

Leadership for Learning

Final Report

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CONTENTS

Acknowledgments	3
Executive Summary	4
Chapter 1 - Introduction and overview of study.....	6
Chapter 2 - Literature review and stakeholder interviews.....	15
Chapter 3 - Learning Environment online survey.....	26
Chapter 4 - Four case studies	37
Chapter 5 - Curriculum analysis	70
Chapter 6 - Discussion	72
Chapter 7 - Conclusions and recommendations	75
References.....	76

Appendix 1 Stakeholder interview schedule

Appendix 2 Interview schedule

Appendix 3 Online questionnaire

Appendix 4 Dissemination

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Executive summary

This study investigated how changes in nursing leadership roles have influenced the ways in which student nurses learn in practice settings in the new NHS (DH 1999, DH 2000). We focused on new leadership roles and their influence on student nurse learning, given the change in the ward sister's role during the 1990s. At the same time as these workforce changes were being introduced, major changes in nursing education occurred as a result of the introduction of the Project 2000 curriculum in the late 1990s (NMC 2004), the subsequent Fitness for Practice curriculum (UKCC 1999) and the move of nurse education into higher education. Subsequently, concerns emerged in relation to the ward learning environment with the shift in emphasis from the college to practice setting (UKCC 1999).

Following these fundamental changes to nursing careers and nurse education, a change in the public perceptions of nurses had also crept into the public discourse with accusations that the move of student nurses into universities had rendered them "too posh to wash" resulting in a general lowering of standards, including poor hygiene and outbreaks of serious infection (Scott 2004).

Given these changes to ward management and nursing leadership and nurse education, and using Smith's (1992) framework to link emotions and learning to care, the purpose of our study was to investigate the relationship between nursing leadership roles and student nurse learning in clinical practice – in other words, who is responsible for the leadership of student nurse learning in clinical practice?

Stage 1 included a literature review and stakeholder interviews with leaders in nurse education. In stage 2, using a case study research approach, data collection involved three main methods: an online survey, clinical fieldwork and documentary analysis of the written curricula in four case study sites: London (Universities A & C), the North West of England (University B) and the South East of England (University D).

Our main finding in stage 1 took the form of key questions for data collection in stage 2. These questions were:

- What is nursing?
- What should student nurses learn?
- Whom should they be learning from?

Our main finding in stage 2 is that the policy changes in both the education of nurses, such as the move into the higher education sector, and the workforce changes in nursing, such as the changes to students' and health care assistants' roles, brought about partly by these very same educational developments, have had profound effects for both student nurses and staff who teach, mentor and work with them both in practice and in the higher education setting.

The effects of the move into higher education and role changes on student nurse learning are evident in the literature and illustrated in great depth by the findings from this study and our data suggests that students experience an *uncoupling* of their learning in clinical practice from their theoretical learning. For lecturers, the changes have meant an increasing lack of clinical academic confidence; and for mentors, they have been left with the daily responsibility of learning if not the leadership which has increased their workload.

This uncoupling may be part of a wider shift to skills and competency based education and practice which Scott (2008) identifies and a move from relational caring where emotions are not identified as a key component of nursing and therefore not taught or assessed in education or practice. Our data suggest that emotions remain a strong feature of learning, mentoring and practice and that support is required to focus on how to manage feelings and learn from them.

Clinical learning continues to be the remit of ward managers and although they are supported by practice educators, ward sisters, staff nurses, clinical nurse specialists, lead nurses or modern matrons, they maintain overall responsibility for ensuring that the learning environment, including mentor training and support, is provided at ward level. However, due to an increased workload, including Trust wide responsibilities, their presence and attention have been taken away from the ward and students in many ways. Clinical learning appears to be secondary to the drive for achieving clinical throughput and targets apparent through a return to task allocation. We argue that the nursing process which was the predominant form of care delivery during the 1970s and 1980s, has now largely been abandoned due to the pressure to achieve targets. Task allocation in its new form of meeting discharge and bed targets and delivering trained nursing tasks (e.g. giving drugs) appears to have been reintroduced and we observed a return to 'team' or 'sides' nursing (by which the work was divided into two separate 'sides' of the ward to which the nurses were then separately allocated) and a move away from patient allocation.

Our data suggest that bedside care continues to be regarded as low status work (as Goddard [1953] and others found) by student nurses. Being associated with such work leads students to feel stigmatised which in turn leaves them feeling unprepared for their future role as trained nurses who are not expected to perform such tasks.

Based on these findings, we identify indicators that could be used to assess leadership for learning in clinical practice. These indicators should be evident in the working curriculum and in the working relationship between the clinical practice areas and the higher education institutions (HEIs). By 'working' curriculum and 'working' relationship we mean the formal, informal and hidden curriculum evident in the written documents and student evaluations which record their learning in clinical practice and the key roles played by link lecturers, ward managers and mentors.

We suggest that these indicators could feed into the current policy agenda around modernizing nursing careers to demonstrate ways to empower ward managers in their leadership role by linking student nurse learning to quality standards for care.

Chapter 1 - Introduction and overview of study

Background and introduction

This study investigated how changes in nursing leadership roles have influenced the ways in which student nurses learn in practice settings in the new NHS (DH 1999, DH 2000). We focused on new leadership roles and their influence on student nurse learning, given the change in the ward sister's role during the 1990s. The NHS Plan in 2000 (DH 2000) introduced new nursing roles intended to provide clinical leadership and revitalise clinical nursing careers (DH 1999). These developments were partly in response to workforce demands created by the need to reduce junior doctors' hours (DH 1998) at a time when nursing careers were identified as needing revitalisation and restructuring. These changes followed previous debates around what being a nurse means, what nurses do and at what level and what knowledge they need to practice at different levels (RCN 2003). This questioning of the value of nursing, and the fundamental values underpinning nursing (Horton et al 2007; Allan et al 2008) followed major changes in nursing education after the introduction of the Project 2000 curriculum in the late 1990s (NMC 2004); the subsequent Fitness for Practice curriculum (UKCC 1999) and the move of nurse education into higher education.

At the same time as these fundamental changes to nursing careers and nurse education, a change in the public perceptions of nurses had also crept into the public discourse with accusations that the move of student nurses into universities had rendered them "too posh to wash" resulting in a general lowering of standards, including poor hygiene and outbreaks of serious infection (Scott 2004). As a result of these concerns, another leadership role was introduced, the modern matron or lead nurse (Allan & Smith 2004).

Against this background, our study focused on student nurse learning in the context of new clinical leadership roles and their influence on student nurse learning given the change in the role of the ward sister during the 1990s. Until that time, research showed that the ward sister held a pivotal role in facilitating student nurse learning in terms of the emotional support required to develop a positive learning environment and provide high standards of care (Orton 1981, Fretwell 1982, Ogier 1982, Smith 1992). Recent research suggests that new leadership roles such as the specialist nurse, the modern matron and the nurse consultant, have replaced the ward sister in providing emotional support to facilitate patient care (Smith et al 2003; Allan & Smith 2005). Their relationship to student nurses' learning however remains less clear.

More recently, concerns have emerged in relation to the ward learning environment with the shift in emphasis from college to practice setting (UKCC 1999). These concerns include attitudes towards mentoring among trained staff (Hyde & Brady 2002), the mentorship of internationally recruited nurses (Allan & Larsen 2003), the mentorship of midwives (Pope et al 2003), the preparation and support required for preceptorship roles (Allen 2002), the time constraints imposed on the mentor's relationship with student nurses (Lloyd-Jones et al 2001) and the effects of introducing support workers to replace student nurses as frontline workers in clinical settings (RCN 2003).

Smith (1992) found that paying attention to emotions was a useful way to examine and explore the links between clinical leadership, student nurse learning and the emotional effects on individuals delivering and receiving care. Other studies have demonstrated that emotional support influences patient care (Revans 1964; Menzies 1970) and clinical leadership (Smith 1992; Smith & Gray 2000). Recent understanding of the role of emotions in the functioning

of organisations (Huy 1999; Goleman 1998; Obholzer & Zagier Roberts 1994) has demonstrated that understanding the role of emotions in organisations improves effective management of staff and creates an environment that supports and facilitates care.

Given these changes to ward management and nursing leadership, and using the framework of emotions in organisations, the purpose of our study was to investigate the relationship between nursing leadership roles and student nurse learning in clinical practice – in other words, who is responsible for leadership for student learning in clinical practice?

Research aims and objectives

Research aims:

- To investigate the impact of changes in ward management, new nursing roles and clinical leadership on student nurse learning in the practice setting.
- To identify factors in the educational curriculum, which facilitate and impede student nurse learning in practice.

Research questions:

- What is the impact of changes in ward management, new nursing roles and clinical leadership on student nurse learning in the practice environment?
- Who facilitates student nurse learning during their practice experience?
- What approaches to learning are evident in practice?
- How have changes in nurse education affected the structure and content of student nurse learning and the theory/practice balance?

Study design

The study was designed in two stages over two years. In Stage 1, we undertook a literature study which involved consultation with key stakeholders by telephone and face to face interview; and a critical analysis of the grey and published literature to investigate national changes in the curriculum and the clinical learning environment. The influence of policy on student nurse learning was the focus of this literature study. A conceptual framework of leadership for learning was developed at the end of Stage 1 to derive interview questions for the empirical data collection in Stage 2.

In Stage 2, four case studies of leadership for clinical learning were undertaken in four sites across England. Burawoy (1991) argues that case studies are ideal to test theory against people's understandings of the everyday world. In this study, Burawoy's (1991) methodology was used to study students as they learn and work in clinical areas and elicit their reality and understandings about how they learn and who emotionally supports their learning. The case study sites were selected from higher education institutions (HEIs) that offered diploma and degree level education for pre-registration nursing and in addition had been early providers of degree level education for nursing students [the so called experimental degrees]. Data were collected from the higher education institutions as well as a range of clinical practice settings where students were allocated for their clinical experience; these settings were all acute NHS Trusts. The case study sites A-D were: London (Universities A & C), the North West of England (University B) and the South East of England (University D).

Successful applications were made to the NHS National Research Ethics Service and the University of Surrey Ethics Committee as well as the Research and Development Committees in each case study site.

Methods

Case study research methods included qualitative and quantitative data collection using three main methods: an online survey, fieldwork and documentary analysis of the written curricula.

Online survey

To gather a broad range of responses to our research questions, we decided to use a census sample from the total population of pre-registration (diploma and undergraduate) students in each site who were asked to complete a Likert questionnaire to rate their perceptions of the clinical learning environment adapted from Fretwell (1982) and Smith (1992). The questionnaire was administered online and a summary of the findings are discussed in Chapter 3. The complete survey findings are presented in a separate report.

The survey had a narrower focus than the qualitative aspects of the study in that data were collected from just one stakeholder group (students) and tested themes from the 1984 survey with contemporary students; these themes corresponded to components identified by Smith as key to the successful learning environment. Open-ended questions were also used in the survey which gave the students opportunities to describe their experiences in their own words.

Fieldwork

To illuminate the survey data and test our conceptual framework developed in Stage 1, we used fieldwork in a range of clinical settings across the four sites to collect qualitative data. Each period of fieldwork lasted 5 days in each site. We interviewed a range of clinical, management and nursing staff with teaching responsibilities to elicit their views on how nursing management and ward management structures in the new NHS influence student nurses' learning in clinical placements. At the same time, we undertook periods of observation in a range of clinical settings to observe the student experience of the learning environment and informally interview student nurses and their mentors and managers through working alongside them.

During participative observation, a total of ten sessions were spent in clinical areas in Sites A, C and D including the Accident and Emergency Department (A & E), medical and surgical wards and a day surgery ward; each observation period lasted three to four hours during a morning shift starting at 07.30 especially to observe handover and allocation of nursing duties. The researcher spent time observing and not participating when students were working with their mentors e.g. doing the morning drug round. She also worked with students, performing nursing duties such as bed making, handing out breakfasts, washing patients, preparing patients for operating theatres and dressings and doing observations; in this way she engaged them and their mentors and the staff working that shift in informal interviews using her observations as probes to explore their thoughts about student learning, leadership roles in the new NHS and ward management in general. The researcher also undertook informal interviews with student nurses over coffee after working for a shift with them. In total, she informally interviewed and worked with four second year, seven third year and two first year student nurses (13 in total). This meant that she was able to explore informally, observations she made about learning in clinical practice directly with the students observed and while these observations were fresh in her mind.

Six days were spent in Site B based in an NHS acute Trust. During an exploratory visit the researcher informally interviewed three modern matrons, a lead nurse (General Medicine) and the Director of Nursing. During the five day site visit she interviewed 11 student nurses

both individually and in focus groups and spent two morning shifts observing and working alongside two of them. She also interviewed two practice educators who were employed to liaise between the university and the Trust and conducted a focus group with three ward-based practice educators two of whom had combined roles as ward sister (Respiratory Medicine) and consultant nurse (Cardiology). The third participant was a full time practice educator in the Special Care Baby Unit.

Ethical approval and informed consent were important features of the research process, and at times, constrained the participative observation. The researchers followed the recommendations of Moore & Savage (2002) who argue that as well as process consent [or continuously checking out with participants that the researcher is not intruding] researchers need to judge for themselves when they feel intrusive. If they do, then they should remove themselves from the clinical interaction or activity and re-enter the field later. While undertaking 'participative' observation, the researchers held the status of privileged observers as they were easily able to gain access to clinical settings once their identities became known (Wolcott 1988). This in itself presents ethical issues as the researcher has to then self-monitor to ensure that her presence is appropriate and not intrusive for either the staff or the patients/carers. This was accomplished through the use of body, self-presentation and actions. Savage (2000) calls this participative observation, while Kleinman & Copp (1993) refer to it as the use of 'emotions in fieldwork'.

Formal interviews and focus groups in the four sites were undertaken using a prepared interview schedule developed by both researchers and based on the conceptual framework developed in Stage 1 (Appendix 1). We requested to interview key stakeholders in the clinical settings who were identified in the literature as having a role in leadership for clinical learning. The numbers and types of staff we interviewed as well as the type of interview method we undertook were determined to some extent by local fieldwork conditions. Formal interviews and focus groups were arranged by the Director of Nursing's Department in each Trust. The informal interviews with students and staff were undertaken by the researchers as opportunities arose during participative observation periods and are summarised in Table 1 overleaf.

Table 1: Summary table of staff interviewed across four fieldwork sites

	Site A	Site B	Site C	Site D
Student nurses		8 [Individual] 3 [Focus group]		
Lead nurses/ modern matrons	4 [Focus group]	1 [Individual] 3 [Joint interview]	3 [Focus group]	3 [Focus group]
Mentors	3 [Focus group]			3 [Individual]
Link Lecturers	2 [Joint interview]		2 [Individual]	4 [Individual]
Ward manager	6 [Focus group]			1 [Individual]
Practice development nurses [PDNs]	6 [Focus group]		5 [Focus group]	
Placement co- ordinator	1 [in same Focus group as PDNs]			
Deputy Director Nursing	1 [Individual]	1 [Individual]		
Senior Trust nurse practice education			1 [Individual]	
Senior Trust nurse leadership			1 [Individual]	
Practice educators		2 [Joint interview] 3 [Focus group]		

In summary, the following samples, settings and methods were included in the study:

- Consultation with stakeholders and literature study to evaluate clinical learning and leadership in the new NHS in order to produce an evidence base and conceptual framework to generate questions for focus groups and interviews.
- Ward learning environment questionnaire survey was distributed online to a census sample of diploma and undergraduate student nurses in each case study site.
- Informal and formal, individual and joint interviews with a sample of student nurses from first, second and third year groups in each case study site.
- Informal and formal, individual, joint and focus group interviews with a sample of ward managers, mentors, specialist nurses, nurse practitioners, lead nurses, modern matrons, practice educators, practice development nurses and lecturers.
- Participative observation in a sample of acute clinical settings in acute NHS Trusts.

Data Analysis

Field notes were kept manually by both fieldwork researchers, written up electronically and shared between the research team and also used as a data source for data analysis. Interview transcripts were transcribed verbatim by an administrator and then corrected by the interviewer. Data analysis was undertaken manually and transcripts were shared between the two researchers and several meetings were held to discuss emerging themes. At these meetings, comparison was made between the survey and the qualitative (interview and observation) data and hypotheses from the qualitative data were tested within the survey data. The key themes from the quantitative and qualitative data analysis are discussed in

Chapters 3 and 4. Lastly, a curriculum analysis of the common foundation and branch pre-registration and undergraduate nursing programmes (e.g. child; adult; mental health; learning disability) was undertaken from each of the institutions' published curricula. The themes from this analysis are presented in Chapter 3, 4 and 5.

Findings

The findings from stage 1 are presented and discussed in Chapter 2 and the findings from the survey (stage 2) are presented and discussed in detail in Chapter 3 while a summary and diagrammatic overview of the full study's findings in Figure 1, are presented below.

Our main findings from the qualitative data in stage 2, integrated with the stage 1 findings and the survey data, are that the policy changes in both the education of nurses, such as the move into the higher education sector, and the workforce changes in nursing, such as the changes to students' and health care assistants' roles, brought about partly by these very same educational developments, have had profound effects for both student nurses and staff who teach, mentor and work with them both in practice and in the higher education setting.

