure the students that their private data would not be disclosed, this
had to have a caveat regarding potential safeguarding concerns, if certain
issues had been disclosed, I would have to have taken action, which would
have involved a breach of confidentiality (Ritchie and Lewis 2003). Kvale and
Brinkmann (2009) point out, however, that this should not be used as an excuse
for researchers, which allows them to interpret the participant's statements
without being challenged. Anonymity can protect participants, but it can deny
them their voice – they may want to be named. I had not really thought about
this when I undertook my study and so I did not offer the students the
opportunity to be named if they wished; I assumed that they would not want
this. On a more practical level regarding data storage, the audiotapes and
transcripts were not labelled with the student's real names and were stored
separately and securely away from the data.

3.15.3 Consequences

In all ethical research projects, the participants must be protected from harm, particularly when dealing with sensitive subjects (Moule and Goodman 2014). This is particularly so, when individual interviews are used to collect the data, as participants can be seduced into revealing more information than they later feel comfortable with (Legard et al 2003). Furthermore, the ability to listen attentively, an essential interviewing skill can lead to a quasi-therapeutic relationship, which can be problematic: the researcher treads a fine line between 'going native' and empathy (Kvale and Brinkmann 2009). Holloway and Freshwater (2007), however, argue that this is acceptable and maybe even desirable. This was definitely a concern for me. Some of the students had experienced very traumatic events during their placements, including patient deaths, errors in practice and distressing encounters with other members of staff. I also have a close relationship with some of the students and I really care about all of them, so I had to be sure that I felt confident to deal with such discussions appropriately, to know when I should refer the student for further support, and what services were available for this. After several of the interviews, the student carried on talking to me about more everyday matters, which is a good way of debriefing the participants who had distressing stories to tell (Ritchie and Lewis 2003). The ethical principles underpinning this include beneficence, whereby any risk of harm must be minimized and from a utilitarian ethical perspective, any researcher must be sure that the sum of the potential benefits to future students and the importance of any knowledge gained, should outweigh risk of harm to participants (Ritchie and Lewis 2003). As I am very

familiar with the field of inquiry, I felt able to anticipate many of the potential

ethical transgressions involved in this study and hence avoid them (Ritchie and

Lewis 2003).

3.15.4 Role of researcher

The researcher's personal integrity is critical to the quality of knowledge

produced and the soundness of their ethical decisions. Ritchie and Lewis

(2003) describe integrity as a mix of knowledge, experience, honesty and

fairness. In order to ensure personal integrity, Kvale and Brinkmann (2009)

suggest that a researcher should consult their community of practice, including

peers and supervisors to discuss ethical issues and I certainly discussed such

issues with my supervisors.

In terms of research governance, it is essential to follow the guidelines laid

down by the relevant regulatory bodies. For me, as I was undertaking research

in a university setting, with university students, I applied to the university Ethics

Committee to gain approval for the study. My ethics application included

background to the study, a participant information sheet, and a consent form for

all the participants to sign (see **Appendix 5**). Kvale and Brinkmann (2009)

argue that research governance is closely linked to Aristotle's virtue ethics,

where there is less emphasis on a universal theory about morality, but rather a

focus on personal phronesis, or practical wisdom. In terms of research, this

means a researcher requires the ability to write thick ethical descriptions, and

the ability to see and describe events in their value-laden contexts, and judge

them accordingly. Ethical guidelines are necessary, however, and it is essential that the researcher is familiar with and complies with them (Kvale and Brinkmann 2009).

3.16 Personal reflection

The selection of a qualitative research framework was fairly self-evident to me, due to the nature of my research question. I feel comfortable with the epistemology and ontology associated with qualitative research and I believe that my personal axiology aligns well with such an approach. After that things become much more complicated, why interpretive description and narrative inquiry, in particular? I have to admit that after attending a qualitative research conference in Canada and hearing Sally Thorne speak, I was very drawn to the underlying philosophy of interpretive description and similarly narrative inquiry. At this point, however, I needed to be able to say why not phenomenology, particularly hermeneutic phenomenology, which has both descriptive and interpretive elements, or grounded theory, or action research. I felt that I needed a framework, which allowed for a strong focus on the students' experiences, an opportunity to incorporate relevant theory and other evidence into the interpretation of that experience, the opportunity to allow for a close and as equal as possible relationship with the participants and with the ultimate aim of working collaboratively with the participants, to produce new knowledge, which will ultimately, improve practice. I also love stories and think that they can be very illuminating and I have had years of listening to the stories of student nurses and mentors, which after their telling are often lost. I am also

keen to find interesting ways to present research data and I thought that the findings from this project could be used as a basis for new teaching materials, particularly case studies, and inform approaches to helping prepare student nurses and student mentors for practice. For these reasons, narrative inquiry seemed to be a useful approach.

In terms of study design and the practical implementation of the project I was influenced by two summer schools I attended. These were both very much focused on how to do qualitative research and so my decision to use Framework, for example, was heavily influenced by being taught how to use this by the person who originally designed it. Also, as I started to work on my research design, I presented my initial outline at a student research conference and this helped to clarify in my mind what choices I had made and why. The design was also influenced by discussions with my research supervisors.

My main concern at this point in the research process, was that by using my own students as the participants, they would feel pressured into being part of the study and that I would be too close to the phenomenon being investigated to be able to rise above my assumptions and beliefs. I undertook the project when I was not actually teaching or assessing those particular students, although they did all know me quite well by that point in their training. They all agreed to participate and did all complete the reflective diaries, with only one student deciding not to be interviewed. In fact, when I discussed the project with them as a group, they were very interested and keen to be involved. I knew that many of them had strong opinions about their placements and that they

welcomed the opportunity to have their voices heard. They also expressed a wish that their experiences might be used to help other students. I felt quite a responsibility at this point to get the research right and was very aware of my lack of experience as a researcher. I now wish, however, that I had offered them the opportunity to be named in the research and to be present at conference presentations, or encouraged to co-author articles. I felt that some students see themselves as a disempowered group, having no control over the quality of their placements and so, again, they were keen to use this opportunity to have their voices heard. If I had allowed them to participate more fully in the study, however, this would have been even more empowering.

The interviews themselves caused me great anxiety, from the technology, to depth of detail – Hermanowicz (2002) describes the difference between a great and a good interview by the amount of detail elicited from the interviewee, and to do this the interviewer needs to get to the '*core of that person*'. The article called *The Great Interview: 25 strategies for studying people in bed* by Hermanowicz, which is very amusing piece and written in an accessible manner, uses the metaphor of going on a date, to give tips for interviewing and this did give me some excellent practical pointers for interviewing. Some of my interviews were very detailed, others were not, I found some people much easier to interview than others and I found that some participants pushed me into moving away from my role as a researcher. During the interviews emotions ran high with some, including tears, but others remained very aloof and 'professional'. Some of the events recalled were prefaced with statements such as '*I am not sure I should tell you this, but…*' but with other students their

accounts remained very superficial. Although Hermanowicz says you should not date your own family, I think that knowing the students did help to generate a feeling of trust and a sense of safety so that difficult events could be relayed, even when the students felt they had made an error.

There were two participants in my study who had had particularly negative placement experiences. One of these two really worried me, as she seemed to have no insight into how she might have some responsibility for the issues she faced on placement.   I found it very difficult to remain neutral, as I felt that in my role as a tutor, I was colluding with her, whereas as a researcher, I was unable to comment on her perceptions. I did, however, follow this up at a later date, and outside of the research project.

Although the reflective diaries were much less problematic for me, I was worried that the students would not complete them, but they all did so. The quality of the diaries in terms of richness of data was extremely variable and many were purely descriptive, with little or no reflection, some people are definitely better storytellers, than others (Clandinin and Connelly 2000), but, overall, they did offer some interesting insights and help to formulate my interview topic guide.

According to Clandinin and Connelly (2000) narrative inquiries are always autobiographical – research comes from the researcher's own experience and that it is essential to be able to articulate a relationship between one's own personal interests and larger social concerns. I can honestly say that the topic of my study is a subject I feel passionately about and an area of nursing

practice, I believe to be crying out for improvement, based on high quality

research evidence.

Chapter 4 Findings

After analyzing the data from the reflective diaries and interviews, the following themes were identified:

1. **What the student brings to the placement experience**

2. **Learning from others**

3. **Different ways of learning**

4. **Ward culture**

5. **Role of the university**

This chapter explores each of these themes in more detail, and where a direct quote from one of the participants has been used to an illustrate a point, the student is identified by a letter and the origin of the quote is noted as being either from their diary (D), or their interview (I). The imbalance in representation of participants in the verbatim data resulted from the fact that some participants gave much more detailed accounts than others, finding it easier to relate their experiences in a narrative manner. All the themes identified in the research were, however, mentioned by many of the participants.

4.1. What the students bring to the placement experience

Most of the students talked about themselves as an important factor, in whether or not their placements were successful. The students who demonstrated the highest levels of self-awareness, and who were the most successful in

placement (obtained higher grades, reported feeling happier in their placements and reported receiving the most positive feedback), were particularly conscious of this fact. The students noted that being confident and assertive enhanced their ability to maximize their practice placement learning experiences.

> *...being assertive is actually quite important...you've got your role as a trainee nurse...rather than just someone who's kind of observing or an extra pair of hands to do some other stuff...You have to see it as being in training for a job L I*

> *I think I am going to be a more assertive on my last placement...and make sure that my mentor knows what I want to get from it TA I*

The students also noted that a lack of assertiveness not only affected their learning opportunities, but that it could also compromise patient safety

> *I felt I should have spoken up about using the equipment he* (patient) *had been assessed for...this has made me realize how important assertiveness is when working with other team members D D* (The patient went on to fall)

The students acknowledged, however, that there is a fine line between being assertive and being seen as too pushy and they talked about negotiating with

their mentor concerning ensuring that the work gets done, before attending to their own learning needs.

All the students noted that in addition to be being assertive, a positive attitude, including the ability to proactively seek out learning opportunities in the practice placement setting, was also essential if they were to survive and thrive in their practice placements. In order to do this, however, good negotiation and interpersonal skills are required on the part of the student.

> ...there is no place that is perfect, but I think sometimes that it is just a case of changing your attitude, even in situations where maybe you are faced with people you feel you are not working well with...sometimes it is just a case of changing your attitude, rather than expecting someone else to change their attitude, or for a situation to be different...so I think be positive and take positive things out of the placement to build on T I

The students also observed that generally, they needed to accept the, sometimes, chaotic nature of practice and the resulting pressures on their mentors, and adapt their behaviour accordingly; they realized that they needed to learn how to steer a course through practice placements by adopting a very pragmatic approach. They also noted that there is often a tension for their mentors between delivering nursing care and teaching students and most of the students took it as a given that patient care will always come first.

Sometimes there is just so much pressure on people...that they don't really have time to teach you, so you just get on, help out with the washes and that kind of thing and try and grab a bit of help if you can L I

There was, however, one very specific aspect of their practice placement experiences that all the students talked about as being problematic and this was the fact that they are on a master's level training programme. The students commented that many mentors, nurses and other students often viewed this very negatively in practice and so they described how they tried to handle this antipathy to their training. It is assumed by others that the students on this course will bring with them particular attitudes and aspirations, so these prejudices, particularly their mentors' prejudices, had to be managed. Sometimes this manifested itself in the belief that the students were perceived as being 'too clever to care', or 'too posh to wash', or they made the mentors feel that they did not have the skills or knowledge to mentor these students.

...Apparently year's back when the course started, they used to get students from this course who would go on the ward and not do anything. They would not wash patients...they would be like "Oh, we are here because we are going to be managers" C I

She (mentor) *was worried, because she said oh, I'm a diploma nurse, why are you giving me a master's student, I can't teach her anything and I remember thinking oh no she's not going to like me very much!* TA I

This antipathy towards these master's level students sometimes spilled over into outright hostility. When they encountered these difficulties with their mentors, some of the students felt that the responsibility to resolve the issues lay primarily with them, but at the same time they were also aware of the power imbalance in their relationships, particularly with their mentors.

> *You have to make the most of it and if you're not having a good time...it's up to you to try to kind of work things out, or kind of suggest what things could be changed...I think it's kind of the student's role to make it work. But I understand how that might be difficult...it is a bit scary because they're signing off your book   D I*

The students also observed that the student-mentor relationship is not, however, necessarily a one-way process and that mentors can benefit from being mentors. This is not just in the sense of providing an extra pair of hands when the ward is busy, although this is important, but students can also bring new knowledge, experience and skills to the placement.

> *I think they* (mentors) *felt they gained a lot from doing it...I said "oh why are we doing that?" it kind of enabled her to rethink why and we'd get a book and have a look, oh okay, that's why we are doing it. Obviously we get loads from them, but they're also gaining something from us...on this placement I felt it was a two way thing D I*

The students were all very motivated to learn in practice and they expressed a strong need to feel that they 'know what they are doing', both as a student nurse, but particularly, once they are registered nurses.

I want to feel confident in thinking, in this scenario, I would do this... D I

This motivation to learn was also apparent in the student's awareness of the need to prepare for each practice placement, but this is not always easy, as the placements often change at the last minute and sometimes the material being covered in the university did not align with the contiguous placement.

