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Transition: an exploration of student nurse experience in their first practice placement.

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ABSTRACT

Nurse education has altered considerably in the past 30 years. The combined demands of a growing population with diverse health needs and an expansion of career opportunities for those traditionally recruited to nursing have made it increasingly difficult to recruit and retain a viable workforce. At the same time pressure to establish nursing as a profession has influenced how the nursing curriculum has been delivered. Schools of nursing are now established in universities and away from clinical control.

However, the retention of student nurses has remained an issue for many universities and studies have identified that students are particularly at risk of leaving around the time of their first practice placement. Whilst underlying factors associated with either the student or the practice environment have been identified which may be predictors for attrition at this time, no studies have given detailed consideration to the way students cope with the process of transition from the academic setting to the practice setting.

This thesis aims to research and understand how first year student nurses manage the transition into their first practice placement and studies this process through the lens of human, social and identity capital theory. Questionnaires were used to collect the initial data from an entire cohort of first year student nurses. These data were then explored in depth via face to face semi-structured interviews with 20 of these students.

The findings show that the transition process is highly complex and stressful for the student. It has been made more difficult by the separation of academic and practice settings. As a result students are expected to adapt rapidly to a strong occupational

culture as they enter the practice setting. In order to do this they rely heavily upon building human, social and identity capital. The students who struggle and falter at this time appear to be those who lack the skills or support they require build capital successfully. These findings have significant implications for nurse educators who must consider how a student's abilities to build and exploit capital can be encouraged within the nursing curriculum.

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CHAPTER 1

INTRODUCTION

International debates surrounding globalization have emphasized the need for a dynamic workforce which is able to compete and adapt if it is to survive (World Bank, 1998; Pettinger, 2002; House of Commons - Innovation, Universities, Science and Skills Committee, 2009). As a result of this discourse the concept of lifelong learning has acquired considerable significance in adult education research as it acknowledges the ability of the individual to continue to learn throughout their lifetime (Field 2000; Rogers 2006). It now forms the core concept of the educational and training policies of the European Commission, as well as providing an underpinning to the work of the Organisation for Economic Co-operation and Development (OECD) (Field, 2000). A number of recent policies have been devoted to equipping individuals with the capital needed to negotiate routes through education and the labour market (Schuller, 2004, Harris *et al*, 2009).

One of the largest sections of the public workforce that has attempted to respond to these policies is nursing, which has faced a number of challenges in maintaining a substantial proficient resource. Perpetual nursing shortages in the past have led to widening of entrance criteria and broadening the recruitment strategies to target areas of the population who had been previously overlooked as sources of the nursing workforce (Buchan, 2007, Harris *et al* 2009).

The resulting curriculum changes, flexible working patterns and large increases in student numbers have become major features of nurse education (HEFCE, 2006). Yet it remains the case that nurse recruitment and retention continue to experience major problems (Mackintosh, 2006). Despite an expansion in student numbers in

recent years, the Department of Health (2006a) has raised concerns about attrition. In particular, disquiet has related to the 'numbers of newly qualified nurses and midwives who either never take up jobs in these professions; or quit very shortly afterwards' (ibid, p6). This situation is also reflected within the registered nursing population. The 1994 report 'Stepping Stones' surveyed 10,000 nurses across the U.K. and found that 11% planned to leave within the next two years whilst 29% said they would leave if they could (Ball and Pike, 2003). When considering those leaving pre-registration education, studies have identified attrition rates varying from 20% (DoH, 2002) to as high as 50% in recent years (Waters, 2006). Particular concerns are now being raised in relation to the high numbers of students leaving in their first year, (Yorke and Langdon, 2008) and most notably after the first 6 months (Park, 2006; Mallik *et al*, 2009).

In studying the reasons why students leave pre-registration education, nurse educators have come to realize that the factors influencing a student's success are wide ranging and complex (Young *et al*, 2006, Yorke and Langdon, 2008). For some time it has been the prevailing view that failure to recruit or maintain a thriving nursing population was due to the competing needs to provide a nursing service whilst at the same time provide a nursing education (Melia, 1987; Taylor *et al,* 2009). As a result a number of inquiries, commissions and reports have been established to consider the complex of problems bound up in the question of nurse recruitment and training and the provision of a hospital nursing service (Lancet 1932; Horder, 1943; RCN, 1964 [Platt Report]; DHSS, 1972 [Briggs Report]; UKCC, 1986; DoH, 2006a; DoH, 2007). Changes in nurse training have gradually occurred and the necessity for student training needs to be separate from hospital needs

have led to the setting up of schools of nursing away from clinical control (Anderson and Kiger, 2007).

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) set out the basis for pre-registration nurse training in its report *A New Preparation for Practice* (UKCC, 1986). Following this report, the focus in British nursing education moved from a traditional apprentice model, with students being part of the workforce, into higher education (Anderson and Kiger, 2007). This plan, known as Project 2000, aimed to produce a 'knowledgeable doer' or a well educated individual able to cope with the growing demands of a rapidly expanding health service. As a result of these changes, current degree and diploma students now rotate from placement to placement as unpaid supernumerary learners. However, since Project 2000 was introduced concerns have been reported about the competence of newly qualified nurses (Carlisle *et al,* 1999; Runciman *et al,* 2002). In order to address these concerns the UKCC reviewed nurse education once again in the Peach Report [*Fitness for Practice*] (1999) and recommended earlier and longer placements, an increased emphasis on clinical skills and the need for education and practice to work more closely together. More recently attempts to provide a more flexible workforce that is able to treat the health needs of the current population have led to the governments of all four UK countries setting a policy blueprint for registered nurses. *Modernising Nursing Careers* (DoH, 2006b) aims to provide an all graduate profession that is able to deal with the complexity of the current nursing role. Therefore nursing now requires recruits that are not only able to negotiate the demands of moving between academic and practice settings but also who are able to study at degree level.

All of these changes have had an impact upon the student experience. In order to explain why many student nurses are leaving the profession we must not only consider the way their programme is designed, but also the environment they encounter in practice. The clinical environment represents an essential element of nurse education (Midgley, 2005). Major studies of the 1980's initiated an emphasis upon the clinical learning environment for student nurses (Orton, 1981; Fretwell, 1982). These studies identified some key attributes of a clinical environment conducive to learning such as the pivotal role of the ward sister in providing an environment conducive to learning. The findings were used to try to improve support for students in practice at the time.

The clinical learning environment of today has changed significantly since the 1980's. In order to offer students a wider variety of practice experiences, the length of clinical placements has been reduced (UKCC, 1986). In addition, the emphasis within the hospital environment has become focused upon highly acute and specialised short term care (Midgley, 2005). It has become commonplace for acutely ill patients to be cared for on general ward areas. State and public expectations of healthcare have also changed. The current focus upon audit and governance has come from a drive to produce a more accountable and responsive health care system.

This has brought a renewed focus upon the needs of students in practice. One particular area of focus is the gap between student experience of theory and their experience of practice (Carr, 2008). When student nurses enter the clinical environment they find themselves within a strong occupational culture. A number of authors have found that this culture can have a profound effect on shaping the attitudes and behaviours of the new workforce (Willis, 1977, Collinson 1992,

Henderson *et al*, 2006). Within nursing, socialisation of an individual into a professional group has been identified as an ongoing process since the 1950's (Mackintosh, 2006). At the same time the profile of the nursing student has changed. Their life experience, expectations and coping strategies have an effect upon how they manage the pressures of a nursing course (Yorke and Langdon, 2008). There are increasing arguments that these new graduates, as part of a younger generational cohort, may experience incongruence between the environment in which they were raised and educated and the professional setting into which they emerge as nurses (McNeese-Smith and Crook, 2003). Indeed authors have asserted that initial expectations of the nursing profession and the influences of these impressions require educators to provide different approaches to practice learning (Ungar, 2007; Widger *et al*, 2007)

To some extent, the experience of student nurses in practice may be viewed alongside Bourdieu's 'theory of practice' (1992) which was developed in order to understand and explain individual and group actions in the social world. Bourdieu recognises that the actions of social groups cannot be explained simply as the aggregate of individual behaviours, but rather as actions that incorporate influences from cultures, traditions and objective structures within the society. These influences are incorporated into his theory through the concepts of 'field', 'capital' and 'habitus'. Indeed, the concept of capital as a range of resources which may help the individual negotiate their way into cultures such as nursing has a particular interest for me.

My own experiences over the past 27 years as student, registered nurse, mentor and university lecturer have greatly influenced my interest in the initial experiences of students as they enter the practice setting. Recollections of entering an acute ward for the first time as a student are surprisingly clear given the time that has

elapsed. Whilst I understood that my expectations did not match my initial experiences I wondered why I was successful, completed and embraced nursing as a career whilst friends and colleagues who had worked equally hard in order to gain a place as a student nurse left disillusioned and chose different career pathways. As a registered nurse I began to recognise and appreciate that students are a diverse group with individual values, and that registered nurses are in a powerful position to support and guide students as mentors and role models. As a lecturer I noted that the period when students were most likely to leave their nursing programme was around the time of their first practice placement. I also felt strongly that it was too easy to accept reasons as 'the wrong career choice' or that it wasn't the 'type of student' we needed, without a more thorough exploration of the issues. Therefore I chose to make a detailed study of the period of student transition into the practice setting for the purpose of identifying why this appears to be a peak time for attrition.

The notion of transition is well documented (Meleis, 1986; Brennan and McSherry, 2006). Meleis (1986) identifies that transition is never a singular event, but rather an individualised process, occurring over time. During this transition, the individual's patterns of behaviour change in relation to abilities, identity, role and relationships. Therefore, in order to examine reasons for the high attrition rates within the first year of undergraduate nursing courses at present, this study will explore the experiences of first year student nurses during their transition from the university to the practice setting. It will identify the coping mechanisms they employ in order to manage their transition and consider the formal and informal support mechanisms they utilise. In order to provide a deeper understanding of the way students engage in this process it will also explore the findings alongside an examination relevant human, social and identity capital theory.

The Aims of the Research and the Research Questions:

The aim of this research is to focus on first year student nurses in order to understand and interpret the understanding, reasoning and techniques they employ to manage their transition into the practice setting. This leads to the following research questions:

(a) How do student nurses perceive the occupational culture of nursing following their first practice placement?

(b) What strategies do student nurses use to manage transition into their first practice placement?

(c) What are the formal and informal support mechanisms utilised by student nurses in order to manage the transition into their first practice placement?

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter will provide a background to the study through an overview of the literature in four main areas. It will consider the major changes that have influenced nursing and nurse education over the past 30 years. It will examine how this has influenced the practice environment that students encounter. It will explore factors relating to the changing profile of the student nurse population and finally consider a number of related theories which might be used to explain some of the difficulties first year students encounter during their transition into the practice setting.

The Changing Face of Nursing

During the 1970s, attempts were made to replace the apprenticeship system of nurse training with an academic education, seen as fundamental if nurses were to have parity with other professions (Dingwall *et al*, 1988) and the *Report of the Committee on Nursing* (1972), under the chairmanship of Lords Briggs, put forward radical proposals. Amongst these was that all entrants should complete a basic course of 18 months' duration leading to a certificate in nursing practice followed by a further eighteen month course leading to registration in a particular branch or midwifery. Although not implemented as proposed, it prepared the ground for a series of changes that have profoundly affected nurse education. This section examines the underlying factors that induced this change and the subsequent influences that have shaped nurse education. It explores the impact of professionalism, managerialism and the struggle to recruit and retain the nursing

workforce. Finally it examines how these factors now influence the experience of student nurses today.

The Move into Higher Education

Prior to 1989, 98% of nurse education took place within schools of nursing and the majority of students were employed by the District Health Authority (RCN, 1985). According to Davies (1985) the education of nurses had been criticised for many years for the variability of course design, course content and the quality of the nurses who qualified. However, inaction had been the result of conflict between the three main interest groups. These comprised the generalists who wanted nursing to remain a highly practical occupation, those who wanted to professionalise nursing and managers who wanted to sustain a flexible workforce.

The early 1970's and 80's saw a concerted push by professional nursing organisations to raise parity issues amongst all health professionals (Deans, 2003). This coincided with broader social issues concerning equal opportunity for women. In addition there was an increasing awareness of the importance of a focus on education as opposed to service and the need for development of evidence based practice through nursing research (McCoppin and Gardner, 1994). The expansion of medical research and specialisation, accompanied by increasing appreciation of the right to quality nursing care, had produced a growing knowledge base required for nursing practice (Russell, 1990).

Amidst a backdrop of wrangling between the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), Royal College of Nursing (RCN) and English National Board (ENB), the UKCC produced a five year plan in 1984. One

objective of this plan was to prepare an educational policy to prepare nurses, midwives and health visitors to meet the needs of society from the 1990's and beyond. Subsequently the UKCC set out the basis for pre-registration training in its report *A New Preparation for Practice* (UKCC, 1986). This proposed a number of reforms to nurse education including the move to one level of training (with the cessation of enrolled nurse training); supernumerary status for nursing students; and an 18 month common foundation programme and links with higher education. The main points of the report were eventually accepted by 1987. Subsequently, the focus of British nurse education moved from a traditional apprentice model, with students being part of the workforce, into higher education. The stated aim was to produce a nurse who was 'a thinking person with analytical skills' (UKCC, p40). No longer regarded as NHS employees, students were not to be included as part of the workforce. It was hypothesized that these changes would;

do much to put [academic] staff in a better position to liaise with their counterparts in the general education sector…and…will help in achieving the higher standards which the professions seek (UKCC,1986, p. 59).

According to Davies *et al* (2000) the aim of the transfer was to provide an opportunity to increase the professional status of nurses and enhance skills, focusing on wider community care. Other predicted potential benefits included a rationalisation of pre- and post-registration education programmes leading to reduced costs, lower wastage rates among student and qualified nurses, and greater productivity from nurses educated under Project 2000 (Deans, 2003). However, the increased emphasis on a solid theory base meant a longer period of training was required to cover the extra academic input and in order to offer students

a wider variety of practice experiences, the length of clinical placements was reduced (UKCC, 1986).

As a result of many of the resultant changes to nurse education, Project 2000 was soon criticised for being overtly academic and lacking in clinical practice, particularly during the common foundation of the first year (Stevenson, 1996). In order to address these concerns the UKCC reviewed nurse education once again. In April 1998 Sir Leonard Peach was commissioned by the UKCC to chair their Commission for Education. The Commission was established to evaluate the results of this new education system for nurses and to make recommendations for change. As Peach was involved in the 1980's in approving Project 2000, he was thought to be an obvious choice when the time came to evaluate the outcome. During the consultation there were calls for a renewed emphasis on clinical practice and a more responsive curriculum. The Peach Report [*Fitness for Practice*] (1999) recommended earlier and longer placements, an increased emphasis on clinical skills and the need to education and practice to work more closely together. The resulting changes mean that the student nurse of today will spend blocks of weeks in university and blocks in the practice setting and the typical first year student can expect to be allocated to between two and six placements in their first year.

Since the Peach Report there have been growing calls for nursing to move to an all graduate profession (RCN, 2002) and in 2008 the NMC ratified proposals to complete this move by 2015. However, there are considerable implications of this development. Mooney (2009) states that around one third of entrants to the profession at present do not have sufficient qualifications to undertake a degree. In addition, the current cohorts of graduate nurses have been accused of a lack of competence when they first qualify (Roberts and Johnson, 2009).

Professionalisation

Professionalisation within a professional group is often equated with development, improvement and progress. It implies development from amateur, everyday and practical knowledge to expert. According to Datwyler (2007, p.7):

professional knowledge should be located in the 'academy', which should also become the site of professional training. This promises the possibility of connecting research and teaching and of linking the human and material resources required for each. This was the ultimate aim of those who sought move towards a professional status for nurses.

The fight to professionalise nursing began over 30 years ago. A small proportion of nurse education had taken place in higher education prior to the 1980's. Nursing degrees had been available in only a limited number of universities since Edinburgh had been validated to deliver a degree in 1960 (Abbott and Meerabeau, 1998). By 1985 there were 22 degrees in nursing based in universities and polytechnics representing about 2% of students (RCN, 1985). The full scale movement of nurse education into higher education has been relatively recent. According to Hart (2004) the body of nursing 'theory' was beginning to grow and the influence of the nursing process was being felt from America through the work of Hildegard Peplau. So for many Project 2000 was seen as a move towards professionalisation as nurse 'training' was replaced by nurse 'education'. According to Bond and Bond (1994) the adoption of the proposals of Project 2000 giving entrants student status introduced a discrete 'body of knowledge'. They maintained that:

the shift of nurse education into the higher education sector, the process of specialization in nursing through both initial and continuing education and the

development of certified specialist practitioners who can act as consultants to other nurses makes nursing more like the professional education of doctors (ibid, p205)

Hart (2004) argues that those who historically sought to advance its cause through enhanced professional status were the proponents of longer hours, low pay, harder work and stricter discipline. The professionalisers' motivation was seen as lying in career progression and in enhancing the status of nursing. However, the 'generalist' nurses argued that nursing was no different to any other occupation. They saw it as;

essentially a practical activity, carried out by many people, qualified and unqualified, skilled and unskilled (Holt,1998 p.149).

For them, status would be achieved through earning good rates of pay and winning better conditions of service through their own efforts and they felt that:

the professionalizers were not just misguided but promoting a philosophy that was detrimental to nurses' best interests (Hart, 2004 p.9).

Many shared Illich's (1977) view that professionalism was a conspiracy to create dependent client groups, depriving them of their right and ability to determine their own welfare. Indeed Mackay (1989) claimed that nursing in the late 1980s was characterised by a strong vocational orientation. Those with a vocational orientation were assumed to have a strong commitment to their work with patients that motivated them to persevere whatever their circumstances. She predicted an imminent exodus from the profession as a consequence of the rise of this alternative professional orientation. This exodus, however, did not occur as she had anticipated.

Although evidence for a move towards professionalisation can be seen through the expansion of nursing research, the move of education into higher education institutions and the move towards a graduate profession, the debate continues as to whether nursing has reached true 'professional' status.

Hart (2004) has examined the debate surrounding nursing as a profession. He argues that some nurses proudly declare themselves as professionals whilst others would argue that nurses do not fulfil the sociologically defined criteria which may be described as:

- possession of a distinctive domain of knowledge and theorising relevant to practice;

- reference to a code of ethics and professional values;

- the ability to exert control over admission to the group via the establishment, monitoring and validation of procedures for education and training;

- the power to discipline and potentially disbar members who infringe the ethical code or whose standards or practice are unacceptable;

- participation in a professional culture sustained by a professional association

(Whittington and Boone, 1989).

Consideration of each criterion confirms that although nursing has moved some way towards achievement in certain aspects, it cannot claim to have fulfilled them all. For example, an examination of any nursing curriculum will reveal major elements of

sociology, psychology, medicine and pharmacology. Nurse educators have consistently struggled to identify a distinctive domain of knowledge. Williamson (1981) argues that a profession's specific knowledge base is the pivotal factor that enables it to meet its primary goal, which is one of service to the public. This service cannot be obtained from someone without that particular knowledge base. This specialised knowledge also impacts heavily on the other criteria particularly concerning the practice of that profession, such as the ability to maintain a certain degree of autonomy. It also establishes codes of ethics by which guidelines are set, to enable their members to make use of the knowledge when providing their professional services. In an attempt to develop a distinctive domain of knowledge nursing research activity has been growing in recent years and has been successful in developing a substantial body of nursing research (Lipsett, 2008).

Managerialism

At approximately the same time as nurse education was the focus of debate and reform, concerns were being raised about the escalating costs of the National Health Service (NHS). As a result the NHS Management Inquiry (Griffiths Report, 1983) proposed introducing general management into the NHS and this was to have a revolutionary effect on what nurses could and could not do. It proposed that nurses should become budget holders. Hart (2004) maintains that although they became budget holders, it was significant that they were not able to dictate how the budgets might be spent. The new management culture meant that suddenly nurses became concerned with prices and cost codes. The expectation of working to a budget increased when the policy initiative *Working for Patients* (1989) was introduced. It was anticipated that the problems of efficiency, variations in service,

inadequate financial control and the lack of competition would be addressed through establishing an internal market in healthcare (Hart, 2004). Consumer choice was seen as one of the cornerstones of the White Paper. However, a lack of information for patients and managers alike meant that decisions were often made upon data with no experience or training (*Ibid*).

Walsh (2006 p.95) describes the 'pervasive, supervisory, performance management culture that has emerged in the public services'. He argues that the past 20 years have seen major changes in both the health service and education which are situated within a 'general transformation of the public sector as a whole' (p96). This has resulted in some part from the policy initiatives of organisations such as the Organisation for Economic Cooperation and Development (OECD) and the World Bank. These changes have included 'marketisation' reforms linked to new forms of financial 'accountability' and measures of 'effectiveness'. In addition, new conceptualisations of the relations between 'service providers' and 'users' have emerged centering on key buzz words such as 'transparency', 'openness' and 'accessibility'. Mohony and Hextall (2000, p.3) identify this spread of marketisation and managerialism as;

the idea of taking managerial approaches developed within the private sector and applying them to public policy.

Walsh argues that the shift in terminology illustrates a similar shift in the way education is conceived to that of assisting autonomous individuals to maintain their contribution to a national economic strategy. All social sectors have also seen an increased focus upon competence and accountability (Boyne, Day and Walker, 2002). The implications of these developments for the nursing student are that

individuals are now often seen as being responsible for their own development and expected initiate opportunities to engage in learning.

Recruitment and Retention

As early as 1988 there were reservations that Project 2000 and the new type of nurse education would not be able to maintain adequate staffing levels (Francis and Humphreys, 1999). Only two months after the publication of the Project 2000 recommendations, a White Paper proposed a new framework for vocational qualifications for Health Care Assistants (HCAs). In addition in 1989 plans were published for the reform of the National Health Service (NHS) in *Working for Patients* (DoH, 1989) which eventually resulted in the commissioning of nurse education by local 'consortia' of NHS Trusts and other stakeholders. Along with the resultant move to increase efficiency of the health services came cuts in student numbers of 26% between 1992 and 1995 (Hart, 2004). The depth of the problem was revealed when Income Data Services surveyed 23 NHS Trusts and found that 78% were experiencing problems, which had more than doubled in three years (IDS, 1998). With many Trusts experiencing a severe shortage of nurses, the Government pledged to increase nurse-training places by an extra 6,000 (DoH, 1999), and set targets to increase the nursing workforce by 20,000 by 2004 (DoH, 2000). Since then a number of recruitment campaigns have been launched to deal with the national shortage of nurses but some trusts still experience continuing problems (West, 2010).

At the same time, those already employed as nurses were expressing dissatisfaction with their role. A UNISON survey, conducted in 1997, claimed that

approximately 67% of nurses at that time wished to leave nursing (Health Service Journal, 1997). A study of RCN membership in the 1990's by Ball and Stock (2000) was slightly less alarming but still indicated a serious problem with the number of nurses expressing the desire to leave ranging from 25% in 1993, to a peak of 38% in 1996. High levels of dissatisfaction were also reported in the 2005 RCN survey which reported that 47% of all respondents, and 48% of those working in the NHS, would leave nursing if they could (Ball and Pike, 2005). Buchan and Seccombe (2005) maintain that factors contributing towards dissatisfaction commonly include poor working conditions, including inadequate pay and support, which can lead to burn out among practitioners, while the poor image of nursing as a career choice in recent years has been said to reduce recruitment. Meanwhile the nursing workforce, like the population as a whole, is ageing and a high proportion is due to retire over the next few years. Buchan and Edwards (2000) claim that, between 1991 and 2000, the number of nurses under the age of 30 halved, and that in 2000 one in five nurses were over the age of 50. This rose to 23% in 2003 (Ball and Pike, 2003).

According to Bacon *et al* (2000), the ongoing challenge to recruitment is due to both demographic changes and competition from alternative sources of employment that many women find more attractive than nursing. Taylor *et al* (2008) support this view and maintain that there is now a shortage of younger people who are able to contribute to the nursing workforce. Along with an increasing choice of careers and educational opportunities for women and school leavers, there is now a smaller pool of potential successful applicants for pre-registration programmes. Similarly Whitehead *et al* (2007) maintain that young people leaving schools and sixth-form colleges have the opportunity to choose a career path from an increasing number of courses in colleges of further and higher education. Nursing studies are now

competing with a range of health-related disciplines such as health studies, psychology and complementary therapy. They explain that:

Compared with nursing studies, many of these courses appear more exciting and appealing to students who are in the process of choosing a career or programme of study. While the increased choice is a positive move for students, it may contribute to the shortage of students currently entering some areas of nursing. Indeed, some specialties in nursing, including mental health and learning disabilities, are so depleted in students that they are reaching a point of crisis (Whitehead *et al*, 2007 p.464).