The effects of the move into higher education and role changes on student nurse learning are evident in the literature and illustrated in great depth by the findings from this study. One effect for students has been an *uncoupling* of their learning in clinical practice from their theoretical learning. For students, one of the signs of this uncoupling has been that their so-called supernumerary status has become a hurdle which the more successful can negotiate in order to learn effectively in practice. For those students who do not learn to negotiate this status, learning can be difficult and their status as students rather than workers becomes a barrier to learning in a ward team.

For lecturers, there has also been an uncoupling from practice which is manifested and shaped by the lack of clinical academic career pathways – lecturers are employed within a structure which does not effectively encourage a connection with practice. This is experienced in some cases as a sense of loss and lack of identity, what might be described as a lack of clinical academic confidence, which is yet to be effectively understood or resolved.

This uncoupling may be part of a wider shift to skills and competency based education and practice which Scott (2008) identifies and a move from relational caring where emotions are not identified as a key component of nursing and therefore not taught or assessed in education or practice. Our data suggest that emotions remain a strong feature of both learning, mentoring and practice and that support is required to focus on how to manage feelings and learn from them.

Clinical learning continues to be the remit of the ward managers and although they are supported by practice educators, ward sisters, staff nurses, clinical nurse specialists, lead nurses or modern matrons, they maintain overall responsibility for ensuring that the learning environment, including mentor training and support, is provided at ward level. However, due to an increased workload, including Trust wide responsibilities, their presence and attention have been taken away from the ward and students in many ways. Clinical learning appears to be secondary to the drive for achieving clinical throughput and targets through a return to task allocation. We argue that the nursing process which was introduced during the 1970s

and 1980s has now largely been abandoned due to the pressure to achieve targets. Task allocation in its new form of meeting discharge and bed targets and delivering trained nursing tasks (e.g. giving drugs) appears to have been reintroduced and we observed a return to 'team' or 'sides' nursing (by which the work was divided into two separate 'sides' of the ward to which the nurses were then separately allocated) and a move away from patient allocation. In one sense then, the ward manager's role has remained remarkably unchanged in relation to student learning *over a 20 year period* during which some of the interviewees had been in post. Yet there are other elements that have been introduced that make these ward managers feel that overall their role has substantially changed for the worse. While essentially elements of the ward manager's role are predominantly similar to that of the ward sister of 20 years ago, what has happened in the interim is that new elements to the current role have been introduced that makes it feel unsatisfying for the post holders to the extent that there appears to be a *harkening* back to some sort of golden time for ward sisters.

We argue that if bedside care continues to be regarded as low status work as Goddard (1953) and others found and which our data suggests continues to be the case among student nurses, then being associated with such work may lead students to feel stigmatised which could then certainly leave them feeling unprepared for their future role as trained nurses who are not expected to perform such tasks. The relationship between the low status of bedside care, the role of trained nurses and stigma is complex and may be interpreted in a variety of symbolic ways. Students may be made to feel outsiders to the ward nursing team and in particular the professional nurses they aspire to be, by being treated as the 'stupid' student for whom there is no time to supervise. They are therefore allocated low status 'care' rather than 'nursing' tasks to perform which in the trained staff's view do not require supervision. The effect on the students is to make them feel devalued, marginalized and 'stupid'.

For the mentors, who have effectively been left with the daily responsibility if not the leadership for clinical learning, the effects of these policy shifts have been to make teaching and learning a requirement for promotion whether or not an individual has the inclination and capacity to teach and work with students.

The questions we asked at the conclusion of Stage 1 were:

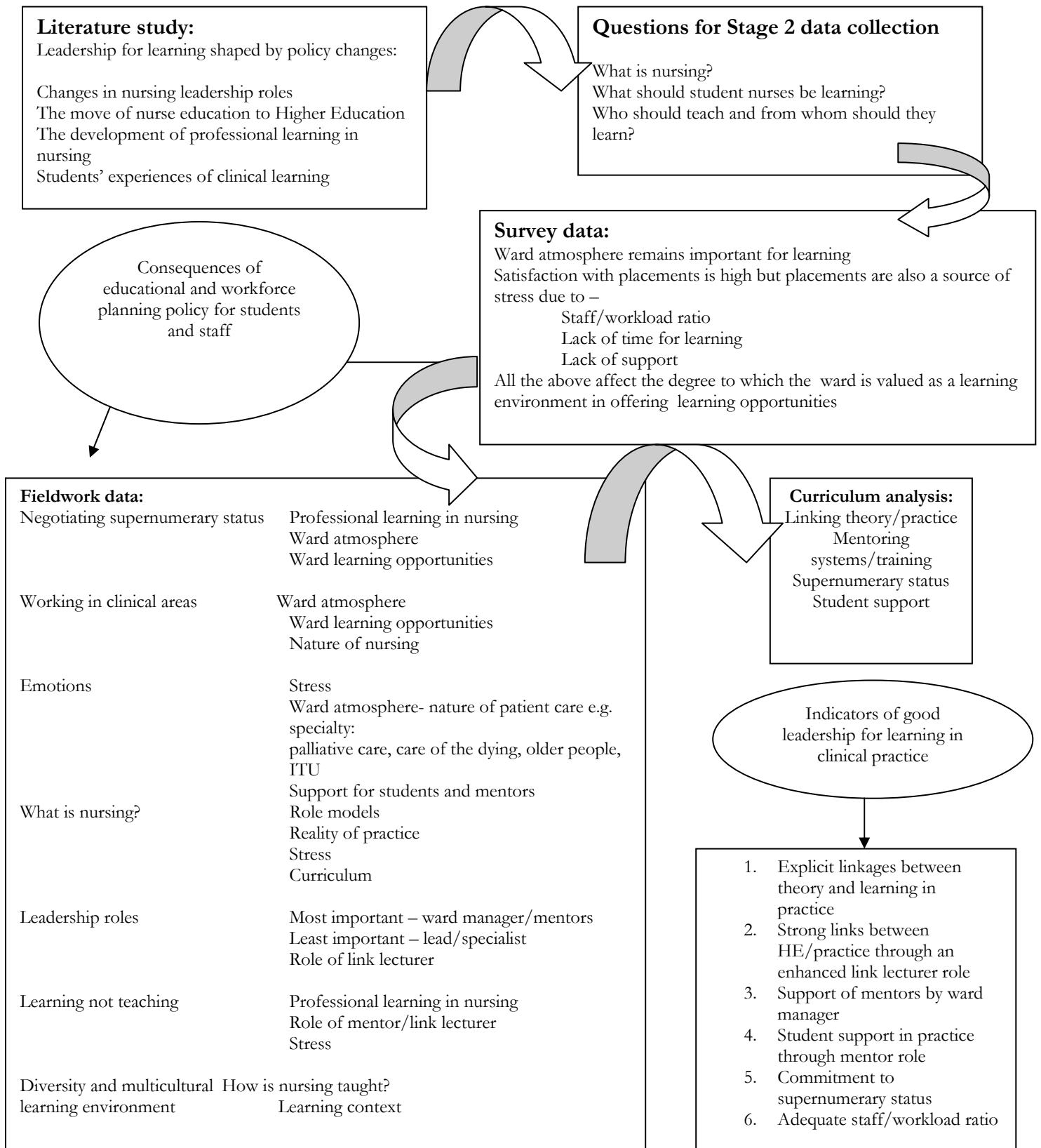
- What is nursing?
- What should student nurses learn?
- Who should teach nursing or from whom should students learn?

Our findings in Stage 2 of the study go some way to answering these questions and suggest indicators for assessing leadership for learning in clinical practice. These indicators should be evident in the working curriculum and in the working relationship between the clinical practice areas and the HEI. By 'working' curriculum and the HEI's 'working' relationship to the clinical practice areas we mean the formal, informal and hidden curriculum evident in the written documents and student evaluations which record their learning in clinical practice. From the study findings we suggest that evidence for the following indicators should be sought:

- Explicit linkages between theory and practice learning
- Strong links between the HEI and clinical practice articulated through the key role of the link lecturer
- Support of mentors articulated through the key role of the ward manager
- Student support in practice articulated through the key role of the mentor
- Commitment to supernumerary status
- Adequate staff/workload ratio

These indicators would feed into the current policy agenda around modernizing nursing careers in order to demonstrate ways to empower ward managers in their leadership role for learning at ward level through linking quality standards for care to learning.

Figure 1: Summary of Study Design and Findings
 The consequences of educational and workforce planning policy on leadership for and indicators of student nurse learning in clinical practice



Chapter 2 - Literature review and stakeholder interviews

This chapter reports the literature study undertaken in Stage 1 which critically evaluated the literature in the area of leadership for learning in clinical practice in the British setting only (Barrientos 1998). A literature study is wider than a literature review and allowed us to critically analyse and evaluate the literature *and* other sources of information on a topic; in our case, stakeholder interviews in order to formulate an argument and present the resulting analysis in relation to new aspects of inquiry.

Our literature study suggests leadership for learning has been shaped by interweaving strands of policy. One of our conclusions at the end of Stage 1 was that ward management had radically altered since the introduction of the National Health Service (NHS) Plan (DH 2000) and that these changes have influenced the nature of nursing leadership for learning in the UK and the relationship between nursing education and practice. Pivotal to these changes have been the changes to the role of the ward manager and the introduction of new nursing leadership roles.

Background

Historically student nurses were the primary care givers as well as learners in wards. Moores & Moulton (1979) estimated 75% of direct care used to be given by students in the 1970s and trained nurses taught and students learned while they worked (Fretwell 1982); at least until the curriculum reforms of the 1980s and the introduction of supernumerary practice for students with the Project 2000 curriculum (Wilson-Barnett et al 1995; NMC 2004). The introduction of subsequent curricula (UKCC 1999; NMC 2004) led to debates about fitness for practice and competency among student nurses and trained staff as well as continuing differences in opinion about the place of nursing in higher education institutions (HEIs) (Altschul 1992; Draper 1996). Nursing education's location in higher education and its consequent relationship with the NHS continue to raise questions for the national stakeholders we interviewed although Lahiff (1998) notes that there was always a resistance to intellectualism in nursing which led to a paralysing ambivalence in nursing vis a vis education.

Repeated research during the 1980s (Fretwell 1982; Lewin & Leach 1982; Ogier 1982) showed that positive working relationships between permanent staff and students led to a good learning environment. In addition, these researchers also found that the ward sister had a key role in determining the ward learning environment. Smith (1992) found that, in addition, a good learning environment for student nurses led to good patient care. However, following this period of relative stability, Wiseman (2002), collecting data in the mid 1990s, found that the ward learning environment was fragile and adversely affected by changes in the ward sister role.

Literature study design

The following terms, learning in practice; nursing leadership; professional learning and higher education, were searched in the following electronic databases: BNI; CINAHL; Medline(Ovid) & Medline Pubmed; PsyInfo; IBSS; British Education Index.

The inclusion criteria were as follows: English language, peer reviewed, national and international journal papers from 1990 until 2006. The focus of the literature and policy was the UK. Reports from national professional bodies and policy documents from the Department of Health were also included. These policy documents generally formed the background to the literature study rather than the focus of the papers included in the review. During the reading of the collected literature, further papers were retrieved which went beyond the original search terms as themes developed in our analysis of the literature. A thematic analysis was then made of the literature (Barrientos 1998) using the following questions:

1. What is the main focus of the paper?
2. What are the main findings?
3. What implications are there in this paper for leadership for learning?

Four key themes emerged from answering these questions following careful reading of each paper. These were:

1. Changes in clinical leadership
2. Evaluation of the move to higher education in the 1990s
3. The nature of professional learning in nursing
4. Student nurses' clinical learning experiences

These themes formed the conceptual framework for the interview schedule in the stakeholder interviews and informed the subsequent data collection across the four fieldwork sites.¹ The interviews were undertaken with four heads of nursing schools, one deputy director of nursing education, two nurse education managers, a participant of a national leadership programme, one professor of nurse education and one professor of nursing research. The interviews were transcribed verbatim and analysed thematically by the research team. The stakeholder interview data are useful as a means to contextualising the reality of policy changes for those driving and indeed implementing the policy agenda. Their views provide an interesting counterpoint to the research data in the literature.

This chapter is based on a paper which has been published in the *Journal of Nursing Management*². The chapter is structured in two sections. The first section discusses the literature concerning the first two themes from the literature review, namely, the changes in clinical leadership and evaluations of the move of nursing education into higher education. The second section discusses the literature on learning in professional nursing practice and students' experiences of clinical learning. We intersperse each of these discussions with extracts from stakeholder interviews undertaken as part of the literature study to illustrate the meaning these policies have for individuals at the centre of policy change in nurse education.

¹ Appendix 1

² See Dissemination, Chapter 8.

Changes in clinical leadership

There were 12 papers which discussed changes in nursing leadership and their impact on learning which were a mixture of original research (7) and commentary³ (5).

Leadership for learning is at the forefront of the new NHS because changing workforce initiatives introduced by Government since 1997 demand new ways of working and learning (Melia 2006). However, in terms of leadership for student nurse learning and drawing on empirical work, Melia argues that new nursing roles are “shaped by changes in the medical workforce and particularly by the desire for a consultant led service” (2006:1) and that delivering the new NHS reforms is driven by a workforce agenda rather than an educational one. The challenge remains for “practice disciplines (who) need to map university qualifications onto skills” (2006:22); and this challenge affects fitness for practice at the point of registration. For example, in a commentary paper reflecting on the changes in the role of the ward sister during the 1990s, Mann (1998) describes her experience of being a ward sister and now a specialist nurse; she observes that the former had a strong emphasis on student nurse learning while the latter has little.

Lorentzon’s review of modern matrons (unpublished) suggests that the changes to the ward sister’s role in the 1990s led to a gap in nursing management filled by the modern matron. She argues that the re-introduction of matrons “reflected a political awareness of public nostalgia, if not for Hattie Jaques character, for the person who was perceived to hold it all together” (unpublished:3). Lorentzon points out that there are few references to learners in the literature on modern matrons (including policy documents). Of the research papers, which do explicitly refer to leadership roles and student nurses, Hutchings et al (2005) cites mentors and matrons as key stakeholders in regard to determining the number of learners who can be accommodated in particular clinical areas. Scott & Savage (2005), in their national evaluation of the modern matron role, list nursing education as a core function of modern matrons but provide no further discussion on this topic. Rather vague references are made to student nurse learning in two commentary papers; Carlowe (2002) reports one matron seeing her role as including supervision of students and Mercer (2002) stresses the need for modern matrons to have an appreciation of the value of learning.

While there are few references to student nurse learning in the leadership literature, learning organisations and cultures (MacCormack & Slater 2006) are seen as a way of promoting leaders for learning and therefore improvement in the delivery of services (Kerfoot 2003).

The relationship between trained nurses and student nurses was traditionally experienced through role modelling where less experienced nurses were expected to learn from more experienced nurses; role modelling continues to be used as a way of allowing students to work alongside practitioners in busy wards as a means for learning (Murray & Main 2005). Davies (1993) argued that clinical role modelling could integrate the art and science of nursing. Students in her study were able to articulate their values to ‘good’ and ‘bad’ care through exposure to clinical practitioners. However, changes to skill mix on wards

³ However while acknowledging that in a literature study the type of paper needs to be identified i.e.: research as opposed to commentary or policy; nevertheless the commentary pieces are frequently written by researchers in the field and can therefore be seen as contributing to the literature study.

(Langridge & Hauck 1998) and the lack of constructive feedback from role models which allow students to convert observed behaviours into their own behaviour (Donaldson & Carter 2005) are noted in both these studies to adversely affect the potential of role modelling for learning.

Evaluation of the move to higher education in the 1990s

In the context of nursing leadership for learning, the relationship between education and practice has had a pivotal role in shaping the occupational culture and politics of nursing (Rafferty 1992; Birchenall 2003; Kirby 2003; Lorentzon 2003); indicated perhaps by the number of papers (35) reviewed in this theme. In all, 14 commentary papers, three policies and 18 research papers were reviewed in this theme.

Overall, the move to higher education has been difficult for nursing education (Burke 2005; Thompson & Watson 2006; Betts 2006) for many of the reasons described by Lahiff in her analysis of the earlier introduction of experimental degrees in nursing. For example, Sastry (2005) cited the HEPI Report which found that nurse training is embedded in higher education without the profile of a typical higher education subject. Nursing admits students with sub-degree qualifications for entry and research is marginal; per capita spending on nursing is less than medicine and dentistry. Lorentzon (2003) comments that this lack of integration into higher education is a result of the socialisation practices of 19th & 20th century nursing students into the nursing profession which continues to be problematic today. These practices meant that a split developed between clinical practice and theory in curricula and the move into older polytechnics meant developing research has been difficult and nursing departments less well integrated as research disciplines in higher education sector. She locates the move historically as a professional agenda of nurse tutors which was unsupported by practitioners.

While knowledge may have been seen as possible within the university, Horrocks (2005) comments that nursing's move to higher education coincided with the introduction of corporatism into universities and nursing became caught in the drive for outcomes and less rather than more scholarly activity. It has also coincided with widening access across the higher education sector generally as Magnusson et al (2006) found in their empirical study of clinical placements.