...Before every placement I write down what I think I might like to learn...so I go semi-prepared D I

4.2. Learning from others

In effective practice placement areas the students noted that there are opportunities to learn from a whole range of healthcare workers and the patients themselves, including, in order of stated importance to the students:

Mentors

Health Care Assistants and Assistant Practitioners

Doctors

Physiotherapists

Occupational therapists

Other students

Patients and their families

Without a doubt, however, all the students clearly identified their mentor as the person they could potentially learn the most from in their placements. Maximizing their learning, however, depended on the relationship they had with their mentor. This could be challenging when they had an unenthusiastic mentor, but some of the more generally positive students, reported good experiences on wards and with mentors that they had been 'warned about'. The student-mentor relationship was then perceived by the students in this study to be a crucial factor in their practice placement learning experiences.

...Most of it is down to your mentors C I

The students also identified the importance of mentors who **wanted** to be mentors and the fact that nurses should not be coerced into the role. The students felt that mentors should be actively selected for the role on the basis of their personal attributes, professional knowledge, skills and their desire to be a mentor.

...She took on her role as a mentor like she wanted to mentor me...
TA I
...as a nurse you are expected to be a mentor...And I wonder if that is a good idea. I wonder if people who actually want to be mentors rather than having to do it for the sake of it D I

They were also clear about the personal attributes and skills and attitude required of a good mentor.

> *...My mentor was lovely...very friendly. She was very reassuring and supportive and ...she communicated really well with patients. And that was really good for me to see, because I can be a bit shy sometimes TA I*

> *...It was the fact that she was always there for me to ask questions...And because she was very hard working and really knowledgeable, I could pick her brains. I was able to observe her and learn, ask questions from her, get the answers, not in a patronizing way...the placement turned completely around...because I had a very, very good mentor. If I'd had a mentor who wasn't nice, I would have left J I*

> *They were both* (mentors) *really, really good, brilliant and I had a lot of fun with them, which was kind of a bonus...they allowed me to use my initiative and say, "well, what would you do in this situation?"...They both seemed to enjoy ...teaching somebody and having somebody to share their skills with...it made me more relaxed and I think I learned so much more in that environment...relaxed and supported D I*

The students really appreciated it when the mentors took time to get to know them personally and felt that it was very important to be seen as an individual and that good mentors go out of their way to ensure that this happens.

I feel that it is an unrealistic expectation, but I would liked to have the opportunity to sit down with my mentor to have a general chat about the ward, why I did nursing, how long he (mentor) *had been there...giving me the opportunity to build a rapport D D*

And she made an effort to learn your name and ask you where you lived, that sort of thing...which she didn't have to...So that was appreciated K I

Many mentors, unfortunately, were identified in this study as having very little idea about what is being taught in the university and so the students really appreciated it when they had a mentor who had qualified recently, particularly from the same programme, as they were more aware of the academic pressures that the students are under.

...She was good… she'd done this course actually so that was really helpful...she said, "You've got this essay to do, I remember doing that" K I

If good mentors are seen as the most important learning resource in placement, less effective mentors can cause the students high levels of distress. The story below illustrates both sides of this dichotomy.

I was thinking, "Oh, how am I going to learn this?" And because she's (mentor) *so fast-paced she wasn't, you know, she wasn't taking time to explain things to me, what I needed to do...so I had to try and learn what*

(acute area) *was all about without anyone explaining...But my second week I started working with my second mentor and she's just the loveliest person anyone could wish for. She took her time and explained things to me...she didn't really use me as an HCA...She wasn't telling me to "go and make beds", it was purely nursing. I learned so much...And another thing about her, she understood that I would make mistakes...some mentors, when you ask them a question, they say "don't you know that?" and they make you feel stupid...She never looked down on me, she was never patronizing. And because she was so lovely, I was determined not to let her down...So by the third week, I knew what I was meant to do...in fact I was managing a bay, so I was really happy J I*

The students also noted that different mentors view their role in different ways, some operate on a need to know level, but others are much keener to push students and to challenge them and this influences the learning opportunities available to students.

"Well I'm not going to teach you that because you won't need to know that...just learn the basics...you're only here for four weeks, that's not enough time to do anything, is it?"...whereas, others will say, "Oh, do you know we do this? or "You could have the opportunity to go and see this" K I

The students do see that the mentorship role carries a great deal of responsibility and accountability with it and understand why the mentors

sometimes seem very risk averse, but again this can lead to lost learning opportunities.

> *They're* (mentors) *very protective. I don't know whether they are scared if anything goes wrong they'll be responsible. C I*

Generally, however, the students noted that their mentor is critical to a good practice placement learning experience; the student-mentor relationship having a great deal of influence on their learning and professional development.

> *A patient I had been caring for and whom I had really grown to like...died while a healthcare assistant and myself were giving him a wash...I was in a state of shock, shaking uncontrollably...crying inconsolably...She* (mentor) *was very understanding, she led me away to the day room and helped me to calm down. She helped me to talk through what I was feeling and assured me that it was natural. She gave me some time to compose myself and reflect on what had happened before continuing with the shift J D*

The students also noted that an inadequate relationship between themselves and their mentor, and particularly a lack of supervision could not only compromise their learning, but also patient safety.

> *A patient had an IV drip going through their gown, she was sweating profusely and she said, "could you help me change my gown?" and I*

100

said "of course" This was my third day and I was doing it by myself and she was attached and I was like "oh well, I'll just unattach it"...I can't believe I even thought I should do it, but then I was like, well, actually if I had been supervised and had watched someone before, and I'm not blaming them...it was me that did it...that made me then just think   D I

The students noted that although their mentor is probably the most influential factor in their practice placement learning experiences, there are also numerous opportunities to learn from other healthcare professionals in the placement setting, including health care assistants (HCAs), assistant practitioners (APs), registered nurses and student nurses.

It was quite nice to see how they (HCAs) *interacted with patients and it was like a good example as to what I could do...The sort of things they talked about, how they did it, and just the approach to it TA* I

The HCA there was really good; she's the only one who can put a cannula in! J I

HCA I worked with was very experienced and had some really good tips to share K D

The students also identified that there are 'HCA skills' to learn (personal care, observations) and there are 'nursing skills' (drug rounds, paperwork, dressings)

to learn and it is possible to learn HCA skills from HCAs, although interestingly, they learn some of the more technical skills from the HCAs.

The students also noted that they can learn from the associate, or assistant practitioners (APs)

> *The AP was very nice to me...and tried to teach me as much as she could about the patients and how the ward was run J D*

The students similarly reported learning from other registered nurses on the ward.

> *...There were two nurse who'd just qualified and they were really helpful because they could obviously see that I was scared and my mentors weren't being too helpful...they'd ask me about my assignments...this patient might be really good for the case study...They take an interest in the whole thing TA I*

Other student nurses can also provide learning and peer support and this was rated very highly by the students.

> *...She was really lovely* (a second year student) *and I remember thinking that I will be where she is in a years time and that really helped me...she was actually finding that ward difficult as well, so it was kind of nice to know that it wasn't just me who was struggling TAI*

Experiencing this (last offices for the first time) *with another student was actually beneficial, we both chatted about how we felt during the process and agreed that the staff nurse was very thorough and good at how she carried out last offices for this patient D D*

The relationship between students from other universities can however be difficult at times, and again for the students in this study, this often centred on an 'anti-academic' element.

I can't understand it...a couple of students from another university I was friendly with on placement, we even joked about it, "we really shouldn't be friends"...I don't know if it's because we are masters. I like the idea of we're all in the same boat together...we're all students, we need to stick together...so I don't know why there is this "them" and "us" business. It is so funny, but you just get on with it D I

Doctors were also perceived as potentially good learning resources, but the students talked about issues of hierarchy that can determine whether or not this is achievable; only the more confident students in this study felt able to pursue this type of learning opportunity.

...The anaesthetists...were really good at showing you, "Oh, have you seen an airway before? Come round and look at this. This is what I'm doing and this is what we're looking for on the monitor" K I

...I felt quite comfortable to learn from him (a doctor)*...my friend is a children's nurse...and she said she was really intimidated by doctors...what they say goes...you're too scared to speak to them and I think some of them do give off that impression and they are a bit scary...but it was nice to be taught by somebody who's so high up and who knows so much" D I*

Similarly, some allied healthcare professionals were willing to teach the student nurses.

...Physios can be quite helpful...if they've been on the ward (and if) *I don't know how to move a patient...they show me. So they're really helpful...TA I*

Learning from the patients and their families was also identified by the students as being very valuable and the patients can also be a source of much wanted feedback for the students, as they noted that they did not always receive very much feedback in the practice placement setting.

...I think you can learn a lot from patients. They have wise words to say...and especially ones who used to be nurses...I think that it is really nice when patients say, oh, you've done that well TA I

...When you speak to patients and hear their experiences you think...I wouldn't do it like that because you know the effect it has on the patient,

what they think about it. But in the same way if they have had a positive experience you think...I'll remember that, that they thought it was good K

I

4.3 Different ways of learning

The students identified a range of learning and teaching strategies that are in use in the placement areas and discussed these mainly in relation to their mentor. The students noted that being allowed to work things out for themselves in a safe environment, with good supervision, was a very effective way to learn.

...an HDU patient was being transferred back to the ward, so she gave me her and she was like, have some responsibility, go look after her. And the machine kept going...the mentor was at the next bed so she was still watching over me and she said that she could see me trying to work it out...I kept looking at her ...oh, come and help me, her machine's going off and I don't know what the problem is...and this patient was talking to me and her SATs were going and I said to her, sorry, just give me a second while I sort your machine and she stopped talking and her SATs started to improve!... because I knew she (mentor) *was not coming over, I was thinking, I've got to work this out for myself...it was nice to know she trusted me with it TA I*

Similarly, being given responsibility is essential, rather than just shadowing and observing, particularly as students become more senior, but only with the appropriate level of supervision.

Very keen to teach me things (mentor) *To get me thinking, the first couple of shifts she would say, "this is what we do" and then after a few days, "well, what are we doing today? What's our plan? What do we need to do? "Do you want to manage these patients"...just kind of putting a bit more responsibility on, so I had to develop, but also being very keen to teach me things...She'd answer my questions or get me to think about them, or say "look this up"...Some people just go for the drop you in at the deep end kind of approach... L I*

I felt like I got more confident in my role, because I was allowed to work more independently.... she let me hand over and she delegated tasks A I

My first mentor was really lovely...she really let me, encouraged me to do things...My second mentor would rather do the things herself and let me observe, which I don't think I learn as much that way W I

The students were very clear that constructive criticism, given in a sensitive manner, is necessary for improvement and that honest feedback from mentors can be particularly useful.

...they gave me a lot of feedback...they did it in a nice way. So I liked that...the nurses would come up to me and say so and so said this about you...that was really, really nice to hear TA I

I didn't think it was an area I would fit into, but then getting that feedback from the matron, or from my mentor...it sort of made me think...I have got the skills to work in an area like that T I

The students appreciated it when mentors recognized their particular learning needs, usually identified through asking them about their current knowledge. If they then set them tasks to meet this need, for example, to research the anatomy and physiology specifically related to the patients on that ward, or relevant medications, and then tested them on this learning, this was identified by the students as being an effective way of learning.

…my mentor would say, tell me what the liver does and if I didn't know she would say look it up...and then we'd be looking after this patient with liver failure and she would say what have you learned about the liver that might relate to this patient...That just helped improve my learning ...Well I know we are responsible for our learning, but it's easier on placement...when you're tired just to go home and go to sleep...whereas being set a little task got me thinking and I found that really helpful...it is a good way to learn TA I

...he noticed my eagerness to learn and he (mentor) *was very much facilitating the process by pointing me to relevant texts...he was actually like "This is the Trust policy on this. Are you aware of this?" And he had that interactive learning style, where he would make me do random drug calculations "what is the dose?" A I*

The students also noted that learning by imitation and role modelling was very powerful.

she (mentor) *was good; she was good with patients...she was just very structured in her work...she didn't get stressed or anything. She just did job by job and everything was just in order. I think she was really good as a nurse...She got on well with her colleagues...She was like a role model really W I*

Learning clinical skills through observation of a skilled practitioner was also noted as being a helpful learning strategy.

...you just learn by experiential learning...the more you see, the more you know...Just by repetition essentially L I

But there are limits to just observing others, and the students remarked that they also needed to practice their skills.

Personally, I find it easier to learn when someone shows me, someone stays with me for the thing, like maybe commenting on how I'm doing it and then they let me do it. And then at the end of it they can say, oh actually, you did this well, but improve on this. And I need the hands on, rather than just watching it, or reading about it TA I

Several students had also been involved in drug errors and what they took away from these mistakes, what they learned, was in a large part determined by how the incidents were handled in the practice placement setting; they could be a positive learning opportunity, or they could damage the student's confidence.

...there was a drug error that I witnessed...it kind of scarred me a bit...that threw me back a little bit for other placements, so it wasn't until the stroke unit that I started to learn about drugs and do drug rounds D I

The students also commented on the importance of reflection as a good way of learning and felt that it was helpful to be able to talk about placement experiences whilst still in the placement, as well as after the placement. Indeed, several of the students commented on the fact that they had enjoyed being interviewed for the research study, as sadly, nobody had ever really listened to their practice placement experiences prior to this interview.

...it's nice to talk to someone about it (placements) *just to kind of clarify your thoughts...it's just a kind of learning and thinking back about your*

experiences and kind of thinking how you will improve your next

placement, or how you'll approach your next placement D I

It's quite a journey. I've never really thought about it, like gone through it

in detail...and now I am actually keen to be a mentor because I'm

thinking this is what I wouldn't do, this is what I'd be aware of. I'd want

my student to be able to approach me D I

4.4. Ward culture

Different practice placement areas offer varying levels of support and learning

opportunities, with some offering a far more positive learning culture than

others. The students also noted that when they felt comfortable in a setting,

they were less anxious and hence learned more. The students felt that this

learning should be a cumulative process, increasing with each placement, but

some students did not experience this – sometimes it was more two steps

forward and then one step back – depending partly on the ward culture, their

mentor and partly on how their practice placements were sequenced. Several

features of a good learning environment were, however, noted by many of the

students as being important and these included good teamwork.