Over the same period the demand for nurses has increased, partly because, as inpatient stays became shorter, the need for acute care increased, requiring higher staff-to-patient ratios. The clinical environment of today has changed significantly since the 1980's. The emphasis within the hospital environment has become focused upon highly acute and specialised short term care (Midgley, 2005). It has become commonplace for acutely ill patients to be cared for on general ward areas. State and public expectations of healthcare have also changed. The current focus on community care ensures that more nurses are needed in this area, while the UK's ageing population raises the pressure on staff caring for those with long term conditions. In addition the growth of the independent care sector has drawn nurses away from the NHS (Kirk, 2007).

As Jarvis (2005, p.659) explains:

Society is changing rapidly. Nursing practice is also changing rapidly. No practitioner prepared for nursing can now expect to be performing the same job in ten years time.

Indeed within nursing there is a growing acceptance that nurses will leave and re-enter the profession, train later in life and expect access to ongoing educational opportunities throughout their careers. In addition, the concept of lifelong learning has acquired considerable significance in adult education research as it acknowledges the ability of the individual to continue to learn and contribute throughout their lifetime (Field, 2000; Rogers, 2006). For example;

Economic success is increasingly based upon the effective utilization of intangible assets such as knowledge, skills and innovative potential as the key resource for competitive advantage. (ESRC, 2005).

For many, education is seen as the main route to maintaining economic success:

The need for change in education is largely cast in economic terms and particularly in relation to the preparation of a workforce and competition with other countries. Education is described as being a key component of countries' ability to improve or often even to maintain their economic welfare.(Levin, 1998 p.131).

In order to respond to these demands Watson and Thompson (2004) maintain that many universities are now talking a language they barely understood five years ago including such concepts as 'widening the entry gates' in order to make up the numbers. They argue that accreditation of prior learning, or even of experiential learning, has been used to circumvent traditional educational qualifications. For example, since the Peach Report there has been nearly a seven fold increase in the number of nursing cadet schemes (Watson *et al*, 2005). These admit students with lower qualifications than required for pre-registration programmes and offer them an alternative route onto nurse education. Other initiatives have also been successful in

recruiting and retaining mature students on nursing programmes (O'Brien *et al*, 2009).

However, widening the entry gate is not without its problems. Increases in the number of mature student nurses have reduced the amount of time they can spend in professional practice after qualification (Hart, 2004). Indeed initiatives aimed at widening the entry gate to nursing have not been sufficient to maintain adequate recruitment levels within our own borders (Alexis, 2005). The Department of Health has continued to recruit nurses from overseas. In 1998, 600 nurses were recruited from South Africa and in 2000-01, 3396 nurses were taken onto the register from the Philippines (Hart, 2004). In order to promote the notion of diversity and recognising the benefits of a diverse workforce, the Department of Health has developed the Positively Diverse initiative (DoH, 2001).

Against a background of poor recruitment to nursing, with many Trusts experiencing a severe shortage of nurses, the Government pledged to increase nurse training places by an extra 6000 (DoH, 1999), and set targets to increase the nursing workforce by 20,000 by 2004 (DoH, 2000). This was followed by a number of education and training reforms centered on delivering a well educated workforce to meet the needs of the (DoH, 2001; DoH, 2002; DoH, 2004). However, despite an expansion in student numbers in recent years, the Department of Health (2006) has continued to raise concerns about attrition.

In trying to identify reasons why students leave nursing courses Yorke and Langdon (2008) point out that the majority of studies are small, local 'autopsy' studies that remain descriptive. Therefore, in an attempt to summarise predictors of student nurse attrition Mallik *et al* (2009) combined published reports on student nurse

attrition with Yorke and Langdon's (2008) national study and suggest a list of possible contributory factors (see table 2.1).

They found the main contributory factor to be poor choice of programme (wrong career choice); followed by lack of personal commitment to study; teaching quality; lack of contact with academic staff; inadequate academic progress; and problems with finance.

Table 2.1 Predictors/causes of voluntary student nurse attrition suggested by UK studies

Predictor/Cause of Attrition	Studies
Younger students	Pryjmachuk *et al* (2009); Mulholland *et al* (2008); Park (2006); Kevern *et al* (1999)
Male Students	Mulholland *et al* (2008)
Students with degree on entry	Mulholland *et al* (2008)
Students with minimal entry requirements	Pryjmachuk *et al* (2009);Glossop (2002); Kevern *et al* (1999)
Personality/ low self efficacy	McLaughlin *et al* (2007)
Course demands and theory practice tensions	Brodie *et al* (2004); Last and Fulbrook (2003); Young *et al* (2006)
Personal – health and family reasons	Glossop (2002);Trotter and Cove (2005)
Financial reasons	Glossop (2002); Young et al (2006)

(Source: Mallik *et al,* 2009)

However, the weakness of many of these studies are that they took place after students had made the decision to leave. To date, little has been done to explore the process that students go through that leads them to the decision that they have made the 'wrong career choice'.

Timing of Departure

The literature suggests that the highest risk of student nurse attrition is during the first year of their course. In Park's (2006) study covering the years 2000-2005, the average attrition rate fell over the Diploma course from 10.8% in the first year, to 8.2% in the second and 3.6% in the third. Further studies have also highlighted that the first year is a vulnerable time for students in higher education (Tinto, 1993; Yorke and Langdon, 2008).

Interestingly, Tinto (1988) maintains that the reasons for leaving may be different for students leaving at different times of the course, arguing that the forces that shape departure during the early stages of the programme are qualitively different from those in later stages. Indeed Harrison (2004) argues that students who do not fit into their course or the university environment (social integration) leave in the first term; students who struggle to achieve the standards for the course leave in the first year (academic integration); and finally, students who encounter personal, financial or health problems are likely to withdraw at any point in the course.

Yet Mallik *et al* (2009) suggest that there is a further area for consideration in courses such as nursing which lead to a professional qualification. This is the integration of students into the work environment of health care delivery. They argue that the impact of the first clinical experience may be a potential catalyst for either

retention or attrition. In their study of 391 first year students they found that 70% had considered leaving the course. When asked to identify the peak time for this consideration, this was found to be approximately six months into the first year at the end of the first practice placement.

Therefore, closer inspection is required in order to explain this phenomenon. Young *et al* (2006) refer to key themes in the programme when students are making 'transitions' either in coping with their initial expectations and the reality of the programme, adjusting to the academic demands at multiple levels, coping with student centered learning, and also with the experiences of the NHS culture in practice placements.

The move into higher education came as the result of a wealth of factors including dissatisfaction with existing nurse education, the tussle over professionalisation and the pressure to manage costs in a growing health service. Yet this move has come at a time when recruitment levels have struggled to meet the growing demands of an expanding healthcare system dealing with increasingly specialised and technical care. In addition, the occupational choices for those traditionally choosing nursing as a career have increased. A study of student attrition shows that many students who leave cite 'wrong career choice' as a major reason for leaving and studies of the timing of departure have identified that the peak time for leaving a pre-registration nursing programme is around the 6 month point, around the end of the first practice placement. In light of these findings it is therefore important to look more closely at the student experience in practice, with a particular focus on the initial student experience.

Student Experience in Practice

Until the introduction of Project 2000 the vast majority of students had been part of an apprentice system, employed by the District Health Authorities. Indeed, in order to offer students a wider variety of practice experiences, the length of clinical placements had been reduced (UKCC, 1986). Hart (2004) maintains that the move into higher education and reduction in the length of time students spent in practice immediately altered the socialisation process that had previously taken place within the school and workplace that was controlled and modified by senior nurses.

This process of socialisation of an individual into a professional group or culture has been identified as an ongoing process since the 1950's (Mackintosh, 2006). A number of authors have found that this culture can have a profound effect on shaping the attitudes and behaviours of the new workforce (Willis, 1977; Collinson, 1992). Goldenberg and Iwasiw (1993, p.4) describe it as*;*

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

The recognition of the impact of socialisation on the nursing profession and on the pre-registration student nurse, has resulted in the development of a number of explanatory models describing how socialisation may work. Students are socialised into their workplace and learn ways of interacting with patients (Mackintosh, 2006). These observations shape the interactions that they themselves choose to have in the future. According to Rhynas (2004) much of this process is unconscious, as principles and customs of the care setting are transmitted into the mind of the new

nurse. Tusting (2005) explains that socialisation into a common practice involves engaging with other people in the pursuit of some joint enterprise. Where this engagement is sustained over time, the people involved develop a repertoire of ways of engaging in practice, which includes ways of thinking, speaking, discourses, tools, understandings and memories which are to a greater or lesser extent shared amongst members of the community. Shared 'doings' (practices), shared 'understandings' (learning) and shared 'senses of one's own self' and of the other (identities) forge each other within the frames of certain communities or groups that exist because their members have common interests and aims (Wenger,1998 p.47).

Nursing practice has a strong socialising influence and can have both positive and negative results for the student. Olesen and Whittaker (1968) and Wyatt (1978) provide two of the earliest studies which describe how professional socialisation affects pre-registration student nurses, both focusing on the impact of education and the educational system on the individual. Wyatt (1978, p.274) identifies one of the key aims of this educational process as the 'integration of the nurse into a team of a normative nature but not into a change orientated system'.

However, Mackintosh's (2006) interviews with 16 pre-registration nurses indicates that they encountered a loss of idealism about care as they progress through their course. Mackintosh (2006) argues that there is a clash of values within the nursing role. Although a caring ethos is linked to the professional role, the socialisation process directs the student to place importance away from the development of personal and emotionally stressful caring relationships with patients and towards a system of doing work which prioritises physical care at the expense of other elements.

In order to understand how nursing students make meaning of their experiences, Idczak (2007) asked 28 first year nursing students to record responses to six questions in electronic journals. She identified five themes that emerged from the data. The first she described as 'fear in nurse patient interactions'. This included feelings of being nervous, scared afraid, intimidated, frightened, anxious worried or concerned. Examples of an impact on behaviour included being too timid to approach a qualified nurse, too embarrassed to ask a question or rehearsing what they were going to say. A second theme described was 'developing confidence': often this came from successful completion of a nursing skill. The third theme is described as becoming self aware. They did this through reflection on their thoughts and feelings about their interactions. Two more themes related to their developing skill. These were 'connecting with knowledge' and 'connecting with patients' The complexity of learning these new skills is reflected in the work of Kevern and Webb (2004) who discovered that student nurses often referred to their training as a 'game' in which they had to learn the rules of how to survive academic course work and develop their role as a nurse.

When students enter the practice setting they are required to be allocated to a qualified member of nursing staff. These nurses are usually called their 'mentor' (occasionally 'preceptor'). Studies have revealed that nurse mentor behaviours such as compatibility, role modeling and feedback contribute significantly to the promotion of student learning and the ultimate success or failure of the mentorship experience (Coates and Gormley, 1997; Myrick and Yonge, 2002). The evidence suggests that the expertise of the mentor plays a prominent role in student experience. If students are given the message that they must fit in with the practice setting, their ability to question without fear of reprisal is limited. The mentor capacity for role modeling

featured prominently in Bidwell and Brasler's (1989) study. Role modeling is a process in which the individual identifies with and assumes the values and behaviours of another person, which ultimately results in behaviour modification that is usually permanent. The role model is someone who reflects specific skills, and exhibits techniques that an individual lacks, and from whom through exposure to that behaviour the individual can profit or learn (Kemper, 1969). Mentorship is a perfect medium by which students are afforded the opportunity to translate theoretical knowledge into their learning in practice (Myrick, 2002). In nurturing critical thinking, key factors such as 'respect', 'flexibility', 'openness' 'safety' and 'trust' on the part of the mentor were found to impact on whether or not students moved forward in their thinking.

Myrick and Yonge (2004) in their study of the experiences of mentors and nursing students found that as with most interpersonal associations, individuals bring to a relationship contextual attitudes and behaviours derived from their own personal and professional experiences. The student-mentor (or preceptor) relationship is no different. Indeed students identified their own vulnerability as intrinsic to the student role. Students often saw themselves as vulnerable, especially in relation to the assessment of their development as nurses.

Assessment is a generic term for 'a set of processes that measure the outcomes of students learning in terms of knowledge acquired, understanding developed, and skills gained'(QAA, 2000). It is a means of collecting data to demonstrate that an acceptable standard of practice has been reached by a student and on which a decision to declare a practitioner competent can be made. Competence is defined by the NMC (2004) as having the skills and ability to practice safely and effectively without the need for constant supervision. Rowntree (1987, p.50) maintains that

when we assess, we enter into a human encounter whereby we make attempts to know that person; what that person is becoming or has accomplished. He explains further;

assessment in education [occurs] whenever one person, in some kind of interaction, direct or indirect, with another is conscious of obtaining and interpreting information about the knowledge and understanding, or attributes and attitudes of that other person.

Assessors make judgments about students and their progress. Assessment of competence aims to reveal changes in the cognitive, psychomotor and affective domains of learning (Curzon,1990). In other words, healthcare students should have increased their knowledge, acquired or developed their skills and developed professionally in their attitude and performance.

As was noted earlier, the *Peach Report* (UKCC, 1999) was commissioned in 1999, driven by concerns that the Project 2000 curriculum was failing to deliver competent nurses. The review emphasised the need to develop programmes that would produce practitioners who were fit for practice. To achieve this, practical skills were taught earlier on in the programme and pre-registration education was to be focused on outcomes- based, competency principles (Taylor *et al,* 2009). In order to achieve this, continuous assessment in practice was developed.

Continuous assessment is a 'planned series of progressively updated measurements of student achievement and progress' (ENB, 1997). Clifford (1994) states that continuous practical assessment implies that student performance is monitored continuously during day-to-day activities in clinical practice. In practice the mentor allocated to the student often acts as his or her assessor as well.

However, Hand (2006) argues that this dual role is problematic, particularly if there has been a prolonged period of contact between them. For example, Stuart (2003) describes the 'halo affect' where the student arrives at the placement preceded by an excellent reputation and where the assessor is therefore expecting the student to achieve. The opposite of this is the 'horn effect' where the student is immediately viewed as problematic in the light of previous experiences. A further problem may arise with the views and attitudes of the assessor. Objectivity in assessment is crucial but the involvement of two or more people, as in a nursing assessment process, establishes the potential for subjectivity (Wallace, 2003). There may be a clash of personalities or the assessor may dislike some aspects of the student. Stuart (2003) notes that physical appearance (body piercing, tattoos and hair colour), the age and social class of the student or the student's accent can be potential sources of bias. There may also be factors relating to the student that affect the interaction. Physical and emotional factors will prevent students from performing at the best of their ability; they may forget certain details or become clumsier when using equipment because of the pressure of being observed. Some factors, such as physical illness, for example, can seriously affect performance. Laird (2006) notes that studies in the 1980's and 1990's showed repeatedly that simply having someone tagged as one's mentor was not enough to provide equal opportunity. She likens finding a mentor to 'blind dating' (p.237).

Therefore, the socialisation process can have both positive and negative consequences for the professional development of the student nurse. Negative influences include a lack of critical awareness of professional practice; the continuance of ritualised practice; the importance of an assumed set of professional

nursing characteristics, and the loss of idealism (Wilson and Startup, 1991; Andersson, 1993; Day *et al*, 1995).

The complexities of development of the nursing role are reflected through research and theory in nursing practice. Often it is defined and described as both an art and a science. In one sense, the ability to negotiate the complex social structures and symbols may be said to comprise part of the 'art' of nursing. Doane (2004) notes that science is the technical doing of nursing and that nurses should open up to the feeling and the being of nursing.

Idczak (2007) maintains that nursing students intertwine the art and science of nursing in nurse/patient interactions and that nursing education must be restructured to include a balance of the art and science of nursing. While the science of nursing is based on the acquisition of skills and knowledge across the curriculum as well as the theoretical knowledge of nursing (O'Brien, 2001), Paterson and Zderad (1976, p.3) describe nursing as 'an experience lived between human beings'. Equally, Chinn calls the art of nursing 'the art/act of the experience-in-the-moment' (2002, p.24). Given that the socialization of student nurses into this complex role is such an important process a more detailed examination of the clinical learning environment is required.

The Clinical Learning Environment

Three major studies of the early 1980's initiated an emphasis upon the clinical learning environment for student nurses. These studies identified some key attributes of a clinical environment conducive to learning. All were relatively large exploratory studies which reached broadly similar conclusions. Orton (1981) and

Olgier (1982) identified that attitudes within the organisation and particularly that of the ward sister were pivotal to the learning climate. Similarly, Fretwell (1982) found the ward sisters' attitude to student learning was key with highly structured and hierarchical wards being less able to meet the learning needs of students.

However, as was noted earlier, the clinical learning environment of today has changed significantly since the 1980's. In order to offer students a wider variety of practice experiences, the length of clinical placements has been reduced (UKCC, 1986). In addition, the emphasis within the hospital environment has become focused upon highly acute and specialised short term care (Midgley, 2005). It has become commonplace for acutely ill patients to be cared for on general ward areas. State and public expectations of healthcare have also changed. The current focus upon audit and governance has come from a drive to produce a more accountable and responsive health care system.

This has brought a renewed focus upon the needs of students in practice in the academic literature also. Studies have aimed to establish students' perceptions of their learning environment. Dunn and Burnett (1995) sought to develop a reliable scale to effectively evaluate those factors of the clinical learning environment that are functioning well and could be nurtured. The scale was later utilised by Dunn and Hansford (1997) to determine undergraduate student nurses' perceptions of the clinical placements. The major finding of the study was that interpersonal relationships within the clinical care setting could have a considerable impact upon student learning.

More recently, Chan (2001) developed the Clinical Learning Environment Inventory (CLEI) to be used specifically in the practice area to establish student views on their current clinical placement. This tool was later administered to 67 nursing students by

Midgley (2005) who found once again that interpersonal relationships were influential and that students seek respect, support and acknowledgement from their mentors in practice but do not always receive it. Papp *et al* (2003) studied the views of 16 student nurses who were asked to describe the significance of clinical learning experiences as well as good and bad learning experiences. In this study students valued the appreciation and support they received, as well as the quality of mentoring. Thus, for nursing students elements of the socialisation process remain highly important factors in their leaning experience. Expectations by clinical staff have also been seen to affect the student experience. Melia's (1987) study of the experiences of student nurses during their training students revealed nurses to be a divided occupational group whose organisation presented considerable problems for those attempting to gain acceptance into its ranks. Certainly there have been ongoing issues around qualified staff's expectations of student nurses, based on traditional views of old-style ward based training (Last and Fulbrook, 2003). The demands of current curricula mean that students will often spend no more than a few weeks in each of their placement areas. Demands from service providers that qualifying nurses should be equipped to practice in the broad nursing arena and pressure to provide valuable experiences mean that a three year course can often comprise up to 20 of these placements. The prevailing view is that the move of education away from the apprenticeship model has reduced the bond with practice and affected the socialisation process (Roberts and Johnson, 2009).

Academic Demands versus Practice Demands

Along with the renewed focus upon the importance of the socialisation process has come growing evidence that students are finding it difficult to balance the demands

of academia with those of practice. Some studies suggested that the curriculum had become too heavily weighted in favour of academic learning, as opposed to clinical practice (Fulbrook *et al*, 2000). Other studies confirmed that many students often see the amount of academic work as overwhelming (Timmins and Kaliszer, 2002; Clarke and Ruffin, 1992). Last and Fulbrook (2003) found that 75% of students they surveyed believed that attrition was mainly due to academic demands. Students described a constant 'worry' of assignments, which invaded their lives and inhibited learning when on the ward. Similarly Brodie *et al* (2004) maintained that students often found that academic deadlines and increased paperwork in placements produced added stress for them whilst on clinical placements.

And yet within nursing, it has long been recognised that more formal modes of teaching students do not always produce the best outcomes. Bereiter and Scardamalia (1993) argue that students are 'forced to assimilate new knowledge by stuffing their mental filing cabinets with explicit scientific facts'. They maintain that this kind of teaching often produces shallow understandings and may be ultimately unproductive. In order to give some structure to this process, Davis (1975) identifies a six stage process of socialisation known as doctrinal conversion, which follows a student from initial neophyte status to a final internalisation of the norms and values of the profession. However, Davis has been criticised by subsequent authors for failing to recognise the existing values which a student may bring with them at the start of their training (Shuval and Adler, 1980; Nicholson,1984) although critics conclude that the final stages of internalisation offer valuable insights into the culmination of the socialisation process.

The Student

Research suggests a third contributory factor influencing the reasons for this continuing attrition. Problems appear to lie not only with student socialisation into the nursing role, or the difficulties balancing academic and practice demands, but also in the personal qualities of the student that is entering nursing. With the widening of the entry gate the student profile has changed dramatically which is likely to have an impact upon their experience in practice. Myrick and Yonge (2004) in their study of the experiences of mentors and nursing students found that as with most interpersonal associations, individuals bring to a relationship contextual attitudes and behaviours derived from their own personal and professional experiences. A number of other observers have argued that social life in contemporary western societies is becoming increasingly problematic for the individual (Gergen,1991; Giddens, 1991), especially in terms of establishing a stable and viable adult identity based on commitments embedded in a community of others**.** In order to explore first year student attrition it is therefore important to focus upon the qualities of the student themselves. In order to explore student transition into practice it is useful to consider how theories relating to the concept of human capital can contribute to this debate.

Capital Theory

Sociologists and economists have studied various strategies people use in actively investing in themselves. One strategy is represented in the concept of 'human capital' (Becker, 1974). This is the stock of productive skills or talents that an individual possesses. The acquisition of skills may therefore increase an individual's

capital. Human capital theory has had a strong impact on educational policies and is based on the assumption that investment in a skill orientated knowledge generates economic activity. A related notion, cultural capital, grew out of more recent sociological theories of social-class production (Bourdieu and Passeron,1977), and was originally based on the assumption that knowledge of high culture gains access to the upper classes.

However, for some theorists, these terms did not account for the broad social sphere that may influence the success or failure of an individual. For example, Schuller (1996) argues that human capital ignores the broad social context in which human capital may be acquired. Whilst Ashton and Green (1996, p.61) argue that;

the fundamental weakness of the theory…..is that in regarding human capital as a thing to be acquired and utilised alongside other factor inputs, it misses the social context of skill and technology.

Thus, the concept of social capital was subsequently developed to account for how social background, educational experiences, and other 'investments' such as these benefit individuals.

The relationship between social capital and human capital has attracted considerable interest ever since the first publication of James Coleman's seminal paper (Coleman, 1988). Coleman demonstrated that schoolchildren's performance was influenced positively by the existence of close ties between teachers, parents, neighbours and church ministers (Field, 2002). Since then the concept has seen increased popularity. Indeed in the OECD publication *The Well- being of Nations* (2001) it was recognised that the conventional use of human capital alone is an inadequate tool to understanding the development and functioning of knowledge

and skills (Schuller, 2005). Thus the focus upon social capital has emerged with an increased examination of the outcome or *results* of investment in human capital. An exploration of the concept of social capital may therefore help us to understand why investment in human capital in the form of nurse education is not always successful.

Social interaction is central to our day-to-day activities and influences our success in most occupational settings. Theorists have been increasingly concerned with this key social resource that appears to 'oil the wheels of market economy and politics' (Côté, 1996, p.2). As Buitrago (2002, p.1) states:

Human beings are consummately social. When interacting with individuals and groups not met before, people are often very alert to behaviours that tell them of someone's position within a group. These first perceptions help one to map out the network of relationships within a particular setting, so that ultimately one can avoid conflict, find support and identify affinities and openings for fitting in.

He argues that this ability to identify lines of authority is a central part of the initial assessment. In this way we apprehend guidelines for successful interaction, and develop the ability to perceive subtle changes in those guidelines.