Importantly in relation to clinical learning, Stew (1996) argues from empirical data that the move into higher education led to an increased theory practice gap as nurse teachers were viewed by practitioners as lacking clinical credibility; this perception of nurse teachers has adversely affected student learning and the acquisition of clinical skills. The role of the clinical teacher and the nurse tutor/lecturer are relatively well researched in the literature and continues to generate a source of anxiety among the nurse teaching profession (Millar 1993; Davies et al 1996; Carlisle et al 1996; Kirk et al 1996; Kirk et al 1997; Camiah 1998; Glen & Clark 1999; Ioannides 1999; Humphreys et al 2000; Murphy 2000; Fairbrother & Mathers 2004; Brown 2006; Gillespie & McFetridge 2006). The role of the university based nurse lecturer and nurse tutor is seen to be to support the mentors, to remain actively engaged with evidence based practice if no longer clinically delivering hands-on care and to support the learning environment and practice development. For example, in one of these research papers, Humphreys et al (2000:311) argue that a realignment of the role of the lecturer is

overdue given the “shift in responsibility for clinical learning”; namely from the tutor to the mentor.

Ashworth & Morrison (1989) suggested that the move to higher education would lead to stronger links between academia and practice while at the same time acknowledging the difficulties they saw for student nurses in negotiating the ambiguities the new role offered them as undergraduate students. Drawing on empirical data, they argue that these ambiguities arise firstly from the theory practice gap and the learning opportunities it presented in terms of the role the student undertook either as the learner *or* the producer of work; secondly from the placement experience and the short term nature of their membership in clinical teams.

Along with these concerns with the role of the link lecturer, the ambiguities of nursing student identity as learners in both the university and the NHS (Burkitt et al 2000) and the supervision of learning in practice have been well researched. There has also been concern with ‘fitness for practice’ expressed in commentaries in the literature (Bradshaw 1997; 1998; 2000; Chambers 2007). However, in a comprehensive policy review commissioned by the Nursing and Midwifery Council (NMC) into *Assuring Fitness for Practice*, Moore (2005) concludes that the concerns expressed in the literature are exactly that, concerns rather than substantiated evaluations or research studies; “there is no robust evidence to indicate systematic failure to prepare nurses who are fit for practice at the point of registration” (2005:76). Indeed, in comparison with international regulatory bodies, the UK system of regulation and accreditation is well regulated, well structured and rigorously delivered. He does report evidence of weakness in assessment and a lack of standardisation in measuring clinical competence, pressures on clinical placements due to the increase in student numbers and inadequate preparation and shortages of mentors. However, Chambers (2007) usefully points out that a basic discrepancy between views held by nursing management and education around what constitutes ‘fitness for practice’ has always existed. He argues that education educates students to be fit for the future and nursing managers want newly qualified nurses who are fit for purpose; these two views have always held sway (see also Lahiff 1998) within nursing but recent Government reforms are bringing them into conflict more openly.

In two public statements, the Council of Deans & Heads of UK University Faculties for Nursing and Health Professions has made clear its concerns with the problems raised by Moore (2005). In their draft response to the NMC consultation on current standards on mentoring (2006), they argued that there are limitations on learning in the current practice environment i.e. a higher turnover and dependency of patients in clinical areas. The Council urged the NMC to move away from its emphasis of hours completed in clinical practice irrespective of the quality of those hours; instead they argued that to deliver competent nurses on qualifying, more use could be made of practice gained in simulated environments. Likewise it disagreed with the NMC’s suggestion of an advanced level of mentoring while continuing to emphasise the importance of mentoring and suggesting replacing the hours in practice and therefore the stress on mentors with increased hours of simulated learning and assessing practice with objective, clinical skills examinations. They emphasised support and development of all mentors rather than creation of a new role of “experienced” mentor suggested by the NMC.

In a press statement from the Council on local funding, commissioning and contracting issues in England, the Council argues that the current cuts in places for nursing, midwifery and allied health professions students are short sighted and take no account of workforce needs in the future (2006). In particular, they draw attention to the problems created by commissioning and contracting between the NHS and higher education institutions which are destabilising the education and training infrastructure” and “totally undermining the partnerships between universities and the NHS” (2006:1). In a Hansard Report of a debate on the impact on higher education of NHS commissioning 20th February 2007, these points are again raised.

The stakeholder interviews

During telephone and face to face interviews we consulted with key stakeholders to generate further literature searches and research questions and test some of our emergent findings. The stakeholders’ main reactions to questions around leadership for learning and the move into higher education focused on the difficulties of establishing relationships between higher education and practice and the effects of those relationships on student learning. For example, when asked about the nature of commissioning in higher education, one interviewee said learning in clinical placements was:

“Worsened by a lack of communication between HEIs [higher education institutions]and practice and lack of IT skills in clinical staff and lack of “refined” processes in clinical areas which conflict with expectations [in HE]that students will develop different set of skills e.g.: analytic and critical skills” (STGNC402/06).

One interviewee commented on the physical spaces students negotiated between education and practice saying: “role modelling is more difficult with students being located in HE” (STGNC203/06).

And another said there is: “Confusion among students whether nursing education is campus or practice based learning. Role models are needed for students to identify what nursing contribution nursing makes to multi disciplinary teams – specialist nurses have deskilled general nurses and students need exposure to all nursing leadership roles. Specialist nurses don’t see pre-reg as part of their remit – [they] prefer to work and teach registered nurses within the speciality” (STGNC503/06).

This interviewee explained that while nursing leadership roles had developed:

“Ward managers were seduced into managerialism at the same time as the resurgence of clinical roles which don’t seem clear as to their focus on student nurses’ learning – it appears to be left up to the individual practitioner” (STGNC503/06).

In the absence of leadership from senior nurses in practice and a physical space between practice and education, leadership for learning has become relocated as the following quotes suggest:

“Academics can’t support effectively in practice – pressure is on mentors and [there’s a] lack of an academic clinical career – the model we’ve got in nurse education is historical... if you were picked out for being bright and teaching was your thing, then you were sort of lost to the profession. We can’t sustain that in the future” (STGNC402/06).

“Modern matrons are not really fitting with student learning; [they are] more interested in making wards run properly. I think the qualified accountable nurse as mentor is much more important than the Ward Sister in showing that learning is done. They are responsible for their students’ learning” (STGNC706/06).

And the consequences of leadership for learning being situated with mentors was suggested as having implications for the future structure of education of student nurses at Diploma level:

“Undergraduates have role models in HE but do Diploma students? Schools of nursing are being recreated in ‘parent trusts’ and student nurses have an identity with practice not HE” (STGNC303/06).

In summarizing the move to higher education, one interviewee said:

“We’ve lost our way in having any genuine oversight of [our] students’ learning on the ward” (STGNC503/06).

The nature of professional learning in nursing

The search was narrowed in this theme to focus on 25 research papers which dealt explicitly with professional learning in nursing due to the large number of papers available on professional learning more generally (for example, Evans et al 2005). Stickley & Freshwater (2002) explored in a qualitative study the question, why do people enter nursing? They argued that healthcare delivery systems drain the capacity to care which prompts students to enter nursing; this draining of the capacity to care has a bearing on learning and the development of the individual student’s nursing or professional identity. In a later paper, Freshwater & Stickley (2004) suggest that emotional intelligence and the capacity to care influences nursing behaviours and the delivery of care. Emotional intelligence is, they suggest, also linked to what students understand nursing to be and what student nurses learn to do as nurses. The notion of vocation or the attraction to caring work and its role in learning is commented on by others (Hugman 1991; Rozier et al 1992; Danka 1993; Barnitt 1998). In relation to learning and socialisation in nursing education and drawing on empirical data, Akerjordet & Severisson (2004) argue that developing *moral character* in relation to clinical practice is important on fostering the mental health nurse’s identity. Supervised learning in clinical practice fosters emotional intelligence, responsibility, motivation and the deeper understanding of patient relationships and the mental nurse’s identity and role.

In several research papers, the importance of how students learn in the clinical setting given that learning is culturally situated and individually constructed by a variety of different sources is emphasised (Jarvis 2005; Swanick 2005). For example, Lave & Wenger (1991) discuss the role of the sociocultural acquisition of knowledge and cite earlier work which

explored everyday cognition in a variety of social contexts. In the nursing context, Spouse (2001) argues that sociocultural learning with supervision to foster professional and education development is effective in developing competency in nursing students. She also emphasised the mentor's role in making craft knowledge explicit and facilitating understanding through repeated exposure to experience.

Inherent to the professional learning goal is the question of professional identity. For example, Holm, Lanz & Severissson (1998) found that nursing students' experiences of process-oriented group supervision fostered nursing students' professional identity and their preparedness to act and reflect; they also found that professional identity includes increased understanding and ability to sense patients' needs, as well as increased self-confidence and responsibility towards patients.

In a literature review of learning in clinical practice, Field (2004) argues that the most recent national curriculum in England acknowledged the importance of competent nursing practice and shared responsibility for achieving this by making NHS employees jointly responsible for this with teachers based in higher education. She argued that the drawback of adopting Benner's learning framework in pre-registration education (as in the Project 2000 curriculum) meant that there was little emphasis on psychomotor skills and how the student acquired the expertise to deal with risk and decision making. For Benner & Wrubel (1989) learning is practical knowing without understanding through experience. Field argues students need to access hidden means of professional learning and suggests that situated cognition describes methods of practical learning used in professional education. Benner's approach relies on a good learning environment and stimulating dialogue between a good mentor with good knowledge who in turn requires senior support; as Finnerty & Pope (2005:315) found in their study, the transfer of craft knowledge in professional practice "occurs through a range of subtle, often hidden, methods".

A number of research papers dealt with emotions and learning. Clouder (2005), learning occurs where knowledge encountered is "troublesome" and the student has to integrate new knowledge with existing thoughts and knowledge. Learning in this way has been defined as threshold or transformative in nature and as such "liminal". She suggests some concepts are particularly troublesome such as caring where the messiness of practice conflicts with the ideals students hold of caring; students would like learning to care to be trouble free! But it is exactly this messiness where learning occurs and where emotions are a fruitful and creative part of learning – the emotions in practice give rise to indeterminacy in decision-making and then learning takes place. Of particular interest is the notion that emotions do not interfere with rational choice or decision making but enhance decision making in situations of indeterminacy which a lot of nursing is. Meyer & Land (2005) refers to this aspect of learning in indeterminate situations as drawing on emotional capital.

How students learn effectively is another focus of the research literature. For example, Burkitt et al (2000) investigated the cognitive and affective processes used by students to learn. As important as cognitive processes were, they describe how students learn to be nurses in communities of practice which act to integrate students because they help students and staff identify with "their" community of practice and develop an identity as a nurse. Olsson & Gullberg (1991) also argue that nursing curricula in Sweden have failed to

recognise the professional status part of learning through role modelling; they argue that the professional role is transmitted through tacit knowledge and registered nurses consolidate their role in their first year through work experience and role modelling.

Two recent studies show how important role modelling and socialisation processes are in student learning. Ousey (2006) investigated how students learned nursing and showed how students described becoming a *real* nurse through learning fundamental skills from observing and working with health care assistants (HCAs) in practice. For the observing students, trained nurses were assessors, planners and evaluators and managers of care. Students could not identify who they should learn from and what they should learn; this led to a theory/practice gap and an idealisation of theory by students. Trained nurses acknowledged the theory practice gap and said they did not practice as the students were taught in college. As Bradshaw has argued, nursing has developed a culture where nursing is seen as managing care and not delivering basic care (Bradshaw 2000). Ousey's work also raises another issue: what do student nurses see as nursing work and does it include delivering as well as managing care?

Another recent study by Mackintosh (2006) investigated the impact of socialisation on student nurses' ability to care. She observed that during their training, to fit in with the system, students become desensitised and lost the capacity to care and the value of care which is what attracted them to the profession in the first place; she describes this as caring less, coping more. Student nurses developed hardiness to protect themselves and cope; they gritted their teeth and switched off.

Students' clinical learning experiences

In 18 research papers reviewed in this theme, it appears that student experiences are affected by placement capacity, audit and the management of learning in the new NHS as well, perhaps most importantly of all, their relationship with their mentor. Hutchings et al (2005) explored stakeholders' views of how decisions are made on how learners can be supported in practice. They found that these decisions are shaped by conflict between the expanding numbers of student nurses and the practice setting's capacity to support learners. They argue for a need to develop necessary roles and strategies to enhance support for learning in practice and the structured management of placement experience. New roles have been introduced to improve links between HEIs and placements (Burns & Patterson 2005; MacCormack & Slater 2006); these include practice based educators (Allen 2003); practice development facilitators (Clarke et al 2003); placement co-ordinators (Smith et al 2003) and clinical education facilitators (Wilkins & Ellis 2004).

Mentors remain the key leaders for learning in current nursing curricula (Andrews & Chilton 2000; Pearcy & Elliott 2004; Pellatt 2006). For example, Lloyd-Jones et al (2001) emphasised the importance of regular mentor-student contact to avoid hanging around; they found that a mentor's absence can mean students working with untrained staff (HCAs) doing HCA work. Effective sponsorship by the mentor allows access to cultural knowledge and practices of clinical team. The type of mentoring a student receives as well as the quantity is important; in exploring students' perceptions of the mentor's role, Chow & Suen (2001) and Orland-Barak & Wilhelm (2005) found that instrumental learning and mentoring is more important for students than adopting an advisory or counselling role. Andrews & Roberts

(2003) argue that what constitutes appropriate support for learning remains unclear and there is little agreement as to which methods promote deep learning in practice. They argue that current systems of mentoring do not promote deep learning and offer the clinical guide as a role which can promote such learning. It appears from this literature that the role of mentor requires further exploration and evaluation (Andrews et al 2006; Watson N A 1999).

For mentors, causes of stress in clinical learning environments were the nature and quality of support they received from HEIs in practice environment (Watson S 2000) and assessment (Neary 2000). As discussed above, Moore (2005) argues that systems of assessment of clinical competence are variable and this may be influenced by mentors undertaking mentor preparation courses not because they choose to become a mentor but to enhance job prospects (Watson S 2003). Watson concludes that the mentor role should not be a requirement for promotion in clinical nursing.

Stakeholder interviews 2

While the nature of learning was discussed in the stakeholder interviews, what is striking about the stakeholders' data is the strength of feeling about *what* students should be learning in terms of essential skills and *who* they should be learning from. For example:

“Preparation in curriculum should be as close as possible to what they’re actually going to do – but they aren’t doing that [basic care] but we never did [as staff nurses]. This is really where the problem lies – what should we be teaching student nurses?” (STGNC303/06).

“Leaders of nursing should supervise care and you need to give care to know how to supervise it’ (STGNC503/06).

“Dilemma in that ‘students are no longer the workforce providing basic care; HCAs are doing this and students no longer seek to do basic care; they seek to instruct others to do it rather than have a lifetime of doing it. The role of staff nurse is the management of care, administration, organisation and communication outside the ward” (STGNC303/06).

In this last extract, a nurse lecturer reflects that nurse education’s concern with learning (how to learn) has deflected our attention away from the purpose of nurse education for nursing (what and where we should be teaching):

“The other thing about nurse education is we get bored and we invent things all the time...in nurse teaching, I get very excited by it [how to learn/new technologies], it’s great but actually what we’re required to do is quite simple” (LL3GNC104/06).

Conclusions

The themes which emerged from this literature study suggest that there is debate, even concern, within the nursing profession (or at least those who are publishing), the NMC and within government as to the nature of nursing and the educational needs of future generations of nurses as well as concern over who should be teaching student nurses and

where that teaching should take place. Three questions coalesce around these collective concerns:

- What is nursing?
- What should student nurses be learning?
- Whom should they be learning from?

It was with these questions in mind that we began data collection in Stage 2 with the purpose of gaining an opportunity to explore practitioners' and students' views of the nature of leadership for learning in the field.

Chapter 3 - The learning environment online survey

Introduction

In this chapter a summary of the findings obtained from an online survey on the ward learning environment is presented and a comparison made with the data obtained from a survey undertaken in 1984 using a similar questionnaire. The full survey findings are presented in a separate report.

Survey data were collected between November 2006 and January 2007. An online questionnaire was distributed to 4,793 pre-registration nursing students' university email addresses at four English HEIs via departmental administrators. Response was maximised through attractive questionnaire design, stressing to students that it was their chance to have their say, and using two reminders. The overall response rate for the survey was 20% (n=937), which is within the normal range for an online survey. Response rate was highest at University D (19.3%, n=216) closely followed by University C (17.76%, n=174). 14.24% (n=170) of University A nursing students responded and response was lowest at University B where the response rate was just under 10% (n=140).

The survey used an adapted version of Smith's original 1984 questionnaire. The survey component of the 2007 study incorporated many of the survey items of the 1984 survey. Although many of these items from the 1984 study were modified in the 2007 study to reflect the current clinical situation it was possible to compare the 1984 and 2007 surveys directly on some items (using identical question text). It is important to bear in mind the limitations in comparing the two surveys, particularly in that they are drawn from different populations. The 1984 study was of one hospital school of nursing (12 medical wards) in London on the eve of the introduction of Project 2000, when students were still apprentices. The 2007 survey sampled pre-registration nurse populations from four HEIs (one in the north west of England and two from London and one from the South -East of England) whose placements were provided in a diverse range of NHS health care trusts and in the independent sector e.g. care homes). The survey mode was also quite different in 1984 (a self – completion survey) than it was in 2007 (an online survey).