I think the team… is incomparable to any other ward. It's just amazing; I

think because they are so focused, it's that kind of cohesion. They are

so focused on the task, that it doesn't matter who does what when they

are in their clinical roles...you just get it done A I

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The team was so supportive...they made me feel welcome...I knew I could go to any member of staff, even the sisters, all the nurses, all the physios, all the healthcare assistants...And I just felt like part of the team from day one! TA I

And it seems like they all got on quite well, outside of work as well...And the ward sister was good, she was helping out making beds and things...they're normally in the office! K I

The most highly rated placement areas also had less hierarchy and more equality between the members of the team; there was a mutual respect between the ward staff

... one of the first things she said (mentor) *was to challenge medical decisions if they're not correct and to call people up on errors...So it's been good to see that even as a student, you can go and challenge these things L I*

...there was a lot more respect between the doctors and nurses...they (doctors) *valued their* (nurses) *opinion... TA I*

…they (nurses) *have a lot of respect for the HCAs...I think because they do the obs, they rely on them so much...they're the ones who notice if a patient is deteriorating...they depend on their feedback to make sure that things go well J I*

In such good practice placements everyone was involved in teaching.

I sort of thought well if it is an (acute care setting)*, they may not have the time...but they did and they were really helpful and I found that it was actually really easy to ask for help...and everyone seemed really willing to teach T I*

…people wanted you to learn and wanted to support you....generally, it's a learning atmosphere W I

Time is always an issue...then you have to find time...But then some wards can have time and still not do enough, so it's probably just their culture...it's more accommodating for students, which is good C I

...even the dates my mentor wasn't in... they were all happy to have me...even the doctors...I knew I could go straight to the doctor TA I

There are, however, negative aspects of practice placement settings that militate against learning. The students noted that poor organisational management at practice placement level, a lack of nursing leadership and incivil behaviour all inhibit learning.

...the ward was very busy so I was thrown into the deep end...not knowing who my mentors were and then not being put on the correct shifts T D

...There is an associate practitioner who hated students. She was so rude to me. She spoke to me horribly in front of patients. She really put me down. So that patient then lost confidence in me, I lost confidence in my self and that was really quite horrible. TA I

And they were a very cliquey team and anyone who wasn't part of the team was a bit sort of on the outside K I

...initially I found it (the departmental routine) *a bit difficult because I was used to the formal structure that you get from wards and even though there was a structure… it sort of felt like organized chaos...not a comfort zone T I*

4.5 Role of University

Although this study focused on the practice placement experiences of the students, the students talked about aspects of that experience over which the university has direct control. The practice assessment documents, including the learning contract (PADs), which are generated by the university, are an example of this. The students noted that they can have a positive effect in a placement - they can focus learning in the placement.

...they're quite sneaky because it helps you to...say "well, actually, I need to get this skill signed off", you can use it to guide your learning and saying "this is what I need to achieve" D I

This works particularly well when the PADs are directly aligned with what the students are studying in the university.

...the placement definitely coincided with what we were doing in the OSCE and the case study, so that was really helpful...and even sessions we have been having recently you're thinking "oh, we learned that on the stroke unit" D I

My mentor informed me that he had mental capacity training at 10 am and asked if I wished to join him. I told him that I was doing an assignment on this and joining him in the training would be great. The session was useful in clarifying the use of the mental capacity act in a hospital setting D D

They can also, however, have a negative effect - they are perceived by some mentors as being too large and difficult to complete, the mentors do not understand them and often the students have to explain the documents to them.

He (mentor) *just didn't do it* (complete the PAD) *He said they were too much hassle...he just didn't have the time TA I*
I do think that the books can be a bit complicated...they are quite wordy and ...a bit scary for some, if you've never seen it before TA I

The students noted that the grading system could also be disheartening, as it is open to mentor interpretation and so is not consistently applied.

...even on my last placement, he was going through it and he was like well I could do you a four, but there's always room for improvement. And I'm like yeah, but a four would be really nice! That was a bit disheartening, actually. TA I

Sometimes the pressure of trying to complete university assignments whilst on placement and getting the practice assessment documents signed off, however, detracted from learning in the practice placement setting.

I have found that the assignments...take away from the (placement) *experience, because you are constantly thinking about them...not thinking about the skills book helps as well, because you learn...but you are not thinking okay have I done this, I need to go and get this signed off T I*

4.6 Mapping of identified themes

The themes identified by the students were then mapped against relevant theories and concepts identified from the existing literature:

What the student brings to the placement	Emotional resilience Emotional and social intelligence Student as a self-directed learner Mentor attitudes to students Self-efficacy
Learning from others	Role of mentor in practice learning and teaching Interprofessional learning in practice Peer learning

Different ways of learning	Learning theories:
	    Experiential learning, including reflection
	    Scaffolding and coaching
	    Social learning theory and role modelling
	    Andragogy
	Student / teacher relationship
	Student-centred teaching

Ward culture	Communities of practice Learning organizations Situated learning Belongingness
Role of university	Relationship between university and placement Curriculum design Practice assessment documents Nature of nursing knowledge

After mapping the themes identified by the participants to the relevant concepts and theories from the literature, it became clear that if the student learning experience is to be maximised then attention needs to be paid to the individual preparation of each student and mentor, using appropriate teaching and learning strategies. It is also appears to be essential to develop high quality learning environments within every practice placement setting, characterized by their ability to maximize student learning. Finally, it is clearly essential to have a close and collaborative relationship between the university and the practice placement provider. These four areas are explored in more detail in the next chapter

Chapter 5 Discussion

5.1 Introduction

The importance of practice placements in nurse training cannot be over-stated; it is where students learn the necessary clinical skills and practice knowledge to be proficient nurses (Field 2004, NMC 2008, Benner et al 2010, NMC 2010). It is also where student nurses learn what it means to be a nurse and to develop professional phronesis, or professional wisdom; the internalization of what it is to be a good nurse (Scott 2007, Ghaye and Lillyman 2008, Sellman (2011). Crucially it is also often the deciding factor in whether or not student nurses remain in the nursing profession (Bradbury-Jones et al 2007, Taylor 2009). The students in this study all clearly stated that the practice placement setting was, without a doubt, where they learned the majority of the skills, knowledge and behaviours required to be a competent, compassionate and confident registered nurse.

The purpose of this study was then to identify ways of improving practice placement learning and it is clear that, if the students' practice placement experiences are to be improved, according to the participants in this study, attention should be paid to the following components of the practice placement learning experience:

- The preparation of individual student nurses for their practice placements, with an emphasis on self-efficacy, emotional and social literacy, emotional resilience and self-directed learning.

- The preparation of individual mentors for their mentorship role, with a particular emphasis on facilitation and coaching skills, experiential learning, scaffolding and role modelling.

- The design and development of humanistic and transformative pre-registration nursing and mentorship preparation curricula, including consideration of the wider professional and regulatory standards and frameworks underpinning nurse education.

- The development of effective practice placement learning environments, with an emphasis on communities of practice within learning organisations, including consideration of how both students and mentors are supported and valued in those practice placement settings.

The rest of this chapter will explore each of the above areas in detail and offer suggestions for possible developments in practice and policy, with a view to improving pre-registration nurse training, with particular reference to the practice placement learning experience.

5.2 Preparing student nurses for practice placement learning

It is evident from the findings of this study that individual students require effective preparation before entering into a practice placement setting. This obviously includes completion of all the required statutory and mandatory training and an opportunity to practice essential nursing skills in a safe, simulated environment, but the students in this study noted that in order to ensure a positive practice placement experience, where learning is maximized, they also needed to have good intrapersonal and interpersonal skills. In particular, the students talked about how being self-aware, self-confident and assertive would enhance learning and, conversely, how being shy and behaving in a passive manner, would limit their learning opportunities; they needed to be able to assume responsibility for their own learning experiences. These skills are required so that the students can deal with difficulties in interpersonal relationships, particularly in the student-mentor relationship. These skills are also required to deal with the emotional nature of nursing work. Furthermore, they are also necessary to deal with the tensions inherent within practice-based learning; the need to deliver nursing care and at the same time the desire to meet their own personal learning needs. Finally, these skills will also help students to develop the ability and confidence to identify and embrace all the learning opportunities available in the practice placement setting. As far back as 1997, Dunn and Hansford noted that students needed to be encouraged to recognize the potential influence they have over their own clinical learning and that they needed to work to promote an environment where their needs would be met. More recently, research has also highlighted that positive student

attitudes (Courtney-Pratt et al 2011, Crombie et al 2013) a confident manner (Houghton et al 2012, Killam and Heerschap 2012) and taking responsibility for their own learning (Grealish and Rance 2009, Gidman et al 2011), are attributes which will all enable student nurses to maximize their practice placement learning. Furthermore, Freshwater (2000) argues that nurse education needs to place as much emphasis on developing a student's self-awareness, as on the teaching of skills and knowledge, because this transformatory approach to education leads not only to learning, but also to personal empowerment; an essential attribute for all nurses.

One of the most important aspects of ensuring a positive student practice placement experience noted by the students in this study was their ability to establish productive relationships with the ward staff and in particular with their mentors. The students acknowledged that they needed to be empathetic towards their mentor and to take at least some responsibility for managing their relationship with their mentor, particularly when the relationship was not going well. The most resourceful students in this study drew on rebuilding and redirecting strategies as outlined by O'Mara et al (2014). O'Mara et al (2014) noted that when students find themselves in a challenging clinical learning environment, with an unsupportive mentor, they can react in one of four ways:

Rebuilding – students actively take responsibility for rebuilding poor relationships with difficult members of staff

Redirecting – students turned to peers and other nurses for help, rather than mentor, or they became more independent learners

Retreating – students keep a low profile, do not want to make waves, and actively avoid certain people and situations, just want to get through the placement

Reframing – student notes that they will never behave that way, or felt that a poor experience could increase their self-confidence – if I can get through that, I can get through anything

The importance of the student-mentor relationship has been noted frequently in the literature, but often the onus to ensure a good relationship has been seen as the responsibility of the mentor (Earnshaw 1995, Gray and Smith 2000, Koontz et al 2010, Luhanga et al 2010, Courtney-Pratt et al 2011, Jokelainen et al 2011b, Kelly and McAllister 2013), but there is also evidence to suggest that students do need to take some responsibility for establishing and maintaining this relationship (Webb and Shakespeare 2008, Gidman et al 2011, Thomas et al 2012, Crombie et al 2013, O'Mara et al 2014). Jackson et al (2011) similarly suggest that although it is not the role of the student to lead in the creation of a supportive learning environment, they do need to develop a sense of professional identity that is sufficiently resilient to cope with the hostile behaviour and attitudes that students, regrettably, sometimes experience in the practice placement setting. Ghaye and Lillyman (2008) also note that the student has certain responsibilities in the student-mentor relationship, for example, they need to have a positive attitude towards the relationship and be willing to work at sustaining the relationship. Furthermore, Lewallen and DeBrew (2012) note that successful students could be characterized by their ability to develop good interpersonal relationships. The ability, however, to

develop and sustain an effective student-mentor relationship depends to a large extent on the emotional and social literacy of the individual student, as outlined by Goleman (1998)

Self-awareness – being aware of one's emotions and the root of such emotions

Self-management – being able to manage one's emotions, even in stressful situations

Social awareness – identifying and acknowledging other people's emotions

Managing relationships – ability to work with others in a constructive manner, even in difficult circumstances

The students in this study clearly felt that the responsibility of establishing and maintaining the student-mentor relationship lay, at least partly, with them and they talked about the need to be self-aware and to be able to 'manage' their mentors. I, however, was worried at times about the extent to which these students felt that it was their responsibility to resolve these difficult interpersonal relationships and the students in this study, unfortunately, had an additional interpersonal relationship challenge to deal with in the practice placement setting; they reported that their mentors sometimes made assumptions about them, because they were on a master's level training programme. These prejudices had to be managed by the students. Stacey et al (2010) noted this phenomenon in their study of master's level students, and, more generally, Jackson et al (2011) found that students are often '*othered*' by clinical staff. They use the concept of 'other' to describe the marginalization and subordination of student nurses in practice. This can take the form of being

ignored, subjected to verbal abuse, bullied or treated unfairly and can lead to students feeling anxious, depressed and disillusioned with nursing. This process of 'othering', along with horizontal violence and aggression is, unfortunately, prolific in the literature exploring student nurses practice placement experiences (Levett-Jones and Lathlean 2007, Del Prato 2013). One specific aspect of this process is the undermining of students who are not the ideal type of student, including, interestingly, those who are perceived as being too clever (Gallagher 2005, Crombie et al 2013). Nursing culture, more generally, is permeated with bullying and horizontal violence (McKenna et al 2003) and there is often a lack of respect for student nurses '*nurses eat their young*' (Daiski 2004: 46). Bradbury-Jones et al (2007) suggest that students need to be empowered to deal with this horizontal violence, through high quality placements, with a good mentor and, they suggest that given these conditions, nursing students can increase their self-esteem within the practice placement setting. In such situations students can develop their reflexivity to become empowered and 'find a voice'. The students in this study, however, described times when they felt very disempowered, and they also noted very worryingly, that this could adversely affect patient safety, particularly if they felt unable to speak up in the clinical setting. Del Prato (2013) also argues that it is essential to educate and empower student nurses to manage uncivil behaviour in practice placements, in an attempt to stop the cycle of horizontal violence in the nursing workplace. Furthermore, it is crucial that students develop a sense of empowerment, so that they do not become disillusioned and disengaged and decide to leave the nursing profession (Bradbury-Jones 2007, Taylor 2009).