However, social capital has its origins well before the Coleman paper. Educator and reformer L. Judson Hanifan used the phrase 'social capital' first in 1916 (Laird, 2006). The term was later used by Loury (1977) to refer to the resources inherent in family relations which are drawn upon in the cognitive development of the child. Later theorists were able to apply the term to broader social situations. Definitions initially tended to focus upon the social benefits of contact with others in the form of institutions, clubs and associations. A structural definition of social capital was mainly derived from the work of Bourdieu (1985) and Coleman (1990), both of whom

define social capital as a range of resources available to individuals thanks to their participation in social networks. More specifically Bourdieu defines it as the;

aggregate of real or potential resources that are associated to the possession of a durable network of more or less institutionalized relations of mutual recognition. (Bourdieu, 1985 p.2)

According to Robert Putnam, social capital is built particularly effectively through civic engagement, which appears to be more or less synonymous with active citizenship. Putnam sees this active citizenship as an important source of social capital because it is the main way in which people - particularly those who are strangers to one another - experience reciprocity through their pursuit of shared objectives. This in turn helps to create a dense web of networks underpinned by shared values and producing high levels of social trust, which in turn foster further cooperation between people (Putnam, 2000).

According to Coleman (1990) two key features characterise social capital: it consists of some aspect of the social structure, and it facilitates certain actions by individuals who are situated within this structure. Therefore, it is the membership of social networks that determine the individual's potential stock of social capital (Sandefur and Laumann, 1998). In an attempt to explain how social capital advantages the individual, Field (2005) maintains that it consists of 'social networks, the reciprocities that arise from them, and the value of these for achieving mutual goals' (Schuller, Baron and Field, 2000 p.1). However, Vasquez (2004) argues that it is not the relation itself that is the source of social capital, but the access this provides to resources such as reciprocity and private information.

In order to explain the advantages of social capital, Rees (2006) explains that individuals' own interests and personal resources can develop best in a society in which individuals co-operate in associations that are tied by definition to the interests of their members. In an attempt to broaden this definition, Grootaert and Bastelaer (2002) define social capital as 'the institutions, relationships, attitudes and values that govern interactions among people and contribute to economic and social development'(.p2).

However, this broad definition distinguishes two forms of social capital. The first, which Uphoff (1999) calls 'structural social capital', refers to relatively objective and externally observable social structures such as networks, associations and groups. This is the form of capital that the majority of theorists have described. The second form, known as 'cognitive social capital', comprises more subjective and intangible elements such as generally accepted attitudes and norms of behaviour, shared values, reciprocity and trust. Indeed Morgan (2000, p.3) defines social capital as the 'interpersonal ties embodied in a social network that can be invested in capital goods in order to lower the production costs of private and public goods'. He argues that norms and information are the two most important types of capital goods in which social capital can be invested, as shared maxims that guide behaviour in recurrent contexts, effective norms maximise social welfare. Information, on the other hand, builds knowledge about productive processes themselves, necessarily lowering costs.

Individuals are able to gain an advantage by building and exploiting their social capital. Field (2005) argues that people can use their social capital to gain access to skills and knowledge in a variety of ways. For example, they use their connections in a very straightforward way to find out how to do new things such as master a work

process, meet regulatory requirements, or tap into a new market. The process can also be more indirect. He argues that in a complex and fast-changing training market, reputations are passed from individual to individual, informing people's choice of provider, and influencing the trust they place in their trainer. At the most general level, the strength of social bonds may shape general attitudes towards innovation and change, as well as determine the capacity of particular groups to survive external shocks or adapt to sudden changes in the external environment. The existence and maintenance of social trust and networks in communities appear to lower the amount of drug use, criminal activity, teenage pregnancies and delinquency, to increase the success of schools and their pupils and to enhance economic development (Fukuyama, 1995; Jencks and Peterson, 1991; Knack and Keefer, 1997)

Taken at face value, the concept of social capital would appear to offer an explanation and indeed a strategy for individuals to increase their 'capital' and therefore their attraction to employers. However, it also leaves us wondering why some individuals are better able to acquire skills than others. Evidence suggests that nursing students encounter considerable difficulties enhancing their social capital within the practice setting (Kevern and Webb, 2004; Melia, 1987). Mackintosh (2006) argues that these and similar studies describe a one way process of socialisation whereby students have to fit into the system or comply with it, in order to gain acceptance (Day *et al,*1995; Manninen,1998). In an attempt to account for these difficulties we must look beyond social capital and towards the individual for an explanation.

Identity Capital

A number of other observers have argued that social life in contemporary western societies is becoming increasingly problematic for the individual (Gergen, 1991; Giddens, 1991), especially in terms of establishing a stable and viable adult identity based on commitments embedded in a community of others. James Côté (1996; 1997) argues that the existing concepts of capital are useful but none comprehensively describes what seems to be necessary for individuals to negotiate 'late-modern' society Côté links these two concepts with his 'identity capital model'. Within it he argues that a high degree of psychological commitment should be associated with more involvement in more structured or normed communities. He argues that a committed person would be more likely to choose to live in a structured community supportive of his or her goals, values, and beliefs, and to maintain a connectedness, integration or rootedness with others, while the uncommitted person would tend to be alienated, loosely rooted, or disconnected from others. He maintains that in what he calls 'pre- modern societies', identities tended to be ascribed by the community, but in modern societies by the individual. In comparison, 'late-modern societies' such as ours appear to be increasingly manipulative, chaotic, and less supportive of stable, long term identities. Instead, a more diversified portfolio that includes psychosocial skills is required for the individual to succeed. The resources and heightened awareness required he calls 'identity capital'.

Côté has developed a framework called the 'culture-identity link'. In it he suggests that the socializing influence of institutions cultures nurture certain personality types. In order to explain identity capital Côté describes his own taxonomy of social identity formation. He argues that identity formation differs in each type of society (Côté,

1996) Thus, identity tends to be 'ascribed' or inherited, in pre-modern societies, 'achieved' or accomplished, in early-modern societies, and 'managed' in later ones. By managed, Côté argues that individuals must fit themselves into a community of strangers by creating the right impressions. He maintains that the need for management of identity formation has come from the lack of guidance that individuals receive. Côté has suggested (1996) that there have been two types of response to these social conditions: passive acceptance and active adaptation. The passive response appears to be widespread and involves simply acquiescing to the identity manipulation that characterises 'contemporary consumer-corporate identity'.

Alternatively, the individual invests in a certain identity (or identities) and engages in a series of exchanges at the level of identity with other actors. In order to do this, Côté argues that the individual requires a range of skills including the ability to self-monitor and adjust behaviours to suit others. Most generally, the term 'identity capital' denotes what individuals invest in who they are. To be a player in these markets, one must first establish a stable sense of self which is bolstered by social and technical skills, effective behavioural repertoires; psychosocial development to more advanced levels; and associations in key and occupational networks.

Identity capital resources can be tangible and often rooted in behavior (speech patterns, personal deportment, and physical attractiveness) or intangible and rooted in personality (self-efficiency, cognitive flexibility, self-monitoring, moral reasoning abilities).

An examination of identity formation and identity capital indicates that one reason for student nurse dissatisfaction with practice may relate to their own identity formation. If students approach practice with a weak sense of their own identity they may take one of two routes. One is simply to drift with the cultural tide and alter image to

reflect social trends. In contrast, the active, agentic response is to develop strategies for dealing with these influences in terms of sustaining some sense of direction and meaning and taking initiative in one's own development. Thus they will either passively accept the prevailing identity of 'nurse' and quickly adopt the culture they enter, or they will strive to take control of their own development. Either route can be stressful for the student. The passive student will encounter a string of practice placements where cultures and traditions differ and will need chameleon-like abilities to blend in with the prevailing practices. The active student will encounter a strong occupational culture in each placement and will need to fight hard to maintain a sense of their own identity.

The Influence of 'Habitus'

As Côté (1997) argues that the attributes associated with identity capital are likely to be context specific; what is effective in one context may not be in another. This brings us to examine Bourdieu's concepts of 'field' and 'habitus' and how they might be interpreted alongside student nurse experience. To some extent, the experience of student nurses in practice may be viewed alongside Bourdieu's 'theory of practice' (1992) which was developed in order to understand and explain individual and group actions in the social world. Bourdieu recognizes that the actions of social groups cannot be explained simply as the aggregate of individual behaviours, but rather as actions that incorporate influences from cultures, traditions and objective structures within the society. These influences are incorporated into his theory through the concepts of 'field', 'capital' and 'habitus'.

Lane (2000) describes the field as a series of structures, institutions, authorities and activities, all of which relate to the people acting within the field. Every person acting within the field is capable of producing effects on it, and competition between people is important in determining the future direction of the field. Within nursing this can be seen as the social and hierarchical relationships within the practice environment. Capital represents the power of a person that can be exchanged or used in order to improve their position within a field. For student nurses, this will involve the power they hold from attributes they bring with them to each placement, and the power they acquire through their experience as a student. Habitus represents the cultural and traditional aspects of life. It is developed by imitation as people unconsciously incorporate behaviors into their lives. Nursing practice presents the student with a range of cultures and traditions that have a powerful influence upon their development.

Habitus is individual. It involves personal values, traditions, cultures and beliefs. However, it is also developed through socialisation and through personal understandings and learning. It influences how nurses, both individually and in an occupational group, understand and interpret their patients' conditions and care needs. The process of conceptualisation may not be explicit but may be a key determinant of nursing practice (Rhynas, 2006).

Within a typical three year degree programme it is not unusual for a student to be allocated 10 or more practice placements. These are likely to range from acute clinical settings such as neonatal units and intensive care to community settings such as care homes and nurseries. Each of these will present the student with a new 'field' (social structures within the practice environment) and a new 'habitus' (nursing culture and traditions) to negotiate. According to Mauss (1934, p.3), habitus

involves 'the totality of learned habits, bodily skills, styles, tastes, and other non-discursive knowledges that might be said to "go without saying" for a specific group'.

Nurses are formed to some extent by the culture in which they develop and various theorists can contribute to an understanding of this process. According to Rhynas (2004), the development of our initial perceptions of a person or event has been described as a dynamic process (Asch, 1946), which selectively categorises the ideas used to understand the encounter (Hollander,1981). The formation of perception is an important stage in conceptualisation; however, other factors are also influential. It is only through interpreting the world that we can interact with it.

The concept of 'communities of practice' was developed by Jean Lave and Etienne Wenger (Lave and Wenger, 1991b). The starting point for the idea of a community of practice is that people typically come together in groupings to carry out activities in everyday life, in the workplace and in education (Barton and Tusting, 2005). It presents a theory of learning which acknowledges networks and groups which are informal and not the same as formal structures. Members intersect with each other in a number of ways, which Wenger refers to as 'mutual engagement'.

As Chouliaraki and Fairclough (2000, p.121) point out, people's positions depend on the access, the lived experiences with the available discourses and the social orders and structures that configure these positions. This 'affects the degree of openness or closure to the practices in which they are involved'. Harris and Shelswell (2005) argue that when individuals feel that by taking part in a collective activity they will gain improved control and better quality of life, they are motivated to positively contribute to the creating expansion of the activity in new directions. Conversely, when collective activity seems to offer a person little possibility of improvement, they will tend to focus on coping with the contradictions between their own and collective

needs, defensively seeking to avoid any lessening of their sense of control (Roth, 2002).

Keating (2005) maintains that in participating in everyday social action, individuals change to meet other individuals' ways of doing things, in a constant negotiation of meanings that implies participating in practice and 'reifying' it (giving form to experience). Symbols play an important part in that interpretation, as they hold certain meaning for the individual and represent specific thoughts and ideas (Blumer, 1969). Symbols contribute to conceptualisation as we interpret them against our specific cultural and experiential backgrounds to form our individual concepts of the world around us. Nursing is one of the many professions where symbols play a part in unifying the members whilst at the same time excluding all others. We use them in our record keeping, in our language, and as a way of maintaining a distance from other medical disciplines (Kaufman and Harald, 1999).

Sociologists have used the term 'socialisation' as the extent to which people are left by their culture to their own devices in terms of meeting their own survival needs, determining directions their lives will take, and making choices along the way. Tusting (2005) explains that practice involves engaging with other people in the pursuit of some joint enterprise. Where this engagement is sustained over time, the people involved develop a repertoire of ways of engaging in practice, which includes ways of thinking, speaking, discourses, tools, understandings and memories which are to a greater or lesser extent shared amongst members of the community.

Shared 'doings' (practices), shared 'understandings' (learning) and shared 'senses of one's own self' and of the other (identities) forge each other within the frames of certain communities or groups that exist because their members have common interests and aims (Wenger,1998 p.47).

Barton and Tusting (2005) maintain that social interaction varies in terms of the degree of fluidity of social relations of power and authority, the types of historical structuring and change, the degree of formal framing or scripting and the degree to which its boundaries are agreed or contested. Indeed, Wenger (1998, p.47) defines practice as 'doing, but not just doing in and of itself. It is doing in a historical and social context that gives structure and meaning to what we do.'

Students and newly qualified nurses are socialised into their workplace and learn ways of interacting with patients. These observations shape the interactions that they themselves choose to have in the future. Much of this process is unconscious, as principles and customs of the care setting are transmitted into the mind of the new nurse (Rhynas, 2004).

Summary

Student nurses today face a number of challenges as they enter nursing practice. Their ability to negotiate these challenges is likely to have an influence on whether they stay the course or leave. A study of educational and sociological perspectives indicates that practice placements may present a social minefield for some students. Theorists suggest that weak familial and societal bonds within contemporary society may leave some floundering in practice, still trying to form their own personal identities. Of those students in this position, they are likely to take either an active or passive response in their identity formation. Either route is likely to be challenging.

In addition, there is clear evidence that students have to deal with a strong occupational culture where they feel they must 'fit in' in order to succeed. This culture involves traditions and symbols that can vary from placement to placement.

Each placement therefore may present the student with a new set of 'rules' to learn. As mentorship and assessment are central to each student's success, they become the focus for the student in this respect. Not surprisingly then there is also evidence that students quickly lose their idealised view of nursing as a caring profession and learn to 'play the game'.

The widening of the entry gate into nursing has resulted in an increased number of 'non-traditional' nursing students entering a setting with an established occupational ethos. This is due in no small part to the fact that the ongoing tension which exists in nursing between curriculum needs and service demands for a large, flexible workforce calls for a particular kind of work organisation and socialisation.

The learner is no longer regarded as the eighteen-year-old fresh from school, but now includes those entering and re-entering education at many different points throughout the life-course. This brings a new dimension to practice, where mature students with a wealth of life experiences are now entering the placement setting and finding challenges of their own. However, it appears that the profession is being slow to accept and adapt to these new recruits.

A detailed study of the first year experience of transition into the practice setting is necessary to provide a clearer understanding of the way students manage the process and why the first practice placement continues to be a peak time for attrition.

CHAPTER 3

METHODOLOGY

This chapter will present the methodology selected to examine the students' experiences of their transition into their first practice placement. This involves discussion of the chosen methods of research, sampling technique, data collection and analysis. Issues of rigour and trustworthiness of the study will be identified and ethical considerations examined.

The aim of this study was to focus on the first year student nurse and to understand and interpret the understanding, reasoning and techniques they employ to manage transition into the practice setting. This kind of people-centred method of enquiry emerges from a qualitative (interpretivist) paradigm. As Denzin and Lincoln (2005, p.22) state:

All research is interpretive; it is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied.

Schwandt (2003) maintains that to find meaning in action it requires us to interpret what that action means. He argues that Interpretivists view human action as meaningful, and attempt to understand the meaning of an actor's actions in an objective manner. Therefore the intention was to explore transition in order to understand the actions of students as they managed the process.

In order to achieve the research aim, an appreciation and selection of the available methods was required. Sanenye and Robinson (2005) argue that any method of enquiry should begin with the question under study. Thus, the methodology should naturally emerge from consideration of the best way to answer the question. There

also needs to be deliberation of how the planned research will work in practice, so each researcher must consider elements of the methodology such as sample size, sample location and data collection tool and decide upon the most appropriate when balanced against available resources such as time, finance and manpower (Polit and Beck, 2006).

According to Manicas (2006), the social sciences can build their approaches following the natural sciences since most natural sciences do not aim at prediction, but description and understanding. He argues that the job of the social sciences is to understand how social mechanisms structure but do not determine the outcomes. Theory in his view, does not aim at explanation, prediction, and control but it;

 'abstracts from the concrete reality of the actors and situations to get at the logic of social processes' (p.102)

And yet empirical studies, largely based on interviews, may generate masses of data suitable for statistical analysis, but in the end lead to few conclusions of any significance for an understanding of society. These methods on their own are relatively unsuccessful because of the infinite ways in which humans behave. Thus Interpretivists tend to favour qualitative rather than quantitative methods (Denzin and Lincoln, 2003c). This is because, on the whole, researchers find that people's words provide greater access to their subjective meaning than do statistical trends. Indeed Murphy and Dingwall (2003, p. 84) point to the flexibility of qualitative research design as an advantage of this methodological approach in that it allows the researcher 'to follow up interesting leads and to open up new dimensions as they arise during the data collection'. However there are good arguments for using both quantitative and qualitative methods in pursuing explanations at the levels of both cause and meaning (Lazar, 2004).

Feyerabend (1975, p.20) claims that the history of science shows that there is no single scientific method. He argues that much can be gained by using a diversity of methods to gain knowledge;

the world we want to explore is an unknown entity. We must, therefore, keep our options open…..Epistemological prescriptions may look splendid when compared with other epistemological prescriptions….but who can guarantee that they are the best way to discover, not just a few isolated 'facts', but also some deep-lying secrets of nature.

Research Method

The arguments surrounding positivist and interpretivist methodology often emphasise differences in quality (Denzin and Lincoln, 2005c). However, an examination of the underpinning theoretical positions reveals that neither is superior. Both methodologies can be used appropriately and successfully depending upon the circumstances as both provide their own contribution to the search for knowledge. Lincoln and Guba (2003 p. 266) argue that there are times when mixed methodologies (strategies) 'make perfectly good sense'. Similarly Howe (1988) believes that quantitative and qualitative methods are compatible and, because of this, investigators could make use of both of them in their research.

One positive effect of this blurring of the boundaries has been the mixing of research methods. Jones and Sumner (2007) see this as having a number of different functions – to enrich or explain, or even contradict, rather than confirm or refute. It may even tell 'different stories' on the same subject because quantitative methods are good for specifying relationships (i.e. describing) and qualitative for explaining

and understanding relationships (Thomas and Johnson, 2002). Hunter and Brewer (2003, p.10) define the multi-method strategy as;

the use of multiple methods with complementary strengths and different weaknesses in relation to a different set of research problems

Whilst Cresswell (2003) offers the following definition:

A mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research (p.212).

Tashakkori and Teddlie (2003) argue that there are three areas where mixed methods are superior to single approach designs: First, mixed methods can answer research questions that the other methodologies cannot; secondly, mixed method research provides better (stronger) inferences; thirdly, mixed methods provide the opportunity for presenting a greater diversity of divergent views.

Research Design

This study contains both quantitative and qualitative methods. For an educationalist interested in revealing not only behaviour, but also the causes of behaviour, a mixed method approach provides both the scope and richness required. Both quantitative and qualitative methodologies have particular strengths. One can complement the other. Quantitative method can produce the breadth of results whilst qualitative data can produce a depth to the findings. Research studies of this type use qualitative and quantitative data collection and analysis techniques in either parallel or

sequential phases. Tashakkori and Teddlie (2003) maintain that when quantitative data precede qualitative data, the intent is to explore with a large sample first to test variables and then to explore in more depth with a few cases during the qualitative phase. In this study the techniques were used in sequential phases as the intention was to explore transition via a questionnaire using a large sample first and then explore emerging themes in more depth with a smaller number of interviews at the qualitative phase.

The quantitative elements comprised of the use of two questionnaires, which were shaped by the literature review. Questionnaires were administered to a full cohort (n=356) of first year students immediately before and immediately after their first practice placement. The qualitative element was in the form of interviews. A sample of 25 students were randomly selected and invited to interview.

Questionnaire Design

Previous research at this time in the student programme has been limited and usually conducted on a small scale. It was therefore necessary in the first instance to find a tool that would facilitate the gathering of a large amount of information from a large sample (n=356). Therefore a questionnaire was chosen for Phase 1. The purpose of the questionnaire was to gather qualitative and quantitative responses that would elicit data about the student nurses' views of their transition into the acute care setting which would then provide information which could be explored in more depth at interview (Verma and Mallick, 1999).

A questionnaire is a self report data collection instrument that is filled out by the research participants (Tashakkori and Teddlie, 2003). It can take a variety of forms

ranging from those that contain purely structured, closed questions that may ask recipients to choose from pre-determined scales or ranks to open ended items where participants responds in their own words. Polit and Beck (2006) note that both open and closed-ended questions have strengths and weaknesses. Closed-ended questions are more difficult to construct than open ended ones but are often easier to administer and analyse. In addition, closed-ended questions are often completed more rapidly by participants than open-ended questions. However, a major drawback of closed ended questions is that by using these alone the research may overlook potentially important responses. Thus, open-ended questions allow for richer and fuller information.

For the purposes of this study a mixed questionnaire was chosen. This involved construction of both closed questions relating to demographic information and open-ended questions asking for information relating to student transition into the practice setting. Tashekkori and Teddlie (2003) maintain that questionnaires can be an important component of inter-method mixing. They can be used to identify emerging themes that can be explored in depth at interview.

For phase 1a ten questions were developed from an initial review of the literature alongside the research aim. These explored student background; preparation for practice; and student expectations of their first practice placement (see Appendix A).

In phase 1b the same students were asked similar questions post placement (see Appendix B). These questions were designed to elicit student reflections of their transition into their first practice placement in areas that explored preparation and experience of transition into the practice placement. Apart from demographic information each of the questions were open ended which allowed students to respond to questions in their own words. The resulting data from questionnaires 1a

and 1b were analysed (see Appendix E) and provided the basis for development of the interview questions.

Interview Design

The decision to talk with student nurses in the form of interviews was based upon the belief that perception, feelings and expectations are expressions of how each individual might react and act upon social phenomena. According to Silverman (2003) the researcher's goal is to make sense of the interviewee's experience. Indeed as Fontana and Frey (2005 p.698) argue:

The focus of interviews is moving to encompass the 'hows' of people's lives (the constructive work involved in producing order in everyday life) as well as the traditional 'whats' (activities in daily life).

So for the purposes of this research interviews were seen to be a useful tool in eliciting information relating to 'how' students managed the transition process into practice as well as describing 'what' they did during this process.

An interview may be defined as 'a conversation between interviewers and interviewees with the purpose of eliciting certain information' (Polit and Hungler, 1991 p.119). Fontana and Frey (2003) state that the individual interview is a valuable method of gaining insight into people's perceptions, understandings and experiences of a given phenomenon and can contribute to in-depth data collection. It was anticipated that interviews would therefore allow the first year student nurses to give their own account of their transition into the practice setting.

Interviews can take a variety of forms and are commonly categorized as 'structured', 'unstructured' or 'semi-structured'.

Structured interviews are commonly used in large scale survey research as they contain a set of standardized questions that can often be administered to large numbers of respondents (Denzin and Lincoln, 2003). Often, the questions will be closed and may give the interviewee a limited number of choices (Newell, 1994). Thus, all respondents are asked to respond to the same set of questions, with the same set of pre-determined answers (Fontana and Frey, 2005). The main advantages of this method are that coding and analysis of the data may be easier than for other forms of interview. However, forcing the respondents to choose from categories provided involves the risk of limiting elaboration of responses or even missing important responses that are relevant to the study. These may be areas that the researcher had not previously considered.

In contrast Rose (1994) maintains that unstructured and semi-structured interviews are useful in qualitative studies as they allow informants to 'tell their own stories' (p.26). Unstructured interviews are commonly held to be those which are unorganized (as opposed to disorganized). During these interviews the researcher does not attempt to influence the range or depth of responses. Polit and Beck (2006) observe that completely unstructured interviews are used when researchers have no preconceived view of the content or flow of information to be gathered. The aim here is to elicit respondent's views without imposing their own. However, Rose (1994, p.24) argues that;

in practice, it can be very difficult to conduct a completely unstructured interview. However open-minded you are about what sort of information you are seeking to

obtain from the informants, you go into the interviews knowing at least what the general research question is that you are posing

Therefore, semi-structured interviews offer a more flexible approach to the interview process and it allows the researcher to focus on issues on the topic area that needs to be covered with some prompts question (Fontana and Frey, 2005). Indeed, semi-structured interviews will often be used to allow the researcher to focus on issues of particular importance to the study, or to probe and clarify responses made by the interviewee (Rose, 1994). For this study semi-structured interviews were chosen to provide structure alongside the flexibility of being able to explore responses in greater depth if required. As the focus for the research was student nurse perceptions of their transition into their first practice placements, individual face-to-face interviews allowed exploration of the issues that had been raised in phase 1 and consider them in more depth.