Demographic profile of respondents and academic qualifications

- 40% of respondents were under 26 years old and therefore a significant majority (59%) were mature students.
- 89% of respondents were female and 11% were male (n=701).
- Nearly seven in 10 respondents (68%) described their ethnicity as White or White British; the next largest ethnic group was African (9%) followed by Black or Black British (7%).
- A majority of respondents (55%) described themselves as single and 37% were either married or living with a partner.
- 60% of respondents did not have children; 36% had 1-3 children; just 4% had more than 3 children.
- Nearly one in five respondents (18%) were graduates and almost a fifth (19%) had GCSEs / O Levels. Nearly half (48%) had A Levels. 13% had at least one GNVQ. A very small proportion (2%) had a master's degree and one respondent had a Ph.D.

Profile of respondents – mode and programme of study

- 96% of respondents said that they were studying full-time; just 4% were studying part-time (n=707).
- 83% of respondents were studying for a diploma and the remaining 17% were studying for a degree.
- Over three-quarters of respondents (77%) were on an adult nursing programme; 14% were on a mental health nursing programme and 9% were on a child health nursing programme. Just two respondents (less than 1%) said that they were on a learning disability nursing programme.
- 45% of respondents were in the second year of their programme; 29% were in year 3 and 26% were in year 1.

Findings

In the 2007 questionnaire, as in the 1984 questionnaire, we focused on four areas of the clinical learning environment: satisfaction with placement; staffing levels/supernumerary status; support from mentors/clinical staff; perceived standards of care.

Satisfaction with placement

Overall, 76% of respondents agreed or strongly agreed that they were happy with the experience they had had on their current or most recent placement and a majority of respondents were satisfied across all specialties. Overall, 82% of respondents agreed or strongly agreed that their current or most recent placement was a good placement for student learning. These survey items were most strongly correlated with satisfaction with placement (this was a good placement for student learning): I am happy with the experience I have had on this placement; there is much to learn on this placement; sister and trained staff work as a team with learners; sister and trained staff provide an atmosphere which is good to work in.

Satisfaction (in terms of happiness with most recent placement experience) was highest in relation to the specialties of intensive care (92%); community and primary health, and surgical (78% satisfaction in each case) acute medical (77% satisfied) and mental health, and accident and emergency (76% in each case). Satisfaction dropped below two-thirds in relation to placements where care of older people was the specialty or the placement was in a care home (64% satisfied in both cases).

Staff levels / supernumerary status

There were mixed views regarding whether staffing levels were adequate for the workload in placements. A very large minority (41%) disagreed or strongly disagreed that staffing levels were adequate and 11% were neutral. Just over half of respondents (51%) felt that the workload interfered with teaching and learning i.e. they disagreed or strongly disagreed that the workload did not interfere with teaching and learning.

Support from Mentors / clinical staff

Just under a quarter of respondents (24%) said that their mentor was a ward manager, sister or modern matron; 14% said that their mentor was a staff nurse (Grade D); 31% that their

mentor was a staff nurse (grade E) and 16% said that their mentor was a staff nurse (Grade F). Three-quarters of respondents considered that their current or most recent placement provided a good atmosphere to work in. Just under three-quarters of respondents (74%) agreed or strongly agreed that the ward staff (ward manager, ward sister and trained nurses) are available and approachable. A large majority of respondents (68%) agreed or strongly agreed that in their current or most recent placement the learner is praised and encouraged in their work.

Perceived standard of care delivery

Nearly seven in ten respondents (69%) agreed or strongly agreed that 'patients receive the best attention and nursing care' (during the students' current or most recent placement). Just 15% disagreed or strongly disagreed with the statement. Satisfaction with placement experience was significantly and positively correlated with perceived standard of care delivery.

Comments on the survey data: then (1984) and now (2007)

The following section compares findings from the 2007 survey with selected findings from a 1984 study (Smith 1992). It is important to bear in mind that it is students' perceptions that are being captured in both of the surveys and it is these perceptions which therefore form the basis for comparison. Perceived satisfaction with placements (whether in terms of the learning environment or the standard of care delivered to patients) is partly to do with the expectations which individuals bring to the placement and one might speculate that expectations of all stakeholders have changed in the 23 years between these two surveys. The government acknowledges that patient expectations of healthcare are ever-increasing and that meeting these constitutes one of the major challenges for the NHS in the 21st Century.

It is possible that students' expectations, both of the quality of the teaching and learning they receive in placements, and of what constitutes good patient care have also increased and are continuing to do so. Therefore, even if there had been real improvements in the time between the two surveys in the quality of teaching and learning, or in the standard of patient care, this would not necessarily be reflected in higher satisfaction ratings from the students. What the comparison between the two surveys can indicate is the extent to which students' *perceptions* of particular issues have changed.

Overall satisfaction with the ward/placement

Table 2 (overleaf) compares indicators of satisfaction with placements from the 1984 and 2007 surveys.

Table 2: General indicators of satisfaction with the placement: 1984 and 2007

Items taken as indicators of students' general satisfaction with placement	Mean from 1984 study	Mean from 2007 study	Comments
This was a good placement for student learning	3.78	4.00	Overall, satisfaction with placements is high, in both studies. There is a very small increase in satisfaction (0.22) from 1984 to 2007.
I am happy with the experience I have had on this placement	3.98	3.89	Again, satisfaction with placements is high in both studies. There is a very small decrease in satisfaction (0.09) from 1984 to 2007.
There is much to learn on this placement	4.25	4.03	Agreement with this statement was high in the 1984 study and remains high in the 2007 study despite a small decrease (0.22).
<p><u>Question text in 1984 study</u></p> <p>There are enough trained nurses in relation to learners and <i>auxiliaries</i></p> <p><u>Question text in 2007 study</u></p> <p>There are enough trained nurses in relation to learners and <i>health care assistants</i></p>	3.73	3.25	The mean agreement with this statement in the 1984 study was moderate to high and there was a slight decrease in agreement in the 2007 study (0.48). This suggests that students still perceive that there are insufficient trained staff in relation to students.
The number of staff is adequate for the workload	3.46	3.05	The mean agreement with this statement in the 1984 study was moderate to high and there was a slight decrease in agreement in the 2007 study (0.41). This indicates that understaffing is an issue in 2007. This is confirmed in the fact that understaffing was frequently mentioned in the open-ended survey responses as a cause of stress and anxiety and a barrier to teaching and learning.
The workload does not interfere with teaching or learning	3.06	2.76	Mean agreement with this statement was moderate in the 1984 study and was somewhat lower (0.29) in the

Items taken as indicators of students' general satisfaction with placement	Mean from 1984 study	Mean from 2007 study	Comments
			2007 study. This is perhaps surprising given that students are supernumerary in 2007 (but were part of the staff in 1984). However the open-ended survey responses very clearly indicate that supernumerary status is often a theoretical entitlement which is absent in practice. Students frequently report that, due to insufficient staff for the workload, students are used as a 'spare pair of hands' and that trained staff frequently do not or cannot attend to the learning needs of students.

Stress and anxiety

Questionnaire data in the 1984 study showed that 'hierarchical and unfriendly staff relations' were a major source of stress and anxiety for students because of the feelings they generated. Students described feelings that were triggered by hierarchical management styles such as having their confidence undermined so that it was difficult to show initiative; being made to feel inadequate if uncertain about care, resulting in the student being on the defensive because of criticism.

The mean stress rating for 12 wards (see Smith 1992:182 - Table E6a) was 1.81 (The scale ran from 1 (least stressful) to 3 (most stressful). The stress ratings for individual wards ranged from 1.44 to 2.24.

In the 2007 survey, students were asked to indicate whether they had experienced stress or anxiety in their current or most recent placement. Just under a quarter of students (23%) said they experienced stress or anxiety 'frequently' and a further 41% had experienced stress or anxiety 'occasionally'. 25% 'hardly ever' experienced stress or anxiety and 11% 'never' did so. To put this another way, two-thirds of students (67%) had experienced some degree of stress or anxiety. This experience was elaborated by open ended comments from 717 respondents. The themes which emerged from analysis of open-ended survey responses (using SPSS Text Analysis v1.0) are summarised overleaf in Table 3. These themes resonate with the findings of the 1984 survey.

Table 3: Students' perceived causes of stress and anxiety on placement - themes and sub themes from open-ended data, 2007 survey (n=717)

Major theme	Sub – theme/s
Lack of time for learning	<ul style="list-style-type: none"> • Inadequate staffing levels for the workload • Workload restricting time available for teaching and learning • Supernumerary status not a reality; students being used as a 'spare pair of hands' or as 'HCA' • Lack of continuity in placement (being switched around from team to team or locations to location; no time to build up relationships with trained staff)
Problems with support from mentor and / or link lecturer	<ul style="list-style-type: none"> • Cannot get access to mentor • Do not have time to meet regularly with mentor • No / poor rapport / working relationship with mentor • Poor communication from mentor • Mentor is not adequately trained / qualified as a men
Lack of support for learning from staff	<ul style="list-style-type: none"> • Lack of communication from clinical staff • Resentment from clinical staff / conflict with clinical staff
Rudeness / lack of co-operation from staff (generally rather than in relation teaching an learning)	<ul style="list-style-type: none"> • Poor / no relationship / no rapport with clinical staff • Not valued / appreciated by clinical staff
Lack of self confidence	<ul style="list-style-type: none"> • Worried about not being 'up to the job / task' • Too much responsibility / daunted by task / responsibility
Emotional demands /Consequences of being on placements	<ul style="list-style-type: none"> • Sick / dying patients
Role conflict	<ul style="list-style-type: none"> • Difficulty of balancing competing demands of between family. Home, university and placement)
Dissatisfaction with standard of patient care	
Not being prepared for placement adequately	

Students' Perceptions of Patient Care

In the 1984 study (Smith 1992:183 Table E7a), students rated patient care highly, with a mean score of 4.15 for 12 medical wards on a scale of one (lowest) to five (highest). Interestingly, the wards that were rated lowest as learning environments also tended to achieve lower scores on the patient care dimension of the ward learning environment

questionnaire (ranging from 3.63 to 4.38). This relationship between perceptions of learning environment and perceptions of care delivery was replicated in the 2007 study (see section 8.1).

Table 4: Student perceptions of patient care – 1984 and 2007

Items taken as indicators of student perceptions of the standard of patient care (individual item means given for 2007 data)	Group Mean (1984)	Group Mean (2007)
Nursing care is tailored to meet the individual needs of patients 3.75	4.15	3.64
Patients receive the best attention and nursing care 3.72		
The placement manager promotes good staff/patient relationships 3.62		
Patients get plenty of opportunity to discuss their feelings and anxieties 3.47		

The mean score for the four items taken as representing student perceptions of patient care was 3.64 in 2007, a decrease of 0.51 compared to 1984 suggesting an overall lower perception of standard of care by the student body in 2007 compared to their counterparts in 1984. This could be related to the supernumerary status of the current student body and a consequent loss of identification of themselves as part of the work force and therefore a lesser feeling of ultimate responsibility for the care of the patients. The student body of 1984 were more likely to regard themselves as part of the frontline work force.

Overall rating of the ward as a learning environment

Table 5: Overall rating of the ward as a learning environment 1984 and 2007

Items taken as indicators of student satisfaction with the ward as a learning environment (Ward Teaching). (individual item means given for 2007 data)	Group Mean 1984	Group Mean 2007
Trained nurses in the placement teach regularly 3.19	3.46	3.12
Trained nurses teach as they work with learners 3.78		
Learning objectives are in use on this placement 3.60		
The ward/ placement manager initiates teaching 2.87		
The ward/ placement manager devotes a lot of her/his time to teaching learners 2.84		
There are regular sessions in which the trained nurses discuss the nursing care of the patients 3.28		
Learners are taught on doctors' rounds/ case conferences 3.02		
Teaching and learning activities are routine 3.14		
Doctors are interested in teaching 2.77		
The shift handover is used as an occasion for teaching learners 2.72		

In the 1984 study (Smith 1992:184 – Table E8a) the mean for the above items was 3.46 [mean for 12 wards] in the 2007 study it was 3.12. This slight decrease between the mean in the two studies (just 0.34) perhaps suggests that there is still a significant gap between the expectations from students in terms of the quality of learning and teaching in placements and what qualified staff actually provide. Although one might possibly expect a much large increase in student satisfaction with teaching and learning on placements (given their supernumerary status in 2007) open-ended survey responses clearly show that supernumerary status is often a theoretical entitlement rather than a reality in practice and therefore many of the obstacles to teaching and learning which were present in 1984 may remain in 2007.

Table 6: Items regarding satisfaction with the ward as a learning environment which were used in the 2007 survey but not in the 1984 survey

Items regarding satisfaction with the ward as a learning environment (ward teaching) (individual item means given for 2007 data)	mean
Mentors in the placement teach regularly	3.37
Health care assistants are interested in teaching	3.16
Practice nurses are interested in teaching	3.28
District nurses are interested in teaching	3.02
Clinical nurse specialists teach regularly in the placement	2.91
Community psychiatric nurses are interested in teaching	2.96
Health visitors are interested in teaching	2.91
Modern matrons teach regularly in placements	2.19

Learning opportunities

In the 1984 study (Smith 1992:186 – Table E10a) the mean for the above items was 2.76 [mean for 12 wards] in the 2007 study it was 3.56, an increase of 0.8 which may indicate that the students’ status as learners has raised the profile of their need to learn while being in practice.

Table 7: Student perceptions of Learning Opportunities on placement 1984 and 2007

Items taken as indicating student attitudes towards Learning Opportunities on placement (individual item means given for 2007 data)	Group mean 1984	Group mean 2007
The placement manager attaches great importance to the learning needs of the student 3.30	2.76	3.56
The placement manager and trained nurses give learners an opportunity to watch or perform new procedures 3.94		
Trained and learner nurses work together giving a full range of care e.g. bathing and dressing; drug rounds; health promotion advice; aseptic dressings 3.81		
Learners are given an opportunity to use their initiative and discretion 3.79		
The placement manager gives learners the opportunity to read case notes and text books 3.51		
Learners are taught on doctors' rounds/case conferences 3.02		

N.B. This item was used in the 2007 survey but not in the 1984 survey: 'Clinical placement facilitators/practice educators support learning during the placement' (mean 3.18).

Ward Atmosphere/ Staff Relations

In the 1984 study (Smith 1992:187 – Table E11a) the mean for the items below (ward atmosphere / staff relations) was 3.77 (mean for 12 wards), whereas in the 2007 study it was 3.62 - a decrease of just of 0.15. This perhaps suggests that tensions remain between learners and trained staff. Indeed there is some reason for believing that such tensions have increased as a result of educational changes. As previously touched on, the students are (in theory at least) supernumerary and therefore not part of the workforce as they were in 1984. Trained staff may view students with hostility or envy and may be unwilling to support the students' learning. Tensions between trained staff and students are frequently reported in open-ended comments in the 2007 survey data. It should be borne in mind of course that many qualified staff do support students' learning, regardless of the route by which they themselves have qualified.

Table 8: Student perceptions of Ward Atmosphere and staff relations : 1984 and 2007

Items taken as indicating student perceptions of Ward Atmosphere and staff relations (individual item means given for 2007 data)	Group mean 1984	Group mean 2007
The sister and trained nurses are:		
Available and approachable 3.81	3.77	3.62
Provide an atmosphere which is good to work in 3.77		
Praise and encourage the learner in his/her work 3.68		
Work as a team with learners 3.64		
Give feedback in private 3.60		
Concerned about what a student is thinking or feeling 3.49		
Keep staff and learners well informed about placement activities 3.37		

Summary of survey data

The key features highlighted by the survey and in our comparison between the two survey data show:

- Satisfaction with placement continues to be high although insufficient staff and understaffing are barriers to learning and add to students' stress and anxiety. Student regard supernumerary status as a theoretical concept.
- Experiences of stress and anxiety continue to be a feature of clinical learning and key sources of stress are a lack of time for learning; lack of support for learning from mentors, staff and link lecturers as well as a lack of co-operation generally from staff. Clinical placements continue to evoke difficult emotions and role conflict continues to be stressful for students. Students do not feel prepared for placements which adds to their stress and anxiety.
- The correlation between perceptions of high standards of care delivery and perceptions of a good learning environment continues.
- A slight decrease in overall rating of learning environment.
- A slight decrease in learning opportunities in clinical placements.
- The ward atmosphere/staff relations continue to shape clinical learning.

Chapter 4 - Four case studies

This chapter discusses the findings from the participative observation and interviews with a sample of clinical, management and teaching staff *and* student nurses across the four case studies. There are seven broad themes which build up a picture of leadership for learning presented in the discussion of our findings. These themes are:

- Negotiating supernumerary status
- Working in busy clinical areas
- Emotions of nursing work
- What is nursing?
- Leadership and leadership roles
- Learning not teaching
- Diversity and multicultural learning environment

Negotiating supernumerary status

Historically, students were part of the workforce and included in the rostered numbers for particular shifts; since the Fitness for Practice [FfP] curriculum, students no longer have rostered time as part of their training and work as supernumerary in the clinical areas. In the focus groups with trained staff, it is this supernumerary status which is viewed as a barrier to students acquiring competencies in clinical skills. But this theme also reflects more general concerns trained staff have with students' attitudes to care delivery and how the nature of nursing is perceived to have changed over time.