The students in this study also talked about a specific aspect of the student-mentor relationship that required sensitive management - the need to balance their own learning needs, with the need to provide nursing care. This tension between delivering patient care and teaching and assessing students has been noted in the literature (Pulsford et al 2000, Duffy 2003, Murray and Main 2005, Wilkes 2006, Gleeson 2008, Jokelainen et al 2013, Elcock 2014) and Wilson (1994) suggested that students want to be seen as 'good' students and thereby achieve high marks, but also they wanted to be seen as 'good' nurses, by helping patients and the other nurses to provide nursing care. The desire to be a good nurse was, however, often stronger and sometimes learning opportunities were passed over, in order to attend to patients. In this study, the students felt that this dilemma could sometimes be negotiated with their mentor, but to do so required tact and a certain degree of pragmatism. One student noted that on a very busy and short-staffed ward, she would negotiate with her mentor to work with the HCAs in the morning, but then accompany her mentor on the drug round at lunchtime. But even when students are proactive in managing the student-mentor relationship regarding negotiation about this issue, the power imbalance between students and mentors cannot be ignored and Garvey et al (2009) argued that although a positive mentoring relationship can help to free students from oppressive power, power is still an issue, particularly as mentors not only teach, but also assess students. As the students noted in this study, they are dependent on their mentor to sign their practice assessment documentation, in order to pass their placements. The specific tension created by the fact that the mentor is teacher and assessor in the student-mentor relationship has been noted in the literature for many years,

with Neary (2000) suggesting that the solution would be to have a named, supernumerary practitioner to supervise and assess students.

When considering how students should be prepared for their practice placements, it also needs to be remembered that these environments are often emotionally highly charged, due to the emotional nature of nursing work, the fact that there are often staff shortages, there is a fast though-put of patients, and the fact that the patients being cared for are often acutely unwell (James 1992, Neubauer 1997); indeed, the students in this study described it as working on the edge of chaos. Furthermore, the students noted that mistakes can, and do, happen in these busy and sometimes stressful practice placement settings. In order to survive and thrive in such circumstances then, student nurses need to develop a strong sense of self-efficacy. Bandura (1977) introduced the term self-efficacy, which is similar to self-confidence and can be defined as the self-belief that one can do something successfully. According to Bandura (1977), it is shaped by the following factors:

Performance accomplishments – previous success raises expectations and even occasional later failures, if handled well, can raise level of self-efficacy and this is the most powerful factor in the development of self-efficacy
Vicarious experience – seeing others successfully survive difficult situations
Verbal persuasion – people can be persuaded that they can cope with things that may have overwhelmed them in the past, but this is a weak source of self-efficacy

Emotional arousal – high arousal can inhibit performance and fear reactions generate further fear

Self-efficacy is then concerned with the development of a person's conviction in his or her own effectiveness. This will then determine whether, or not they will be able to cope with difficult situations, as people only fear threatening situations, if they feel that they will be unable to cope. As self-efficacy lowers anticipatory fears, through the expectation of eventual success, this also determines how much effort and time a person will devote to an activity, even in the face of barriers, to achieve their goals (Bandura 1977). A low sense of self-efficacy can be associated with depression, anxiety, and a feeling of powerlessness, whilst a high sense improves academic performance and decision-making. High self-efficacy also enables people to recover more quickly from setbacks. It is clear then that self-efficacy is an essential attribute for all nurses and student nurses, as they are frequently required to work in a positive manner in challenging environments, and they need to be able to experience negative events as a source of learning (Neubauer 1997, McCabe and Timmins 2013).

The students in this study commented that they often found themselves in emotionally demanding situations, involving both patients and other staff members, but that these difficult situations often, however, have the potential for great learning. In order to deal with such situations, Theodosis (2008) argues that high levels of emotional labour are required on the part of the student, or emotional resilience (Thomas et al 2012), in order to cope with such situations

in a positive manner. Hochschild (1983: 7) talked about this emotion management as being

'*The management of feeling to create a publicly observable and bodily display*'

In Hochschild's study of airline cabin crew (and it could be argued that many aspects of the job requirements for airline cabin crew are transferable to nursing), she asserted that emotions are complex, and as they arise through interaction with others, they are linked to cognition and rational choice; individuals cannot choose their emotions, but they can choose how to respond to them. Theodosius (2008) argues that this emotion management requires work and learning how to do it, requires effort. In nursing she suggests that there are three types of emotional labour:

Therapeutic emotional labour - the therapeutic relationship between the nurse and a patient, which is designed to promote health and wellbeing in a patient
Instrumental emotional labour - by being calm, reassuring and hence minimizing patient anxiety, helps to ensure that nursing procedures are carried out efficiently.
Collegial emotional labour - communication between nurses and with other professionals, which is aimed at improving patient care, but which can lack respect and be impolite.

It can be seen that there is a high level of emotional labour required in nursing and the students in this study described examples of all three types of

emotional labour and were definitely aware of this aspect of nursing, but they did focus mainly on collegial emotional labour, particularly regarding their relationships with their mentors. Spouse (2003) also notes that, although nurses are required to support people in distress on a daily basis, support for nurses is sometimes limited, often with no effective supervision, nor training in how to cope with this. She goes on to suggest that in order to retain sensitivity to patients, whilst maintaining their own integrity and not becoming burned out, student nurses require training in how to deal with this aspect of their future nursing role. Similarly, Smith (1992) argued that student nurses need to be taught how to deal with the emotional demands of nursing. She suggests that nurses and student nurses are generally regarded as intrinsically caring and nurturing, implying that they can meet their own personal needs, but this is not necessarily true. This was definitely mirrored in this study – some of the students had much better insight into their own personal needs and had more effective coping strategies than others. In order to avoid becoming burned out and disillusioned, students need to develop their emotional resilience. This will also help them to work in a meaningful, compassionate and productive way with patients, their mentor and others in the practice placement setting and to deal with even the most emotionally demanding situations. Thomas et al (2012) further suggested that students needed to develop emotional resilience, to enable them to deal with the realities of practice placements, including the ability to separate out their personal and professional lives. Learning organisations (Senge 2006) are, however, also required for effective emotional labour, as this emotional labour requires a certain amount of flexibility from the organisation where it occurs (James 1992), so this is not just an individual

student-mentor issue. This was observed by the students in this study, who noted that there can be a tension between giving good nursing care and the organisational priorities, for example, taking time to listen to a patient's fears, instead of ensuring that all the beds are made and this example was also noted by Theodosius (2008). Furthermore, James (1992) suggested that the increasing acuity of patients and shorter stays in hospital could make this tension even more severe. It is clear then that the answer is not just about each individual student becoming emotionally resilient, rather there also needs to be a systems-based approach to supporting students. Curtis (2014) also talks specifically about the link between compassionate practice and the emotional demands associated with this. She suggests that for students to cope with the complexities of compassionate practice and its emotional demands, they need to develop professional wisdom and courage. She argues that the dissonance felt by students trying to deliver compassionate care, versus protecting themselves emotionally, or being professional, can lead to them feeling vulnerable and uncertain (Curtis 2014).

Students must, therefore, be well prepared for their placements and then well supported whilst they are in their placements. Moscaritolo (2009) suggests that nursing students be offered mindfulness training prior to placements to help decrease their anxiety whilst in placement and Curtis (2014) suggests that students need to be taught strategies for self-compassion and healthy emotional labour. Once in the practice placement setting, support should include the opportunity for reflection during each placement, as Jackson et al (2011) suggest, students need space to talk about their feelings, in a mutually

supportive atmosphere, particularly with their peers. Saarikoski et al (2006) found that group supervision whilst on placement helped to alleviate students' fears and anxieties regarding their ability to cope with the unfamiliar emotional and psychological demands of practice. So peer learning and support needs to be promoted and supported both during and after placement practice in order to maximize learning and in terms of providing emotional support. Mamhidir et al (2014) discuss the use of a model of peer learning, where two students under the supervision of a mentor work together to deliver patient care. It was found that by using this model, self-directed learning was enhanced, with the students taking much more responsibility for their own learning. It was also found to empower the students, and increase their confidence and critical thinking skills. Furthermore, the use of action learning sets within the placement setting could also be a positive way forward for the students, (Heidari and Galvin 2003), possibly providing an opportunity for meaningful engagement with the practice placement setting for link lecturers. The importance of opportunities to express distress, anger and frustration in a safe and supportive environment is therefore crucial. These feelings are legitimate and so it is vital that students do not feel weak, or inadequate if they express these emotions (Menzies Lyth 1960, Stein and Falkingham 2015).

Student nurses also need to understand the concept of, and develop the skills to be, a self-directed learner, if they are to maximize their practice placement learning. In this study the students talked about how they had to identify and pursue all the possible learning opportunities offered in each placement setting, in other words, become a self-directed learner, if they were to optimise their

learning opportunities. The key for students is the ability to identify learning opportunities, both formal and informal, and then to have the confidence to pursue them, but to do this they need to be self directed, empowered and autonomous learners (Bradbury-Jones et al 2007). This self-directed or informal learning is just as important as formal learning, as formal learning is only a very small part of the overall learning opportunities that students are exposed to (Coffield 2001, Tusting and Barton 2003). Certainly the students in this study identified many informal learning opportunities in the practice setting, including accompanying patients when they went for investigations, shadowing nurse specialists, working alongside other more experienced students, listening to patient stories, and discussions with members of the ward team, including doctors. However, they also identified barriers to self-directed learning including the need to actively seek out learning opportunities in a tactful manner and not overstep the mark (Papp et al 2003), lacking confidence to do so (Houghton et al 2012), and the importance of providing nursing care, over the need to pursue their own personal learning needs (Wilson 1994). In order to enhance these skills, students need to be introduced to the concept of self-directed learning and it is essential that students have the confidence and skills to pursue all learning opportunities.

Students must then be supported to develop and sustain good emotional and social literacy, to have high levels of self-efficacy and to develop high levels of emotional resilience, so that they can develop the intrapersonal and interpersonal skills required to survive and thrive, even in the most challenging practice placement settings, with the most challenging mentor. It is also

essential that these skills are developed in order to ensure that students do not lose their compassion, or passion for their chosen profession. They also need to learn how to be confident self-directed leaners, in order to maximize their practice placement learning opportunities.

5.3 Selecting and preparing mentors for their mentorship role

'*The relationship between mentor and mentee can bring mutual benefits for both and sustain both. Ultimately, these relationships can be transformational and as such deserve our attention, conscious preparation and valuing.*'
(Rose and Best 2005: 349)

The selection and preparation of mentors is also crucial to ensure high quality practice placement learning settings, as the students in this study reported that their mentor was often the person who assumed responsibility for their practice placement learning. There is no doubt that mentors are a key part of clinical learning and therefore need to be well prepared for that role (Jinks and Williams 1994, Dunn and Hansford 1997, Higgs and Titchen 2001, Duffy 2003, NMC 2008, Luhanga et al 2010, Gidman et al 2011, Crombie et al 2013, Jokelainen et al 2013, Turnbull et al 2014, Willis 2015, RCN 2016). Although the students noted that there were many other people to learn from in a placement setting, including nurses other than their mentor, (both registered and non-registered), doctors, allied health professionals, other students, and patients, it was their mentor who was central to the students' practice placement experiences. All these potential teachers, however, adopt a wide range of learning and teaching

strategies, some of which are more effective than others. All practice-based teachers and, in particular mentors, should be selected and then trained for this important role, in terms of the development of their own personal attributes and in terms of their ability to understand and deploy effective teaching strategies. In particular, mentors need to learn how to articulate their practice knowledge and practice epistemology to others, so that they can facilitate the development of professional practice knowledge in others (Higgs and Titchen 2001). They also need to have a clear personal teaching philosophy (Hegenbarth et al 2015) and to be skilled teachers (Rassool and Rawaf 2007). Brookfield (1993) argues that each learning experience is accompanied by a range of feelings and emotions (and this is particularly so, in a nursing practice placement setting), this means that all mentors, therefore, need to understand their own '*autobiography as a learner*', as their own experiences can help them to empathize with the emotions and feelings of other learners. Without this insight, according to Brookfield (1993), teachers will lack credibility and authenticity. Furthermore, Moscaritolo (2009) notes that student nurses need to be supervised by mentors who are emotionally and socially literate, and who are competent to teach these skills to others. The students in this study similarly noted that effective mentors are characterized by their knowledge and skills in practice, but also and, more importantly, by their emotional and social skills. This can range from the mentors who take time to get to know the students name to how they support students when mistakes happen, or when emotionally challenging events occur, for example, when patients die. The students in this study were very clear about what makes a 'good' mentor, in terms of their personal attributes, and the way in which they approached their

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mentorship role; their views accorded with the research literature. The characteristics of effective mentors are described both by the students in this study and in the literature then as being approachable, friendly, confident, kind, enthusiastic professional, knowledgeable, self-aware and well organized (Gray and Smith 2000, Moseley and Davis 2008, Courtney-Pratt et al 2011, Crombie et al 2013, Jokelainen et al 2013). They are also described as being enthusiastic about their job and about passing on their knowledge, as having good teaching skills and as being committed to student education (Webb and Shakespeare 2008, Robinson et al 2012). Another important characteristic of an effective mentor noted by the students in this study was their ability to help students make links between theory and practice (Field 2004, Wigens 2006, Taylor 2009). There is, therefore, a good evidence base for the attributes of effective mentors. Whilst the students in this study were clear about the attributes and behaviours of effective mentors, they were also, however, clear that not all nurses should be mentors and as Darling (1985) noted toxic mentors can be extremely destructive. They felt that being mentored by someone who did not wish to be a mentor, or who lacked the necessary knowledge, or emotional and social skills, was a very difficult and unproductive experience. Although currently it is an expectation of all nurses that they become mentors, this is clearly not a good idea and something that must change in the future (Gidman et al 2011, Turnbull et al 2014). Similarly, mentorship should not be regarded as a mandatory part of all continuous professional development (CPD) pathways, and promotion should not be dependent on being a mentor (Willis 2015, RCN 2016). It is clear from this study and the wider literature that

mentors need to possess certain personal attributes to be mentors and should only be selected to become mentors if they possess these attributes.