Initial questions asked for demographic information. The rest of the questions followed the themes identified in the analysis of the questionnaire data. The development of these themes can be followed in Appendices E and F and Table 3.1 (p.74). These questions were open ended. Britten (1995) states that this is to encourage the interviewee to give a broad and detailed account. Interviews enabled the participants to discuss their interpretations of their transition into the practice setting. It also allowed students to express how they regarded the situations they encountered from their own point of view (Cohen *et al,* 2007).

Following an initial analysis of the pre- and post- placement questionnaires, the interview schedule was finalised and 25 students were contacted and invited to be interviewed. 20 students responded.

Each of the interviews followed a formal outline where specific questions were asked (see Appendix G) but the interviews remained conversational. This allowed a degree of freedom for respondents to verbalise their thoughts (Ellis, 2010). Occasionally prompts were given or accounts repeated and checked with the respondent in order to ensure that the meaning was clear (Britten, 1995). Data was collected using a voice recorder as this was felt to be the most efficient way of gathering the respondent's views and opinions (Silverman, 2005). The recorded interviews were transcribed word for word (Morse and Field, 1995).

Reflexivity

Demonstrating the method of data collection and data analysis has a long tradition. Hammersley and Atkinson (1983) showed the importance of this procedure in research methodology. They state that it is an inevitable fact of research that researchers are part of the world they are studying.

Therefore, reflexivity is an important factor in the research process. In qualitative methods of inquiry, the researcher not only collects data but also serves as the 'instrument' through which data are collected. According to Denzin and Lincoln (2005) the researcher is by no means a neutral research instrument; on the contrary, it is the researcher who has to make research decisions time and again; which facts to take into consideration, who he wants to speak to, and which questions to ask. Therefore it was important that steps were taken to ensure that any influence I had on the data collection and analysis process was minimized.

In my case this means I was required to reflect on the question of how my own background and experiences as a nurse had influenced the research (Fontana and

Frey, 2003). My background represents a previous knowledge which made approaching the subject easier on the one hand as I had been a student nurse, staff nurse, sister and nurse educator over a career spanning almost 30 years. I therefore had knowledge of the nursing culture which the students encountered, but this also meant that the study might be susceptible to bias. I had to take measures to lessen any biases that might have been caused by personal values and prejudices that may have developed during this time.

As a senior academic within the organisation I was aware of the potential for students to feel coerced into participation. Freedom from coercion means ensuring that potential participants do not feel under any obligation to take part in the study (Britten, 1995). There was a risk that my position within the School, as well as the fact that I was also an experienced qualified nurse might influence responses and prevent me from seeing taken-for-granted aspects of the student experience that might be noticed by an outside researcher (Anderson *et al*, 1994). However, my role within the organisation meant that I had no contact with first year students. Each time I met students I introduced myself as a lecturer undertaking research as part of an Ed.D. and made every effort to communicate to the students that they were under no obligation to take part in the study.

Rew *et al* (1999) provide a number of areas on which to focus in order to address these potential problems. Four of these are presented and explored in relation to this study below:

Appropriateness – The researcher should be clear about how their professional and researching roles are separated. Although I introduced myself as a lecturer I made it clear that the research was being undertaken as part of an Ed. (D) programme and that responses would be anonymised. If any concerning issues were raised during

the data collection process students were directed to their mentor or personal tutor for further advice. Only on one occasion did I feel I needed to immediately address a concerning issue that a student had raised. A student recalled an event that appeared quite traumatic and that had clearly affected the student. Following the interview I offered to spend some time discussing this event with the student to ensure that she was able to reflect on the event and talk through her actions. She accepted and said she found this useful.

Authenticity – This is the researcher's ability to use one's personal history and awareness to perceive and to respond to another person (Paterson and Zderad, 1998). During both phases of the data collection process I explained why I was interested in the student transition into their first practice placement and assured the students that their responses were valued. As I was a qualified nurse this gave me the additional advantage of being able to share the internalised language and experiences which are essential in establishing rapport (Munhall, 2010).

Credibility – This is established when the researcher's presentation of self is believed by the research participants. I took time to establish rapport with the large groups of students I approached during both phases of data collection. In my introductions to both phases I explained that I was both a qualified nurse and a lecturer. I explained that the ultimate purpose of the research was to improve the educational experience of nursing students.

Reciprocity- The intention of the research should be to understand the meaning of participant's experiences and not exert power over those from who data is collected. My position as an 'insider' (a nurse and a nurse educator) allowed me to interpret the feelings and gain some insights into the views of the respondents. It is possible that as an insider researcher I would be able to offer new angles of vision or depths

of understanding that might be difficult for outsiders to access (Labaree, 2002). This position also meant that I may have been perceived as powerful and exerted an influence over the students taking part. In order to avoid this measures were taken to ensure that students were not coerced into taking part (see p. 62).

Sampling

The aim of the sampling strategy is to ensure the selection of a sample that is representative of the population (Polgar and Thomas, 2007). Griffiths (1998) argues that the complexity of human responses, given different experiences, different cultural backgrounds, ages and gender increases the variables in the research so a large sample is preferable. However, Kemper (1990) argues that in an ideal world, a researcher would have ample access to the entire target population of persons in any area of interest with no thought to cost. For practical purposes, this is rarely the case and the researcher is driven to balance the issues of coverage of the topic of interest with the allocation of finite resources.

Since it was not practical to recruit every first year student nurse nationally for this study, it was necessary to define an accessible population. The accessible population is a subset of the target population that reflects specific characteristics with respect to variables such as age and gender, and who are accessible for study (Hulley and Cummings, 1998). The sample was selected using a purposive technique allowing the researcher to choose a pre-specified group of participants on the basis that those selected could provide the necessary data to contribute to the understanding of the problem or phenomena (Parahoo, 2006). As the aim of the study was to examine the transition of first year students as they entered their first

practice placement it was essential to access a sample at this stage of their nursing programme. The researcher therefore gained access to an entire cohort (n=356) of first year student nurses within a large university in the Midlands. This was a large cohort taking a mixture of students from the local and national population. It was therefore typical of those intakes seen within larger universities. The inclusion criterion was any student in this cohort who attended their first practice placement. During the questionnaire phase of the study students were also asked to supply contact details if they were interested in being interviewed. Following initial review of responses from the questionnaire data, 25 of these students were selected randomly and invited to be interviewed.

Data Collection - Questionnaires

356 questionnaires were distributed to students during the theory week prior to their first practice placement. Students were approached via email to introduce the researcher and the study aims. Organising access to the student cohort was quite complex and involved contacting academic leads for each of the centres and consulting timetables. It also involved gaining permission from individual lecturers so that groups could be accessed at the end of academic sessions. Finally it involved organising data collection across all five university sites immediately before (Phase 1a) and after (Phase 1b) their first placement. The pre-placement questionnaire (Appendix A) was administered to the entire cohort of first year students within a two week period. Similar questionnaires were administered in the first theory week after they returned from practice (Appendix B).

Each cohort group was approached and informed of the aims of the study, invited to participate and departed if they were not interested in taking part. Members of the group distributed and collected questionnaires. Students were asked to fill out a separate form to give contact details if they wished to take part in the interviews.

The entire cohort of students was emailed two weeks before data collection in order to introduce the researcher and research topic and explain that they would be approached prior to their first placement. It was stressed that the students had the right not to take part and could withdraw at any time. For both phases 1a and 1b the students were approached at the end of theory sessions so as not to disrupt academic input. Research aims were restated and information leaflets were distributed (see Appendix C) along with consent forms (see Appendix D). Those students who did not wish to take part either left prior to data collection or did not complete the questionnaires.

Data Collection – Interviews

Interviewees were contacted via the contact details they had supplied in Phase 1 of the study. The interviews were arranged at a convenient time and location for each of the students. The majority took place before or after theory sessions in their local education centre. The interviews normally lasted between 30 and 40 minutes.

At the beginning of each interview the study aims were restated (see Appendix H), and consent gained (see Appendix I). All interviews were recorded following consent from the respondents. Ellis (2010) maintains that any participant in a study has the right to expect that he or she will not be identifiable when the findings of the research are made public. Students were informed that any identifying elements

would be removed from transcripts and that they would be able to withdraw from the study at any time.

Research Constraints

The research was constrained in the following ways:

In order to complete the research requirement for the Doctorate in Education programme the study was planned to take place over a two year period. Therefore I chose research questions which could be answered feasibly within this timescale. Similarly the sample size and locations were chosen to enable data collection and analysis within this period. As no sponsorship funding or financial subsidy was involved my study was limited in terms of the cost that additional time or travel might incur. Similarly, finance also acted as a consideration when choosing data collection instruments.

Data Analysis

One of the most challenging aspects of conducting qualitative research lies in the analysis of the data . This is because the researcher themselves becomes the tool by which data is interpreted and analysed and this brings along with it problems of subjectivity (Priest *et al*, 2002). In an attempt to avoid the pitfalls this can bring, systematic approaches for the analysis of qualitative data have been developed. Of these approaches, content analysis was selected for this study as it provided a systematic method of reduction and analysis which best suited the large amounts of data which emerged from the questionnaires and interviews. According to Weber

(1990) categories can be generated through content analysis from question areas in questionnaires or interviews. The text is then coded into established categories to support generalization of ideas.

Data analysis can be undertaken either manually or by using computer packages. Supporters of computer packages argue that they allow large amounts of data to be interpreted, stored and retrieved thus speeding up the analysis process (Seale and Silverman, 2010; Parahoo, 2006). However critics these packages argue that they promote rigid and inflexible approaches and discourage reflexivity (Murphy and Dingwall, 1998). They maintain that the intended meaning of comments cannot be interpreted by a computer. Therefore manual data analysis was undertaken.

Denzin (1989) uses bracketing to analyse and refine data. He suggests the following steps:

1. Locate within the personal experience, or self-story, key phrases and statements that speak directly to the phenomenon in question.

2. Interpret the meanings of these phrases as an informed reader.

3. Obtain the participants interpretation of these findings, if possible.

4. Inspect these meanings for what they reveal about the essential, recurring features of the phenomenon being studied.

5. Offer a tentative statement or definition of the phenomenon in terms of the essential recurring features identified in Step 4.

For phase 1 of the data collection process this form of analysis was followed in order to identify phenomena or initial 'themes'(see Appendices C and D) which were then used to develop the interview questions in Phase 2 of the study (see table 3.1).

Table 3.1   How quantitative data fed into qualitative question design

Theme identified by the literature Review	Quantitative Data informing question design	Interview Question
Perception		
Expectation of Nursing Culture	Demographic Information Codes 1/1a - 1/1h Codes 1/2a – 1/2f Codes 1/3a - 1/3k Codes 1/4a – 1/4i Codes 1/5a – 1/5h Codes 1/6a – 1/6d	What did you expect your first placement to be like?
Perception of Nursing Culture	All data	Was it what you expected?
	Codes 2/4a – 2/4g Codes 2/5a – 2/5d Codes 2/6a – 2/6g	What was the nursing culture like on your placement? (hierarchy of staff/nursing language/ways of behaving/uniform/your time with the patients/values)
	Codes 2/3a – 2/3g	a. What did you enjoy?
	Codes 2/4a – 2/4g	b. What did you dislike?
Transition		
Preparation	Codes1/7a – 1/7h Codes 2/4a – 2/4g Codes 2/8a – 2/8f	How did you prepare for your first placement?
Managing the transition process	All phase 2 data	What do you remember about your first day on placement?
Theory/practice interface	Codes 1/7a – 1/7h Codes 1/8a – 1/8g Codes 2/8a – 2/8f Codes 2/9a – 2/9e	What helped you manage the transition from school to practice? (before you started/once you were there)
Reflection	Codes 1/6a – 1/6d Codes 2/7a – 2/7d	What were the main differences between learning in the school and learning in practice?
	All data	If you were able to prepare for your first placement again, is there anything you would do differently?
	All data	What advice would you give a new first year about to start their first placement?
	All data	Do you have anything else to add?

For each of the Phase 1 questionnaires, the focus of each question was used as a master code and responses were interpreted and categorised into second level codes. These can be found in Appendices E and F. The emerging themes were then used to develop the Phase 2 interview questions (Appendix G).

During the interview phase of data collection a voice recorder was used to collect and store the data initially. In order to become familiar with the data the recordings of the interviews were listened to, transcribed, read and re-read. Burns and Grove (2007) maintain that during this process the researcher should be able to select, focus and simplify the data. During data reduction, essential features and recurring themes were identified. Initial common themes and ideas were noted and sections of the data were coded accordingly. Following data reduction, constructs were formulated through a process of interpretation based on the concepts initially identified and explored in the literature review (Chapter 2).

Braun and Clarke (2006) identify a theme as something that captures something important about the data in relation to the research question. In order to ensure reliability coding decisions were confirmed by revisiting previously coded data to check the stability over time (Roberts,1999). If several pieces of text, either from one or a number of texts pertained to the same concept they would be copied and pasted into the appropriate sub code. Eventually the sub codes were organized into six main themes (see Table 4.5, p.82). If several respondents used similar words, manifest content was possible otherwise interpretation of meaning was made through latent content analysis (Braun and Clarke, 2006). My position as a qualified nurse enabled me to interpret and categorise responses that a researcher unfamiliar with nursing language and technical terms might have found difficult.

Ethics

Cohen, Manion and Morrison (2007, p1) argue that '*each stage of the research process may be a potential source of ethical problems'.* Bogden and Bilken (1998, p.65) highlight the two concerns in research ethics; subjects consent and the protection of subjects from harm. They argue that research subjects should:

enter research projects voluntarily, understanding the nature of the study and the dangers and obligations that are involved. Subjects are not exposed to risks that are greater than the gains they might derive

They provide the following general principles related to ethics in qualitative research;

- unless otherwise agreed to, the subject's identities should be protected so the information you collect does not embarrass or in other ways harm them.

- Treat subjects with respect and seek their cooperation in the research

- In negotiating permission to do a study, you should make it clear to those with whom you negotiate what the terms of the agreement are, and you should abide by that contract

- Tell the truth when you write up your report findings

In order to conduct the research according to these principles students were fully informed about the research. As was noted above, both written and verbal information was given to all participants at each stage of data collection. Students were informed that they could withdraw from the research at any stage. Participation was voluntary and students were asked informed signed consent at each phase of the process.

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Although student nurses are not a vulnerable group there may be individuals within the cohort who may be vulnerable subjects. Therefore a protocol was developed and followed should any student demonstrate discomfort discussing their experiences. Ethics approval was given by both the Faculty of Medicine and Heath Sciences Ethical Committee and also the School of Education Ethical Committee.

All data was confidential to the researcher. Completed questionnaires bore no identifying marks. Anonymity in reporting was also assured with any direct quoted material coded.

CHAPTER 4

RESEARCH FINDINGS

This chapter presents the findings of phases 1 and 2 of the data collection. It begins with an exploration of the pre- and post-placement questionnaires and then continues with presentation and analysis of the interview data. The interview responses have been organised to explore the themes identified in Phase 1. Arguments and analysis are presented alongside selected responses to questioning in order to illustrate the themes derived from data analysis (Woods and Roberts, 2000).

Phase 1 Pre- and post-placement questionnaires

Questionnaires were distributed to students immediately before and immediately after their first practice placement. The response rates in both phases can be found in tables 4.1 and 4.2

Table 4.1 Phase 1a Response Rate

	Centre 1	Centre 2	Centre 3	Centre 4	Centre 5	Total
Population	47	52	55	59	143	356
Responses	46	47	47	51	121	312
Percentage						88%

Table 4.2 Phase 1b Response Rate

	Centre 1	Centre 2	Centre 3	Centre 4	Centre 5	Total
Population	47	52	55	59	143	356
Responses	38	46	44	54	108	290
Percentage						81%

Demographic details

312 students returned questionnaires in Phase 1a: an 88% return rate.
Demographic details provided in Table 4.3 show that female students far outweigh
male students in this intake. The national ratio of female to male nursing students
currently stands at 9:1 (Radcliffe, 2008). This study reflects these figures with a
similar ratio.

Table 4.3   Demographic Information

	Centre 1	Centre 2	Centre 3	Centre 4	Centre 5	Total
Male	5	4	5	6	15	35 (11%)
Female	41	43	42	45	106	277 (89%)
HC worker previously? Yes	17	16	19	23	49	124 (40%)
No	29	31	28	28	72	188 (60%)

Students were asked whether they had ever worked in health care before as it was
felt that this may have an impact upon their transition into their first practice
placement. 40% of students identified that they had worked in healthcare previously.
The majority had worked as Health Care Assistants (HCAs) but there were others
who had worked other health care related roles such as paramedics, phlebotomists
and dental nurses. 60% of the students stated that they had no previous health care
experience. Current policy is encouraging the increased recruitment of HCA's into
nurse education (DoH, 2000).

With the widening of the entry gate the student profile has changed dramatically which is likely to have an impact upon their experience in practice. The students ranged in age from 17 to 52 years. Figure 4.1 shows the age distribution of the students in this intake.

Figure 4. 1   Age Distribution of Students in Phase 1
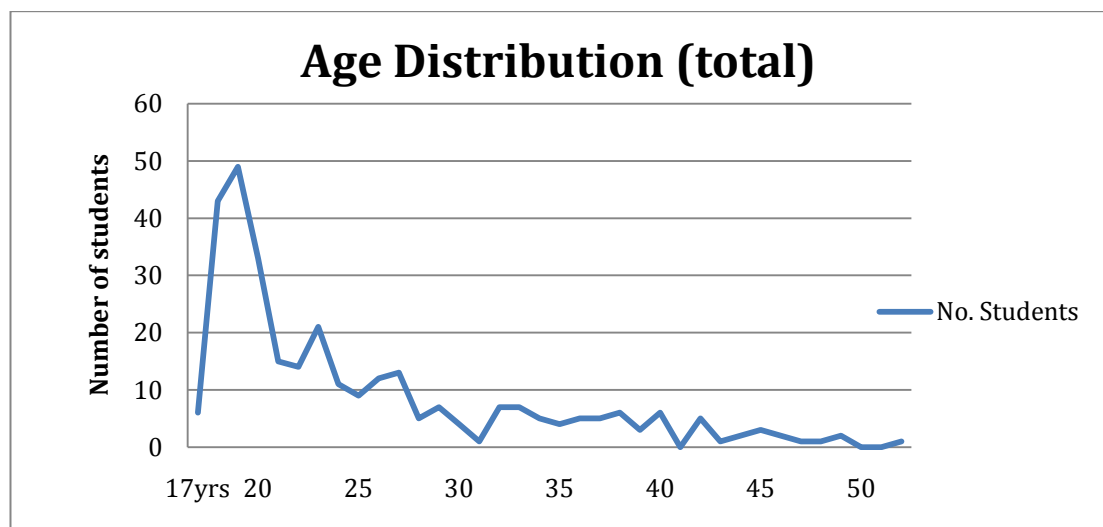
Although the largest group of students can be found between the ages of 17 and 21 years, it is also clear that the intake has a large number of mature students (over 26 years). 62 (20%) of the students were found to be over the age of 26 years.

These findings reflect the growing acceptance that nurses will leave and re-enter the profession, train later in life and expect access to ongoing educational opportunities throughout their careers.

Phase 2 Results of the Interviews

25 students were invited to interview. 20 students attended. Student profiles can be found in Table 4.4.

Table 4.4   Interviewee profiles

Student	Healthcare experience	Age	Gender	Student	Healthcare experience	Age	Gender
1	None	29	Female	11	HCA	38	Female
2	None	20	Female	12	HCA	32	Female
3	HCA	28	Female	13	None	21	Female
4	None	19	Male	14	None	18	Female
5	HCA	34	Female	15	None	19	Female
6	None	21	Female	16	None	19	Female
7	HCA	26	Female	17	HCA	33	Female
8	None	18	Female	18	None	18	Female
9	Phlebotomist	27	Female	19	HCA	23	Female
10	Home carer	30	Female	20	HCA	33	Female

19 females and one male attended for interview. The interviewees ranged in ages from 18 to 38 years. 10 of the students had worked in healthcare previously and 10 had no health care experience.

Table 4.5 The main themes to emerge from analysis of the interview dataInitial themes	Sub code	Main themes	Code	Definition
Ward contact	Wc	**Prep for Practice**	PP	Activities students engaged in before they went on placement to prepare for practice.
Research	R			
School Based Prep.	Sb			
Colleagues	C			
Fear	F	**First Impressions**	FI	Student reflections of how they felt during their first few days on placement.
Uncertainty	U			
'Spare part'	Sp			
Isolation	I			
Organisation	O	**Nursing Culture**	NC	The main aspects of the nursing culture that the students said they encountered.
Language	L			
Unpleasant sights	Us			
Shifts	S			
Paperwork	P			
Mentors	M	**Student Support**	SS	The main sources of help and support on placement.
Other staff	Os			
Family	F			
Tutors	T			
Fitting in	Fi	**Engagement**	E	The techniques students would use to gain support from staff.
Initiative	In			
Latching on	Lo			
Nursing role	Nr	**Measuring Success**	MS	The ways students would measure the success of their transition into the practice setting.
Theory/practice link	Tp			
Mentor feedback	Mf			

Analysis of the interviews provided a wealth of data that was subjected to content analysis and organized into six main themes. The themes and their definitions are given below:

- Preparation for practice – This comprised activities students engaged in before they went on placement to prepare for practice.

- First impressions – This theme comprised described student reflections of how they felt during their first few days on placement.

- Nursing culture – This theme describes the main aspects of the nursing culture that the students said they encountered.

- Student support – The main sources of help and support on placement.

- Engagement – This theme comprised the techniques students would use to gain support from staff.

- Measuring success – This illustrates the ways the students measured the success of their transition into the practice setting.

Preparation for the Placement

Students were asked to explain how they had prepared for their first practice placement. The interviewees related a range of activities utilised to aid preparation. These included visits to the placement area; researching the ward and its specialties; accessing school information; making use of the school preparation for practice sessions and talking to the friends and colleagues. In their answers students reflected upon the success of their preparation.

a) Ward Contact

All of the students who were interviewed had been placed in acute care settings. Mallik *et al* (2009) found that early integration of students into the ward environment

was an important factor in reducing student attrition. All but one of the interviewees reported that they had made some form of preparation for their first practice placement. A majority (15) had contacted or visited their ward. First impressions of the placement and staff appeared to have a lasting effect on the students:

I contacted the ward, I went up in person three times and they kept saying "come back". I met the ward secretary and I soon as I met her I just thought I like this place. I got a really nice feel for the ward. All the staff were really nice. (4)

All of the students expressed some form of anxiety about visiting their placement for the first time. Many students expressed the need to see where they were going as a way to reduce their fears. They stated that the contact reduced the level of stress they were feeling about their placement. One student explained:

They suggested coming in but it was quite busy at the time cos there was staff shortages. That didn't give me much confidence. I had a quick look around. It was only a small ward so it wasn't too bad. It was a really nice ward, it was a new hospital so everything looked clean and tidy. Although they were short staffed it looked organised and so it sort of helped me calm my nerves. (5)

Price (2008) found that nursing socialisation is strongly associated with a person's preconceived notions and expectations of nursing. They noted that early experiences, such as interactions with nurses and healthcare settings, strongly influence an individuals' view of nursing.