Students found their supernumerary status problematic if they were given too much responsibility for care delivery, yet unsupported in their learning if they were not given sufficient hands on experience. We suggest that the notion of negotiation is a way of understanding this tension which both staff and students experience around the degree to which students are considered part of the workforce and how 'involved' they are with the delivery of care. We argue that this tension arises because, despite the changes to nurse education over 20 years, learning is expected to occur through doing, through delivering hands on care; and skills competency for registered nurses is expected on registration not after a period of preceptorship following registration. This theme seemed to resonate with a key statement made in the literature that the NHS was a workforce orientated system rather than a learning orientated system (Melia 2006). Essentially, students are still expected to provide a modicum of labour and on registration are expected to be able to work immediately as fully competent, registered nurses. A quote from a focus group discussion with ward managers in Site A illustrates this view:

“The impression I get now with students, when they qualify, that’s when they start to learn. They don’t really learn very much about nursing at all while they’re students. In some ways, the first newly qualified band 5s seem like second or third year student nurses of previous years” (WM2GNCA).

During observation periods, one researcher observed a variety of ways in which students engaged with the 'work' in the clinical areas and varying degrees of supervision. More specifically she observed students working in a supernumerary capacity e.g. junior nurses working with trained staff very closely as described in the following extract from her field notes:

(17/01/07 Site D day surgery, morning shift) “I came onto the ward and the staff nurse and student (2nd year) are arranging shifts to work together. Staff nurse walked off from the station saying for the student to follow her which she didn’t immediately. Staff nurse gestured ‘come on’ like there was a lead tying the student to her. They both laughed”.

While this may seem patronising, this mentor explained later to the researcher that ensuring students felt safe but at the same time gained competencies and confidence was very important to her. As she said, “I was a P2K student and I’m sick of people saying ‘P2K can’t organise xyz’. One person actually said that ‘P2K nurses, if there wasn’t a tape measure, wouldn’t fit TED stockings; they aren’t flexible!’ I had to say ‘I’m sorry, I don’t think so!’ I promised myself I wouldn’t let students go through what I went through”.

The balance required between needing to learn and being safe was raised by the students during coffee on the same shift. A male 3rd year student explained that:

“My uncle says in his second year he was in charge of wards and was responsible. But it had to change. You have to be accountable for safe care and you can’t just do things to patients”.

At the same time, this student recognised that being safe and accountable had left him feeling deskilled: “We’ve been out of practice for a year during our second year and it felt very strange coming back”. He felt that on this ward (a mixed surgical ward) they were given responsibility as 3rd years and expected to work as part of the team. This was different to other wards where they had been junior and the senior students were generally given this preferential treatment. Here, as third year students, they were treated preferentially and their mentors allowed them to check intravenous (IV) drugs, run through IV lines, change IV lines all under supervision. And they appreciated that, as they would have to do those tasks when qualified, they wanted them “under their belt” before then.

In a contrasting example from the researcher’s field notes, a 3rd year student was described as working unsupported by trained staff on a busy medical ward one morning shift:

(23/01/07 Site D mixed surgical ward, morning shift) “Staff nurse and student allocated a bay and a transfer to the bay from side room; staff nurse went straight away to do drugs asking student to move patient (very sick man) with healthcare assistant (HCA). Man needed to change to 40 % O₂ from nasal cannula; sounded as if he had a chest infection and student went to fetch mask. Came back with no tubing to attach mask to oxygen (O₂) ; went to find some; came back with wrong tubing; came back with correct tubing and then started fitting mask and tubing. Hadn’t done so before, neither had HCA. There was a degree of fluster and patient got more breathless; HCA suggested turning up O₂. Student went to ask sister who said ‘yes’ and came back and turned up O₂. I asked student if she felt okay and understood the reason for turning up O₂. She said ‘no’; I explained rationale. This went on for some time before the patient was successfully settled in his new bed; the staff nurse did not appear to supervise the student with a very sick patient neither did the sister.”

Now while this experience may have involved some learning, it was not clear to the researcher observer how the student was facilitated to process any learning for transfer to the next acute clinical situation or indeed to feel safe.⁴

Despite these mixed experiences, supernumerary status was considered when allocating mentors to students at the beginning of shifts; ward managers were observed at handover allocating students according to their learning needs as the following extracts from field notes demonstrate:

(28/02/07 Site C haemato-oncology morning shift) “Sister organised work, everyone hung around the desk as she looked at the patient dependency, the staff and students. Asked students what they wanted to do, whether their mentors were on and knew one 3rd year had a drugs assessment. When I was introduced after handover, she reallocated the students to include me”.

And then not so well in this extract from field notes:

(26/02/07 Site C gynae-oncology morning shift) “Morning shift had handover; I waited for the ward manager to come out of the office. She did, then staff nurses, then two students trailing behind; allocation already done. Students look hesitant but then started breakfasts. I then introduced myself and was told to go and find the students. Later that shift while having coffee with these students, the 3rd year student was angry about what had happened at the start of the shift ‘you saw what happened? – we just sorted it out – the other student is pregnant so I took the heavy side. The staff nurses were already busy on the phone so we had to do the work, decide what to do. No-one supervises you.’ ”

Students managed this negotiation through taking stock and assessing the handover to see whether the staff took their learning needs into consideration as the 3rd year student did in the above extract. Another 3rd year student described her negotiation skills explicitly in the following extract from field notes:

(5/01/07 Site D A&E morning shift) “Very slow start to shift with mentor appearing slow to ask students what they needed to do or indeed identifying them as students who needed to work with mentors if present – my student said to me later ‘I wait to see – is she going to sort me out? Obviously not! – Then I decide what I want to do and who to be with’.”

But other students found this allocation difficult and did not know how to negotiate so as to ensure they worked with their mentors as described in this extract:

(15/01/07 Site D A&E morning shift) “At handover, sister gave out areas of A&E to different staff – then went through students – 6 student nurses – sister didn’t ask who had worked with their mentor, who was mentoring whom, or who needed to learn what. Allocated students to three or four mentors randomly. My student said her mentor was working in ‘majors’ (major injuries) and she was in ‘minors’ (minor injuries) with other student nurse; he couldn’t take both so my student volunteered to go to ‘minors’ thinking

⁴ At several points during the participant observation, it had been necessary for the researcher to intervene to ensure the safety of a patient.

that she wouldn't argue to get to work with her mentor that shift even though she hadn't worked with him yet during this placement."

Supernumerary status was important to students because it affected their feeling part of the team which was especially important for the 3rd year students I worked with as this extract from field notes shows:

(17/01/07 Site D day surgery morning shift; 3rd year, older, female, part-time student)
"At coffee, student described how she felt they were told to be assertive and self-empowered in college and to be agents of change yet the NHS and nursing was hierarchical and bullying and she said 'I feel like I'm in the playground again. On ICU, nobody said goodbye to me when I left, too busy doing internet shopping, obsessing about off duty and character assassination of anyone coming into the unit.' She felt that staff referred to the students as 'the student' and staff didn't bother to learn their names; rarely felt part of the team. She used the word 'burden' to describe the mentoring relationship in the clinical areas".

These negative views were supported by those of an E grade mentor in charge on a day shift who was working with a 2nd year student; when asked whether she liked mentoring, she said "I had dreadful mentors when I was a student and I swore I wouldn't be like that with anyone."

Working in clinical areas/ward learning environment

One of the reasons students were *informally* expected to work as part of the workforce was because the ward areas were busy. The following quote from a ward manager in Site A illustrates how staff felt that clinical areas were very busy, busier than they had previously experienced, and that learning opportunities were adversely affected:

"It's quite difficult sometimes, especially when they're supernumerary and it's extremely busy and you have to tell them 'If you're lost, please go back to the nurses' station because they can be wandering around quite aimlessly and things have changed and it's extremely busy" (WM2GNCA).

Staff blamed this situation on the most recent NHS re-organisation and in particular on the targets relating to bed occupancy as these ward managers in a focus group in Site A indicate:

"But the patients come in, they have their operation, they're told 'You can leave now' and somebody will appear with a chair 'OK discharge' without even properly discharging the patient. So the patient goes home, still unwell, so they come back in again."

"I think it's changing so much and I don't think the students are prepared for this and I don't think the college prepares them before they come in. They've expectations of learning all this whereas it's really quick and fast and I think they need to be prepared more for the environment they're coming into" (WM2GNCA).

However, as this quote from a link lecturer shows, lecturers were also aware of the busy state of the wards: "It's busy and stresses both sides make student experiences difficult" (LL2GNCC).

The following extract from 1st year student nurses show their awareness that their learning environments are busy and that even where they are supernumerary, they feel busy. In the 1st extract, the student notes the difference between feeling busy and feeling unsafe:

(17/01/07 Site D day surgery morning shift) “Although I’m supernumerary, I’m kept very busy. I don’t feel unsafe just very busy. Brenda’s always around (the student’s mentor)”.

In the 2nd extract, the student explained that having gained experience of care work in the calmer context of a care home equipped her for the business of the NHS.

(17/01/07 Site D day surgery morning shift) “Coffee break with student nurse 1st placement was care home. I asked what she’d learnt in the care home. She said immediately ‘confidence’ as she’d never done care work before and she felt she did ‘all that there’; she’d learnt confidence in meeting people, making relationships with them, getting to know them. And in surgery, these skills had given her confidence (again!) to cope with the faster pace and higher turnover.”

In the last quote, the student feels that not only is she busy but she has to learn fast:

(17/01/07 Site D day surgery morning shift 1st year student nurse) “Very busy, short stay, patient turnover is high – have to be out in 23 hours. Student commented that having to work in bay with 6 patients on ½ hourly post operative observations was difficult ‘How do you keep up?’ ‘You learn to do things faster’.”

The business of the clinical areas therefore is a source of stress for both student and staff as the link lecturer above noted and learning is difficult and stressful.

Other factors in the ward environment which affected clinical learning were the roles of the staff, the ward manager and the skill mix. In her field notes, the researcher commented on the role of the ward manager while having coffee with three students as the following extract demonstrates:

(26/02/07 Site A gynae-oncology morning shift) “Things have changed and during coffee when I told them I’d trained 30 years ago, one of the 3rd year students asked me what exactly had changed. I said:

- Ward sister role is broader and busier and driven by targets (audits, bed management, paperwork)
- Students have to negotiate learning
- Healthcare assistants are part of the team giving care and ratio of untrained to trained staff (excluding students) is about the same”

These changes in patient turnover, bed pressures, skill mix mean that students need to take responsibility for their learning as noted above. This was confirmed by an interview undertaken in Site B. The researcher interviewed a student, who was an experienced nurse undertaking a Masters degree in Advanced Operating Department Practice. She gave the following view on the pressures on student learning in the clinical environment:

R: “Looking at leadership for learning, so what is it that a clinical leader needs to do?”

St3: To promote that atmosphere that people feel happy learning in. It’s not always easy either on the ward to be able, always to be that, that manner of leadership, there are times that I think unfortunately when you’ve just got to turn round and say to somebody ‘I haven’t got time to explain I need you to do this, this and this, go and do it’. You can see the look on some of the students’ faces, particularly if it’s an emergency ‘Why aren’t you telling me what I should be doing? ... and then its a case of taking them aside afterwards and explaining and most people are quite happy with that, but the situation demanded you just did what you were told and accepted it rather than being given that detailed explanation” (St3GNCB).

The researcher heard from some students in Site B that they felt that the formal aspect of their training included a lot about government policy and that they were aware of these pressures on ward areas and staff to meet targets. This observation was confirmed by practice educators during joint interview in Site B. They listed such policies as Essence of Care, National Service Frameworks (NSF), NICE guidelines, Clinical Risk, the four hour wait in A and E, the six week surgery waiting times which put both students and trained staff under pressure. They agreed:

“The effects of these policies are felt down to the Grassroots and the students will be well aware of the A&E targets” (PE1&2GNCB).

They explained that the current hospital had incorporated two huge hospitals in the south of a large northern city with the result that in their view there were not enough beds to serve the population. They described the interaction of the “4 hour A/E wait target” and too few beds in the following way:

“There is constantly a pressure on empty beds. Students will be aware of the constant telephone calls to check the bed state and the number of empty beds so that patients can be moved from A&E within the four hour target. There have also been a number of initiatives to deal with throughput. One is setting up the Clinical Decision Unit (next to A&E). This means that patients can be transferred out of A&E to what is effectively a “holding bay within the four hours. There the patient continues to be assessed and observed until they are either deemed able to be discharged or a bed can be found for them. The other initiative is the “Discharge Lounge”. This has been set up so that when patients are ready for discharge from the wards they can vacate their bed on the ward and wait elsewhere in the hospital for transport, drugs to take home etc. Another consequence of this policy is that patients get shipped all around the hospital as they get transferred to meet targets. This is a nightmare for infection control. It also means that patients often get moved inappropriately and not necessarily in the best interests of their welfare. In this fast pace and patient turnover, learning other than observing becomes difficult for both the mentor and the student. Especially when statutory training days are difficult to organise to ensure safe levels of knowledge among trained staff” (PE1&2GNCB).

Other practice educators (PE3,4&5GNCB) reported during focus group discussion that the demands made on them to organise statutory training days (another type of target) for all staff detracted from them being able to give sufficient time to ensuring the students’ learning needs were met at the same time as trained staff were undertaking mentor preparation

courses. They perceived these demands as having increased since the Trust was awarded Foundation status a few months previously. Ensuring staff attended statutory training days was deemed to be a requirement for being awarded the top grade of three stars by the Health Care Commissioners. These practice educators also felt they were put in the position of having to “get people to do courses even though they don’t want to”. One practice educator (PE3GNCB) described how frequently she had to insist the ward manager released students from the ward handover to permit them to attend planned teaching seminars. “I almost escort them into training sessions” she said.

They concluded that heavy workloads, low staffing levels, insufficient designated mentors and high patient dependency interacted to prevent them from ensuring good learning experiences for students with the result that “We don’t have the time to teach” (PE3,4&5GNCB).

Emotions

We have seen how the business of the ward areas was acknowledged by staff and students to be a barrier to learning. Another barrier was the emotional preparedness of students for the type and pace of work as well as their emotional maturity when caring for sick and dying patients. However, while there was an awareness that students could be overwhelmed by the busy nature of the clinical areas and by the nature of the work, opportunities for reflection appeared to be rare even when dealing with difficult emotional situations such as gynaecology. Reflection was not routine practice for trained staff either; where opportunities for reflection existed, they were offered by practice educators and lecturers.

During focus group discussion in Site B, the practice educators (PE3,4&5GNCB) felt that emotional preparation for clinical areas was important and discussed the need for placements to match the students’ stage of training and prior placement experience. They gave the example of acute care not being suitable for a first year student, or for a second year who had come straight from having had only community or nursing home experience. Such students were described as experiencing a “culture shock” being “frightened” or “out of their depth” when they were placed in an acute setting. Cardiology as a specialty for example was described as “too technical for them”.

One practice educator in this focus group described the following situation:

“I had a student who was at the end of her first year. It was her first time in a hospital setting and she had never taken any one to the toilet or given anyone a urinal. Well she felt stupid so she didn’t like to ask how to do it” (PE2GNCB).

A Masters in Advanced Practice student who was also an experienced operating theatre nurse in Site B described the importance of making students “feel at ease” in a new placement area. She also demonstrated the importance of recognising students have different needs:

“A lot of students when they come into theatre act like wall flowers and you can’t really blame them because it is totally different to what they’ve seen. They will come in looking very uncertain, very unsure of literally where they stand, where they go and what they do and they seem to fall into two categories, the ones who push themselves forward and the ones who won’t and the ones who push themselves forward I’m not too bothered about, it’s the ones that are reluctant. Is it because they have never seen an operation before and it’s a little bit unusual for them, or is it just because of the environment, or is it because

nobody's spoken to them and why? So it's making them, for me, making them feel at ease and understanding what we're doing and why, that takes a bit of one on one discussion or finding themselves somebody who's able to talk to them so that they feel more at ease" (St3GNCB).

It has been noted that students felt that their lecturers placed the burden of being change agents on them (noted in another extract from the same field notes on page 38: "We're told to be assertive and empowered and to be agents of change and yet the NHS and nursing is hierarchical, bullying. I feel like I'm in the playground again"). In addition, students felt that they were stereotyped and treated as outsiders to the ward team; this created a barrier to learning as the following extract from field notes demonstrates:

(17/01/07 Site D Emergency unit and surgery) Three 3rd year students complained of feeling left out and agreed that they "feel students are seen as stupid, clumsy, and that we'll make mistakes". One student added "I resent this".

So in addition to the emotions of caring for sick and dying patients, working in busy ward environments with seemingly little opportunity to reflect on their experiences, students felt like outsiders with the additional burden [imposed by their lecturers] of needing to act as change agents. And on top of these feelings, several 3rd year student nurses expressed their anxiety about qualifying and feeling unskilled.

The data presented so far illustrates the business of the current NHS ward environment and the stresses of the ward manager's role in meeting targets and managing a fast patient through put. Another level of stress is, of course, the emotional effect of working with sick patients and their relatives for trained, untrained and student nurses. Taylor (2006) argues that the emotional toil of caring for people in sickness and as they die is rarely referred to in policy. In contrast to Taylor's point, the observation data showed how present and yet how uncontained emotions are for student nurses. Here is an extract from the researcher's field notes (12/02/07 Site C gynae-oncology, morning shift):

"The ward was gynae-oncology and that shift there were two patients dying aged between 35 – 40 years old and one patient who'd had a total abdominal clearance and had come back to the ward in shock and was being resuscitated; the curtains were drawn around her and one of the Sisters kept going in and out. Neither of the students were looking after these patients. The shift started at 07.45 when the sister, staff nurses and HCAs emerged from handover followed by two very hesitant students who hung around looking uncertain; eventually after the staff nurses started drugs rounds on both sides, the students started giving out breakfasts. I approached the sister and she said to go and find the students....We then made beds, did a dressing and observations and later went for coffee. At coffee during a morning shift with a second year and a 3rd year student nurses, the 2nd year student asked me if I'd always enjoyed nursing?