Once selected, student mentors then need to be trained to be emotionally intelligent teachers, with good facilitation skills. Mortiboys (2005) describes the characteristics of such teachers as including, someone who has subject expertise, has knowledge of how to teach, and has knowledge of how people learn. Such teachers are able to create an emotional environment where students feel valued, safe, curious, engaged and motivated (Mortiboys 2005). These environments can be challenging, but they are not threatening, they are motivating, and built on mutual trust and respect. Similarly, Nakamura and Csikszentmihalyi (2002) describe an ideal learning state where the student is offered the opportunity to become absorbed in a task, in a goal-directed and structured context. Although Mortiboys (2005) is talking about a traditional classroom as the learning environment, the principles also hold true for the practice placement setting, as can be seen from the students' observations in this study. Such teachers then take on the role of a facilitator, rather than a traditional teacher, which Rogers (1983) suggests requires the following personal qualities:

Genuineness – facilitator needs to come across as a real person, not an ideal model

Trust and acceptance – facilitator should demonstrate acceptance of the student and treat them with care and respect

Empathic understanding – facilitators need to be able to see things from the student's perspective

Given that all those who assume a teaching role in the practice placement setting need to be able to demonstrate the qualities of an emotionally intelligent teacher and a skilled facilitator, they need to be introduced to these concepts and allowed the opportunity to develop the skills required to ensure that this approach underpins all their teaching within their mentorship training programmes. Furthermore, mentors and others responsible for teaching in the practice placement setting also need to become what Ghaye and Lillyman (2008) describe as 'reflective mentors'. This was highlighted in this study by the students as being one of the most important and appreciated aspects of any mentor. These mentors have high levels of social and appreciative intelligence and have the ability to look for and note what is good in student's work, rather than focusing on what they can't do. They can also help students to reframe experience by exploring other options with them and this, in turn, can help the student to build practical wisdom and to develop core values. This process of critical reflection can enable students to develop and transform their practice and so it is imperative that the development of critical reflective skills is part of every mentorship preparation programme.

Good mentorship training then should ensure that all mentors have the opportunity to develop their teaching and facilitation skills to enhance their personal effectiveness as a teacher, but they also need to be familiar with a range of effective teaching strategies, including mentoring, experiential learning, scaffolding, coaching, role modelling and reflection.

In nursing, mentoring has a very particular meaning, but the concept of mentoring, in a more general sense, as a dyadic interpersonal relationship, according to Garvey et al (2009:159), can offer opportunities for deep understanding of attitudes and behaviours. This, in turn, offers the prospect of improving the student's ethical decision-making, and changing their attitudes and behaviours. These attributes are clearly all vital for the mentorship role and so mentors need to learn how to become mentors in the NMC sense and in the more general sense, in order to facilitate the growth and development of student nurses. Furthermore, Schon (1987:3) argues that

'*On the high ground, management problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy confusing problems defy technical solution.'*

And mentoring is, according to Garvey et al (2009:96), concerned with the *lowlands,* where many nursing challenges lie. Meaningful learning conversations between mentors and students can then help students to gain new insights and hence assist in helping student nurses to develop into effective learners.

The students in this study gave many examples of how they had learned new skills and knowledge whilst in the practice setting, through contextualized experiences, including making mistakes. They all felt that the practice setting was where they learned most, compared to the university setting. This learning was particularly powerful, however, when accompanied by an opportunity for

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reflection, practice and constructive feedback, namely, experiential learning.

Kolb (1984) saw experiential learning as a move away from previous learning

theories such as cognitivism, with its emphasis on the structure of learning

(Bruner 1960) and behaviourism, with its emphasis on measurable behaviours

(Skinner 1971) and as having its intellectual origins in the work of John Dewey

(1938). He described it as

'…*a holistic integrative perspective on learning that combines*

experience, perception, cognition, and behaviour' (Kolb 1984:21)

Dewey (1938) claimed that learning is maximized when it is gained through

experience, rather than solely through books and teachers. He described this

as progressive education. Dewey (1938) did not, however, consider that all

experiences are equally conducive to learning. In fact some experiences could

be '*mis-educative*' and could actually lead to '*callowness, lack of sensitivity and*

responsiveness' and thus would restrict learning opportunities in the future. For

nursing students this concept is clearly very important, as they need to remain

sensitive and responsive to lifelong learning. He also argued that if experiences

are disconnected, even if enjoyable, then the energy generated is wasted and

leads to an inability to control future learning experiences. This continuity is

then the principle that defines, whether experiences are worthwhile, or not, as

every experience takes something from those that have gone before and

modifies the quality of those that come after. In terms of practice placement

learning this means that someone, probably the student's mentor, needs to plan

and co-ordinate the learning experience in placement. Similarly, Spouse (2003)

claimed that one of the most important, but less well acknowledged aspects of mentorship, is that of planning. Dewey (1938) argued that every experience could modify a person in terms of the formation of their attitudes and values. Educators, therefore, need to be able shape learners' experiences by ensuring that the learning environment is conducive to growth. This requires an interaction between the educator, student and the environment. Furthermore, an educator needs to understand the needs and capacities of each individual learner; it is not enough that a certain strategy has proved effective with other individuals at other times. Lifelong learning is crucial - not just knowing the subject matter, but also developing positive attitudes towards learning, and a desire to go on learning. All learning should, according to Dewey (1938), start with what the learner already knows. The next step is the progressive development of what is already experienced into a fuller, more organised form. Learning is then about gaining new facts and also a better arrangement of those facts: analysis and synthesis. Teaching and learning should, therefore, be a continuous process of the reconstruction of experience, and this can only be achieved fully with a good teacher. This ability to be a flexible and critical learner is clearly essential in today's fast moving healthcare environment.

The students also noted that being questioned by their mentor to ascertain their individual learning needs and then set tasks, with varying levels of support from their mentor, based on their current level of knowledge, was an excellent learning strategy. Vygotsky (1978) described this process as scaffolding and he argued that individual learner's have a '*zone of proximal development*'. This is the difference between a learner's current levels of knowledge, as determined

by independent problem solving ability, and their potential, problem solving ability under guidance, or in collaboration with others (Tusting and Barton 2003). Scaffolding is the means by which such learning is facilitated and refers to the support a teacher provides to help the learner carry out a task. This help may involve the teacher carrying out the parts of the task that learner cannot yet manage, and it could also involve co-operative problem solving by the teacher and the learner, in which the intention is that the learner assumes as much of the task on their own, as soon as possible (Cullen et al 2002). The students in this study certainly valued those mentors who took the time to ascertain their current level of knowledge and build on it through decreasing supervision and increasing complexity of delegated activities.

Closely related to scaffolding, is the use of coaching, particularly appreciative coaching (Orem et al 2007). Coaching is increasingly being considered as a useful teaching strategy for practice-based learning (Turnbull et al 2014) and Gallwey cited in Whitmore (2009:10) describe coaching as '*unlocking people's potential to maximize their own performance'.* Coaches act as facilitators, they listen, ask questions, and enable the coachee to work things out for themselves. Unlike mentorship, it is not just about transferring knowledge, giving expert advice, or sharing personal experiences (Garvey et al 2009). The students in this study regarded coaching as a very effective teaching strategy and this is mirrored in the literature (Chandon and Watt 2012). Such an approach to teaching is essential when there are not necessarily 'right answers' to every problem. Schon (1987) argues that the move from technical rationality, to reflection-in-action means that professionals can no longer claim to solve

problems by using scientific theory and practice alone. Similarly, Neubauer
(1977) argues that practice is characterized by ambiguity and often involves
working on the edge of chaos, so again a skilled coach working alongside a
student in the practice setting, is the ideal way of learning how to function well,
in that context.

Most of the students in this study talked about clinical staff, mostly mentors,
whom they described as being role models and of the importance of role
modelling as a learning strategy. Whilst this normally had positive connotations
and was seen as a way of learning how to practice as a nurse, it could also be a
way of deciding, how they would not behave. Levett-Jones et al (2007) discuss
the importance of role modelling, from another perspective; a student may
conform to poor practice, in order to be accepted and to fit in to the practice
placement setting. It is then essential that mentors are fully aware of the power
and potential influence that they have over student's practice placement
learning, particularly regarding role modelling and its close link to professional
socialization (Holland 1999). According to Bandura (1977) role modeling is part
of social learning theory; his theory suggests that when an event, or behaviour
is modelled and, if certain criteria are met, this can result in new learning. For
this to happen, however, four processes need to occur:

Attentional processes – people will only learn if they attend to the event and
take note of the modelled behaviour, and some individuals command greater
attention than others.

Retention processes – experiences must be retained in the memory, either as images in the memory, or through discussion. Rehearsal improves retention, as new skills are not perfected through observation alone, nor are they just trial and error.

Motor reproduction processes – ideas need to be turned into action, with feedback for learning to occur.

Motivational processes – there is a difference between acquisition and performance of a new skill, people do not enact everything they learn, but if a learner perceives a behaviour to be effective, they will be more likely to model it, also if past experience has been positive, this will create expectations of mastery.

This appears to be a powerful learning method in practice placements according to the students in this study, so it is imperative that all clinical teachers, particularly mentors, are positive role models and understand the impact that their behaviour, attitudes and values, have on their students. The importance of role modelling is also clearly noted in the literature (Murray 2005, Luhanga et al 2010, Houghton et al 2012, Jokelainen et al 2013). A good mentor can promote the professional socialization of student nurses, particularly through role modelling (Earnshaw 1995, Papp et al 2002, Murray and Main 2005, Koontz et al 2010, RCN 2016) and enhance the credibility of the profession (RCN 2016). Whilst this is normally a positive process, if mentors are not competent practitioners, then students may learn poor practice and inappropriate values and attitudes from these mentors (Papp et al 2002, Thomas et al 2012).

Whilst the importance of selecting nurses with the appropriate personal attributes, values, knowledge, skills and motivation and then training them for their mentorship role can be seen to be crucial in ensuring high quality nurse training, it must be remembered that, as Paley (2007) points out, we need to be cautious of the 'education reflex'; training is not always the solution to resolve practice issues, sometimes it is not sufficient to look just to the individual, but rather to the wider system.

5.4 Designing and developing high quality nursing curricula

The first step in ensuring that practice placement learning is maximised is to ensure that both students and mentors are well prepared and this requires the development of high quality, effective curricula. In terms of adult nurse training, this includes both the pre-registration nursing curriculum and the mentorship preparation curriculum, which should be closely aligned in terms of their philosophical, and, in particular, epistemological underpinning. In order to ensure that curricula are relevant and effective, they should be developed in collaboration with representatives from the practice placement providers, practitioners, including mentors and board level nurses, service users and carers, students - recently past and present, and university faculty (Boore and Deeny 2012). Such curricula must be developed in accordance with current NMC standards and criteria for programme approval (NMC 2004, NMC 2008, NMC 2010, Health Education England 2014) quality assurance processes, and university programme validation criteria. Once these imperatives have been met, however, it is down to the local stakeholders to decide on the exact

philosophical and epistemological approach of any curriculum, and it is essential for all the stakeholders to develop a shared philosophy and epistemological approach. The results of this study suggest that, philosophically, a humanistic and transformational curriculum, with an andragogical underpinning, would be a preferable choice. Andragogy, or adult learning theory, as defined by Knowles et al (2015), builds on the humanistic principles outlined by Maslow (1971) and Rogers (1983). Andragogy is then a process model, contrasting with the content model of traditional education and although not appropriate in every practice placement learning situation, for example, students cannot always negotiate their own learning outcomes, it does provide a useful underpinning educational approach in all nursing curricula.