Several learners linked the visit with the ability to meet their mentors and other ward staff:

I went in before I started as well. I went in and got a brief introduction to understand what they do there and it prepared me for…. the placement. I think it was in the first week that I met my mentor though I met the sister, she was very helpful and took me round (13)

Another student stated:

I did go, but they just showed me around quickly. It was my mentor that showed me around but at the time I didn't know it was going to be her. It wasn't the kind of ward that I expected 'cos I'd seen other wards but this one was set out differently with two bed bays and side rooms (14)

Some students found it useful to visit in order to run through the travel and logistics of getting to their placement. Two students explained:

I went there - I actually walked down to where I was going so I knew where I was going (2)

I rang the ward and visited the ward and sort of familiarised myself rather than just going in cold (9)

   b) Research

Nine of the students stated that they had explored elements of the placement and speciality that the area nursed. For most, it was important to know more about the medical and surgical conditions they were about to encounter. Again, many felt that the research would help them to settle more quickly. A number of studies have indicated that student nurses feel vulnerable in practice (Massarweh, 1999; Campbell *et al*, 1994). The students in this study used research as a way of feeling prepared. One student stated that:

For me, once I found out where I was on my placement I did loads of research on burns, read around on burns. (2)

Another student said:

I got a journal out of the library on colorectal care and the kind of surgical procedures that take place on that ward and I photocopied it all and I just kept reading through that. (4)

Other students accessed ward based information. One student explained:

I read up about the placement and when it said what it specialised in I looked up those things in a bit more depth and I just kind of familiarised myself with what I thought I'd be doing and made sure that I knew what to expect. And also when I got to placement, if there were any illnesses I came across that I was unsure of then I'd make sure that I'd note them down and research them. (17)

It was clear that research was an important tool to help students feel more knowledgeable. As one student explained:

I knew it was a fracture clinic so I looked into bones because I had this morbid fear of looking stupid in front of everybody. (8)

   c)   School based preparation

Seven of the students had accessed information about the placement on the school of nursing website. This gave them information about the placement, address, contact numbers, uniform and travel details. Two students explained:

I looked on the school website to find out about the ward it said it was a medical ward, how many beds they have and what sort of things the children go in for. (16)

I looked on the school website and got a bit of information about the placement, like the kinds of children it took and who to contact. (18)

However, a number found the information limited for their needs:

I had a quick read of the school website but it doesn't really give you a feel. (6)

I did a bit of research on the place through web CT but there isn't a lot you can research 'cos they don't really publicise much about mental health. (1)

Four of the students mentioned sessions they had attended in their school of nursing which were aimed at giving an introduction to the first practice placement. Young *et al* (2006) recommend an induction programme focused on students immediate needs with a continuous output of information targeted at key transition times in the first year. One student said:

We had sessions at Uni. Basic things like how to make beds and things like that, just to get a bit of practice before we went. (16)

However, other students commented upon the limitations of these sessions. As one explained:

The Friday before we started placement we had a preparation for non branch placement, cos people were going to different kinds of things, some people were going to wards, some people were going on units – it was more of a general introduction rather than the specifics of where you were going so I didn't feel there was a lot of preparation for what to expect from the unit. (1)

Mallik *et al* (2009) in their study of first year student nurses found that the first practice placements could be either perceived as positive or negative and much depended on the quality of the support systems available.

d) Colleagues

Four students mentioned that they had spoken to colleagues in order to explore what their placement might be like. Day *et al* (2005) had found that most impressions of nurses had been formed through knowing other nurses, having experience with nurses in a health care setting, or just through representations of nurses in the media.

Some found it useful:

I know some people who had been on wards and units and was asking them questions about what happens, what do you do and what's the daily kind of set up so I had kind of a vague idea of what to expect. (1)

Whilst others noted that asking the views of others might not always be the best way to obtain information:

You sort of talk to people and get their view but everyone's subjective and because they say one thing is it really going to be like that? A lot of people will quite cheerfully tell you the worst. (15)

Studies by Beck (2000) and Gregg and Magilvy (2001) also found that participants mentioned knowing others who were nurses and using them as sources of information.

Interestingly, one student who had worked previously as a care worker reported that they had made no preparation for their placement:

I didn't really do anything to prepare for it, I just tried to remember what we were told in lessons and I was kind of hoping that my mentor would guide me. I'd had previous

care work of personal hygiene and things like that so I kind of knew about that side.
(5)

First Impressions

In exploring student transition into their first practice placement the students were asked to reflect upon their first day. A large proportion (16) of the students responded with clear recollections of how difficult they found this initial point of their experience.

Three of the students mentioned feeling fearful. One of these noted:

I remember being scared. I was absolutely petrified on my first day 'cos I'd never been on a ward in that situation before. I was quite scared about knowing where things were and if like something happened and they asked me to get something would I know where it was. (10)

Another recounted how this affected her behaviour:

I was scared. I didn't want to do anything wrong. Everything that you do you're just double checking it all the time. (14).

These findings reflect the results of Idczak (2007) who asked 28 first year nursing students to record responses to six questions in electronic journals. She described feelings of being nervous, scared afraid, intimidated, frightened, anxious worried or concerned. Examples of an impact on behaviour included being too timid to approach a qualified nurse, too embarrassed to ask a question or rehearsing what they were going to say. This study showed similar effects on behaviour. Three of the

students recounted the uncertainty that they felt about their new nursing student role. One explained that:

After handover everybody got up and went out and me and the other students thought 'should we follow'? and we kind of followed and I stood there like a right numpty. In the end I asked them 'what should I be doing?' She went 'Oh' and it kind of clicked it's the students first day. We were all quite young as well.(6)

Another recalled trying to find the courage to speak:

I just remember sitting in the staff room and all these like nurses and auxiliary nurses bustling about and getting their coffees and talking about whatever happened at the weekend and I'm just sitting there thinking 'God, help please you just got to find your voice, you got to say 'I'm here, does anybody know who my mentor is'?' (8)

This student remembered feeling so uncomfortable that she hoped no one would notice her:

I didn't really draw attention to myself, I just stood with my little polystyrene cup in the corner thinking 'please don't notice me'. (8)

Many of the students recalled how strange their new environment felt:

I felt a bit like a fish out of water. I was unsure of what would be expected of me, whether or not I should have done more research or whether I'd done too much. I didn't want to appear to be cocky because I'd know about research a bit but then I didn't want to appear that I wasn't interested. I wanted to get that sort of balance. (11)

Another student used the same analogy to explain how she felt:

I felt a bit like a fish out of water really. I got there really early 'cos I was worried about being late. I introduced myself and we went into report. They said a lot of things I didn't understand in report.(18)

Buitrago (2002) argue that first impressions help individuals to map out the network of relationships within a particular setting, so that they can avoid conflict, find support and identify affinities and openings for fitting in. One student's comments reflected those of others in how deskilled a number of the students felt:

I don't know, it's like starting a new school or a new job and you know, you're completely the rookie. You've got no clue 'cos the minute you walk through the door everything you know or prepare for is gone. (8)

Whilst another who had previously worked as a transport manager expressed how hard it was to take a more limited role than she had been used to:

It was mmm..I felt like a spare part cos I'm like in my old job as a transport manager I'm used to getting on and doing what I have to do and you get your orientation and that bits fine as you're involved in your own orientation but then you're kind of floating about and sitting with patients and you kind of think 'do I say this'? or 'do I say that'? (1)

Last and Fulbrook (2003) found that students in their study felt undervalued by nursing staff. They described mentors as not having time for them and placements not being prepared for them.

Interviewees noted how difficult it was to feel unsure about what they were supposed to do. As one student explained:

It was a culture shock. I felt a bit useless. On your first placement there's not a lot you can do really. I just felt kind of in the way rather than actually helping and being a part of something. I wasn't confident in doing the paperwork, working with the doctors, the social workers and the families. I was kind of on the edge looking in, feeling a bit surplus. (12)

Many expressed the need to want to be useful when they could see how busy the qualified staff were:

It was nerve wracking at first, not knowing anyone or knowing what you were meant to do. The thing is when you don't know what you're doing you're kind of hanging around looking like an odd piece of furniture. That's the worst thing. So when someone say's 'you'll be doing this' that's really helpful... there was a lot you couldn't do as a student so when it was busy I felt a bit of a spare part at times. I spent a lot of time watching but trying not to get in the way. (17)

The evidence suggests that the initial experience of practice learning can be stressful (Brodie *et al,* 2004). In this study students also noted how isolated they felt. They felt the separation from school and their friends quite keenly at this time:

it was like being left out at sea on your own, I felt isolated. Just things like – we've got the handover now and it's like, they're all friendly but you don't know anybody and it's your first day .....you feel like you're out on a limb a bit 'cos there's no contact with the school really while you're out there. (1)

Sharif and Masoumi (2005) noted that nursing students often reported anxiety about moving into the clinical area and were often unsure how they should behave in practice.

Another recalled the difference between being in practice and being in school:

You're not sitting in a lecture with all your friends, you're not helping each other get through, you're on your own and you have to get on with it on your own .(12)

Interestingly some of the students who had worked as care assistants previously found the transition into their first practice placement easier. As one student explained:

Because I'd had a bit of a background in care anyway I didn't find it hard. I think it is an advantageous part of having a care background. I'd only been caring for about a year before I'd started this course but I think it does prepare you a bit you know just of what you can come across – the smells and the work involved. (3)

Another experienced care worker acknowledged the difference between herself and the students who had less experience:

It wasn't that difficult for me, because I feel like it helped me having the experience beforehand of doing the care work, but I think for somebody who hasn't got that it might be quite difficult, especially for younger people – helping people with personal care they might feel a bit embarrassed.(7)

Nursing Culture

Throughout the course of the interviews, the students commented upon many aspects of the nursing culture. It was clear that this had a great impact upon them. A number of authors have found that this culture can have a profound effect on shaping the attitudes and behaviours of the new workforce (Willis 1977, Collinson

1992). Students reflected upon areas relating to organisation, medical language, clinical practice, shift work and being assessed. One student explained:

It was a very close knit community, everyone worked together and they worked really well. Like it had a 'bitchy' side but everyone did all they could to help me fit in and make me feel like staff really. (20)

Three students remarked upon nursing as a new role and noted the uncertainty about routines on each placement:

I think it's the same anywhere, it's like starting a new job isn't it? Different routines, it's somebody else's culture and it's always very, very difficult. People can be very welcoming and kind but you're kind of 'Ooo.. Can I take my break now'? or am I allowed to do this?, can I say this? You know and it's kind of adapting to everybody else. It's like changing jobs three times a year. (1)

Shen and Spouse (2007) similarly found that the organisation of ward routines could have a significant effect upon the students, and that many found it daunting to understand and adapt to new practices. A second student remarked upon the differences between expectations of behaviour and realising she needed to learn new ways of acting:

The seriousness, the responsibility. Even though you have to act in a certain way as a student in Uni all the time it's more relaxed whereas when you're on the ward you know you have to act professional. (4)

Rhynas (2004) found that students are socialised into their workplace and learn ways of interacting with patients. These observations shape the interactions that they themselves choose to have in the future. Much of this process is unconscious,

as principles and customs of the care setting are transmitted into the mind of the new nurse . This finding also reflects that of Kevern and Webb (2004) who discovered that student nurses often referred to the set of rules they had to learn which would show them how to survive academic course work and develop their role as a nurse.

However, along with the new role the students noted some difficulty in coming to terms with certain elements of their task. Six students mentioned the vast array of medical and nursing terms used in practice, and their difficulties grasping this new language:

They were speaking to their medical students so that part was a little bit overwhelming. It was the medical terms they were using I didn't understand. They went really, really quickly. I thought it was quite intimidating. (4)

This point was echoed by a second student who said:

Handover was quite nerve wracking, hearing all these long phrases that you've never heard before and you think' Oh my God what does that mean'? My mentor said not to worry about the words, she gave me a clip board and a piece of paper. So I did write a few things down. (7)

Blumer (1969) argues that symbols play an important part in that interpretation, as they hold certain meaning for the individual and represent specific thoughts and ideas. He maintains that they contribute to conceptualisation as we interpret them against our own cultural and experiential backgrounds to form our individual concepts of the world around us. Nursing is one of the many professions where symbols play a part in unifying the members whilst at the same time excluding all others. Kaufman and Harald (1999) argue that we use them in our record keeping,

in our language, and as a way of maintaining a distance from other medical disciplines.

Yet it was clear that as the student confidence increased they began to ask what the terms meant. As one student explained:

Some of the medical terms took a bit of getting used to. There are a lot of things they use letters for like MSU and TTO's that I had to learn. I got used to pushing myself forward and feeling brave enough to ask questions. (18)

A second recalled how she recorded new terms to help her remember them:

I asked questions, like 'the T.O's, the T.O's' 'why do you keep mentioning that word? What does it mean?' and she was like 'Ooo that's like the take out drugs'. So just asking questions and writing things down in my book. (2)

Tusting (2005) explains that practice involves engaging with other people in the pursuit of some joint enterprise. Where this engagement is sustained over time, the people involved develop a repertoire of ways of engaging in practice, which includes ways of thinking, speaking, discourses, tools, understandings and memories which are to a greater or lesser extent shared amongst members of the community.

Other challenges students revealed often centred around clinical experiences that they felt unprepared for. Commonly the students recounted an experience that would involve a nursing procedure involving unpleasant sights and smells:

There was one lady, who had to have a wound bag changed, and we pulled the curtains round to change it and uncovered it and I think my face said it all. I'd never seen anything like it. It was a wound that was this size, it was huge and it was completely open and it was leaking faeces. It was awful. There was an opening and

I had to put my hand inside and I remember actually saying "I haven't got to do that have I?". (4)

As the emphasis within the hospital environment has become focused upon highly acute and specialised short term care (Midgley 2005) it has become commonplace for acutely ill patients to be cared for on general ward areas. Others students recalled how difficult they found dealing with the death of a patient:

An auxiliary said "oh will you help lay this patient out"? and I said "yeh, yeh I've done it before" and I actually cried and I thought 'why am I crying I've done this so many times before?' All the family, including children they were all crying as it was their grandma. I don't know what set me off – I just cried. The poor lady's face just looked in pain and it was just overwhelming. They said "are you ok?, you go" but I said "no. no I want to carry on". (4)

Five students noted difficulty coming to terms with the shift patterns expected of them:

I was really shattered with the move from theory hours to practice hours. In theory we would spend like six hours a day in school, then we went to 12 hour shifts. That was a killer (18)

Last and Fulbrook (2003) found similar problems identified by students in their study. 91% of students in their study mentioned travelling to and from placement added to their stress levels. In particular students in this study found that the longer working day with additional travelling time very difficult:

I find it really difficult getting used to the long hours. Luckily my boyfriend's in the same cohort so he lives in (town) so I've been getting two buses but I have to be up

and out for six. But I did find the long hours at first really difficult to get used to. If I'm in (town) then I have to be up for four and it kills me. But I prefer long days then at least I've got the days off to do my work and rest. (6)

Studies by both Harrington (1994) and Poissonnet and Veron (2000) have found shifts to be unpopular and describe adverse effects both in terms of physical and mental health. Certainly, shift work and workload have been identified as important factors in leaving the nursing workforce (McVicar, 2003; Storey et al, 2009).

Four students stated that an additional challenge of their new role came from having to record the evidence of their practice achievement in the form of a portfolio. One student explained:

As we went on placement we had to do a portfolio and I'd never done a portfolio before and it was like 'It's all on web CT'. It's like you're learning yourself as you're going along and to me it felt like my mentor wasn't sure of the paperwork that I was giving them. The tutors were saying 'explain this to them'. It's like how do you explain something when you don't know yourself? It felt like the blind leading the blind with paperwork and the portfolios. (2)

Similarly Brodie *et al* (2004) found that students often found that academic deadlines and increased paperwork in placements produced added stress for students on clinical placements.

When students had difficulty some would approach their mentors or other students for help:

Our mentors helped us a bit trying to do the portfolios 'cos it's really hard to do all your learning outcomes when you're not hands on all the time.(8)

It was only 'cos there was a second year student that was on there that could help me that guided me as such on the outcomes otherwise I don't think I'd have had much of a clue. (3)

Student Support

The majority of students interviewed felt vulnerable and looked for support and encouragement during their first practice placement from a variety of places. These included mentors, other staff members, other students, friends and family. A small number mentioned support from the School of nursing, but this appeared limited.

Papp *et al* (2003) found that student nurses require a lot of support in clinical practice. The students in their study reported that the nurse mentor was a vital role in this respect. All of the students in this study were informed before going out on placement that they would be assigned a mentor who would be expected to support and supervise them. It was clear from the student responses at interview that this was not always the case. Almost half of the students had had some sort of difficulty either accessing a mentor or forming a useful relationship with them. As one student explained:

I wasn't assigned a mentor, not until half way through my placement, because one of 'em was off sick and the other one was leaving so didn't want to take me on. So then they gave me another mentor and I only actually got to work with her on my last shift. (4)

The lack of support from a mentor clearly had an effect upon student experience:

My mentor who unfortunately wasn't there till midway through the second week so the first week and a half was just a nightmare 'cos nobody wanted to take responsibility for me. (1)

Some students were allocated a series of mentors, which they found unsettling. One student said:

I was allocated a mentor but he wasn't a qualified mentor so he couldn't sign me off and my mentor changed like 3 times. I just felt like I was pushed from pillar to post. (12)

Lloyd-Jones *et al* (2001) found in their study of 81 pre-registered nursing students that those students who did not work their mentor were usually not supported by any other trained staff. Another student said:

I had several mentors, one was really good. But she did a lot of nights. When my mentor wasn't there I did feel a little bit vulnerable but obviously someone else would take that role on. I didn't like just being left to it. I like someone to be in charge and who I can go to when I need help. (17)

Chan (2001) found that a mentor's management style and interpersonal skills were of prime importance to students. Often students would cite problems relating to task-orientated mentors. During the interviews students would occasionally explain that they and their mentor would not be able to work together successfully. This could be due to a variety of reasons. As one student explained:

She was very 'you do this, this, this and this happens'. There was a bit of a personality clash there. She had very definite ideas about how you should train and

it should be more about the process than the whole organic let's see how we are. She'd be 'no, we're doing it this way because this is the way we've learnt'. (15)

Midgley (2005) found that interpersonal relationships were influential and that students seek respect, support and acknowledgement from their mentors in practice but do not always receive it. Both Spouse (2000) and Hinds and Harley (2001) found that nurses, especially students, often spoke of being confronted with examples of poor role models by nurses who did not reflect their ideals. Another student said:

There was one staff nurse I didn't get on with out of everybody and I asked her a couple of questions and she said 'for goodness sake, why do you ask so many questions'?. She wasn't very nice so I just stayed out of her way. (7)

A number of studies have indicated that student relationships with mentors and staff can be a major influence on the success of transition and clinical learning (Dunn and Hansford, 1997; Papp *et al*, 2003; Anderson *et al*, 2007). Interviewees revealed the positive effect of a good relationship with their mentor. For example one student explained:

My own mentor was nice. She gave me a tour round at the beginning of the day and showed me where things were, what the children come in for and then I just worked with her. (16)

Dunn and Hansford (1997) found that the mentor's willingness to engage in the teaching relationship is most important. Studies have revealed that mentor behaviours such as compatibility, role modeling and feedback contribute significantly to the promotion of student learning and the ultimate success or failure of the student-mentor experience (Coates and Gormley 1997; Myrick and Yonge 2002). In

this study the students who identified their mentors as good seemed to value the fact that the mentors would spend time with them and help them settle.

Similarly Myrick (2002) found that mentorship is a perfect medium by which students are afforded the opportunity to translate theoretical knowledge into their learning in practice. In nurturing critical thinking, key factors such as 'respect', 'flexibility', 'openness' 'safety' and 'trust' on the part of the mentor were found to impact on whether or not students moved forward in their thinking.

MacIntosh (2003) found that willing and supportive mentors were an invaluable resource to nurses in coping with the stress of the realities of the first practice placement. These finding were reflected in this study. One particular student noted the time and energy her mentor had offered:

I was able to sit there for an hour with just one patient with the mentor and just go through so many things and you know, really understand the patient's condition.(4)

When the students were asked what other forms of support they received at this time, many of them identified other staff members. Often the more junior staff members would be seen as more approachable. As one student explained:

Actually I found a lot of support came from the auxiliary nurses in the clinic 'cos they really looked after me they took me under their wing and they were the ones beckoning me over if I was stuck because the staff nurses were always busy in the plaster room so we'd have a laugh and a joke, do the clinic together then go for a coffee or whatever. (8)

Another explained why it was easier to approach the junior members of staff:

I think initially I got support from the nursing assistants. The nurses are not really there. You can see that they're busy. They're not trying to avoid you. It's just the workload. (13)

This finding also reflects that of Dunn and Hansford (1997) who found that non-nursing staff were often just as influential upon clinical learning as the registered nurses.

To palliate stress nurses talk to other staff members, have good working relationships, get support from family and friends, This finding is supported by Dewe (1987). A small number of students also identified that they received some support from other nursing students on their placement at that time. For example:

I got lots of support from the third year student. I didn't understand how you're supposed to write about your outcomes so she directed me and gave me a lot of advice about how to fill the paperwork in. (14)

Similarly, Peyrovi *et al* (2005) found that support was commonly found from other nursing students. Ranse and Grealish (2007) also reported that students acknowledge the importance of support from other students as they are willing to share their knowledge and experience and learn from each other.

One student explained that she got support from her family and friends:

My mum's a nurse as well so I would talk to her about the placement and she understands. I'd talk to friends 'cos you can share your experiences with them and if they're feeling upset you can help them, or the other way around. (16)

Both Dunn and Hansford (1997) and Papp *et al* (2003) identified that good co-operation between the school of nursing and the clinical staff contributed towards an

effective learning environment for students in practice. When asked whether the students had received any support from the School of nursing, a number of the students said they felt well supported:

I felt supported by my personal tutor. She was really good throughout the first placement. (10)

Some students explained that they knew they could contact their tutor if they had a specific problem:

My tutor came to the ward once to see how I was getting on as well. When I said I was having a few problems with my outcomes, he came back again. So I had the support there. (15)

Whilst others did not appear to see the necessity to meet with their tutors. Two students explained:

I think I would have been able to contact my personal tutor but I didn't need to. (20)

I didn't contact the University when I went on placement, I didn't really see the need. (8)

A small number of the students interviewed stated that they had very little support from their tutors. Young *et al* (2006) found that students expect some support and continuity from the university team when they are on placements, However, Mallik *et al* (2009) found that tutors were not viewed as significant in making student experiences positive whilst on placement. One student saw explained:

I never got any support from the actual University itself. My tutor came round a couple of times but I was never there but I still think he could have rung the ward up and asked the ward. I mean my shifts had been set out like the day I started so he

could have easily have said when he came up the first time 'when's she next on'? and then come back maybe when I was on.

Engagement

When the students were asked how they managed the transition into the practice setting many of them (15) gave examples of how they had attempted to fit in with the nursing culture. Some students said they had tried to keep an open mind and be willing to take on any task. One student explained:

I just – If someone needed help making beds I'd go and do that, so they knew I was willing to do anything. The kind of dirty jobs that no one wants to do – I would do them. (10)

Another detailed the kinds of tasks she would offer to do:

I tried to be helpful. I asked if there was anything they wanted me to do. I'd go and do observations on the children or try and see if there's anything to wash up or tidy up really. I kept myself busy and spent time talking to the parents and the children. If there was any prescriptions that needed taking to the pharmacy I'd go and do that. (16)

Ranse and Grealish (2007) described the importance that students ascribe to being able to take responsibility for care on placement. Loefmark and Wikblad (2001) outlined that students also valued the ability to work independently. One student who had previously worked in health care explained that they found their existing skills very useful I this respect:

Honestly, using what I'd already got. Buzzers were going, I answered them. Just used common sense. Somebody asks for the toilet, you take them rather than just stand and look a bit gormless. Just pitch in, get on. Just act like I acted when I was an auxiliary. Cos they all said 'you've adapted really well, we've got third year students who don't use their initiative like you do'. (4)

A large number of the students expressed how important they felt it was to appear motivated to learn. As one student remembered:

Just anything I could do, if I wasn't busy I would do it. My mentor said, 'you do try very hard, and you do seem very enthusiastic which I do like'. But she did say I had to work on my skills at managing people, but then it was only my first year, first placement. (15)

Another explained:

If you're stood around not doing much I would ask 'is there anything I can do'? So look motivated and do something rather than just standing around. (9)

Some students seemed to work out how the ward routines operated very quickly and would alter their activities as a result. As one student explained:

I learned the times when obs were done and I'd try and use my own initiative. I'd keep a watch of how it all worked. In the afternoons it was dead quiet so I'd know it was the time to go and talk to my mentor. (6)

Another student echoed the point that using her initiative was important:

I just used my initiative, I thought – I can do that. If I can do it I'll go and do it. (7)

Buitrago (2002, p1) states:

Human beings are consummately social. When interacting with individuals and groups not met before, people are often very alert to behaviours that tell them of someone's position within a group. These first perceptions help one to map out the network of relationships within a particular setting, so that ultimately one can avoid conflict, find support and identify affinities and openings for fitting in.