I replied 'yes' but it had been difficult. How was she finding it?

'It's been difficult; shocking coming into nursing from school; the amount of work'.

The 3rd year then said that she found the 'stress and psychological [effect] builds up and feels heavy on your shoulders until you explode which is what I did the day before with the practice educator. You know what am I doing here? I qualify in a month and not

even drugs yet. I won't be able to do anything as a nurse. What have I done today? Caring not nursing; I know we have to do that, it's okay. Washes, beds, breakfasts, observations – but when they do drugs they should call me to look and learn. But they don't, so another shift wasted!

A 2nd year asked me if other link lecturers (I had told her I taught as well as researched) worked with students. 'They're not here. Sometime in other areas they're useful; I had one in my first placement, a care home. Here the practice educator comes and.'

3rd year interrupts 'it wasn't reflection. It was should! Should! Should! Not helpful. He fires questions at me and I can't think. I hate being asked "what have you learnt?"'

2nd year 'I can't think quick enough and they continue to fire questions at me. We have reflection in college'.

3rd year 'Yes but there you don't want to share with 30 others. It's difficult, gynae-oncology and you can't share this (nodded towards the ward) with others. It's the emotions of caring for them, (nodded again) that gets on top of you'.

Clearly, the possibly well intentioned reflection session had not met the 3rd year student's needs which concerned her anxiety about feeling unskilled just prior to qualifying and the emotional effects of caring for gynae-oncological patients. And when offered, as in this case in college after a clinical placement, "there may be resistance to exposing oneself to the gaze of others".

Just how difficult it is to talk over the emotions one encounters on a shift was brought home to the researcher after a morning shift on a medical ward as presented in the following extract from field notes:

(09/02/07 Site A medical ward morning shift) "07.45, very busy, linen bags, sheets etc all down the corridor; doctors, nurses darting in and out of bays. Sister greeted me with open arms! 1st year student was working with sister but very busy ward and patients in bay needed full washes/bed baths. We set to...2nd patient was confused, had kept the bay awake by shouting, smelt of faeces and needed a full bed bath. Student went to gather things we'd need and we started. The woman had a big sacral sore, necrotic and 'dirty' with faeces. The bed bath took about 45 minutes; it was hot, smelly, and difficult to move the woman and the student was unsure of herself. However the woman kept saying 'thank you' and looked better afterwards; she then went on to be incontinent of faeces 10 minutes afterwards. After two more bed baths including assessing a lady who'd 'gone off' (it turned out to be a trans ischaemic attack) and doing a set of observations and calling sister who did a superb mini teaching session, we staggered off to coffee. I remarked how tired I felt and joked I wasn't used to hard work. The student said she liked to be busy and hated being bored; gets bored with two-three hour lectures. Prefers mornings so she can be busy; she likes her mentor to show her once and then leave her to get on with things (as she doesn't like not doing). But if it's something like ECGs then she's scared of them and keeps asking to observe.

I then remarked I'd found the woman's sacral sore difficult to deal with – it was a long time since I'd seen one. 'Oh you just get one with it. I've never seen anything like that before but I have now and it's fine. I just think if you can help someone, like we were,

she kept saying we were, then that's okay. But before Christmas there was a man with legs that were very painful, they were falling apart and he was in pain. I couldn't do anything and I found that difficult. To see someone come in and then in a week, like that go downhill and die. We couldn't help. That's what I found difficult when I'm not in control. The other stuff is okay because we can do something'.

I asked if she talked to anybody about stuff like this.

'Well all the staff were really upset too. The other student in my cohort and I were holding his hands and trying to reassure him and it was upsetting – there was nothing we could do'.

I asked if she talked to her friends.

'No I don't see them during placement and I live at home. We have reflection at college and sometime talk about what we've done. But I didn't with that one, no''.

This experience made a big impression on the researcher, partly because she was tired after working in a busy ward environment again; and partly because this is what the staff had to do *and* cope with the emotions described by the student at coffee. Yet these emotions would have been unexpressed partly because there were not any structured opportunities for reflection, partly because the ward was very busy, and also because there is no longer any sense of student peer group sitting in the canteen talking through the shift.

What is nursing?

Another striking feature of the 3rd year student's outburst to the researcher (as described on the previous page) was her frustration and anxiety at not feeling competent when nearing qualifying. For this 3rd year student, washes and making beds are not equipping her with what she sees as the essentials of trained nurse work. As she says:

“You know what am I doing here? I qualify in a month and not even drugs yet. I won't be able to do anything as a nurse. What have I done today? Caring not nursing; I know we have to do that, it's okay. Washes, beds, breakfasts, observations – but when they do drugs they should call me to look and learn. But they don't, so another shift wasted!”

The nature of the work students were asked to learn through was a disputed area between students and the trained staff and this led to discontent among both groups. The staff felt that students should be learning to deliver what they had themselves learnt to deliver as students; however as they were unable to deliver this care because of the 'business' of the clinical areas. There was an awareness for some staff of the difference between the reality of practice and learning and what they espoused to both assist students to learn and practice themselves.⁵ As O'Connor has found (2007) the role of the health care assistant was key to understanding what students saw as the nature of nursing; if they observed assistants delivering hands on care and trained nurses involved in the more technical aspects of care as well as the organisation of the ward, then they somewhat naturally aspired to the latter rather than the former as student nurses.

⁵ We return to this idea of the reality of learning vs the ideal of learning in practice in a discussion of the hidden curriculum in chapter 6.

This difference in what trained nurses do (drugs and co-ordinating the ward work confirmed by Mooney [2007] among others) and what they expected students to do (deliver basic⁶ care) is recognised by participants across the sites. As is testified in the following exchange from a focus group with practice development nurses and practice facilitators in Site C:

“One: I think there is a place at the University, if you think that ultimately nursing has changed. We’ve changed from being the doers of care to the prescribers of care, so in that sense I think we need to be more advanced in what we think and what we do. I just sometimes feel in despair that by the time students become qualified they still haven’t gained some of the practicalities and common sense, and stuff that we would have learnt as a student, things like time management, basic assessment skills, that we would have automatically been doing on our first ward. Okay, we may have only have done the washing, but we had to get them all done at a certain time, therefore we had to time manage.

Two: Because some students don’t perceive doing nursing care as nursing, but the healthcare assistants do so much work that we as students used to do, they don’t see themselves as learning any more.

One: I think that’s a big difference. If they’d just done basic nursing care, it’s not basic, but washing whatever, they haven’t learnt anything all morning. And I think ‘Well, actually you have. You’ve worked very hard all morning and you’ve given what you’re supposed to be giving – nursing care.’

Three: I think you’re quite right there because I have staff coming to work, permanent staff coming to work, they’re so keen to get to know how to do all the advanced practice care, that the basic stuff that you have to have a good grounding in before you can advance on to the more difficult tasks, the more acute tasks, they just don’t want to do. And you see the change.

Two: They don’t perceive it as nursing” (PDN3PF2GNCC).

Student nurses were well aware that trained nurses did not deliver bed side care; this awareness was borne out by the following incident in field work as described in the following extract:

(15/01/07 Site D A&E morning shift) “The researcher had come on at 07.30 and watched handover and then walked out with the ‘minors’ team including two students. The night staff nurse handed over a lady from a care home who’d fallen over, was mildly concussed and needed rehydrating. She said very tiredly ‘That elderly lady needs this tea’ and pushed the beaker towards the two students; neither of them moved. I then went and gave the tea. Later that morning, the student and I went up to watch a scan and I was explaining the physiology behind this to her; she observed that this was helpful and she’d learnt something. She then said had I observed her not giving the elderly lady that beaker of tea? Of course I said ‘yes’ and she then went on to say: ‘I keep being asked to do things which won’t help me learn – clear up poo, mop up blood; give patients tea and toast. I realised that I needed to be more focused to learn and I don’t do those sorts of

⁶ We use the word ‘basic’ care as this is used most frequently by both trained and student nurses.

things now. I hadn't learned anything today – I've observed triage which had lasted 5 minutes, transferred someone to discharge (10 minutes) – I've refused to do an ECG as I spend all my time doing that'.

There were many incidents in the fieldwork similar to the above account which led the researcher to ask why students rejected what to her and the trained nurse participants, was the crux of nursing – i.e. bedside care. Perhaps this is not surprising given the skills that students observe trained nurses performing. Scott (2008) argues forcibly that the workforce orientation of the NHS (noted by Melia 2005) has produced a concentration on skills and competencies rather than relational caring in both nursing practice and education; she suggests that this new form of instrumental caring is problematic for achieving the goals of government, namely, patient focused care and egalitarian nurse-client relationships.

We argue that if bedside care continues to be regarded as low status work as Goddard (1953) and others found and which our data suggests continues to be the case among student nurses, then being associated with such work may lead students to feel stigmatised which could then certainly leave them feeling unprepared for their future role as trained nurses who are not expected to perform such tasks. The relationship between the low status of bedside care, the role of trained nurses and stigma is complex and may be interpreted in a variety of symbolic ways. Students may be made to feel outsiders to the ward nursing team and in particular the professional nurses they aspire to be, by being treated as the 'stupid' student for whom there is no time to supervise. They are therefore allocated low status 'care' rather than 'nursing' tasks to perform which in the trained staff's view do not require supervision. The effect on the students is to make them feel devalued, marginalized and 'stupid'.

Leadership and leadership roles

So far, we have presented data which suggest there are differences between how students and trained staff understand how nursing may be learnt; we agree with Melia (2006) that the workforce agenda seems to shape students' experiences of working and learning in clinical areas largely because the ward areas are busy and focused on achieving targets rather than learning. A disputed understanding of how nursing may be learnt through performing caring work added to the negotiated and disputed nature of students' supernumerary status as learners. Students experienced difficult emotions while adapting to learning and working on the wards and added to these emotions were the emotions evoked through working with sick and dying patients.

We now turn to the new leadership roles within clinical nursing and nursing management which are the focus of this study. We suggest that *what* the student nurse should be learning and *from whom* is a key concern of staff. The ward manager role continues to be seen as having a key leadership role for student nurse learning although changes to this role were understood to have eroded everyday practical mentoring of students by ward managers. They were now seen to have an 'overview' of learning while the day to day management of learning rested with the mentors who were in turn supported by the ward managers, ward sisters and the practice educators.

There is an interesting reflection here about whether the ward manager's role, while recognisably more busy and outward looking than 20 years ago, has actually altered in relation to having this overview role for students' learning. One feature of care delivery is a modified task allocation system with the disappearance of general areas of holistic care delivered through the explicit use of the nursing process that had been apparent when Smith

undertook her study in the 1980s. Rather the data suggest that trained nurses focus on tasks which only trained nurses can do while students continue to deliver the unqualified care, now supervised by HCAs. This concentration and division of labour between trained and untrained workers has led to a division by students of nursing work into high and low status work (as described above), a position akin to that found by Goddard (1953) Fretwell (1982), Melia (1982), Alexander (1983), Smith (1988) and Ousey (2006).

Our findings suggest that mentoring was considered to be an undervalued and neglected area of leadership within the NHS. Some participants recommended that mentors should be rewarded for and allowed to choose to be mentors rather than be forced to do so as NHS Trusts strove to meet targets associated with patient care rather than learning priorities. The role of clinical nurse specialist, nurse practitioner and nurse consultant were not considered to have a direct impact as role models for students nor contribute directly to leadership for learning. Although students appreciated placements where they could shadow nurses in these roles, ward based staff suggested that these specialist roles provided students with an opportunity to avoid the 'basics of nursing' by offering a model more orientated to medical teaching and learning.

We now consider in more detail the specific leadership roles we encountered that were identified as having a role in the student's education and practice learning. These roles were varied with a range of generic and site specific titles, locations and emphases but included link lecturers, ward managers, practice educators, clinical nurse specialists, nurse consultants, nurse practitioners, matrons and mentors.

Role of link lecturer and the anxiety of teaching in the new education system

In Site D the researcher was told that the role of the link lecturer was to:

“Support students in practice, support mentors and audit ward environments, not to work with students or to be practice role models. We've been told [by university managers] to lessen our actual presence on wards in the current financial circumstances – a telephone call once a month is sufficient. Only to visit if necessary” (LL1GNCD).

This lecturer, who had been a senior specialist nurse in practice, did not agree with this approach. And such an approach shows the extent to which universities without a tradition of clinical academic careers are struggling with accommodating nurses who wish to support learning in practice.

Another quote from Site C shows this is happening across different educational institutions:

“The link lecturers themselves find it quite difficult and probably feel that they'd like to be doing a lot more with their areas than they are. They do try and I think if we have problems they do...come. I only have to email R and she'll come. Sometimes they say 'I'm coming on such and such a date' and then they'll get a deadline from their boss for something and they email back and say 'ever so sorry. Can't come that day'. (WM2GNCC)

This lack of contact led many staff to say they had the name of their link lecturer but no working relationship. Two practice educators in Site C said:

“With some exceptions, I don’t even know what they look like, which is awful. It’s something on my account I guess but more on theirs.”

“The ward staff don’t know what their link lecturer looks like”

And trained staff in Site D, on being asked who their link lecturer was:

“I’ve forgotten her name. I saw her – we had an audit a couple of weeks ago. I feel that if I have any problems I could contact her.

I don’t know now.

R: Do you have a telephone call from them?

No.

R: But like with the action pack?⁷

Yes. That’s going back a year. I can’t even remember who we phoned.”

In the literature, the debate concerns the link lecturers’ role in practice and the practice/university relationship (Carr 2007a; 2007b; Barrett 2007); it was accepted that lecturers had a role in maintaining an effective and, for some, credible practice presence and link. These quotes would suggest that the relationship is tenuous in the four case studies we visited.

As in the literature, though, the link lecturers we interviewed experienced uncertainty and doubt over their role. This uncertainty was most clearly expressed in the following quote from a tutor in Site D who was an experienced nurse teacher:

R: “You were saying to start with, before you started, that it was a confusing role for you. Could you just talk about why you feel it’s a confusing role?”

Because I do not feel I have strong guidance from here or from practice in terms of what I should and shouldn’t do. I’ve sort of gone in and done what I think is relevant, but I have no clue as to whether it is the right thing to do, whether it is the expected thing to do and I am unsure about what impact I have on the students; and there have been times recently when I have not been able to go into practice because of the pressures here and the students still have their experience, I’ve not identified any major problems and life has gone on without me...” (LL3GNCD)

We argue that the nurse teachers’ experiences of uncertainty and doubt mirrors the students’ experiences of supernumerary status as they too remain uncertain and doubtful about their role and connection with clinical practice. As a lecturer in Site A responded when asked what their role was clinically she replied: “Trouble shooting - students not turning up.” It appeared from this account that lecturers’ links with clinical practice had developed into “troubleshooting” the mentor and the student relationship and supporting mentors in

⁷ This action pack referred to some work which had been done on the ward around learning.

practice rather than teaching or providing care directly in practice. This lecturer went on to say that the placement for some students had become less important as a site for learning:

“These are the students who just seem to think that the placement is something that they can do as an option, they don’t have quite the same view of it, they just think its something that, well if they don’t feel like coming in they don’t have to.” (LL1GNCA)

Another lecturer reflected that this unease with the ward which she had observed in students was mirrored in lecturers:

“Well, there’s not the same motivation to teach them in order to be able to do the work if you like, or to train them. [And] in the student, a dreadful kind of desire to be away from the clinical area.” (LL2GNCC)

Based on these findings we argue that as these teachers become distanced from their clinical practice, the patient becomes more and more excluded from the classroom because there is no contemporary context of practice upon which to draw. As the senior lecturer in Site C continued:

“What we don’t do, if education becomes so unable to tolerate patients (laughs) as a role... I don’t want to push anyone to do clinical nurse teaching or anything but we should all be able to bear patients in our teaching some way, whichever way it is...” (LL3GNCC).

The lack of contemporary practice on which to draw is reflected in the following lecturer’s comments:

R: “And do you have a speciality, would you say?”

Well, I seem to have that eroded in that originally I was sort of critical care renal, the wards I did were medical/surgical/renal/cardiac, then I somehow get asked to take over other areas like day surgery which I wouldn’t have said I was a expert in but I managed to get mugged up on that enough there. Then I got asked to do oncology, again apparently because I knew nothing really about it but, it seems that I got asked to do things that I managed to be able to accommodate and I now cover, I would say that I’m actually, I have done outpatients experience as a staff nurse and I now cover 14 OPDs (Outpatient Departments).” (LL2GNCD).

This lecturer says quite plainly that her sense of having a specialist practice base has been *eroded* to the extent that she now covers 14 outpatient departments. The reason this erosion is important to her is because it means she has no clinical role and feels the expectations of her remain those of a clinically competent teacher as she went onto explain later:

R: “And do you, what are your links with practice now, can you describe your role now. I think in very much what I would say a link lecturer, I would not say that I do any hands on work. Its not possible really in outpatients because of the nature of it, so I think I’ve been sort of, you gradually move away from hands on activity yet... obviously I go into the outpatients and talk to the students in their areas and I talk about their work there but its not really I think for me to sit in as well as a student on a medical consultation, which a lot of the students do there, so I really haven’t had

any, I can't see myself having a clinical, and as I have also a role as the pre reg programme route leader and I have a lot of other modules to run, pre reg and post basic as well, I just don't have the time. That's our problem I think – I think and life clinical time is very protected and the reality is the expectation to do what was the old clinical teacher's role, which was a full time job and a tutor's role is impossible and I know that people would do lecturer practitioner roles seem to eventually do one or the other because its two jobs and I think the organisational stuff that you have to keep up with..."