The main aspects of the andragogical approach are summarized in the table below:

Process elements of andragogy	Traditional approach	Andragogical approach
1. Preparing learners	Minimal	Provide information Prepare for participation Help develop realistic expectations Begin to think about content
2. Climate	Authority-oriented Formal Competitive	Relaxed, trusting Mutually respectful Informal, warm Collaborative, supportive Openness and authenticity

		Humanness
3. Planning	By teacher	Mutual planning teacher an student
4. Diagnosis of needs	By teacher	By mutual assessment
5. Setting objectives	By teacher	By mutual negotiation
6. Designing learning plans	Logic of subject matter Content units	Sequenced by readiness Problem units
7. Learning activities	Transmittal techniques	Experiential techniques
8. Assessment and evaluation	By teacher	Mutual re-diagnosis of needs Mutual evaluation of programme

Adapted from Knowles et al (2015:52)

Traditionally in nurse education, however, a didactic pedagogy has been adopted (Scanlon 2006), in direct contrast to andragogy. In such curricula teachers are regarded as the expert transmitting knowledge, to a passive learner, they are content-driven and favour theoretical over experiential knowledge (Ironside 2001, Candela et al 2006, Thomas and Davies 2006). There is also often a gap between what nurse educators say they do – run humanistic, student-centred programmes and what they actually do, which is much more teacher-driven (Argyris and Schon 1978, Scanlon 2006). Student nurses are, however, adult learners and hence bring with them an array of previous knowledge and skills, the learning potential of which is lost in such traditional approaches and, as Freire (1993) argues, this 'banking education' is a mirror of an oppressive society and, therefore, detrimental to the production of

liberated, empowered learners. Greendorfer (1991), Ironside (2001) and Webb (2002) argue that an andragogical approach and feminist pedagogy are both essential for nursing curricula. This is where the teacher is seen as a facilitator of learning and the emphasis is on learning how to learn, through a collaborative approach. There is also a sensitivity to the fact that the values underpinning much teaching are the dominant ways of thinking and, therefore, not necessarily inclusive and representative of all perspectives. One particular issue that was clearly highlighted by the students in this study was the fact that the students often experienced negative reactions to the fact that they were undertaking the course at master's level; the concept of horizontal violence (Webb 2002), this is definitely one issue that might benefit from such a feminist analysis. This demeaning treatment of students can be passed on through mentors and repeated by future generations and Webb (2002) suggests that transformatory education, as defined by Freshwater (2000) and Mezirow (2000), which links learning to individual and social empowerment, and conscious raising education as suggested by Freire (1993) could be utilised to break this cycle. Belenky et al (1986) also note that if women are to flourish in any educational setting, and the majority of nurses are women, there must be an emphasis on connected teaching, which welcomes diversity of opinion, open discussion and where the teacher is a 'midwife-teacher' who draws out knowledge, as opposed to 'banker teachers' who deposit knowledge. Such teachers are genuinely interested in their students and are always totally present with them. This approach engenders a sense of community, power and integrity in students, particularly the female students (Belenky et al 1986) and would therefore be very beneficial for student nurses.

The students in this study also noted that another important aspect of curriculum development is that of ensuring that there is a close temporal and cognitive alignment between what is currently being studied in the university and the learning opportunities available in the contiguous practice placement. Houghton et al (2012) also suggest that there needs to be close liaison between universities and practice and Neilsen et al (2013) advocate the use of a clinical education model in the practice setting, which is developed collaboratively by faculty and practice staff, and which moves away from the random access to learning opportunities, with an emphasis on total patient care, to the intentional design of increasingly complex practice learning experiences, which are individually tailored for each student. In a time of placement shortages, and last minute changes to placement allocations this close temporal alignment is, however, often difficult to achieve and it requires a very close working relationship between the education commissioners, practice education providers and the universities (Turnbull et al 2014).

It is also essential to ensure that the teaching and assessment strategies used in such curricula are commensurate with this epistemological approach. Appropriate teaching strategies might include reflection, discussion, problem-based learning, peer teaching (Boud and Feletti 1991, Savin-Baden 2000, Ramm et al 2015), and include the development of contemplative pedagogies, with a focus on mindfulness (Moscaritolo 2009) and feminist pedagogies (Ironside 2001). Such teaching strategies are typified by their ability to encourage the co-creation of knowledge, with the teacher assuming the role of facilitator, rather than expert. Appropriate assessment strategies could include

the use of practice-based scenarios and Objective Structured Clinical Examinations (OSCEs); this assessment strategy being commended by the students in this study, as being one, which enhanced their knowledge and confidence, and reflective portfolios that span across university and practice placement learning.

Although the discussion so far has centred on the development of the formal curriculum, Del Prato (2013) notes that where there is a disconnect between the formal and the informal, or hidden curriculum, for example, when staff do not role model compassionate care, students find this emotionally difficult to deal with and this can lead to disillusionment. This disconnect was certainly noted by the students in this study, with some commenting that what they learned from some mentors was how not to do things, or as O'Mara et al (2014) suggest reframing. It is essential then to ensure that the formal, the taught and the hidden curricula are closely aligned, through the collaborative development of all curricula (Quinn and Hughes 2007).

When designing and developing curricula it is also crucial to consider an appropriate epistemological approach to nurse education, which includes an exploration of the nature of knowledge, particularly nursing knowledge (Rutty 1998, Landreneau 2002). The students in this study identified several practice-university gaps, which they perceived as problematic and O'Driscoll et al (2010) talk about the 'uncoupling' of education and practice. The origin of these gaps appears to be partly rooted in a particular understanding of the nature of nursing knowledge, whereby propositional knowledge is perceived as being completely

separate from practice knowledge. In this study the students noted one

particular manifestation of this gap, which is the assumption that certain types of

knowledge can only be learned in certain settings; more specifically, theoretical,

or propositional knowledge within the university, and clinical and professional

skills, in practice. The students, however, noted that knowledge often perceived

as propositional, for example, anatomy and physiology and therefore

traditionally taught in the university, is actually best learned in the practice

setting. This perception of 'what' can legitimately be learned in practice is

potentially a barrier to learning and Gidman et al (2011) argue that there is

currently a very narrow perception of practice learning, which needs to become

more holistic, in order to enhance the development of competence in nurse

training. This unhelpful divide, going back to Aristotle and his distinction

between theoretical and practical reason often shapes nursing curricula.

Edwards (2007) and Lum (2007) also argue that theory and practice should not

be seen as two competing ways of achieving effective performance: this is a

false division. Similarly, Higgs and Titchen (2001) argue that practice

knowledge should incorporate propositional knowledge, professional craft

knowledge and personal knowledge, and argue that all aspects of practice

knowledge can, and should, be learned in the practice setting. They suggest

that such practice knowledge should be developed by practice-based educators

and then incorporated into the educator's own practice and the profession's

evolving practice knowledge base, as this is how practice knowledge is created.

It could be argued that this unhelpful divide has been exacerbated by the move

of nurse training into higher education. Rolfe (2012) asserts that although there

have been advantages for nurse education by being moved into higher education, there are also disadvantages for nurse academics and for students. One disadvantage is the separation of nurse education from practice, physically and professionally. Universities employ most nurse lecturers and clinical academic career pathways are rare, despite the fact that nursing is a practice and practitioners learn primarily from their practice (Higgs and Titchen 2001, Rolfe 2012, Willis 2015). In higher education research comes first, then theory and then application, whereas in nursing, challenges in practice often underpin research and the generation of theory, and this can lead to a tension between the aspirations of universities and the nursing profession (Rolfe 2012). Papp et al (2003) also argue that there needs to be a closer collaboration between practice and the universities and that this would be enhanced if the role of the lecturer was clarified, in terms of how they can support students whilst in practice placements. One suggestion they make, is that lecturers can be very helpful in signposting students to possible learning opportunities in their practice placements. Interestingly, the students in this study never mentioned the link lecturer as a resource for practice placement learning, although they were aware of them and noted that they had found them supportive in difficult placements. Similarly, Foster et al (2015) also call for a strengthening of the link lecturer role in order to enhance practice placement learning to lessen the practice-university gap.

The practice-university split is similarly mirrored in the practice assessment documentation used on preregistration nursing programmes. Such documents are normally focused on the acquisition of clinical skills, as determined by the

NMC in the Essential Skills Clusters, (2004) and the appropriate attitudes and values as found in the NHS Constitution (2013) and in the 6 Cs (DH 2012), rather than on propositional knowledge. This has led to concerns about the reductionist nature of practice assessment documents, particularly as there is increasing pressure to simplify these documents, in order to make them less onerous for mentors to complete. The students in this study frequently mentioned their practice assessment documents, with opinion divided on their merit, or otherwise. Some students felt that the documents helped to structure their practice placement learning, whilst others noted that they could be problematic and disheartening, particularly regarding inconsistent use of the grading system by mentors. The students also noted that whilst on placement, they could not always concentrate on the learning opportunities on offer, as they were too concerned with completing their university assignments and getting their practice assessment documents signed off. Furthermore, getting their practice assessment documents signed off by less enthusiastic mentors was a particularly challenging. It is clear, therefore, that the development of effective, epistemologically appropriate, understandable and proportionate practice assessment documents is a crucial part of any curriculum development process. Most importantly, however, they need to move away from the task-based approach they often currently have.

It can be seen then that the current practice-university gap is unhelpful and requires immediate attention. Willis (2015) suggests that the development of clinical academic career frameworks for nurses could offer a solution to this problem, as such roles would span both university and practice settings. If a

new nursing career framework is adopted, however, it is imperative that it captures and rewards the importance of the mentorship role in nurse training (Turnbull et al 2014, RCN 2016). It is also important to revisit the link lecturer role, to ensure that it is a meaningful one. The current regulatory and professional frameworks and standards governing pre-registration and mentorship education similarly require attention, as they are predicated on the view that knowledge is transmitted from expert to novice and that there is a separation between propositional and experiential knowledge. They militate against interprofessional learning and do not acknowledge the current move towards integrated health and social care provision and so are in urgent need of amendment (RCN 2016).

5.5 Developing effective learning environments, where students and mentors both feel supported and valued

Whilst it is important to ensure that individual students and mentors are well prepared for their respective roles within the practice placement learning dyadic, it is also imperative to ensure that practice placement settings are positive and dynamic learning environments. Such learning environments offer high quality safe patient care (Allan et al 2008, Henderson et al 2011), also noted by the students in this study. Furthermore, the students in this study described ideal practice placement settings where there was a good team spirit, and where the students felt that they belonged in that team. The students talked about different wards having different atmospheres, or cultures, some of which were more conducive to learning than others. All of the students clearly understood the

characteristics of these positive learning environments, which normally included less hierarchy, good teamwork and equality between team members, good management and leadership, mutual respect and a welcoming approach to students. In the literature there is much written about the importance of a positive ward atmosphere in the creation of a good learning environment (Papp et al 2003, Henderson et al 2011, Jokelainen et al 2011b, Jokelainen et al 2013). The students in this study did, however, note that the opposite was true of many practice placement settings, which echoes the findings of Dixon-Woods et al (2013). In their study looking at culture and behaviour in the English NHS, they note that despite the fact that the vast majority of staff in the NHS wishes to deliver best care, there were inconsistencies, due to factors such as poor organisation and management, and a lack of staff support, factors the students in this study also noted. It is clear then that effective learning environments need conscious development and this requires inspirational leadership at both organisational and ward level, plus effective management (Carnwell et al 2009, Allan et al 2008, Webb and Shakespeare 2008, O'Driscoll 2010, Henderson et al 2011, RCN 2016). The Kings Fund (2011) similarly note that there needs to be a focus on the development of organisations and teams in the NHS and a focus on followership, as well as leadership, in order ensure that the NHS delivers the highest possible care and the best value for money. Congdon et al (2013) also note that roles such as learning environment managers can help with this process and Turnbull et al (2014) suggest that it is essential to have a named person in each practice placement setting to take responsibility for student learning. There are also numerous examples of new ways of structuring practice placement settings to ensure the optimum learning

experience, including dedicated education units (Grealish and Ranse 2009, Nishioka et al 2014), clinical education units (Nielsen et al 2013) and real life learning wards (Branson 2014). They may also help to address the issue identified by White (2010) namely, that the move towards supernumerary status for student nurses may have inadvertently made it more difficult for students to become part of the team in their practice placement settings. It would appear that all these alternative mentorship models are attempting to create communities of practice (Lave and Wenger 1991, Wenger et al 2002). The community of practice model involves the concept of learning and developing expertise through '*legitimate peripheral participation'* and such communities of practice are characterized by a:

Domain – a shared domain of interest, with members who are committed to it and have shared competence

Community – members engage in joint activities and discussions, share information and learn from each other

Practice – members are practitioners and have a shared practice

A given community will have experienced practitioners engaging in practice that defines that community, and novices, who have a peripheral role, but gradually move into a more central role, as they participate more and more in community's activity (Tusting and Barton 2003). Wards can be communities of practice and, as such, will be excellent learning environments for student nurses (Thrysoe et al 2010). In such environments, problem solving is overt, people ask others for their experiences dealing with similar problems and colleagues

will offer help freely, to avoid reinventing the wheel (Tusting and Barton 2003).

When a student starts a placement, they are initially on the periphery of the

group and learning in this situation is equated with increasing participation in the

group and can be perceived as an evolving set of relationships, and is thus

more than just experiential learning.

According to Wenger there are three modes of belonging:

Engagement – when students observe and participate in the work activities

Imagination – when students challenge situations

Alignment – when encounters with different nurses help to shape the student's

professional identity

Lave and Wenger (1991) point out that it is a human characteristic to want to be

an integrated member of society, work on its behalf and thus gain a sense of

identity, and this was certainly true for the students in this study, who all worked

very hard to 'fit in'. When newcomers stop feeling exposed and vulnerable,

through the support and protection of colleagues, they can become productive

members of the team and their learning will be enhanced, so an important

aspect of good mentoring, according to Spouse (2003) is that of 'befriending'.