Some students found that they had to push themselves forward and make links with others. Some did this through conversation:

When I went for breaks I tried to talk to people and engage in conversation so that when you were on the ward I could just go 'oh' like that (attracting a nurses attention) and be a bit less formal I suppose. It's nicer to talk to someone you consider more of a friend than someone you consider as your boss. (6)

A second student explained how she would use commonalities to build relationships:

I suppose a conversation would strike up and I'd try and get in on the conversation like something stupid like celebrities or whatever and then they'd start asking me questions and we just got on. I found myself smiling and saying 'hello' to people and trying to reach out a bit and saying 'I am here, I am approachable you can talk to me if you want to'. (8)

A number of the students expressed how important they felt it was to be useful to their mentor. One student explained:

When my mentor made a list of what she needed to do in report, I'd make a similar list and try and prepare the way or do some jobs for her. I answered the phones as

much as I could, anything I could do to help the nurses 'cos they were rushed off their feet. (17)

Another said:

In the first few days like I said I just stuck to my mentor like glue. Gradually I got more used to the ward layout and could go and fetch things for her. (18)

As well as their mentors, the students explained how they might find other members of staff they could make links with. They often described this as 'latching on'. Two of the students explained:

I like latched on to someone and just followed them (1)

I latched on to a couple of people. There was a lady who spent most of her time in the plaster room. She had a very dry sense of humour and I loved that so we got on really well so when I was in the plaster room she'd take me under her wing (8)

Measuring Success

When reflecting upon how they had managed their transition into nursing practice three main areas emerged during the interviews illustrating how students had measured their success. These comprised reflections upon the nursing role, the link between theory and practice and feedback from their mentor.

a) The nursing role

As time went on students began to get more involved with the clinical aspects of the nursing role:

I enjoyed getting into the swing of doing the obs. And learning what to do. They got me to do the drugs round with them to show me what drugs they used and how to prescribe them. I found that bit really interesting. I did a lot of like catheters and things like that with them. I preferred the practical side of it all.(10)

I got to go to theatre and I watched bowel surgery. That was the first time I'd ever been to surgery so that was really interesting – I really enjoyed that. I got to do different procedures I'd never done; phosphate enema, taking a catheter out, they even had me drawing up IV fluids.(4)

As the students became more able to participate in care and interact with the patients they appeared to get more satisfaction from their experience. One student recalled:

The bit I enjoyed most was the interaction with the patients and seeing how much of an impact what I did made on the patients and realising that it was the smaller things that people often take for granted that make the most difference to the patients in that particular setting. For example just helping people with washing and helping people to the toilet and allowing them to accept help. (11)

Students in Anderson and Kiger's (2008) study stated that an interpersonal relationship with patients was a significant factor in the development of their communication and nursing skills.

Another noted the fact that she could make a valuable contribution:

I liked that you could actually make a difference. If the parents needed someone to talk to, I could do that cos the nurses were really too busy to sit down and talk to them. Or if a child was on their own cos their mum and dad had to go to work I could

sit with them and play with them. I liked that, cos we've got more time than the nurses cos they're busy. (16)

Harris and Shelswell (2005) argue that when individuals feel that by taking part in a collective activity they will gain improved control and better quality of life, they are motivated to positively contribute to the creating expansion of the activity in new directions. Another way the students appeared to measure their success was by looking at how their nursing skills had improved. Many of the students started to recognise that their own skills were developing. As one student recalled:

I speeded up, my skills started to speed up. At the beginning if I was given a job to do I could be quite slow remembering and finding all the things I would needs, but by the end of the placement it would be much quicker. (15)

Loefmark and Wikblad (2001) maintain that the ability to work independently could increase student self confidence and professional development, whilst Papp *et al* (2003) found that in their study students used clinical experience to develop and understand their own clinical learning style. The students in this study also recognised that the skills they had developed could be used to help them in future placements:

I've developed some clinical skills that I can do on other placements without waiting for direction to do things. If someone wants to go to the loo I can confidently toilet them. Most of that has come from the first placement because it was quite heavy work. (11)

As a result the students noted that their confidence had increased during the course of their placement. Two students said that the repetition of basic nursing tasks was particularly useful:

I feel a lot more confident doing things. Just practicing things gave me a lot more confidence – obs. mainly. (10)

What I really liked, and I know people will go well that's just stupid was the fact that it was very busy but they did a lot of basic care. So you just really got to grips with that. At least I know I can confidently wash, and feed you know somebody. (15)

Idczak (2007) found that students in her study would develop confidence and that often this came from successful completion of a nursing skill.

One student in particular expressed the way many students appeared to feel as they realised they were developing in their nursing role:

I enjoyed it all, all the clinical aspects. I enjoyed just talking to the patients, getting to know the patients and learning all the new procedures I'd not done before. I found it all fascinating and I went home excited thinking 'Oh my god I can do this!' (2)

Other students reflected upon the way their added skills and confidence had enabled them to become more a member of their ward team. One student noted:

To actually get out there and be a nurse rather than just a University student. It took a while but by the end of the placement I really felt like I fitted in. It was great working with all the staff, not just the nurses, but the doctors and physios as well and everyone else. It was good to be part of a team.(1)

Reflection also allowed students to evaluate whether the placement had fulfilled their expectations of what nursing would be like. A number of students noted that their first placement had made them assess their choice of career. Price (2008) noted that the experience of professional socialisation involves individuals moving

from previously held assumptions and expectations of nursing towards the reality of the practice setting. For one it confirmed their choice:

I think because I'd never worked on a ward before, I think it just made it so I knew what that was like. It sort of confirmed what I already knew I wanted to do.(9)

Similarly Gibbons *et al* (2007) found that the first practice experience could be an important source of positive reinforcement on career choice. However other students in this study found it made them question their choice of career. One student stated:

I have to give credit to the first placement. It was not enjoyable, because it was hard work and most of the more recent placements have not been as difficult as that one. So it made me think about whether adult nursing is right for me. (13)

However, the majority of the students interviewed found that by then end of their first placement they now saw themselves as nurses:

I think I went from being a University student to thinking more of myself as a student nurse. Even like introducing myself to people, I was like 'I'm a student at Uni' and now 'I'm a student nurse'. Now I'm a lot more grown up. I only had a month on my first placement but in that month I grew up so fast. I'd find myself talking to people and I'd say something and think I didn't even know I knew that (5)

This reflects the views of Gregg and Magilvy (2001) and Dombeck (2003) who found that being a nurse contributed to the nurses self concept and was often inherent in how they identified themselves 'I am a nurse'.

During the interviews one group of students emerged who had been health care workers previously and who had re-evaluated the role of the registered nurse during their first practice placement. One student said:

When I was working in the nursing home as care assistants were always there working with the patients all the time and the staff nurse would be sort of locked away in the treatment room and we didn't know what she was doing, but now I can see she was probably up to her eyeballs in paperwork and drugs and all the different things that she had to do. Now I really appreciate how hard it must have been for her, 'cos she was on her own with 30 patients, whereas at the hospital you know you've got a lot more staff.(7)

Myrick and Yonge (2004) in their study of the experiences of mentors and nursing students found that as with most interpersonal associations, individuals bring to a relationship contextual attitudes and behaviors derived from their own personal and professional experiences. This group of students seemed to develop more respect for the role of the nurse than they had had as health care assistants:

I tell you what I did realise and this is typical from an auxiliary nurse point of view. You actually think staff nurses are quite lazy and you do the bulk of the work but as a student nurse you actually get to see both sides and the responsibility and the amount of paperwork and things they have to remember you know is quite overwhelming and it did make me think 'I take that back', cos even though you work alongside staff nurses you don't always notice what they're doing you get on with your own role, but as a student when everything had to be done a certain way, everything has to be documented. It did open my eyes a bit. (4)

Brennan and McSherry (2006) describe how students in their study who had previously worked as health care assistants began to realise the additional need for accountability as a registered nurse. Many saw this as a positive way of differentiating between their role as a HCA and that of a student moving towards registration.

b) Theory/practice link

During the interviews the students were asked whether they felt able to use knowledge gained from the theoretical part of their nursing course in their first practice placement.

A small number stated that the gap between theory and practice was too wide in some cases to be useful. For example, one student stated:

So going from sitting in a classroom listening to all this biology say about cardiac arrest, and then you see a person with a cardiac arrest – you cannot be prepared for it. (6)

Another stated:

In practice you learn more hands on than you can ever do in a classroom, but it's good 'cos you can take what you've learnt and then apply it. Some things went over my head in theory and then in practice you know I picked them up. (4)

Peyrovi *et al* (2005) argue that students feel the value of clinical practice and see a gap between theory-based education in the university and practical education in the clinical setting.

A few students stated that they had found the theory valuable and could use it in the practice setting. One student stated:

When I was like in theory I felt I wanted to be there but I wanted to put it into practice. I think it works really well for the course, having like a block in the University, and then a block in placement. I could use some of theory in practice. I couldn't do like a year of a couple of days here and a couple of days there, no. I think because I'd been in practice before it helped me. (17)

Anderson and Kiger (2007) found that students believed clinical practice provided the opportunity for them to develop their knowledge base. Sharif and Masoumi (2005) noted that the integration of both theory and practice with good clinical supervision was the best way to develop effective nurses.

However, most of the students explained that the value of the theory could only be appreciated after they had had time to apply it. One student said:

Well you get shown how to wash someone but you don't actually get to do it properly until you get out into practice. Like feeding the other day, we did it in class but you're doing it with someone you vaguely know and they're kind of trying to help you, whereas when you're feeding someone that you don't know, you don't know what they can do you just have to start from the beginning and see where it goes. So it was 'Ah that's how that works, I see now'.(15)

The clinical learning environment is very important for the student nurse to apply theories in practice and integrate knowledge leant in the classroom (Reilly *et al,* 1992; Shen and Spouse, 2007). This environment may influence the student's growth of professional attitudes, practical skill, clinical knowledge and experience (Marjatta, 2002; Shen and Spouse, 2007).

Finally, one student illustrated her development by referring to her success when she was assessed at her final interview with her mentor. She explained:

My mentor was really, really good and she signed me off for everything. She gave me a level 2 for quite a lot which then gave me a lot of confidence. I followed my mentor around quite a lot, you know when she was doing things I was there watching.(10)

Loefmark and Wikblad (2001) maintain that students find constructive feedback very valuable in building student confidence in practice. Hart and Rotem (1995) found that relations with ward staff and recognition for students' contribution can promote learning. Hinds and Harley (2003) found that the process of socialisation was very much enhanced by others, especially other nurses.

CHAPTER 5

DISCUSSION OF THE FINDINGS

In considering the findings of this study six initial themes emerged from the data. They illustrate the time and effort the students put into preparing for their placement and the way their experiences of the practice environment and the placement staff affected their behaviour. Within the discussion section these themes have been refined further and considered alongside relevant theory. As a result four emergent sections are presented within this chapter that illustrate the complexities of transition and the way students manage this process. They comprise:

- The Stress of Transition

- Culture Shock: How the nursing culture affects student behavior

- Coping with Transition

- Managing Transition : The struggle to acquire capital

In order to understand the student's experience of their transition into the practice setting the findings will also be discussed alongside human, social and identity capital theory. It is anticipated that consideration of these theories will provide some insight into the difficulties students encounter and a clearer picture of why students find this process so challenging. Finally it will discuss the implication of these findings for students, their mentors and those who design and deliver nurse education.

The Stress of Transition

The findings of this study indicate that the move of nurse education away from the clinical setting and into the higher educational setting has caused a major problem

for students attempting to manage transition between the two environments, and particularly the two cultures.

The gap between university and practice settings has become highly problematic for the nursing student. They see theory and practice environments as distinctly separate and dissimilar. As a result, they find the period of transition from one to the other stressful. A major theme to emerge during the interviews was the high level of anxiety that students expressed as they approached their placement and during the initial few days in practice. This confirms the findings of a number of authors (Kevern and Webb, 2004; Macintosh, 2006; Idczak, 2007) who describe similar fears expressed by students on exposure to the demands of the clinical environment. Although many take steps to prepare themselves for their placements, they find it a very different world from the one that they have been preparing for in the School of nursing. The picture that emerges is one of students trying to prepare, but with most having little knowledge of what to expect until they arrive and start to practice.

Students utilized a range of strategies in order to familiarise themselves with the placement and its specialties in order to reduce these concerns. Most had visited their placement before starting practice and noted that this was a useful way of reducing their anxieties. Students who found the placement welcoming at this point noted that their stress levels reduced. They valued the ability to meet staff members and used the experience to establish the logistics of getting there. In addition, many had researched the placement area and its nursing specialties from the ward itself. This type of research enabled the students to feel prepared. Some anticipated that they might be more valuable in practice, others that it might help them appear less foolish.

In order to prepare nurses for the demands of practice changes to nurse education (NMC,1999; DoH, 2006) have been implemented that have increased the number of skills hours taught in schools of nursing. However, indications from this study are that the separation of theory from practice remains a weakness of nurse education especially in preparation for the first practice placement. Other sources of information students identified included their school of nursing website. However, students expressed that these failed to provide detailed information about their placements.

Students also noted that skills preparation sessions had been organized for them prior to their placement but they felt that these had only limited use as they were simulated situations. Although students did acknowledge that towards the end of their placement they began to see links between the theory they had been taught in school and the practice in which they took part, it was notable that this was a slow process. At the same time the educational link tutors appeared to have a limited role in supporting students and staff during the first placement. Most students were happy with the support they received from their tutors and those who did not see their link tutor indicated that they knew how to make contact with them if they needed support. Nevertheless, students did feel isolated during their first practice placement. A number stated that they missed the daily contact with friends and colleagues that they enjoyed in the university setting. Both Mallik *et al* (2009) and Young *et al* (2006) have identified that students feel isolated in practice, suggesting they require increased support both before, and during their placement.

In order to alleviate their anxieties students would speak to colleagues, friends and family in order to gather knowledge about what to expect from their placement. Yet the value of this appeared to be mixed as some found their fears increased if a

friend or colleague had a negative experience of the area. At the same time those students who had previous experience as HCAs appeared to feel better prepared for practice as they felt they had knowledge and skills they could use.

In order to understand why this process is problematic for the first year student nurse it is necessary to consider the influence of the changing nature of nurse education. The move into higher education has made the initial transition from the university setting to the practice setting difficult for a number of reasons. The push for professionalisation came from the drive to produce a solid theory base and enhance the professional status of nurses (Davies *et al*, 2000). The stated aim of this move was to produce a 'knowledgeable doer' and 'a thinking person with analytical skills' (UKCC, 1986 p.40), but taking the student out of NHS employment appears to have presented the student with a wide gap to bridge between academic and practice settings. This move effectively separated academic and practice education. This has therefore presented the student with two points at which they need to acquire capital in order to manage transitions. The first is the point at which they join their Higher Education Institution (HEI) and the second the point at which they first encounter practice as a student nurse.

According to Tinto (1993) successful early transition into the university culture is a crucial factor in retaining students beyond the first few months of the course. He maintains that integration into the social system of the HEI greatly influences persistence. Within this environment, positive social integration has been found to be of crucial importance in the retention of students particularly in the first term. Similarly Mallik *et al* (2009) found that social integration is an issue for many students, particularly in school of nursing centres where students are orientated and

taught in large groups and the opportunity to set up friendships through small group work is delayed.

The results of this study indicate that the transition into the practice setting is equally important as it brings a second occasion when students are required to build capital. A short time after joining the university students are sent out into practice. Yet the nursing culture is found by students to be very different from that which they encounter in the university setting and the findings of this study indicate that first year students find this second transition highly challenging.

Furthermore, the demands of current curricula mean that students will often spend no more than a small number of weeks in each of their practice placements as the service providers expect that their trained staff have a broad range of nursing experience prior to qualification. For most students this means that once they have settled, built relationships and started to engage in learning they are asked to move again. Either they return to the school of nursing or to a different practice placement. Both will involve the student having to manage transition once more.

Culture Shock: How the nursing culture affects student behavior

The need to manage transition into the nursing culture presented a range of challenges for the first year nursing students. As well as high levels of anxiety prior to starting placements students expressed fear and anxiety during their first few days on placement. They described powerful first impressions and mentioned uncertainty about their role, feelings of being an outsider or isolation from the school and their friends.

The students interviewed described a range of behaviours they utilised in order to become accepted members of this new culture. Initially they would try to take a 'low profile', watching and listening but asking few questions. Many students became quiet and reserved and tried not to draw attention to themselves. Often they would follow staff quietly and try not to interfere with nursing tasks. Idczak (2007) also noted similar patterns of behaviour. Gradually students in this study would adopt many of the actions, symbols and language of the nurses they came into contact with. Horowitz (1983) described how this change in behavior could be elicited through group dynamic constraints which can be powerfully coercive. He called this 'role suction' as the individual is sucked in to the position which the group dynamic requires and the requisite behavior is sucked out of that person.

Over the last few decades stress and its management in both trained and student nurses has been an area of great interest but the results are somewhat ambiguous (Jones and Johnston, 2000). In nursing practice stress has been connected with high work-load and time pressure (Janssen *et al*, 1999), role ambiguity and role conflict, staff conflicts (Payne, 2001), decreasing autonomy or loss of control, all of which may lead to moral distress (Hanna, 2004) or burnout (Maslach and Leiter,1997). The stress related to student transition into practice has not been a particular focus of nursing research in the past, which makes these findings more notable. In examining the sources of stress it was clear that students in this study were quick to describe the many aspects of the nursing culture that they found new and unfamiliar. They had to get used to new routines and practices and were swift to notice the increased level of responsibility required when caring for 'real' patients. They mentioned difficult and distressing sights and smells and being uncertain of how to deal with these situations. Students often felt unprepared for some of the

very ill or dying patients as well as the challenging sights and smells they encountered. The move to care for only the acutely ill in the hospital setting has therefore had an impact upon the experiences of student nurses when they enter this health care environment. Similarly Brodie *et al* (2004) found that students were often surprised by the reality of the NHS and the knowledge and skills they needed. As well as the acute nature of care many students had not expected the large amount of paperwork they would be expected to do and found the shift patterns alongside travel requirements tiring. Students also noted that they found the wealth of medical terminology difficult to understand, but they were quick to try and learn.

Students' descriptions of the way they focused upon learning skills whilst at the same time expressing difficulties with some of the distressing and distasteful experiences resonate with work of Menzies Lyth (1959) and Dartington (1994). They described the functioning of social systems in institutions as a defense against anxiety. Menzies' study of a London hospital revealed high levels of tension and distress amongst nurses including students. She noted that:

Nurses are in constant contact with people who are physically ill or injured, often seriously. The recovery of patients is not certain and may not be complete. Nursing patients with incurable diseases is one of the nurses most distressing tasks….their work involves …..tasks which, by ordinary standards, are distasteful, disgusting and frightening.(Menzies, 1961 p. 440)

In this environment it is argued that the characteristic feature of the social defense system was its use in helping the individual avoid experiences of anxiety, doubt, uncertainty and guilt. Thus, the nurse must learn to control feelings and resist excessive involvement with patients. Menzies described a range of defenses that nurses developed in order to cope with these stresses. These included

depersonalising patients; becoming focused upon the task rather than the individual and maintaining a professional distance. Gradually, she argued, in environments such as this a social defense mechanism develops which new members are expected to adopt. Dartington (1994) described this process of the student nurse becoming the 'socialised carer'. Elements of this behavior can be seen in some of the examples given by the students in this study who described how they began to act and feel like nurses. For example:

I enjoyed getting into the swing of doing the obs. and learning what to do. They got me to do the drugs round with them to show me what drugs they used and how to prescribe them. I found that bit really interesting. I did a lot of like catheters and things like that with them. I preferred the practical side of it all.(10)

However, Halton (1994) maintains that the use of defenses such as those described by Menzies are not necessarily a negative feature and argues that some form of defense can be a healthy way for individuals to avoid pain. Ultimately it is clear that the practice setting remains a highly influential socialising element of the student nurse experience. Students in this study were immediately exposed to the new customs of the care setting identified by Rhynas (2004). Gradually, as students began to become familiar with the organisation and terminology they demonstrated increased confidence and pride at becoming part of the 'team'. This sequence of events clearly reflects a process of socialization into the nursing culture that has been identified by a number of authors (Olesen and Whittaker, 1968; Wyatt, 1978; Rhynas, 2004; Tusting, 2005). It was characterized by engaging over a period of time with other nurses in order to develop a repertoire of ways of engaging in common practices.

They identified a strong occupational culture that had a profound effect upon their behaviour. This reflects the findings of both Willis (1977) and Collinson (1992) who identified that this culture can shape the attitudes and behaviours of the new workforce. The findings of this study indicate that transition into the practice setting involves students having to adapt and learn new skills very quickly.

Coping with Transition

Ongoing concerns about nurse staffing levels have led universities to recruit from an increasingly wide pool of the population (Taylor *et al*, 2008). This study reflects these findings as the student profile shows a diverse age range as well as a large number of students with prior knowledge of health care. However, the ratio of male to female students remains fairly static at 9:1.

The students in this study ranged in ages from 17 to 52 years. 40% of students identified that they had worked in healthcare previously. The majority of these had worked as HCAs but there were others who had worked in other health care related roles such as paramedics, phlebotomists and dental nurses. The students who had worked in health care previously often felt more confident that they would be able to cope with transition as they could rely upon the basic skills they had already acquired to engage in practice early on in their placement:

I think it is an advantageous part of having a care background. I'd only been in care for about a year before I'd started this course but I think it does prepare you a bit you know just of what you can come across – the smells and the work involved. (3)

As individuals bring to a relationship contextual attitudes and behaviours derived from their own personal and professional experiences (Myrick and Yonge, 2004) the intention was to explore how these previous experiences might influence the transition process during the course of the interviews. Findings indicate that those with previous healthcare experience believed that they would be able to utilise their existing clinical skills in order to manage the transition process. These findings are interesting when viewed alongside the findings of Dreary *et al* (2003) and Kevern and Webb (2004) who found that mature students who demonstrate certain skills including diplomacy and negotiation are more successful on placement. They relied on their basic nursing skills but realised their role as a student was very different from that which they had expected. The move from working as a health care assistant to student nurse enabled these students to see at close quarters the knowledge and skills required of the registered nurse. In particular interviewees noted the new level of respect they had for staff nurses and the work they did:

It really amazes me that I never really realized what the staff nurses were doing on a day by day basis, I mean I'd get on with whatever I had to do and assumed they were doing something similar. It was only when I got to work alongside the staff nurse as a student that I could see exactly the kind of work they do. (7)

A large number of the students (60%) stated that they had no previous health care experience. The interviews revealed students who had worked for some time in fields completely unrelated to healthcare (i.e. transport management, computer engineering). Despite the diversity found amongst the first year students, the picture that emerges is one where all students found the transition process challenging. Some noted that they found the sudden lack of control and responsibility unsettling:

I was so used to doing my own thing and knowing what the job involved. As a transport manager I'd be in charge of a group of men and had to deal with all the issues they had. So I went from the one making all the decisions to someone who had to ask to do things – it was really strange. (1)

The success of transition was also found to be dependent upon the ability of the student to manage the process. Students found they required a lot of support during their first practice placement. Whilst the range of assistance utilised included nursing staff, family, friends and tutors, overall mentors were found to be the most influential in ensuring the quality of student transition. Those who were able to work closely with their mentors were able to settle, learn new skills and behaviours and enjoy their placement more easily than those who had to struggle for support. This finding reflects those of Myrick and Yonge (2002) who noted that the mentor's capacity for role modeling had a prominent affect on the student. Those students who were given the time and encouragement to work alongside motivated mentors were able to demonstrate positive role modeling behaviors.

It was notable that the students who struggled were either given no mentor or passed from one mentor to another during their placement. Others found it difficult to work alongside mentors who worked in ways they found hard to understand. These findings are similar to those of Myrick and Yonge (2004) who also noted that the student-mentor relationship can be particularly sensitive. They found that as with most interpersonal associations, individuals bring to a relationship attitudes and behaviors derived from their own personal and professional experiences. For some students, this can have an adverse effect upon their ability to build relationships with mentors if they have divergent values and attitudes. Indeed Last and Fulbrook

(2003) identified ongoing issues around qualified staff's expectations of student nurses, based on traditional views of old style ward based training.

A feature of the student responses was that those students in the study who lacked support appeared to feel as though they were left `drifting'. As one student noted:

I wasn't really sure what I was supposed to be doing or who I was supposed to be with (5)

Often the students who lacked encouragement from their mentor would often seek additional help and advice from more junior members of staff or even other students. Often this was described by students as `latching on'.