The next quote suggests that being in practice, in child health, may not be safe or appropriate because practice itself has changed. The role as a link lecturer is to support students and staff through contact in practice:

"But I suppose we have seen the role change and maybe fluctuate and move backwards and forwards and personally, for me, the role does not involve me having any clinical experience or hands on experience. I think it has in the past but at the moment it doesn't and actually in Children's Nursing I don't think that's too bad a thing because what you don't want with children is them breezing in for half an hour or three hours or whatever it is and working, you're just another person who'd be breaking continuity. I do see my role as supporting the students and going down and reflecting with them in practice and whatever, but also supporting the staff to mentor their students and spending time with them. So it's about establishing links and I think it's being present quite often." (LL3GNCD)

But it is not only the nature of practice which has changed; it is the relationship between practice and education which has shaped this tutor's changing relationship with practice:

"It wasn't until very long ago we were expected to go and do so many clinical hours a year. We had to go and work in our practice areas in the holidays when our students were off. It was partly to do with our commitment here and then [people] realised that in fact we were subsidising the Trust, because we were expected to keep up, our competence. So one week in the summer I would work three long shifts on my link area, as a member of staff. But I think people realised that actually the NHS is doing quite well out of this and how can we as a university afford to do that? So that's what stopped; and it was just getting harder and harder to find the time to do it in. It was quite nice in a way, it made you feel at the end of the two weeks or whatever that you'd done, you felt 'Yes, I can do this.'" (LL3GNCD)

This anxiety around being competent and safe in practice was felt by the researchers, as noted in field notes on the experiences of being back in practice after some years of absence. This led us to reflect on the barriers to being in practice for lecturers as they themselves describe above and a lack of their presence on the wards. Consequently it is not the link lecturers who support the students in practice but practice educators and mentors although data suggest that even this support is variable.

Role of ward sister

The importance of the ward manager emerged strongly in trained nurses' interviews. One practice educator in Site B observed that a well run ward is an important backdrop to student learning. She said:

“How a ward is run has a bearing overall. If it is not well run and disorganized it is difficult for them. A well run ward makes the students feel supported in general. If people are interested in them they feel ok, even if their mentor is off sick, on leave or on nights” (PE1GNCB)

And a practice educator reflected that:

“You were saying about leadership and obviously my role covers the whole of the Trust and this [reflection] isn’t just this year and not just this Trust, it’s going way back. You can always tell wards that you’re going to have issues about students with because quite often they will be the wards where the sister and charge nurse isn’t visible. I’ve had to go and find her in her office.” (PDNMNGNCA)

However, the ward manager’s role has changed substantially since the 1980s partly because of the expansion of nursing leadership roles. For example, a group of practice educators in Site B reflected that the development of specialist nursing roles had led to some extent to “deskilling”. They gave the example of the discharge coordinator role which had been created to take over the liaison with social and community services thus denying nurse managers and nurses in general and students in particular, the direct experience of making arrangements for patients to go home.

The role of the nurse managers has also changed, as we have shown, because of the target driven nature of acute NHS Trusts. Another example of the effects targets have on the ward manager’s role is revealed in the following quote. When asked how the ward manager’s role had changed over 20 years, one lead nurse in Site A, who had been a ward sister in the 1980s reflected:

“Obviously the NHS climate has changed since 2001. I think the target culture is here and is unavoidable. Obviously financial things have been much more aware. When I was a ward sister, while I had a little budget for the ward, it wasn’t a priority and our management accountant sent us messages every now and then if we were running into trouble” (PNPE3GNCA).

Data from the ward managers interviewed in focus groups across the case study sites suggest that the ward manager’s role has changed fairly recently i.e. since the introduction of targets for bed occupancy and a commission led NHS (DH 2004). These changes have meant that the role has had to become more outward looking and externally focused than 20 years ago as another quote from a ward manager in Site C shows:

R: “One of the key roles that we’re kind of hypothesising has changed has been the ward manager role, do you think it’s changed since you’ve been doing it?”

The ward manager role, out of all recognition (laughs).

R: I didn’t want to feed you with that line.

I’ve been a ward sister in different guises since the early 80s and initially it was ward focused and it was patient focused and training staff and student focused and that’s where your work lay but now although I do have a reputation for running the ward a bit

like that, you are being dragged into all sorts of political things ...things which really, I don't know that we should be" (WM2GNCC)

One feature of the current mode of care delivery is a modified task allocation and a focus on targets with the disappearance in the general areas of holistic care delivered through the nursing process. As this ward manager describes in the following quote:

R: "The medical ward sisters as far as I understand have been recently given supernumerary...

Yes. Well yes, we were actually doing full time, doing 5 days a week and having to do everything within 5 days, been given some supernumerary status certainly the priority among that is to increase discharges and there's no mistake made about that, it was to and make sure discharges were going through but of course it does have a knock on effect, I have got to do more time to do things with the staff and I do have more time for the students so it has been beneficial but it is to increase the through put in the hospital and you become a sort of, I don't know – what would you call it?

You're just like an automaton, I sometimes come into the ward and I'm looking at the board in numbers and I get quite frightened sometimes because I'm forgetting that they're people and I have to pull back" (17/01/07 Site A surgical ward field notes).

The data suggest that, in addition to meeting bed targets, trained nurses focus on tasks which only trained nurses can do while students continue to deliver the 'untrained' care, now supervised by HCAs. This concentration and division of labour into work to be carried out by staff regarded as 'trained' and 'untrained' has led to a division by students of nursing work into high and low status work, a position not so different to that found by Melia (1983).

But in addition to all these changes, the staff employed have more social difficulties which the ward takes responsibility for as suggested in the following quote from a lead nurse:

"I've had people in my office this week who are having financial problems; someone who's got housing difficulties, immigration status...things like that didn't face the ward sister [then]. It seems to me that the ward sister has to deal with an awful lot and sickness rates are fairly high" (PNPE3GNCC).

The ward managers interviewed seemed to all retain leadership at the ward level rather than the individual student level for mentoring, teaching and learning. In other words, the ward manager created the ward environment where the student's progress was noted and managed as the following quotes from ward managers in Sites A and C testify:

"And it's important to the team isn't it, that the team of nurses actually communicate to one another how the student's actually doing and to address issues as they crop up instead of leaving it for the mentor or for the ward sister" (WM2GNCA).

"I've passed on day to day management of the students and their rota to one of our junior sisters and she does their rota planning and allocates mentors. It's my role to make sure that the students are getting what they need from the placement as well as the fact that the mentors are mentoring properly" (PDNMN3GNCC).

Further evidence for this finding comes from Site B where the researcher noted during observation that on any one shift there could be a variety of qualified nurses on duty described as staff nurses, ward sisters and the ward manager who was the senior ward sister. Grades from D to H were attached to these designations (since Agenda for Change was introduced these grades have been changed to numerical bands). The ward manager delegated the patient care to the ward sisters and staff nurses while she went on doctors' rounds and liaised with a wide range of internal and external individuals and organisations including the matrons, bed managers, community nursing and social services to plan patient discharges. Students reported during interview that any one of these qualified nurses, including the ward manager could and had acted as their mentor. The ward manager's role in mentoring seemed to be as co-mentor and in supporting her staff to mentor 'problem' students as these quotes suggest. Both these ward managers were trained in the 1970s and had seen substantial changes to their role:

"I do work with them sometimes and I also get feedback from the mentors, if there are any problems or anything. If the mentors find they have problems with them, then I'll work a few shifts with them and take it from there.

R: And what do you miss about not mentoring students?

Just seeing them develop really, the way they come on from when they start to when they finish" (WMGNCD).

R: "And are you able to do that [mentor] as a ward manager?

I can make time to do that, I usually end up co-mentoring, I always chat with the mentor and I co-mentor and I don't usually work with the main mentor at all time, I have had a situation on the ward where I've got lots of students that we're mentoring so I often have to co-mentor several but ...I might work the shift with them and then come back to them a few days later and do it like that and they'll be with another mentor at the same time and I can actually see their progress as well then" (WM2GNCC).

As we have seen in previous sections, due to the supernumerary status of the students, the business needs of the ward areas, the nature of learning and lack of time for teaching, the ward manager retains a role in the management of learning but in the capacity of having an overview. S/he may possibly act as the student's co-mentor with the associated risk of being called away to attend to other priorities.

There was a discourse in one focus group between nurse managers, ward managers and practice educators that ward managers *used* to work with students. Yet, during observations, the ward sisters on a medical ward and two surgical wards in Sites A and C were observed delivering care, co-ordinating medical and nursing staff and managing discharges as the following extract from field notes demonstrates:

(23/01/07 Site A mixed surgical ward, morning shift) "Over tea in treatment room (made by HCA and brought through the ward on a trolley with biscuits, toast etc) sister said her role had changed lately – whereas 10 years ago she'd taken patients and not co-ordinated the ward, now she co-ordinated the ward rather than taking patients. Therefore doesn't work with students but 'keeps an eye'. She feels she has overall responsibility for students and supports mentors".

As the researcher's observation extracts show in these data, *co-ordinating* everything on the wards included allocation of students and planning assessments for students but often in a rushed fashion which appeared unsatisfactory for students. Focus group and survey data seemed to support these observations that the ward manager's role is very busy and that they have an arms-length relationship with student learning even when assuming responsibility for mentoring individual students.

While essentially elements of the ward manager's role are predominantly similar to that of the ward sister of 20 years ago, what has happened in the interim is that new elements to the current role have been introduced that makes it feel unsatisfying for the post holders to the extent that there appears to be a *harkening* back to some sort of golden time for ward sisters? We argue that the nursing process which was introduced and worked with during the 1970s and 1980s and gave a holistic focus to the role, has now largely been abandoned due to the pressure to achieve targets. Task allocation in its new form of meeting discharge and bed targets and delivering trained nursing tasks [drugs] appears to have been reintroduced and we observed a return to 'team' or 'sides' nursing (by which the work was divided into two separate 'sides' of the ward to which the nurses were then separately allocated) and a move away from patient allocation. In one sense then, the ward manager's role has remained remarkably unchanged in relation to student learning *over a 20 year period* during which some of the interviewees had been in post. Yet there are other elements that have been introduced that make these ward managers feel that overall their role has substantially changed for the worse.

Role of practice development nurses and practice educators

We were told that these new roles of practice development nurse or practice educator was to support mentors, monitor the paperwork and deal with/work with underachieving students which was described as "troubleshooting almost daily". An extreme example of 'trouble shooting' was given by the senior nurse (practice education) in Site A who had worked on a ward with a student who was refusing to give intimate care to male patients. This senior nurse (practice development) had gone earlier in the week to talk to the student and then discussed the case with the Nursing Midwifery Council representative whose guidance was that the student had to care for male (as well as female) patients if she wished to be registered. She said "I've had to be quite tough with her and given her an ultimatum". The student had been referred to the student counseling service and given time to think through what she wanted to do given the implications of her present position/stance. The senior nurse (practice development) explained that the student would have to decide whether to carry on or resign from the course. This difficult situation was being handled primarily by the practice development nurses, not the student's mentor. Such work relied on good relationships between the practice development nurses and the ward nurses.

These relationships between learning and practice were at risk between the universities and the wards as the Director of Nursing in Site A suggested in an informal chat during an orientation visit by one of the researchers; he said their main problem was with interpreting university regulations "we don't understand them" and ensuring students understood learning opportunities on wards:

"They don't see they're learning except when they're doing drug rounds. The nurse sees this as a task and the students sees it as non-basic and therefore good learning

opportunity. There's more value to washing patients. When I was a student, I was thrown in – washing, bedpans, hand squeezing but that's what I wanted."

Given the absence of link lecturers in the clinical areas as discussed above, the role of the practice development/practice educator nurse has become crucial to ensuring a high quality learning environment and the reason why Trusts invest in such roles. Their importance in relation to supporting the mentors is further discussed later in this chapter.

Lead nurses/modern matrons

The interesting point about the leadership roles in nursing across the sites was that they were not visible in the observation data. However in Sites D, A & C the lead nurses/modern matrons participated willingly in the focus groups and said that their role was as follows:

"They 'mop' up lack of skills and competencies in junior staff and deal with complaints (WM2GNCA)".

In other words, their perception was that they were the leaders of the delivery of care and they ensured that standards were met by addressing the deficits in the system of medical and nursing education as these lead nurses argue:

"It's a bit of a nightmare on the wards because we have junior doctors who can't do anything, they're not allowed to do anything...you've got newly qualified nurses who are in the same position. So for people who are more experienced actually have a nightmare because you've got a whole team of people at a lower level who can't function without that support; so it's very difficult. Which it's not supposed to be is it? We're supposed to be here for clinical support but yeah that's what we do, firefight" (LN2GNCC).

The practice educators at Site B also emphasised the importance of the matrons as well as the ward managers in creating the ward learning environment at a distance because of the constraints on the ward managers in terms of time and resources; however they were critical of a perceived lack of support and leadership.

"I think the ward manager has an impact full stop. If the ward's well run and organized, then learning is more easily facilitated ... I think it goes higher than that though. The influences on the ward manager ...the ward managers are working beyond their means and they have no facilities to do it with...staffing levels are so poor that they are struggling. They are working harder to achieve the basics but there's a lack of support, or a feeling of a lack of support from Management about matrons, senior managers...and I think when your ward manager's burnt out and exhausted, that has a big knock-on effect on the staff" (PE3GNCB)

The lead nurses/modern matrons, and to an extent, the ward managers considered themselves to be leading learning in its professional sense; yet because of their distance from everyday ward life in the case of the former and because of their heavy managerial workload in the latter, they were not seen by students to be leading learning.

For students, these lead nurses were not evident and they looked to their mentors and ward managers as their role models. Students' views are exemplified in these third year diploma students on final module Site B:

R: “And who do the mentors tend to be, because like I said to you, when I did my research 20 years ago it was the Ward Sister and then a team of Staff Nurses who were very identifiable on a ward. So, how is it now?”

Senior Staff Nurses have taken the role. The Ward Sisters tend to be Associate Mentors so they’re there for back up rather than being the full-time mentors. The Ward Sisters where I am at the moment are certainly the Associate Mentors. I think it’s because the Sisters have admin days, they run the clinic, so as far as students working alongside the mentors is concerned, they have more chance of being able to work alongside their mentor who is a Staff Nurse in the team, who is 90% of the time on the ward, rather than have the mentor as a Sister who maybe isn’t on the ward that often. It would (reduce direct) care with patients and they’re in Clinic or they’re doing admin or whatever, so I think that’s why, which is a good thing really, because you actually get to work with your Mentor. The Ward Sister is very good on C Ward and they’ll help you out if you need anything. That’s what I’ve found with them and it’s probably the best placement so far for that, for student support certainly” (St1GNCB).

Another student in Site B when asked about the role of specialist nurses and other advanced practice roles in the student’s learning portfolio said:

“There are quite a few on the ward at the moment (surgery) There’s obviously the matrons that come on and deal with all the bed side of it and discharge and everything like that .. then there’s a clinical practice educator for the burns and plastics unit ... they can do a lot more things than the staff nurses can do, their roles are a lot more extended .. they’re also very teaching orientated” (St4GNCB).

Another student said about the matrons:

“Well we don’t have much to do with higher up ... we have had a talk from them (matrons) on this module (management) . You know we have certain arranged talks for the PSBs (Practice Based Seminars) you know, different nurses come in and talk,... but you do do “spokes” and I’ve done loads, so you do learn from those” (St5GNCB).

Yet another student added to the sense that the matrons were a vague presence when she commented that:

“We had talks from the matron in this module (management) and she said we could come and talk to her at any time but we don’t even know where her office is” (St11GNCB).

When the researcher met the matrons she could see why the student (above) did not know where their office was as they were tucked away in the administrative block some minutes walk away from the clinical areas. There were three of them who shared the office and the researcher sensed that they needed that close contact and peer support away from the hurly burly of the clinical areas. When asked did they have contact with students. One of them said she had had a management student shadowing her who she reported was “very surprised at what we do”(MM1GNCB).

When asked what surprised them about the role, they all agreed that it was the need for “negotiating skills” even “wheeler dealing” to manage beds and to meet targets (note beds rather than patients) (MM1,2&3GNCB). Another matron said that clinical governance and quality to achieve targets had become the focus of their work rather than a clinical focus (MM2GNCB).

One matron told the following wry tale which summed up the tension between achieving targets and clinical practice:

“We were opening up a new clinical area so we were preparing a ward for patients. I was washing down the beds and other equipment with the ward sister. When I told the health care assistant what we had been doing she said well ‘you’re a very expensive cleaner’. I thought ‘well be like that’ when we were doing it to keep them in the clinical areas” (MM3GNCB).

However the matrons were also proud to report that they created the clinical culture “behind the scenes” and all agreed that:

“We do well in recruiting the best students. They want to come here because of the good placement experiences” (MM1,2&3 GNCB).