This is an adult-adult relationship, built on mutual trust and respect, where a

willing sponsor helps the student to adjust quickly to the new environment, and

to give them an identity and place within the team. This means that other staff

can relate to the students and support them when their mentor is busy. The

research literature on practice-based learning is replete with evidence to

support the necessity of students feeling as though they belong in the practice placement setting (Papp et al 2003, Levett-Jones and Lathlean 2007, Del Prato 2013) and Hegenbarth et al 2015 describe this as when the mentor takes a student '*under their wing*'. Levett-Jones and Lathlean (2007) also discuss the importance of belongingness to students, which they describe as the need for students to feel involved in and able to contribute in a meaningful way, which leads them to feel valued and respected by others. When students feel they belong this enhances their self-esteem and feelings of self-worth and as Levett-Jones and Lathlean (2007:169) point out

> '*In the messiness and complexity of contemporary clinical environments it is crucial that students feel that they can negotiate their learning in a self-directed and confident manner.*'

Hood et al (2014) also note that interprofessional clinical learning is a crucial part of the preparation of nurses who will be confident functioning in an increasingly complex work environment, where successful interprofessional teamwork is essential to ensure good patient care. The concept of interprofessional learning, whereby '*when two or more professions learn with, from and about each other to improve collaboration and the quality of care*' (CAIPE 2002), and where learning is collaborative, team-oriented, non-hierarchical and based on real life problems, is then increasingly regarded as being essential for the preparation of all healthcare practitioners. The outcomes of this learning can include changes in attitudes and perceptions, knowledge and skills, changes in individual behaviour, organizational behaviour and

improved patient care (Barr 2003). It is argued that for interprofessional learning to flourish, you need a learning team (De Cuyper et al 2010), in a community of practice (Wenger et al 2002), within a learning organisation (Senge 2006). The students in this study agreed with this idea, but some lacked the confidence to make full use of interprofessional learning opportunities, including being unwilling to interact with doctors. This is a serious concern, as once these students are registered nurses they will need to be able to work confidently with a wide range of healthcare practitioners. There are also barriers to interprofessional learning created by the current NMC (2008) SLAiP framework supporting practice placement learning, where the underpinning philosophy is that it is nurses who should teach and assess other nurses. This framework militates against interprofessional learning and is, therefore, urgently in need of amendment.

As interprofessional communities of practice are more likely to thrive in learning organisations (Barr 2003), it is essential that more practice placement providers become effective learning organisations. Learning organisations are characterized by certain features, including an inbuilt tolerance of uncertainty, an ability to continually reconfigure how problems are solved, and good communication systems that emphasise the exchange of information, rather than issuing directives (Dunne 2007, West et al 2014). This concept emerged from concerns about how organisations can survive in the midst of rapid change (Argyris and Schon 1978) and Tusting and Barton (2003) suggest that by encouraging every employee in an organisation to personally invest in lifelong learning and improvement of quality, organisations will be more likely to

succeed. Senge (2006) described a learning organisation, as one where individuals are valued, so that everyone is committed to delivering the organisational mission. Furthermore, in such organisations there is continual reflection, review and improvement, and tasks are used as opportunities for continual learning. They are, therefore, flexible and adaptable and able to develop new and effective forms of practice. It is essential then that all practice education providers need to consider how they can ensure that they are learning organisations. According to the Department of Health (DH 2014), a good practice-learning environment in a healthcare setting depends on effective multi-professional teamwork and systems thinking. In such settings students are able to observe how all staff contribute to care and how they reflect in action, are proactive, challenging and bring about change. Where a learning culture exists all staff are role models for best practice, they value learning and encourage reflection and evidence-based practice, but for such learning cultures to thrive, effective nurse education leadership and a clear vision for the care patients receive, with everyone working towards that vision is required. This leadership is characterised by '*intelligent kindness'* according to Ballatt and Campling (2011). If then a student finds that they are on placement in a strong community of practice, within a learning organization, their opportunities for learning will be maximized.

It is also essential that all practice placement settings need to acknowledge and value the mentorship role. This includes the need for ongoing support for mentors from employers, their colleagues and from the university. This support should include protected time, supervision, and their role should be tied into a

career pathway (Turnbull et al 2014, Willis 2015, RCN 2016). The practice

placement provider and the university should both acknowledge the role as

important, and effective mentors should be rewarded for their efforts. This

support is fundamental to high quality learning environments, as many excellent

mentors experience feelings of distress, frustration and disillusionment when

they cannot fulfill their mentorship role in the way they would like and so this

issue needs urgent attention (Hunt 2014, Turnbull et al 2014). Indeed,

O'Driscoll et al (2010) note that as the main responsibility for practice placement

learning now falls to individual mentors who have not been adequately

prepared, or supported in their role, this has led to a decline in the quality of

such learning. Part of this support could be a placement debriefing session for

all mentors (Hunt 2014), with an opportunity for reflection. This could be done

on an individual basis, or in groups, to allow mentors an opportunity to explore

their experiences in a safe environment. This activity could help with the

development of a strong peer support group and these debriefing sessions

could be led by link lecturers, thus giving them a meaningful role to play in

practice placement learning.

Evaluation of practice placement experience, using appropriate metrics, is also

essential following all practice placement experiences, by both students and

mentors. Currently the quality of a practice placement setting is judged

primarily on their being sufficient numbers of nurses in that setting who are

qualified as mentors and who have maintained their 'live mentor' status by

undertaking the required mentorship updates and triennial review and that each

student has spent at least forty percent of their time with a live mentor (NMC

2008). It is not enough, however, just to state what percentage of the student's time was spent with a mentor, or how many mentors are on the live mentor register in that area, rather the quality of the experience needs to be captured. These evaluations must then be considered by those with educational responsibility from ward level to board level, in the practice education provider, with directors of nursing taking responsibility for the overall educational quality assurance process (Hutchings et al 2005, RCN 2016). It is also essential that any necessary actions arising from the student and mentor evaluations be acted on in a timely fashion, again with clear lines of responsibility and accountability for this process.

Furthermore, it needs to be noted that one of the key characteristics of a high quality learning environment is a close collaboration between practice and university (Dunn and Hansford 197, Duffy et al 2000, Hutchings et al 2005, Carnwell et al 2007, Congdon et al 2013), particularly regarding good communication (Andrews ad Wallis 1999). This collaboration and communication with the university needs to happen at all levels, from ward to board, with a view to ensuring that there is a clear alignment between the values and views of faculty and practice staff, and at ward level, it can be seen that the role of link lecturer is crucial in this regard, but it needs to be strengthened (Foster et al 2015).

5.6 Conclusion

1. Effective student nurse preparation

Firstly, student nurses need to be supported to develop their emotional and social literacy and their self-efficacy. The development of these skills will enable the students to be able to establish and maintain the student-mentor relationship once they are in the practice placement setting. As practice placement settings can be challenging environments, students also need to develop high levels of emotional resilience, so that they do not became disillusioned, or burned out. Students also need to understand the importance of self-directed learning and feel confident enough to seek out a wide range of learning opportunities in all their practice placements.

2. Effective mentor preparation

Secondly, mentors need to be selected well prepared for their mentorship role. This needs to include the development of the skills and knowledge required to be emotionally intelligent teachers, facilitators of learning, coaches and reflective mentors. Furthermore, mentors need to be supported to develop their personal pedagogy and feel comfortable utilising teaching strategies such as experiential learning, scaffolding, coaching, mentoring, and in being a role model.

3. Designing and developing effective pre-registration nursing and mentorship preparation curricula

Thirdly, both pre-registration and mentorship curricula need to be designed and developed using humanistic and transformative learning strategies, with

commensurate teaching and assessment strategies to ensure that the learning process is an empowering one for all learners. In order to minimise the university-practice gap, a temporal and cognitive alignment between what is being taught in the university and the students' practice placement experience is required, and this includes the collaborative development of appropriate practice assessment documents. Also, the informal and hidden curriculum needs to be aligned with the formal curriculum. The nature of nursing knowledge and how it is best learned needs to be considered and a collaborative philosophical approach to this issue developed. Similarly, all nursing curricula should be developed within sympathetic professional and regulatory frameworks and standards.

4. Development of effective practice placement learning environments

Finally, it is essential to develop effective practice placement learning environments. This means the creation of interprofessional communities of practice, situated within learning organisations and this can only be achieved through close collaboration between practice and university. All students need to feel as if they belong in the practice placement setting and all mentors to feel supported and valued. This involves the development of rigorous governance processes within practice placement providers, with strong nursing leadership from ward to board. Attention also needs to be given to career frameworks for mentors, plus ongoing support, to ensure that they feel appreciated and valued.

Chapter 6 Conclusions and recommendations

The final part of the Framework model of data analysis and interpretation requires the development of strategies for changes in practice and policy (Ritchie and Lewis 2003). In this study the recommendations for change have arisen from the analysis, interpretation and synthesis of the data collected through the students' reflective diaries and their individual interviews, the literature review and the wider literature. This is in line with my stated intention to use abductive logic as a methodological approach for the study (Alvesson and Skoldberg 2009). The data from the study offers an in depth description of the practice placement learning experience from the perspective of each individual student, obtained through listening to the students' their own stories, again in line with my stated intention to use narrative inquiry (Clandinin and Connelly 2000). The students' descriptions were then interpreted in the light of the known empirical data and relevant abstract concepts and theories, as outlined in the methodology of interpretive description (Thorne 2008). Although no grand narrative emerged, as all the students had very different stories to tell, even about the same wards and the same mentors, underpinning philosophies and concepts and a conceptual framework (see **Figure 1**) were identified. The relevant philosophies and concepts identified in this study related to the individual student and mentor, to the practice placement and university and to the wider contextual level, but they are context specific and temporal, again an important aspect of narrative inquiry (Clandinin and Connelly 2000, Besley 2007). However, although the focus in this study was primarily on the individual students' experiences, theory was also important, because as Ely et al 1997

point out, there is often a lack of theory in nursing debates and this detracts from the power of any argument.

The findings of this study suggest that there is no doubt that practice placement learning for pre-registration nursing students is not as effective as it could be – there are examples of excellent practice, but this is inconsistent. To achieve a higher level of consistency and quality, the findings from this study suggest that changes are required at three levels - the regulatory and professional level, the practice education provider and university level, and at the individual mentor and student level.

6.1 How these research findings are located within and extend the existing literature

1. Effective student nurse preparation and support

The findings from this study suggest that student nurses need to be well prepared for and adequately supported during and after their practice placements. One of the most important aspects of this preparation and support is to the need to help the students develop their emotional and social literacy and their self-efficacy; the development of these skills will enable the students to be able to survive and thrive in their practice placement settings and thus maximize their learning. Previous research has also noted the importance of the personal attributes of students in the learning process and as far back as 1997 Dunn and Hansford noted that students needed to be encouraged to recognize the potential influence they could have over their own learning. In

later research more specific skills, attitudes and knowledge have been highlighted as essential for students, if they are to maximize their practice placement learning. These personal attributes include positive attitudes (Courtney-Pratt et al 2011, Crombie et al 20130, a confident manner (Houghton et al 2012, Killam and Heerschap 2012), self awareness (Freshwater 2000), self-efficacy (Rowbotham and Owen 2015) and being effective self directed learners (Grealish and Rance 2009, Gidman et al 2011, O'Mara et al 2014). The existing research does offer some examples of teaching strategies to enhance the development of these characteristics, for example, through reflection and the use of stories (Adamson and Dewar 2015, but unlike this study, they do not explore in any detail the educational philosophies underpinning such pedagogical choices.

The students in this study also noted that the most important factor in ensuring that they had a positive practice placement experience, was their ability to establish an effective relationship with their mentor, but they additionally observed that this could be difficult to achieve. The importance of this relationship has been noted as an issue in the existing literature, (Earnshaw 1995, Gray and Smith 2000, Koontz et al 2010, Luhanga et al 2010, Courtney-Pratt et al 2011, Jokelainen et al 2011, Kelly and McAllister 2013, O'Mara et al 2014). The students in this study, however, felt very strongly that it was their responsibility to establish and maintain this relationship with their mentor and whilst this has also been noted in the existing literature (Webb and Shakespeare 2008, Gidman et al 2011, Thomas et al 2012, Crombie et al 2013, Jackson et al 2011, Ghaye and Lillyman 2008, Lewallen and DeBrew 2012), it

was a very strong theme in this study. One particularly challenging aspect of the student-mentor relationship noted by the students in this study was the marginalization or 'othering' of students by their mentors. This phenomenon has been noted in the literature previously, (McKenna et al 2003, Gallagher 2005, Bradbury-Jones et al 2007, Levett-Jones and Lathlean 2007, Taylor 2009, Jackson et al 2011, Del Prato 2013, Crombie et al 2013), but the students in this study found that for them, this phenomenon often centred on the fact that they were masters level students. There was, however, only one study in the existing literature that looked at this phenomenon specifically with regard to masters level students, and the participants in that study were mental health students, not adult nursing students (Stacey et al 2010), so in this regard, the findings from this study are unique. Another specific aspect of the student-mentor relationship identified by the students in this study was that of perceived time constraints. They noted that their mentors were very busy and that the provision of patient care always came before teaching. This tension has also been noted in the existing literature (Wilson 1994, Pulsford et al 2000, Duffy 2003, Murray and Main 2005, Wilkes 2006, Gleeson 2008, Jokelainen et al 2013, Turnbull et al 2014, RCN 2016). The origin of this tension, in terms of the separation of providing nursing care and teaching has not, however, been well explored in the existing literature, hence the importance of the examination of the nature of nursing knowledge and of how and where it is best taught, in this study. The solutions to this particular student-mentor relationship challenge are varied, with some calling for a division between teaching and assessing roles (Neary 2000, Turnbull et al 2014), and others calling for more time to carry out the mentorship role (Elcock 2014, Turnbull et al 2014, RCN 2016). This study

would suggest, however, that there are many missed learning opportunities in practice placements, which are unrelated to time pressures; the teaching of students is sometimes regarded as being separate from the informal and situated learning that can arise from the delivery of patient care and through working in a team with other skilled healthcare professionals. This unhelpful separation of education and practice has also been noted in the existing literature as a more general issue in nurse education (Higgs and Titchen 2001, Edwards 2007, Lum 2007, O'Driscoll et al 2010, Gidman et al 2011), but this study explores the nature of nursing knowledge, with specific reference to practice-based learning.