Gradually students would learn the new ways of behaving that would enable them to participate in the clinical environment. Keating (2005) maintains that in participating in everyday social action, individuals change to meet other individuals' ways of doing things, in a constant negotiation of meanings that implies participating in practice and 'reifying' it. The students would often measure their success by the new skills and knowledge they acquired:

I enjoyed it all, all the clinical aspects. I enjoyed just talking to the patients, getting to know the patients and learning all the new procedures I'd not done before. I found it all fascinating and I went home excited thinking 'Oh my god I can do this!' (2)

This reflects the 'developing confidence' described by Idczak (2007) that often came from successful completion of a nursing skill. Over time the students demonstrated changes in behavior that enabled them to become part of the nursing team. Many spoke about trying to appear open minded or pushing themselves forward to appear motivated to learn. They did this by offering to do basic tasks or jobs that others

might not want to do. They also spoke about using their own initiative when they could or choosing to do things that would particularly help their mentor.

Students measured the success of their transition in a number of ways. Many noted an increase in confidence and this usually came alongside their increased ability to take part in nursing activities. These activities included performing basic nursing skills and interacting and helping patients. The ability to become competent in these activities enabled the students to feel that they were making a difference to the lives of their patients and that they felt valued as part of the nursing team. This was often reinforced by feedback from their mentor at the end of their placement.

The students who were able to demonstrate success also used this as a way of confirming their career choice. Many found that they now saw themselves as nursing, rather than university students.

Interestingly the HCAs found that their experiences as nursing students challenged their preconceptions about the role of the registered nurse. It was clear that the opportunity to shadow staff nurses had enabled them to see the full extent of this role.

For some students the final measure of success was seen as their ability to make the links between theory learnt in school with the practices they engaged in whilst on placement. At the same time they acknowledged that a sufficient length of practice was important in order to achieve this. One area students did not highlight was the need to balance academic and practice demands found in other studies (Last and Fulbrook, 2003; Brodie *et al*, 2004). Students did not mention this as an issue that affected their transition. However, it is evident from a study of the submission timetable for this cohort that the first assignments due to be submitted were not

required until 2 months after their first placement. The prevailing view is that the move of education away from the apprenticeship model has reduced the bond with practice and affected the socialization process (Roberts and Johnson, 2009).

Coping strategies among student nurses appear to be similar to those among registered nurses. To palliate stress nurses talk to other staff members, have good working relationships, get support from family and friends, try to leave work at work and rest, sleep or read (Dewe, 1987) while nursing students describe talking to relatives, friends and peers and keeping their thoughts and emotions under control.

Managing Transition : the struggle to acquire capital

The opportunity to examine student nurse transition into the practice setting in detail has provided the opportunity to explore this process through the lens of capital theory. It has revealed that students rely heavily upon building human, social and identity capital in order to manage this process. Ultimately student nurses aim to build their human capital via their nursing registration, but in order to achieve this they must rely on building both social and identity capital.

One of the most interesting results of the study was identification of the strategies students would use to negotiate transition into the clinical setting. In order to explain how students managed this transition it is useful to revisit those theories developed to explore the concepts of human, social and identity capital.

An examination of the student profiles provides some (if limited) indication of the human capital that student nurses possess. For example, those students who had previous experience as HCAs appeared to feel better prepared for practice as they felt they had knowledge and skills they could use. All of the students recognized the

need to develop nursing skills in order to become valued members of the nursing team. Students would push themselves forward to engage in new working relationships and learn new terms and new practices:

It felt really great being able to do what the other nurses could do at last. I didn't feel so much of a spare part (4)

Becker (1974) recognized that acquisition of skills such as this may therefore increase an individual's capital. Students in this study actively sought to build knowledge and skills that would help them negotiate transition and become a useful member of the workforce. The introduction of skills sessions and preparation for practice lectures that the school of nursing offered students before their first practice placement could be seen as an attempt to build their capital. However, this was not entirely successful as the students did not appear to value these sessions as they felt they were false situations without real patients. It was only when the students were in the practice setting that they felt able to learn these skills successfully.

In order to build their human capital, students relied heavily upon their ability to build social capital. During the course of this study students were found to use a variety of strategies in order to manage the transition process. They would prepare for transition by researching the ward area and its nursing specialties; they would visit the ward area and talk to staff; and they would talk to colleagues, family and friends. Morgan (2000) argues that norms and information are the two most important types of capital goods in which social capital can be invested, as shared maxims that guide behavior in recurrent contexts, effective norms maximise social welfare. Information, on the other hand, builds knowledge about productive processes

themselves, necessarily lowering costs. When engaging in practice, students would even try to build social capital by doing the jobs no one else wanted to do:

I just – If someone needed help making beds I'd go and do that, so they knew I was willing to do anything. The kind of dirty jobs that no one wants to do – I would do them. (10)

The findings of this study also reflect concepts developed by Bourdieu (1985) and Coleman (1990), both of whom define social capital as a range of resources available to individuals thanks to their participation in social networks. Students described how they would build their repertoire of skills and practices in order to become part of the nursing team. Initially the students would 'latch on' to their mentors and follow them around watching them closely. They would take the opportunity to engage in social conversations with other nurses. The need to be seen as part of the nursing 'team' was evident in many of the interviews. It supports Rees' (2006) assertions that individuals may use social capital to provide access to resources.

When considering Bourdieu's definition of social capital as the 'aggregate of real or potential resources that are associated to the possession of a durable network of more or less institutionalized relations of mutual recognition' (Bourdieu, 1985 p. 248) it is useful to examine the ways in which the student nurses used their social skills to gain access to nursing skills. Evidence of this was found amongst student nurses in this study who would push themselves forward to engage with others in what Tusting (2005) identified as 'the joint enterprise' of learning new nursing skills. Indeed the interviewees were able to recount a new repertoire of ways of engaging in practice that reflected Weger's (1988, p.47) 'shared doings' (practices), 'shared

understandings' (learning) and shared senses of their own self. Often the students would measure their success in terms of the new skills they had learnt, or the way they were able to work alongside staff members as part of the 'team'. As One student explained:

I really felt I had fitted in when I could go to a patient and do their obs without having to ask for help. That was a real step forward for me (6)

Uphoff (1999) describes this as 'cognitive social capital' or subjective and intangible elements such as generally accepted attitudes and norms of behaviour, shared values, reciprocity and trust.

Those students who had previously worked as HCAs used their existing capital in the form of knowledge and skills as a way of aiding their transition:

Honestly, using what I'd already got. Buzzers were going, I answered them. Just used common sense. Somebody asks for the toilet, you take them rather than just stand and look a bit gormless. Just pitch in, get on. Just act like I acted when I was an auxiliary.(4)

This supports the work of Field (2005) who argues that people can use their social capital to gain access to skills and knowledge in a variety of ways. For example, they use their connections in a very straightforward way to find out how to do new things such as master a work process.

Sandefur and Laumann (1998) maintain that it is the membership of social networks that determine the individual's potential stock of social capital. In an attempt to explain how social capital advantages the individual, whilst Field (2005, p.61) maintains that it consists of 'social networks, the reciprocities that arise from them

and the value of these for achieving mutual goals'. Individuals are able to gain an advantage by building and exploiting their social capital. It was evident that some students in this study invested a good deal of time and energy building close relationships with their mentors. They saw the value of being able to become a valuable resource to their mentor:

When my mentor made a list of what she needed to do in report, I'd make a similar list and try and prepare the way or do some jobs for her. I answered the phones as much as I could, anything I could do to help the nurses 'cos they were rushed off their feet. (17)

Indeed Vasquez (2004) argues that it is not the relation itself that is the source of social capital, but the access this provides to resources such as reciprocity and private information. In order to explain the advantages of social capital, Rees (2006) explains that individuals' own interests and personal resources can develop best in a society in which individuals co-operate in associations that are tied by definition to the interests of their members.

As students spent more time learning and practicing the culture and customs of the nursing environment they gradually began to feel like valued members of the ward team. This finding has echoes of Côté's (1996) 'culture-identity link'. In it he suggests that the socializing influence of institutions' cultures nurture certain personality types. He argues that individuals must fit themselves into a community of strangers by creating the right impressions. Many of the students in this study were found to engage in a range of behaviours in order to create the right impressions. In order to do this Côté argues that the individual requires a range of skills including the ability to self-monitor and adjust behaviors to suit others. Students could be seen to alter the way they behaved, the way they spoke, and the language they utilized.

They paid particular attention to uniform, to time keeping and to the way they engaged with their mentors. Often the students expressed the desire to please and to appear motivated to learn.

Students in this study were quick to learn the language and symbols of the nursing culture and many stated that they pushed themselves to engage in practice and become valuable members of the 'team'. Therefore, in deliberating the question of why some students negotiate the transition process successfully whilst others appear to struggle, it is this concept that begins to provide a clearer understanding. Côté maintains that identity formation comes from the guidance that individuals receive. The individual invests in a certain identity (or identities) and engages in a series of exchanges at the level of identity with other actors. He argues that to be a player in these markets, one must first establish a stable sense of self which is bolstered by social and technical skills, effective behavioural repertoires; psychosocial development to more advanced levels; and associations in key and occupational networks.

Implications for First Year Nursing Students

The move to separate the theory and practice of nursing has presented the first year student nurse with a number of challenges. There is now a wide difference between the culture they encounter in the university and that of the clinical setting. First year students are quick to note the many aspects of the clinical setting that they find new and unfamiliar. They have to get used to new routines and practices and are swift to notice the increased level of responsibility required when caring for 'real' patients. When they experience difficult and distressing sights and smells they are often

uncertain of how to deal with these situations. Many do not expect the level of paperwork they are expected to do and find the shift patterns alongside travel requirements tiring.

Students find the wealth of medical terminology difficult to understand, but are quick to try and learn them. Gradually, as students begin to become familiar with the organisation and terminology they demonstrate increased confidence and pride at becoming part of the 'team'.

The failure of the school of nursing to prepare the student adequately for this transition means that their movement into practice is a stressful event. It is evident that they experience high level of anxiety immediately before and then during their initial few days on placement. Yet they use a variety of strategies to familiarise themselves with the placement and its specialties in order to reduce these concerns. Most students take the opportunity to visit their placement before starting practice and find that this is a useful way of reducing their anxieties. Students who encounter a welcoming environment at this point find that their stress levels reduce. They value the ability to meet staff members and used the experience to familiarise themselves with the logistics of getting there. In addition, many research the placement area and its nursing specialties from the ward itself. This type of research enables students to feel prepared. Some anticipate that this knowledge might make them more valuable in practice, others that it might help them appear less foolish.

Other sources of information that students use to prepare themselves for transition into the practice setting include the school of nursing website and preparation for practice sessions. However, students express that these fail to provide detailed information about their placements. Students also speak to colleagues, friends and family in order to gather knowledge about what to expect from their placement but

the value of this appears to be mixed since some find their anxieties increased if a friend or colleague has had a negative experience of the area. Students who have had previous experience as HCAs feel better prepared for practice as they feel they have knowledge and skills they can use.

The fear and anxiety students feel during their first few days on placement is expressed in a number of ways. They experience uncertainty about their role, feelings of being an outsider or isolation from the school and their friends. This affects their behaviour in practice. Many students become quiet and reserved and try not to draw attention to themselves.

Gradually students seek out help and support from those around them, whether this is their allocated mentor or other members of the nursing staff or even other students. They adopt behaviours that will enable them to make links with other members of the health care team. Many attempt to appear open minded to new situations or push themselves forward to appear motivated to learn. They do this by offering to do basic tasks or jobs that others might not want to do. They try to use their own initiative when they can or choose to do things that would particularly help their mentor.

Students measure the success of their transition in a number of ways. Many find that an increase in confidence that comes alongside their increased ability to take part in nursing activities. These activities include performing basic nursing skills and interacting and helping patients. The ability to become competent in these activities enables students to feel that they are making a difference to the lives of their patients and valued as part of the nursing team. This is often reinforced by feedback from their mentor at the end of their placement. Those who are able to demonstrate

success also use this as a way of confirming their career choice. Many find that they now see themselves as nursing, rather than university students.

HCAs often find that their experience as nursing students challenges their preconceptions about the role of the registered nurse. The opportunity to shadow staff nurses enables them to see the full extent of this role.

In addition to the measures above, the final measure of success seen by first year nursing students is their ability to link theory learnt in school with the practices they engage in whilst on placement with the acknowledgement that the length of practice is important in order to achieve this.

When considered as a whole the themes that emerge from data analysis establish transition as a process that the students are required to manage. In fact they reveal that transition of the first year student nurse into the practice setting is a complex and demanding process that places particular demands upon the individual. They highlight the particular anxieties the students felt around the time of their transition, the difficulties they encountered trying to 'fit in' and become part of the team and the strategies they employed in order to negotiate this process.

An examination of identity formation and identity capital indicates that one reason for student nurse dissatisfaction with practice and difficulty with transition may relate to their own identity formation (Côté, 1996). If students approach nursing practice with a weak sense of their own identity they may take one of two routes. One is simply to drift with the cultural tide of nursing and alter their image to reflect social trends. In contrast, the active, agentic response was seen in those who developed strategies to deal with these influences in terms of sustaining some sense of direction and meaning and taking initiative in their own development. The passive student will

encounter a string of practice placements where cultures and traditions differ and will need chameleon-like abilities to blend in with the prevailing practices. The active student will encounter a strong occupational culture in each placement and will need to fight hard to maintain a sense of their own identity. Both routes through the transition process were identified amongst the students interviewed.

Therefore in order to help the student negotiate the transition process we need to foster and encourage personal adaptability. Adaptability may be briefly described as the capacity to respond to challenges with resilience (Hall and Chandler, 2005). It is a personal quality that is important in handling ambiguity, dealing with uncertainty and stress, and in working outside traditional boundaries (Pearlman and Barney, 2000). Adaptability has been defined by Hall (2002) as a career meta competency, which along with personal identity forms the core of a dynamic career. It is at its core, the capacity to change, including both the competence and the motivation to do so (Hall and Chandler, 2005). O' Connell *et al* (2008) suggest that adaptability is shaped by a number of factors that are both internal and external to individuals. They argue that factors such as gender and education can influence adaptability.

In the nursing environment, individuals navigate more transitions from theory to practice as they progress through their course and must be adaptable and competent learners. Hall and Chandler (2005) maintain that in a world characterized by frequent career transitions for the individual and by careers as mini-stages individuals are thrown into more unfamiliar situations and are expected to be resilient and successful. Only those who are capable of responding to these types of circumstances can thrive in today's workforce. The notion of responding with resilience implies agency, the ability to make an impact and to act as an agent in affecting control over one's work environment. Wall *et al* (1996) summarise that

'increased control reduces the effects of stressors by allowing individuals to face demands when they are best able to do so and in ways they find most acceptable' (p.155).

As individuals shape the timing and methods used to face demands, they may also grow in their personal sense of adaptability. O'Connell *et al* (2008) maintain that just as self confidence can influence goals and effort, confidence in the currency and transferability of skills may fuel an individual's ability to adapt to changing circumstances. Specifically, as an individual's confidence in the marketability of her skills increases, both the competence and confidence to adjust to changing circumstances should be bolstered. Social support, 'overall levels of helpful social interaction available on the job from both co-workers and supervisors' (Karasek and Theorell, 1990, p.69) may enhance the way in which followers personally adjust and adapt to changing circumstances.

CHAPTER 6

CONCLUSION

This study has provided a detailed examination of the first year nurse's transition into the practice setting. It has also allowed an exploration of the factors that influence a sensitive period in nurse education. The inspiration for the investigation came from a sense of unease that despite an expansion in student numbers in recent years concerns have been consistently raised about student nurses leaving. The most recent studies of student attrition shows that the peak time for leaving a pre-registration nursing programme is around the 6 month point, at the end of the first practice placement. Often the major reason cited for leaving is having made a 'wrong career choice'. However, experience as a student, mentor and then nurse educator led me to focus upon the process of transition into the first practice setting in an attempt to explore why students decide to leave at this time, and to explore further why students might decide that nursing is not the right career choice for them.

An examination of the literature provided an initial overview of the historical and political background to current patterns in nurse education and provided a framework for the design of a research method that would allow an exploration of transition from the student's perspective. Ultimately, the aim of this research was to focus on first year student nurses in order to understand and interpret the understanding, reasoning and techniques they employ to manage their transition into the practice setting.

Questionnaires were designed following the initial literature review and used to collect initial data from an entire cohort of first year student nurses. The data was

then explored in depth and used to design interview questions which were administered via face to face semi-structured interviews with 20 first year students.

The findings show that the transition process is highly complex and stressful for the student. It has been made more difficult by the separation of academic and practice settings. As a result students are expected to adapt rapidly to a strong occupational culture as they enter the practice setting. In order to do this they rely heavily upon building human, social and identity capital. When viewed through the lens of capital theory, the complex process of transition into the first practice placement can be seen more clearly.

The evidence from this study indicates that students work hard to increase their human capital as they push themselves forward to build social capital as they engage with others in 'the joint enterprise' of learning new nursing skills. Students discover and develop a repertoire of ways of engaging in practice that reflects the shared practices, understandings and shared identity referred to by Wenger (1998). Many students begin this process of building capital even before the placement commences. Examples include visiting the ward, meeting and engaging with staff, researching the nursing specialties they will be working with and looking for sources of information on the school of nursing website.

Despite developing certain strategies to build capital prior to starting their placement it is evident that first year student nurses find themselves lacking the resources required to feel part of the nursing team during the first few days of placement. They then develop numerous approaches to enable them to accrue resources in the form of knowledge and skills. In order to do this students push themselves forward to appear motivated and will often take on tasks they feel no one else wants to do.

Social capital is developed by students as it provides access to a range of resources available to individuals in part due to their participation in social networks. Thus students use social networking to build their repertoire of skills and practices in order to become part of the nursing team. The quality of their mentor is seen by students as a key factor in enabling them to acquire the knowledge and skills required. They use their social capital to gain access to skills and knowledge in a variety of ways. For example, they use their connections in a very straightforward way to find out information but they also use them to gain access to nursing skills. Thus the mentor is an essential aid to students build capital. The students who recognise this make a great effort to foster this relationship by choosing to take on tasks that will particularly help their mentor.

Students measure the success of their transition by the way they have acquired resources and built capital. The ability to perform new skills and retain newly acquired nursing knowledge gives students increased confidence. They recognise this as enabling them to become part of the 'team'.

HCAs take a slightly different route towards acquisition of the relevant resources to become part of the nursing team. Many join pre-registration nursing courses believing that the skills they have learnt as HCAs will provide a good deal of the capital they require to make their transition successful. To some extent, this is the case as they are able and willing to undertake a variety of basic nursing skills as soon as they enter their first placement. However, they soon realise that the role expected of them as registered nurses differs substantially from their previous role as HCAs. They then set about learning the new knowledge and skills (capital) required.

The acquisition of nursing skills increases an individual's capital. Students actively build knowledge and skills that help them negotiate transition and become a useful member of the workforce. But in order to do this successfully students require sufficient support. It is clear that the main source of support comes from the mentor in practice, and if this individual is unsuitable or unavailable students will seek out alternative members of staff or other students for advice and support.

An examination of Côté's identity capital theory has provided one explanation of why some students are successful during transition, whilst others struggle. In order to fit themselves into a community of strangers students must create the right impressions. This requires a range of skills including the ability to self-monitor and adjust behaviors to suit others. Yet in order to achieve this students are required to be highly adaptable.

The students who struggle and falter at this time appear to be those who lack the skills or support they require build capital successfully. These findings have significant implications for nurse educators who must consider how a student's abilities to build and exploit capital can be encouraged within the nursing curriculum.

The opportunity to study the transition process through the lens of capital theory has revealed that most first year students do not possess the capital required to manage the transition process easily and struggle to acquire the many skills they need to make this move successful. For, in order to do this the student nurses rely heavily upon building social capital by way of building relationships they see as valuable in providing access to knowledge and skills. Yet in order to gain access to social capital students have to build identity capital as they struggle to fit in and become accepted as part of the 'team'. This therefore provides an explanation of why student nurses are most likely to leave nurse education after their first practice

placement. Those who leave and cite nursing as the 'wrong career choice' are likely to be those who require the most support in negotiating this complex process or those who find little support forthcoming from either the school of nursing, social network or practice nursing staff in building their capital resources.

Recommendations and Suggestions for Nurse Education

The move of nurse training into higher education came as the result of a wealth of factors including dissatisfaction with existing nurse education, the tussle over professionalisation and the pressure to manage costs in a growing health service. Yet this move came at a time when recruitment levels struggled to meet the growing demands of an expanding healthcare system dealing with increasingly specialised and technical care. In addition, the occupational choices for those traditionally choosing nursing as a career were increasing. In order to address the concerns that Project 2000 was overtly academic and lacking in clinical practice, particularly during the common foundation of the first year (Stevenson, 1996) the UKCC reviewed nurse education once again. The Peach Report [*Fitness for Practice*] (1999) recommended earlier and longer placements, an increased emphasis on clinical skills and the need to education and practice to work more closely together.

The decision to move nurse teaching to the higher education setting has proved problematic for student nurses and is likely to be a contributory factor to the high attrition rates during the first 6 months of their course. Ongoing calls to bring theory and practice closer together have achieved little improvement in closing the theory-practice gap and it is time to reconsider where nurse education should be delivered. This study indicates that the gap between education and practice continues to be a

problem for the student nurse. Students take time to see the benefit of theoretical concepts in the practice setting. They do not see the value of teaching in a simulated environment and see it as a false situation, not the 'real world'.

Student nurses now enter their first practice placement after a foundation period in the university setting. This study has identified that first year student nurses find the transition from the university to practice setting stressful. The first practice placement not only presents an acute clinical setting but also a strong occupational culture with its own customs, symbols and language. Students are called upon to develop their capital rapidly. This process calls for an individual who is dynamic, mature and can cope with the pressures current nursing practice presents. Therefore, the need to acquire resources in order to build social and identity capital occurs in distinctly separate environments and is likely to demand high levels of adaptability. In fact, in the first 6 months of the course students are expected to undertake two separate transitions. The first of these is into the university setting and the second into the practice setting.

Since 2000 there have been growing calls for nursing to move to an all graduate profession (RCN, 2002) and in 2008 the NMC ratified proposals to complete this move by 2015. The current move to degree status for nurses alongside financial pressures on public services will inevitably mean a reduction in nursing commissions. This is therefore an ideal time to take the opportunity to reassess whether nurse education would be better placed within the service setting. If this move of nurse education back into the practice setting was successful, students would be part of the culture into which they will eventually work from the beginning of their course. Nursing staff would be more involved in recruitment and be able to

select candidates they feel would be able to manage the pressures of nursing practice alongside building capital in the form of knowledge, skills and customs.

Students would learn the theoretical underpinning principles from those who can support them in building their capital. In this way students would avoid the many pressures and stresses associated with transition and would therefore see less of a gap between theory and practice environments.

At the same time, we need to acknowledge the high degree of capital building skills and adaptability required by student nurses during a three year nursing programme. Nurse educators can address this need in two ways. Measures should be taken to assess student capacity for adaptability upon application or at interview. At the same time emphasis should be placed upon building a curriculum that encourages the development of skills that would support them in the many transitions they are expected to make during their nursing course.

There are two main areas therefore where we need to concentrate our energies as educators if we are to address these challenges: The first involves an acknowledgement that practice placements can be highly stressful places for student nurses. Each student nurse is expected to move back and forth from university to a range of practice settings numerous times each year. On each occasion they draw on their need to adapt and negotiate transition in new settings and with a range of new staff members. They therefore require a number of skills to negotiate the tricky route through a wide and varied range of practice placements. Energy and resources need to be directed towards developing those social and decision making skills that will enable them to navigate the relationships,

hierarchies, traditions and symbols they will encounter. Thus nursing curriculae need to be designed to develop individual skills in negotiation and adaptability.

The second involves refocusing our attention towards both the preparation of students for the clinical setting and preparation of practice staff for their role as mentors. We need to accept that the movement of nurse education into the university setting has produced a cultural gap between the two environments. Students are expected to behave differently in the two settings. No sooner have they settled into their role as 'university student' than we send them out to take on the role of 'nursing student'. Each individual requires support when moving between these roles and their mentors need to be able to understand how difficult this process can be for the student. The ultimate goal of the student is to build human capital as they complete their nurse training. In order to reach this goal they struggle to gain access to the various nursing skills required through their mentors. The development of a productive relationship with the mentor relies upon the student being able to build their social capital leading to a positive relationship. Yet in order to build social capital the student needs to develop identity capital in the form of the particular behaviours that are expected of the nursing student. For some time we have known that mentors can positively influence their students' success in practice, now we have a more complete picture of why this is the case. With this information we are better placed to encourage mentors to enable their students to develop the capital they require.

Recommendations for further research

The findings of this study have inevitably led to more questions and therefore future research needs. As the ability to build identity capital has been found to be such a major factor in a student's successful transition it is essential that nurse educators find new ways of building and enhancing this resource. Whilst these findings point to the practice setting as the ideal place to build identity capital it is likely that any substantial move in that direction would take a groundswell of political and professional opinion of equal proportions to that which caused the initial separation of theory and practice in the 1980's. Nevertheless, short term advances are achievable. Research is therefore required in order to identify how nurse education can respond to the needs of individual nursing students. We need to be able to identify not only the students who come with human capital in the form of previous experience of nursing or skills which will be useful as nurses, but also those students who lack either the basic nursing skills they require or the identity and social capital required in order to access them.

Secondly, research is required to pinpoint the most effective ways to enhance the student nurses' human, social and identity capital within the educational structure that currently exists. The existing school based preparation for practice sessions and skills teaching appear to be unsuccessful attempts at building human capital. New ways need to be explored to build first year student nurse capital so that the transition process can be managed smoothly.

Finally, we need to consider ways in which the finer elements of identity capital can be encouraged in our students. For example, if adaptability is described as the notion of responding with resilience, this implies agency or the ability to make an impact and to act as an agent in affecting control over one's environment. However,

most nursing curriculae do not encourage students to act as agents affecting control over their own learning. They prescribe a set of standards which must be met and in most cases provide a rigid content in order to achieve them. Research is therefore required to identify how the nursing curriculum can be designed to encourage the student to take an active role in their learning from the very beginning of their course to the point at which they make the final transition into practice as a registered nurse.

Further opportunities to examine the data.

During the course of this research a wealth of data was elicited. The focus of this study meant that the data was used to answer the main research questions. However, it has become clear that the range and depth of information acquired provides an opportunity to expand and extend the research into other areas related to nurse experience. During phase 1, students were asked to disclose the activities in which they had taken part in practice. Data collection took place at five different sites which were in 5 different trusts. Although the initial intention was to complete a cohort study it would now be useful to compare the results produced between students at the five sites to see whether any similarities or differences could be found in student experience of transition and explore reasons for this.

The questionnaires also produced a large amount of data describing practice skills and activities in which first year students took part. Analysis of this data would produce a detailed account of the practical skills that first year students are exposed to in their first practice placement. This would be valuable to nurse educators as the range of clinical skill expected of nurses is changing rapidly. It would provide a

contemporary benchmark that could be used to reassess whether the current skills preparation is appropriate for student needs.

Finally, in asking students about what they were looking forward to, or least looking forward to, a number of students mentioned 'death'. This was a very interesting response which reveals that a number of students may focus on this particular aspect of their potential experience. A detailed study of this phenomenon would provide an insight into student perception of death and the accompanying implications for nurse education.

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APPENDICES

Appendix A   **Phase 1a Questionnaire**

Appendix B   **Phase 1b Questionnaire**

Appendix C   **Questionnaire Information Leaflet**

Appendix D   **Questionnaire Consent From**

Appendix E   **Pre Questionnaire Analysis**

Appendix F   **Post Questionnaire Analysis**

Appendix G   **Phase 2 Interview Questions**

Appendix H   **Interview Information Leaflet**

Appendix I   **Interview Consent Form**

APPENDIX A

<u>Questionnaire 1A</u>

Thank you for taking part in this study, which aims to explore the expectations and experiences of first year student nurses on their first placement.

This questionnaire should take about 10 minutes to complete. Please return the questionnaire to **the researcher in the envelope provided.**

Section 1: about you

1.1 Are you?

Male   □   Female   □

1.2 Please identify your age at your last birthday   …………….. years

1.3 Have you ever been employed as a healthcare worker?   Yes/No

(If yes please give brief details)

Section 2: your first placement

2.1.What do you think you will be doing during your placement?

2.2 Please state what you are most looking forward to:

2.3 Please state what you are least looking forward to:

2.4 What do you think the nursing environment will be like?

2.5 What do you think the nursing culture will be like?

2.6 How do you think learning in the School of Nursing and learning in placement might differ?

2.7 How will you prepare for your first practice placement?

2.8 What will you do to ensure your transition into practice is successful?

Thank you for your participation.

Sally Melling

APPENDIX B

<u>Questionnaire 1B</u>

Thank you for taking part in this study, which aims to explore the expectations and experiences of first year student nurses on their first placement.

This questionnaire should take about 10 minutes to complete. Please return the questionnaire to me when you have finished.

Section 1: about you

1.4 What gender are you?

Male   □   Female   □

1.5 Please identify your age at your last birthday   …………….. years

1.6 Have you ever been employed as a healthcare worker?   Yes/No

Section 2: your first placement

2.1.   What did you do during your placement?

2.2 Please state what you enjoyed the most about your placement:

2.3 Please state what you least liked about your placement:

2.4 Was there anything you felt unprepared for?

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2.5 What was the nursing environment like?

2.6 What was the nursing culture like?

2.7 Did learning in the School of Nursing and learning in placement differ? Yes/No

If Yes, how?

2.8 How did you prepare for your first practice placement?

2.9 Was your transition into practice successful?   Yes/No

Please explain your answer:

Thank you for your participation.

Sally Melling

APPENDIX C

Healthy Volunteer's Information Sheet

Questionnaire

Name of Investigator:

Sally Melling

I would like to invite you to take part in my research study. Please take time to read this information and discuss it with your friends and relatives if you wish. Please ask or email if there is anything that is not clear or if you would like more information.

Background Information

The research is being completed as part of a Doctorate in Education at the University of Nottingham. The aim of this study is to investigate student nurse perception of their first practice placement and to understand the techniques they employ to manage transition into the practice setting.

What does this study involve?

The study involves completing a questionnaire which should take no longer than 10 minutes. At a later date 25 students will be invited to participate in an interview. Therefore you are asked for your PIN number so that I can contact you and invite you to take part in an interview to explore your questionnaire responses. Other than the researcher, no-one will be able to identify you.

Why have I been chosen?

All first year student nurses on the Diploma/Bsc 0901 Nottingham cohort have been invited to take part in the research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet once again prior to the administration of the questionnaire. Once you have completed and returned the questionnaire you will be able to withdraw from the study at any time until the thesis is completed.

What are the possible disadvantages of taking part?

The questionnaire may highlight issues in practice that you have found distressing. If this is the case please contact your personal tutor who can discuss any issues with you.

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If I am unhappy who can I complain to?

If you have a complaint relating to the study please contact the researcher in the fist instance. If you receive no satisfactory outcome, you should then contact the Ethics Committee co-ordinator, roger.murphy@nottingham.ac.uk

Will my taking part be kept confidential?

No person other than the researcher will have access to the questionnaires. PIN numbers will only be used to contact 25 students to invite them for interview. No student will be identified in the thesis. Questionnaires will be stored by the researcher in a locked cabinet until the thesis is completed after which they will be shredded.

What will happen to the results of the research study?

The results of the study will be made available to any participants who wish to receive them following completion of the study.

Who has reviewed the study?

This study has been reviewed and approved by the University of Nottingham Medical School Ethics Committee and the School of Education Ethics Committee.

Contact for Further Information

Researcher: Sally Melling: sally.melling@nottingham.ac.uk

Supervisor: Dr Chris Atkin chris.atkin@nottingham.ac.uk

APPENDIX D

PARTICIPANT CONSENT FORM - Questionnaire

Project title Transition: an exploration of student nurse experience in their first practice placement.

Researcher's name Sally Melling

Supervisor's name Dr. Chris Atkin

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that data will be stored in a locked cabinet and accessed solely by the lead researcher. I understand that original data will be destroyed upon completion of the thesis.
- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

Signed …………………………………………………………………… (research participant)

Print name ………………………………………………………… **Date** …………………………………

Contact details

Researcher sally.melling@nottingham.ac.uk

Supervisor: chris.atkin@nottinham.ac.uk

School of Education Research Ethics Coordinator: andrew.hobson@nottingham.ac.uk

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APPENDIX E

Phase 1   Pre-placement Questionnaire

Code		Definition	C 1	C 2	C 3	C 4	C 5
1DM	Male		5	4	5	6	15
1DF	Female		41	43	47	45	106
1D HCY	HC worker previously? Y	Has worked in a health care capacity	17	16	19	23	49
1DHCN	N	Has not worked in a health care capacity	29	31	28	28	72

Demographic Information

Code		Definition	C 1	C 2	C 3	C 4	C 5
1/1a	Basic nursing skills	Skills involved in patient observation, communication, hygiene, elimination, nutrition, safety	39	31	45	38	107
1/1b	Interacting with patients	Communicating with patients	11	9	7	7	32
1/1c	Shadowing/observing nurses	Working alongside qualified nurses watching what they do	18	31	33	31	67
1/1d	Learning new skills	Learning to undertake nursing skills	5	6	9	8	15
1/1e	Getting used to the ward	Familiarising themselves with the ward environment and its working practices	8	0	4	0	6
1/1f	Proficiencies	Working on those activities that will help them to achieve their nursing proficiencies	2	4	0	5	1
1/1g	Putting theory into practice	Using knowledge and skills learnt in school to develop their nursing skills	3	0	0	0	9
1/1h	Helping nurses	Taking on part of the workload of the nurses	2	4	0	2	11

Q1   What will you be doing on placement?

Code		Definition	C 1	C 2	C 3	C 4	C 5
2/2a	Patient care	Participating in the nursing care of patients	15	8	21	21	45
2/2b	Everything	All aspects of their placement experience	7	3	1	7	13
2/2c	Practicing skills	Participating in nursing interventions in order to develop their own skills	23	11	14	12	66
2/2d	Seeing what nursing is like	Evaluating what nursing entails	4	16	5	9	15
2/2e	Learning new skills	Learning to undertake nursing skills	14	17	21	17	45
2/2f	Working with new people	Meeting and working alongside patients and staff	5	13	12	9	22

Q2   What are you most looking forward to?

Code		Definition	C 1	C 2	C 3	C 4	C 5
2/3a	Workload	The high level of work expected by staff	0	3	0	3	2
2/3b	Nothing	Nothing	3	0	3	2	7
2/3c	Shift work	Coping with early, late or long shifts	4	7	12	2	20
2/3d	Distasteful nursing tasks	Tasks relating to personal patient hygiene or elimination	6	7	6	4	20
2/3e	Making a mistake	Making a mistake that might affect patient care or upset a member of staff	6	4	1	4	17
2/3f	Emergency situations	Being unable to cope with/manage patient care in an emergency situation	6	6	4	5	8
2/3g	Not knowing what to do	Being uncertain of own responsibilities or lacking knowledge needed in order to care for patients	12	7	16	17	43
2/3h	Being treated poorly	Not being treated with respect by either staff, patients or relatives	0	2	1	0	5
2/3i	Being `new'	Being different and standing out from the permanent nursing staff	6	10	6	14	10
2/3j	Death	Coping with/managing the death of a patient	8	9	5	4	2
2/3k	Paperwork	Learning how to complete and manage the nursing documentation	1	2	0	10	2

Q3   What are you least looking forward to?

Code		Definition	C 1	C 2	C 3	C 4	C 5
2/3a	Busy	Crowded with or characterized by activity	33	41	40	41	77
2/4b	Organised	Orderly with good working systems in place	7	1	3	2	17
2/4c	Demanding/stressful	Calling for skills that the student may not have yet developed	9	10	11	7	36
2/4d	Diverse/interesting	A lot of new experiences that the student finds interesting	3	6	6	3	18
2/4e	Rewarding	Enabling the student to achieve development	0	2	0	5	8
2/4f	Clean	A clean physical environment	2	3	1	3	6
2/4g	Caring	Where staff display empathy and sympathy	2	2	1	2	9
2/4h	Professional	Competent, skilful and assured	2	3	0	14	17
2/4i	Friendly/welcoming	An atmosphere where staff are friendly	18	16	17	12	42

Q4   What will the nursing environment be like?

Code		Definition	C 1	C 2	C 3	C 4	C 5
1/5a	Diverse	Showing a great deal of variety	18	13	3	11	25
1/5b	Friendly/Helpful	Kind and pleasant	6	4	6	16	21
1/5c	Professional	Competent, skilful and assured	0	3	5	8	8
1/5d	Caring	Where staff display empathy and sympathy	6	2	11	6	17
1/5e	Team working	Working together to achieve a common goal	3	5	8	5	16
1/5f	Stressed	Causing strain or tension	0	3	4	2	13
1/5g	Clicky	Involving close knit groups who do not let others join them readily	0	6	2	1	1
1/5h	Unsure	Student not sure what it will be like	4	1	8	0	11

Q5   What will the nursing culture be like?

Code		Definition	C1	C2	C3	C4	C5
1/6a	Theory vs practice based	The two learning environments will be very different	25	23	30	32	75
1/6b	Putting theory into practice	Practice will allow the student to utilise theory learnt in school	7	6	4	9	16
1/6c	Practice is the 'real' world	Practice is what nursing is really like	13	14	14	9	21
1/6d	More pressure to get it right	In school the student is allowed to get things wrong but in practice this is not acceptable	1	3	3	9	10

Q6   How will theory and practice differ?

Code		Definition	C1	C2	C3	C4	C5
1/7a	Early night	Student will go to bed early the night before practice	2	3	3	0	9
1/7b	Be organised	Student with ensure they prepare aspects such as route, uniform, paperwork prior to their placement	11	4	13	6	13
1/7c	Ask friends/colleagues	Find out about the placement from friends and colleagues	3	4	6	2	7
1/7d	Research	Find out about the placement speciality through research	20	16	27	29	80
1/7e	Contact ward/mentor	Contact a member of staff and ask them about how to prepare for the placement	21	7	16	27	7
1/7f	Go through documentation	Familiarise themselves with the assessment documentation	18	2	9	16	3
1/7g	Be open minded	Try not to have any preconceived ideas about what the placement will be like	3	3	1	2	0
1/7h	Revise nursing skills	Go over lecture notes on nursing skills	1	5	3	1	2

Q7   How will you prepare?

Code		Definition	C1	C2	C3	C4	C5
1/8a	Be organised	Student will ensure they prepare aspects such as route, uniform, paperwork prior to their placement	9	5	8	18	36
1/8b	Be enthusiastic	Demonstrate through actions that they are willing to learn	22	11	19	15	46
1/8c	Ask questions	Ask questions	14	14	9	17	28
1/8d	Research	Find out about the placement speciality through research	2	5	1	7	8
1/8e	Work hard	Take an active role in practice	5	16	18	13	38
1/8f	Be open minded	Try not to have any preconceived ideas about what the placement will be like	6	4	5	6	9
1/8g	Listen to nursing staff	Take note of staff comments and act upon this	9	8	7	12	27

Q8   How will you manage your transition into practice?

APPENDIX F

Phase 2   Post-placement Questionnaire

Code		Definition	C1	C2	C3	C4	C5
2/1a	Basic nursing skills	Skills involved in patient observation, communication, hygiene, elimination, nutrition, safety	57	57	37	67	105
2/1b	Observed mentor/nurses	Watched the skills and activities in which their mentors and other staff members engaged	8	19	20	20	23
2/1c	Interacted with patients	Communicated with patients	9	13	7	12	42
2/1d	Visited other areas	Visited other wards and departments relating to their placement areas	9	6	9	11	36
2/1e	Patient documentation	Read and added notes to patient nursing records	8	5	7	14	10
2/1f	MDT meetings	Attended multi-disciplinary team meetings	6	3	3	7	11

Q1   What did you do on placement?

Code		Definition	C1	C2	C3	C4	C5
2/2a	Patient contact	Meeting and interacting with patients	17	59	18	28	56
2/2b	Working alongside nurses	Caring for patients in association with nursing staff	10	19	3	8	20
2/2c	Meeting MDT	Meeting other members of the multidisciplinary team	1	3	10	4	21
2/2d	Visits away from ward	Visits to departments associated with the placement	9	6	5	0	15
2/2e	Learning new skills	Learning to undertake new skills	20	5	22	16	35
2/2f	Everything	All aspects of the practice experience	2	0	1	6	5
2/2g	Being a 'nurse'	Engaging in behaviours associated with the nursing role	6	0	7	12	10

Q2   What did you most enjoy?

Code		Definition	C1	C2	C3	C4	C5
2/3a	Challenging/difficult care activities	Engaging in care activities that students might find stressful	4	0	0	2	8
2/3b	Uncertain role	Not knowing the boundaries of what they should do	9	17	14	23	30
2/3c	Lack of support from staff	Staff not giving the students the support they require	8	9	5	10	13
2/3d	Nothing	Nothing	5	8	4	4	11
2/3e	Death of a patient	Coping with/managing the death of a patient	1	1	1	0	4
2/3f	Shift work	Coping with early, late or long shifts	1	1	3	1	11
2/3g	Lack of time with mentor	Not being able to spend enough time with their mentor	7	6	7	3	13

Q3   What did you least enjoy?

Code		Definition	C1	C2	C3	C4	C5
2/4a	Nothing	Nothing	16	20	25	24	40
2/4b	Death of a patient	Coping with/managing the death of a patient	5	2	4	6	6
2/4c	Shift work	Coping with early, late or long shifts	0	3	1	2	8
2/4d	Lack of support from staff	Staff not giving the students the support they require	3	2	2	1	3
2/4e	Emergency/stressful situations	Being unable to cope with/manage patient care in an emergency situation	7	6	5	4	33
2/4f	School documentation	Learning how to complete and manage the nursing documentation	6	2	2	3	14
2/4g	Terminology	Nursing/medical terms	0	1	3	0	0

Q4   Was there anything you felt unprepared for?

Code		Definition	C1	C2	C3	C4	C5
2/5a	Busy	Crowded with or characterized by activity	18	14	28	20	50
2/5b	Professional	Competent, skilful and assured	10	14	9	13	20
2/5c	Friendly/supportive	Welcoming the student and helping them learn	29	19	11	22	39
2/5d	Clean/tidy	Clean and tidy physical environment	7	3	1	3	8

Q5   What was the nursing environment like?

Code		Definition	C1	C2	C3	C4	C5
2/6a	Friendly/welcoming	Welcoming the student	9	5	6	14	35
2/6b	Professional	Competent, skilful and assured	6	4	8	14	19
2/6c	Team working	Working together to achieve a common goal	3	3	0	5	3
2/6d	Mixed	A mixture of ways of working	9	13	7	7	13
2/6e	Holistic	Putting the patient at the centre of care	0	0	0	2	0
2/6f	Caring	Where staff display empathy and sympathy	1	1	5	0	3
2/6g	Terminology	Nursing/medical terms	0	0	6	0	0

Q6   What was the nursing culture like?

Code		Definition	C1	C2	C3	C4	C5
2/7Y	Yes		33	36	37	41	92
2/7N	No		3	5	7	3	12
2/7a	Different practices	Practices are taught differently in to two environments	25	2	5	6	10
2/7b	More 'real' world	Practice in the clinical environment is realistic compared to that taught in school	5	3	13	21	21
2/7c	More hands on	There is more opportunity to practice skills in the clinical setting	14	30	18	16	56
2/7d	Related theory to practice	Practice allowed the student to utilise theory learnt in school	0	3	2	5	2

Q7   Did school and practice learning differ?

Code		Definition	C1	C2	C3	C4	C5
2/8a	Contacted placement	Visited or rang the placement prior to the experience	6	16	18	29	31
2/8b	Action plan	Put together a plan of what they wanted to achieve	5	0	0	0	1
2/8c	Researched	Found out about the nursing speciality found on the placement	22	23	19	33	68
2/8d	Talked to friends/colleagues	Asked friends and colleagues about what to expect from the placement	4	3	7	6	13
2/8e	Was open minded	Tried not to have any preconceived ideas about what the placement would be like	1	6	2	1	7
2/8f	Was organised	Student ensured they prepared aspects such as route, uniform, paperwork prior to their placement	0	0	4	0	0

Q8   How did you prepare for your placement?

Code		Definition	C 1	C 2	C 3	C 4	C 5
2/9Y	Yes		36	39	43	49	100
2/9N	No		2	0	1	3	8
2/9a	Fitted in	Felt like they were part of the nursing team	14	17	11	23	38
2/9b	Grew in confidence	Became more self assured	6	4	11	11	37
2/9c	Linked theory and practice	Was able to see the links between nursing theory and practice	4	1	1	4	5
2/9d	Positive ward report	The mentor documented that the student had made progress during their placement	3	2	3	4	2
2/9e	Felt prepared	The student felt that their preparation had contributed positively to their transition	3	4	8	4	7

Q9   Was your transition successful?

APPENDIX G

Study: Transition: an exploration of student nurse experience in their first practice placement.

Investigator: Sally Melling

Interview Questions

1. What did you expect your first placement to be like?

2. Was it what you expected?

3. What was the nursing culture like on your placement?

    (hierarchy of staff/nursing language/ways of behaving/uniform/your time with the patients/values)

    a. What did you enjoy?

    b. What did you dislike?

4. How did you prepare for your first placement

5. What do you remember about your first day on placement?

6. What helped you manage the transition from school to practice?

    (before you started/once you were there)

7. What were the main differences between learning in the school and learning in practice?

8. If you were able to prepare for your first placement again, is there anything you would do differently?

9. What advice would you give a new first year about to start their first placement?

10. Do you have anything else to add?

APPENDIX H

<u>**Healthy Volunteer's Information Sheet**</u>

Interview

Name of Investigator: Sally Melling

I would like to invite you to take part in the second phase of my research study. Please take time to read this information and discuss it with your friends and relatives if you wish. Please ask or email if there is anything that is not clear or if you would like more information.

Background Information

The research is being completed as part of a Doctorate in Education at the University of Nottingham. The aim of this study is to investigate student nurse perception of their first practice placement and to understand the techniques they employ to manage transition into the practice setting.

What does this study involve?

Phase 1 involved the administration of questionnaires to the 0901 Nottingham cohort. I would now like to explore your questionnaire responses in more depth at an interview. This should take no longer than 30 minutes. Other than the researcher, no-one will be able to identify you.

Why have I been chosen?

You are one of 25 students who have been asked to participate as I wish to explore your questionnaire responses in more depth.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet once again prior to the interview. You will be able to withdraw from the study at any time until the thesis is completed.

What are the possible disadvantages of taking part?

The questionnaire may highlight issues in practice that you have found distressing. If this is the case please contact your personal tutor who can discuss any issues with you.

If I am unhappy who can I complain to?

If you have a complaint relating to the study please contact the researcher in the first instance. If you receive no satisfactory outcome, you should then contact the Ethics Committee co-ordinator roger.murphy@nottingham.ac.uk

Will my taking part be kept confidential?

No person other than the researcher will have access to the interview transcripts. No student will be identified in the thesis. You will be invited to review the transcript of the interview before it is used for the thesis. Interview transcripts will be stored by the researcher in a locked cabinet until the thesis is completed after which they will be shredded.

What will happen to the results of the research study?

The results of the study will be made available to any participants who wish to receive them following completion of the study.

Who has reviewed the study?

This study has been reviewed and approved by the University of Nottingham Medical School Ethics Committee and the School of Education Ethics Committee.

Contact for Further Information

Researcher: Sally Melling: sally.melling@nottingham.ac.uk

Supervisor: Dr Chris Atkin chris.atkin@nottingham.ac.uk

2011

APPENDIX I

PARTICIPANT CONSENT FORM - Interview

Project title Transition: an exploration of student nurse experience in their first practice placement.

Researcher's name Sally Melling

Supervisor's name Dr. Chris Atkin

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.

- I understand the purpose of the research project and my involvement in it.

- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.

- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

- I understand that I will be audio taped during the interview.

- I understand that data will be stored in a locked cabinet and accessed solely by the lead researcher. I understand that original data will be destroyed upon completion of the thesis.

- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

Signed …………………………………………………………………. (research participant)

Print name …………………………………………………… **Date** …………………………………

Contact details

Researcher: sally.melling@nottingham.ac.uk

Supervisor: chris.atkin@nottinham.ac.uk

- School of Education Research Ethics Coordinator:
  andrew.hobson@nottingham.ac.uk