Another aspect of the student-mentor relationship noted in this study was that the students perceived that there was a power imbalance between themselves and their mentors, particularly when it came to negotiating how their learning needs could be met and when being assessed, a fact not well explored in the existing United Kingdom literature, apart from Garvey et al (2009).

The students in this study found practice placement settings emotionally challenging environments and it was clear that the students required a high level of emotional resilience and self-efficacy, to ensure that they did not become disillusioned, lose their compassion, or become burned out. Again this has been noted in the existing literature (James 1992, Smith 1992, Spouse 2003, Theodosis 2008, Neubauer 1997, Scholz et al 2002, Thomas et al 2012, McCabe and Timmins 2013, Curtis 2014) and so the findings of this study confirm previous research evidence.

Finally, the need to be a confident self-directed learner, who feels empowered to seek out a wide range of learning opportunities in all their practice placement experience's is clear from this study and the importance of this has been similarly noted in the existing literature (Wilson 1994, Bradbury-Jones 2007, Papp et al 2003, Houghton et al 2012).

This study acknowledges that the personal attributes of each student are fundamental to their success, or otherwise, in their practice placements, and further argues that such attributes can be taught and enhanced through the use of well designed curricula, based on humanistic and transformative learning strategies, (Rogers 1983, Argyris and Schon 1978, Maslow 1971, Freire 1993, Mezirow 1996, Freshwater 2000, Ironside 2001, Candela et al 2006, Scanlon 2006, Thomas and Davies 2006, Knowles et al 2015), with commensurate teaching and assessment strategies to ensure that the learning process is an empowering one for all learners. The existing literature has included suggestions for improving the student experience by suggesting specific course content and teaching strategies, including mindfulness training (Moscaritolo 2009), teaching self-compassion (Saarikoski et al 2006, Curtis 2014), opportunities for reflection and group supervision during placements (Menzies Lyth 1960, Jackson et al 2011, Stein and Falkingham 2015), developing peer learning and support (Mamhidir et al 2014, Ramm et al 2015, Stenburg and Carlson 2015, Smith et al 2015), action learning sets (Heidari and Galvin 2003), problem–based learning (Boud and Feletti 1991, Savin-Baden 2000), reflection and the use of stories as a learning strategy (Adamson and Dewar 2015), but this study suggests that there is a need to establish an overarching educational

philosophy, including an exploration of the nature of nursing knowledge, to inform the choice of appropriate teaching, learning and assessment strategies for all pre-registration nurse training programmes. Further, there is a need for a greater emphasis on learning how to learn and the development of student confidence and self-awareness, rather than an increase in theoretical content and clinical skills rehearsal. This is essential, not just in a programme's espoused philosophy, but also in practical terms, to ensure that these concepts are embedded into the programme content and delivery, both in university teaching and in practice placement teaching.

2. Effective mentor preparation and support

The findings from this study clearly suggest that as mentors are fundamental to the student's practice placement experience, they should be selected, well prepared for, and supported in, their mentorship role. The importance of the mentorship role and the need for adequate preparation and support is comprehensively discussed in the existing literature (Darling 1985, Jinks and Williams 1994, Dunn and Hansford 1997, Gray and Smith 2000, Higgs and Titchen 2001, Duffy 2003, Field 2004, Wigens 2006, Moseley and Davis 2008, NMC 2008, Webb and Shakespeare 2008, Taylor 2009, Luhanga et al 2010, Courtney-Pratt et al 2011, Gidman et al 2011, Robinson et al 2012, Crombie et al 2013, Jokelainen et al 2013, Turnbull et al 2014, Rees et al 2015, Willis 2015, RCN 2016), but this study goes further by suggesting that the selection of mentors, as they are such an influential part of nurse training, should be as rigorous as that for the selection of student nurses. This particular aspect of mentorship is, however, contested in the literature, with some suggesting that

mentorship should be an integral part of every nurse's job (Dunn and Hansford 1997) and this belief challenges the basis of the current NMC (2008) mentorship framework, which asserts that all nurses should be mentors. This study, however, suggests that the selection of mentors would ensure that only those nurses with the appropriate personal attributes and motivation became mentors and that this would also add value to the role.

This study also recommends that the preparation for mentorship needs to include the development of the skills and knowledge required to be emotionally intelligent teachers, facilitators of learning, coaches and reflective mentors (Rassool and Rawaf 2007, Moscaritolo 2009, Hegenbarth et al 2015). Furthermore, mentors need to be supported to develop their personal pedagogy and feel comfortable utilising teaching strategies such as experiential learning, scaffolding, coaching, mentoring, and in being a role model (Murray and Main 2005, Luhanga et al 2010, Houghton et al 2012, Jokelainen 2013, Wilson 2014, Vinales 2015). What is missing from the existing literature, however, has been an in depth exploration of how to prepare mentors for their role, the only exception being Clemow (2007), who suggested skills simulation; this area definitely warrants further research. This study, however, argues more generally, that the use of well designed curricula, based on humanistic and transformative learning strategies, with commensurate teaching and assessment strategies are essential to ensure the development of excellent mentors, as well as registered nurses. Moreover, the findings from this study suggest that all mentorship and nursing curricula should be developed within sympathetic professional and regulatory frameworks and standards; although

this has been mentioned in previous research, the NMC (2008) standards have not been as rigorously critiqued in previous research studies. This study has therefore added to the literature by critiquing the assumptions found within that framework and showing them to be detrimental to nurse training. These assumptions include the uni-professional focus, particularly for assessment, and the mentor being regarded as an expert rather than facilitator, within a didactic teaching philosophy. Similarly, the NMC (2010) standards for pre-registration nurse training have clearly delineated between propositional and practice knowledge and hence what should be taught where, whereas the students in this study clearly disagreed with that analysis.

In addition, the findings from this study indicate that attention also needs to be given to the ongoing support and training that mentors receive. This includes the development of clear career frameworks for mentors and ongoing support from both employers and university to ensure that they feel appreciated and valued. This has been similarly noted in previous research (Pulsford et al 2000, Watson 2000, Bray and Nettleton 2007, Jokelainen et al 2011b, Turnbull et al 2014, Willis 2015, RCN 2016).

3. Development of an effective context for practice placement learning
The findings of this study emphasise the importance of the development of effective practice placement learning environments to ensure that students maximize their learning in the practice placement setting. In the existing literature there is much written about the importance of a positive ward culture to ensure a good learning environment (Pulsford et al 2000, Papp et al 2003,

Allen et al 2008, Moseley and Davis 2008, O'Driscoll 2010, Henderson et al 2011, Jokelainen et al 2011b, Jokelainen et al 2013, Barr et al 2014, O'Mara et al 2014, Turnbull et al 2014, Willis 2015, RCN 2016) and the students in this study similarly observed that a positive ward culture that embraced the importance of learning was very helpful to them as learners. One of the most important aspects of a good learning environment is that students feel that they belong and are seen as a part of the team and the research literature on practice-based learning is replete with evidence that supports this finding (Papp et al 2003, Spouse 2003, Levett-Jones and Lathlean 2007, Del Prato 2013, Gilbert and Brown 2015, Hegenbarth et al 2015, Sandvik et al 2015, Vinales 2015). The students in this study talked at length about the importance of feeling wanted and having a meaningful role to play in their practice placements. The existing evidence coupled with the findings of this research therefore suggests that this is a key requirement of a positive learning environment.

Another important aspect of an effective learning environment identified by the students in this study, is that it is interprofessional. This study, therefore, proposes that the creation of interprofessional communities of practice, situated within learning organisations and located within wider sympathetic professional and regulatory frameworks are essential, if student learning is to be mazimised. Although this has been noted previously in the literature Barr et al 2014, Roberts and Kumar 2015), this is definitely an area that requires further research because it is a concept that is generally considered to be a good thing,

but how to actually implement it, is not well understood (Roberts and Kumar 2015).

In order to guarantee such learning environments, however, a close cognitive and temporal collaboration between practice and university is essential and this has been reported in the existing literature (Andrews and Wallis 1999, Duffy et al 2000, Carnwell et al 2007, Courtney-Pratt et al 2011, Gidman et al 2011, Killam and Heerschap 2012, Congdon et al 2013, Turnbull et al 2014, Foster at al 2015, RCN 2016). This study suggests that one way to minimise the potential university-practice gap is the collaborative development of appropriate practice assessment documents, within the development of a shared educational philosophy between faculty and mentors. The enhancement of the current link lecturer role, as noted by Foster et al (2015) and MacIntosh (2015), would also support the development of a closer relationship.

The findings from this study indicate that in order to ensure a positive learning environment, there has to be strong nursing leadership and good management within the placement setting, which is subject to a rigorous quality assurance framework. The existing research has also noted the importance of these factors, but that they were often lacking (Allen et al 2008, Webb and Shakespeare 2008, Carnwell et al 2009, O'Driscoll 2010, Henderson et al 2011, Kings Fund 2011, Congdon et al 2013, Turnbull et al 2014, RCN 2016).

The results of this study further suggest that the creation of positive learning environments might be enhanced by the use of alternative mentorship

frameworks, which has also been noted in the more recent literature (Grealish and Ranse 2009, Nielsen et al, 2013, Nishioka et al 2014, Branson 2014, Roxburgh 2014, Bazian 2015, RCN 2016). Such new mentorship models must, however, be rigorously evaluated and it must be remembered that, unlike with the current standardized NMC mentorship model, different models might be required for different settings (Bazian 2015).

In conclusion it is clear that in order to enable students to survive and thrive in their practice placement settings it is imperative that there are higher levels of consistency in terms of the quality of the student experience. The findings from this study will, hopefully, inform and influence the current debates surrounding pre-registration nurse education, by building on previous research, adding to it and by suggesting areas required for further research. The most important principle that this research study has highlighted is the need to explore the philosophical assumptions, beliefs and values that underpin all nurse education, ensuring that all stakeholders share a mutually agreed educational philosophy and epistemology and then live it in their day-to-day practice and pedagogies.

6.2 Limitations of the research and future research

This was a small-scale study undertaken in one geographical area of the UK. The students who participated in the study were from one cohort, at one university, who all undertook their placements, apart from one community placement, in the same acute Trust. The study did not explore the experiences' of mentors and it relied on student reporting through interviews and reflective diaries only. The students also knew me as their programme lead, which may have inhibited their responses. Furthermore, all the students were undertaking their training at master's level, which made them a unique cohort at the start of this study. Despite these limitations, however, the findings from this study are commensurate with the findings from previous research.

In the future, more research will, however, be required to evaluate the new emerging models of mentorship and practice-based learning and such research would be best undertaken collaboratively by universities and practice, maybe utilising action research (Carr and Kemmis 1986), or ethnographic methodologies (Spradley 1979). Some of these studies should be longitudinal and large scale, as this type of research is largely absent from the current literature. Such research might provide a worthwhile role for link lecturers, who sometimes struggle to find a meaningful role in the current system (MacIntosh 2015). There is a definite need for a greater understanding of what we mean by and how to achieve interprofessional learning in the practice setting, as Roberts and Kumar (2015) argue this is still a poorly understood concept. Changes are imminent to the current regulatory and professional frameworks and standards

surrounding both pre-registration nurse training and mentorship training and method of delivery. The findings from this research would suggest that before such changes are implemented it would be desirable that these proposed alterations are scrutinized to ensure their philosophical and pedagogical integrity. These changes would then need to be rigorously evaluated in high quality research studies, in order to move away from an overreliance on tradition and expert opinion, political ideology, or economic expediency, as has so often been the case in the development of nurse education (Kelly and McAllister 2013, Turnbull et al 2014).

As I stated at the beginning of this thesis, the current situation in nurse education has brought us to, as W B Yeats would say, a '*gyre*', or a paradigm shift. At times like this, Yeats would argue that '*Things fall apart; the centre cannot hold;*' So at this time of great challenge for nursing and nurse education a fundamental change is required, with the current system being unsustainable. Although maybe this is a slightly daunting prospect, it also offers an exciting opportunity for real and major change in the future. I would argue, however, that whilst the current situation calls for a position of head in the clouds, we must always also have our feet on the ground, or as Dingwall et al (1998:229) suggest

'*Professional ambitions must be reconciled with economic realities*'

It is essential that all student nurses receive the best possible nurse training, to ensure that they become the best nurses they can be, and, subsequently, the

best teachers of the next generation of nurses that they can be. The caring, compassionate, courageous and intelligent individuals, who participated in this study, had all entered nurse training with high hopes for their nursing careers and this study caused me to reflect on how it is essential to ensure that all student nurses are enabled to flourish in the nursing profession; as nurse educators we have a duty of care for these students.

I have spread my dreams under your feet;

Tread softly because you tread on my dreams.

The Cloths of Heaven (W B Yeats)

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