Role of nurse consultant, clinical nurse specialist, nurse practitioner

None of our participants referred to nurse consultants but there was a mixed attitude among lead nurses across the sites towards clinical nurse specialists and a sense that their role in teaching was negligible and, if present, focused on post registration students. These modern matrons/lead nurses in Site A showed a negative attitude:

“You’ve got the excellent staff nurses who mentor and then become the excellent clinical nurse specialist who aren’t on the wards anymore (laughs).

Yeah true!

R: So where are the clinical nurse specialists?

Well they all manage their own time and disappear off the wards – don’t get me on that one! (laughs)”

In Site C, some lead nurses and a practice educator reflected that the CNS had been a loss to the leadership of learning for students:

“If those roles weren’t there, they would be there giving care and teaching and supporting...” (PDNMN3GNCC).

And for the practice educator in this focus group, CNSs showed a reluctance to teach pre-registration students despite lobbying from her:

“But still some of my other CNS colleagues are very reluctant.

R: Why is that?

Well for all sorts of reasons...Some of them feel that they already do a lot of teaching and they don't need to do anymore. Some of them, quite rightly, [think] that their specialty is so specialist that a 2nd year student nurse isn't going to necessarily get out of its what perhaps a qualified nurse would do" (PDNMN3GNCC).

It was therefore useful to have these focus group data validated during an observation in emergency care in Site D as this extract from field notes demonstrates:

(15/01/07 Site D A&E morning shift) when observing an emergency nurse practitioner "I met the emergency nurse practitioner who said she didn't take students when she was working as an emergency nurse practitioner [ENP] (for three days per week); only if she's nursing for the other two days of her week. She feels she's working at such a high level that they don't need to observe her as her work doesn't meet their learning needs."

However in Site A, I observed ENPs working with students so obviously some nurse working at advanced levels could make their work meaningful for students.

The only data which contradicted these negative views of both nurse practitioners and CNS' roles in teaching pre-registration students came from an informal interview during observation with a male ENP who explained his role as described in the following extract from field notes:

(05/02/07 Site A morning shift) "I work as an ENP and it's everything to do with teaching. It's much easier; one patient and you can focus. I had a patient whose wound needed dressing and 4 new staff and 1 student. We took an hour with me teaching about wound healing."

And from a focus group interview with the lead nurses in Site D who were more positive about clinical nurse specialists (CNS) working in specialist areas like intensive care:

"I think it's probably easier in the high dependency units in terms of care because we've got CNS who will work alongside new staff or students so on a one to one looking after a patient basis they probably get more input than they can get on a busy ward area really" (LN1GNCD).

In Site B, an innovative way of exposing students to these new clinical, leadership roles had been introduced through a method of organising practice based learning called 'hub and spokes'. As reported above practice educators reported that students were most likely to meet nurses in new specialist roles during their "spokes" experience working from outside the ward setting. The "spokes" experiences were said to help them to appreciate the "whole patient experience" and the role of the multidisciplinary team. The mentors were identified as key to assisting the students to make sense of these experiences and prevent their visits from degenerating into a "bit of a day trip." These views were substantiated during interviews with students and generated the insight that the hospital ward is not the only setting where clinical learning can take place.

The difference in attitudes towards these clinical nursing leadership roles appears to be that those viewed favourably were working in specialist areas like A&E and ICU rather than having a specialist role linked to conditions such as diabetes or cardiology.

The question of whom student nurses should learn from also emerged during the literature review; there are clearly two questions to ask: should they learn from trained nurses? And if so, then which level of trained nurse? Our data seem to suggest that some advanced level practitioners may not identify with pre-registration training and teaching and see themselves instead to have more to offer post registration students.

In the following quote, the practice educator suggests that the question of who teaches pre-registration students is related to who delivers care:

“Two: I think the nurse’s role has changed. I don’t deny that and we don’t do as much hands-on care as we used to, and if a student comes on and has an expectation to be paired up always with a mentor who happens to be a qualified member of staff, they’re going to miss out on the other valuable bits of learning which now comes from the HCA. So if they’re expecting to always see their mentor or be paired up with somebody qualified, they may not well do the fundamentals of nursing care. It’s a bit of an issue” (PDNPF2GNCA).

This *issue* was clearly demonstrated in the example of the student nurse who told one researcher during observation that she did not want to give care in emergency care because “it doesn’t meet my learning needs”. This seems to be mirrored by the ENP who was reluctant to have students with her while working as an ENP. These data suggest that nurses and student nurses continue to hold strong ideas about a hierarchy of tasks in nursing as suggested in the Figure 2 below.

Figure 2: High status care vs. low status care

High status = advanced level nursing i.e. clinical specialist; ENP role Low status = giving tea, care
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And as we have indicated in the discussion on emotions, delivering low status care work may evoke emotions which are shameful like feeling ‘stupid’ and stigmatized because of its association with ‘student’s work’.

Role of mentors

We have presented data which suggests that the key role for students in their learning is the mentor. We have also shown how the leadership for learning, which centres on managing the ward effectively to facilitate learning, supporting mentors and acting as co-mentors, and lastly, ensuring mentors are trained and updated in their training, continues to rest with the ward manager. We have also shown how the nature of trained nurse work often means that trained nurses do less care work and more technical work such as drug rounds, dressings and liaising with medical and other staff. Therefore, acting as a role model for care work becomes essentially problematic for them and their students. We have argued that the ways in which students seem to devalue care (low status) work may reflect their aspirations to become trained nurses and be associated with the technical (high status) work; but that their current association with low status work is painful for them in that it evokes painful feelings of being devalued themselves.

Given these difficult feelings, the success of the mentoring relationship depends on the ward having a welcoming attitude to students and not seeing them as a pair of hands but as offering clear learning opportunities as one link lecturer in Site A explained:

“The humanistic approach as they come in and people seem to want them there, that seems to settle the whole, that sort of – like I would say, is like an essential layer in the mentorship relationship. What can make it better and better is how supportive the mentor appears, and how challenging the mentor can be for the student to make them self directed as a learner and how good they are at seeing the learner as somebody that they want to invest in the future and not see them as just pair of hands in the prep room and I think that’s the real issue. You can incorporate the student into undertaking your activities in an area but if they are generally supernumerary they are not there just to fall back on” (LL1GNCD).

A good example of mentoring by staff is shown in this data extract from a practice educator in Site B:

“Just last week I was stopped by a student in the corridor just to let me know how wonderful she thought her mentor had been. They had worked together closely in what the student described as a ‘partnership’ and she had been encouraged and supported by the mentor ‘to do a lot of things.’ She described it to me as “a turning point” in her training” (PE1GNCB).

Another example is given by a second year nurse in Site B, who recalled one of her mentors, an experienced ward sister, who she described as “a dead good nurse”. She observed that in order to be a good mentor “you needed to be a good nurse” with a sufficient level of nursing experience. The student described the importance of the “little things” and the approachability of the qualified staff as being very important to her learning.

Attitudes of mentors may reflect whether they are motivated to mentor as not all trained nurses wish to act as mentors; yet because of the requirements of the curricula in the four sites, expectations of NHS Trust are that they will provide 50% of the input into the student’s learning experiences. Their managers expect that trained nurses will act as mentors and in some Trust link this expectation to promotion as this tutor in Site D explained:

“They’re suddenly pushed into doing things, what was the mentorship course and they’re not ready, they don’t really want to do it because they know that it’s a responsibility having the student and it’s too soon for them. If there was some kind of transitional state where they were encouraged to support students at a non threatening, non assessment level if you like, formal assessment is just formative stuff that they’re doing, that would get them into the way of doing it” (LL2GNCC).

The practice educators in Site B also emphasised the importance of the mentors to students, and the support and resources required for them to do the job effectively; they required “a lot of experience and expertise in their area of care and nursing” (PE1&2GNCB). Currently they were expected to both care for patients as well as students and they were not given any reduction in their workload to do this with the result that they were put under strain. An example was given of the mentor in the Intensive Care Unit (ICU) who could be caring for a very sick patient but with the responsibility for a new student. They also gave a further example of wards where 60% of the nursing staff worked part time further reducing the mentors’ availability and continuity. As noted above they also identified the mentors as key to assisting the students to make sense of their “spokes” even when the mentors were based in general practice areas.

Staff felt that the mentoring relationship also depended on the student being prepared to learn from the mentor and take responsibility for their own learning as these ward managers suggest:

“I quite often get ‘my mentor’s not helping’ and ‘my mentor’s not doing this’ and I have to keep pointing out ‘Well actually you are the person who has to do that, not your mentor’ ” (PDNMN3GNCA).

“We’ve had issues with non-attendance that sort of thing. They come waving their attendance sheets at the end of the placement and then I say ‘Well actually you weren’t here for half of it’ ” (PDNMN3GNCA).

For one practice educator, students often failed to recognize learning opportunities presented during working with their mentors and caring for patients:

“Thy may say ‘I didn’t have any teaching while I was here’. I say ‘Well actually I worked with you for x amount of days...we looked over this case, we discussed this patient and what happened with them, the progression of their care’. But that’s not seen as teaching and I think that’s the biggest thing we try to explain” (PDNMN3GNCA).

Assessing the degree to which students are prepared to take responsibility for learning through caring is a fine art and it can go wrong as this ward manager shows:

“And for them to be aware of what the constraints are in terms of it’s not going to be their mentor one to one for the whole placement. That’s not a good ting; you learn different things from different people but it’s managing their expectations at the beginning that’s the important thing.

R: what are their expectations of you?

They’re quite high and they’re used to being directed and if they’re not specifically directed they can find that quite difficult...you know you can say ‘you can have those two patients there and we’ll keep an eye on what you’re doing’ and sometimes those ways of learning work but sometimes you can see people going ‘Oh they’ve only given me two patients and at other times saying ‘Oh my God they’ve given me five patients!’” (PDNMN3GNCA).

Participants in one of the focus groups judged that a significant issue was failing students by mentors and that this was made difficult by a reluctance to challenge students, by a lack of familiarity with the paperwork and a lack of time as this quote from a practice educator in Site C:

“I think we’re getting much better and the thing is now we follow them through now with our team in place. If we know there’s been a student struggling with one particular ward we can actually keep a bit of a closer eye on them in their next placement...there are still pockets of mentors that because they, for lots of reasons, time, not understanding the importance of it, they don’t really understand the paperwork, they leave things to last minute” (PDNMN3GNCC).

The practice educators in Site B thought that the introduction by the NMC of the new system of “sign off mentors” would put further pressure on the mentors. They also mentioned the Knowledge and Skills Framework (2003) which required that “everyone must be a mentor” and the imminent introduction of “the student passport” which students would take with them from ward to ward. One practice educator concluded: “All this pressure... Sooner or later something will snap. Something’s got to give” (PE1GNCB). But despite all these challenges, as this same practice educator put it: “a good mentor swings the experience for them (the students)”.

Learning not teaching

All the trained nurses and lecturers expressed strong opinions about the nature of learning for today’s students. Some trained staff viewed the students as active learners who needed to take responsibility for their own learning while at the same time needing support (as discussed above); some felt that students resisted learning nursing through the manipulation of their supernumerary status and avoiding the ‘basics of nursing’. Their views were echoed in a key observation made by one of the researchers. While she observed students were keen to learn and sought learning opportunities and staff created those learning opportunities, explanations were in short supply; in other words, there was observed learning and students seemed orientated to learning and staff to creating learning environment, but there was very little teaching. The absence of the lecturers in clinical teaching was also noted by the same researcher in her field notes as well as the short length of time students were in practice which added to the difficulties of learning during placements.

The researcher observed that staff were orientated to allowing students to learn through doing but did not challenge them to expand their knowledge and skills or explore ideas cognitively. Indeed, she observes after one shift as recorded in this extract from field notes:

(17/01/07, Site D day surgery morning shift) “Lots of learning what to do and how to be but not much *why*. It’s as though embodied knowledge is hugely important – acquiring skills through doing – as one staff said today ‘They’ll have to be doing that soon’”.

This led to a few incidents where the researcher observed students caring for patients without knowing what their medical diagnosis was as described in the following extracts from field notes:

(15/01/07 Site D A&E morning shift) “The staff nurse allocated to work with the student that shift had not known what a [particular] scan was or how to explain a pulmonary embolus when asked by the student. So the staff nurse suggested we went up to see the scan. I then explained the scan and pulmonary embolus.”

(17/01/07 Site D day surgery morning shift) “Staff nurse and student doing drug round (2nd year student). Staff nurse letting student pour out tablets and give them to the patients; she didn’t explain the drugs at all. She seemed to guide and facilitate the **doing** rather than understanding. At one point, she leant back, stretched her back and arms and looked for the world like she was bored. She didn’t teach or challenge...at coffee, student said she felt ‘taken care’ of by her mentor who she always worked with.”

(17/01/07 Site A day surgery morning shift) “Student and I were preparing a lady for operation; I asked student if she knew what the operation was; she didn’t know and hadn’t asked. Later mentor and student at the station looking at notes for the same

patient going for parotidectomy that morning; mentor had arranged for student to prepare a patient to follow her through to theatres and watch operation and care for her post-op. So again facilitative and meeting her identified learning needs. However she didn't check student knew what the operation was; so I asked and she gave a brief explanation."

These observations on the lack of teaching by trained staff were validated in an informal interview with a ward manager in Site D as recorded in this extract from field notes:

(23/01/07 Site D mixed surgical ward morning shift) "Sister told me that she thought students learnt how to do things but not why. 'We don't have the time. Don't know where they learn why?'"

This lack of teaching was explained by staff and lecturers in the interviews. Firstly, by a lack of experienced mentors:

"We've had a lot of experienced staff leave who were mentors and a lot of junior staff who aren't up to level of mentorship" (PE3GNCB).

This may be due to the time and experience since qualifying as this quote indicates but also the skills mentors are given on their mentor preparation and update courses as one lecturer suggested:

"My concerns with our mentorship programme is that it was pared to the bones for economic reasons and what was the old 998 which was about teaching has been lost. We now have to focus on documentation. That's an enormous part of the mentorship course and all the stuff about educational audit, the environment, and the bit about the theory of mentoring but there's very little time in that five days to... really discuss and to get to grips with one-to-one teaching" (LL2GNCA).

Secondly, the culture can influence an orientation to teaching as this quote shows:

"I've heard some of my team say 'Oh, why have you done that?' 'Oh, because XX has told us to'. No actually we always explain the rationale for why we do that. But it's easier for people to say 'Oh because we do'. And there's very much a culture within our workforce which does that. A lot of our workforce are not doing [explaining] and our students aren't being brought up with that either" (PDMNGNCA).

Thirdly, mentors have to feel motivated to teach as the following quote from a student suggests:

"It's not all of my experiences have been good with mentors, but I think in order for us to learn they need to be willing to do it and have the time to do it as well, rather than just rushing through things, you know. Sometimes you feel like you're getting on someone's nerves if you're asking questions" (St1GNCB).

But mentors felt that the students' motivation was also central to facilitating good learning as this mentor argues:

“I think it’s enthusiasm from them as well. If they’re not enthusiastic, how do you tackle that? How do you get the key points that you can pull out and help them to learn about if it’s something they’re not interested in... I think it’s on both parts, just trying to get them involved and getting themselves involved” (M1GNCD).

At the same time, there was a feeling that students did not always know how to learn.

“Students need to learn how to learn. I don’t think all of the students are capable of working out for themselves by watching. I think you actually need to baby them in a way” (WM2GNCC).

And in another quote:

“A few of them came to me the other week, for part of their third year they’re doing their dissertations for their final degree and while the Trust will guide them in maybe arranging topics and one of them sat there and she said, ‘Well I thought the Trust was going to tell us’. And I said ‘No’ and I sat there and thought ‘They’re still students. They’ve gone into student mode and expect to be given everything on a plate’” (DND2GNCC).

The ‘student mode’ was inappropriate largely because of the lack of time as this ward manager suggests:

“[teaching] as in proper sit down? There’s teaching and learning the basics on the wards, what’s happening and what’s going on but not on conditions, not the in-depth...they learn quite a lot about nursing but they’re not taught” (M3GNCD).

Diversity and multiculturalism

One of the quotes above suggested that the learning culture of the ward area could influence the degree to which learning opportunities were created by mentors through challenging students. However in Sites C, B and A the ward learning climate was thought to be influenced by the multicultural nature of the student and staff population as well as the student orientated focus of the degree students compared to the diploma students. The multicultural nature of the wards had led to different experiences of, and expectations towards learning; these differences were felt by both lecturers and staff to not be addressed openly within the Trust or the University.

Both clinical and teaching staff expressed concern that a multicultural workforce had led to different ways of learning which were not easy to accommodate in the busy clinical environments. The following long exchange from a focus group with lead nurses and a practice educator in Site C shows how staff are aware that the changing workforce has affected the learning environment.

Three: “... people just don’t seem to do as much in handover, or [ask] why we are doing that. It’s not just because of people’s hesitation to that but I think it’s the also the response they get for doing that. I’ve got a couple of Sisters who work very much in that way and that’s the way I used to work. I don’t know rightly or wrongly. I guess you are putting people on the spot but as long you don’t humiliate them in that circumstance.

But some of the staff have not reacted very well and as a pack have really affected the way the system now works. I think that's got a lot to do with the challenging as well.

R: And why is that?

Three: I guess because they feel slightly threatened.

R: But they presumably have been educated within the same system.

All: No.

Three: A lot of our workforce haven't been educated in the same system and that is something that culturally there are differences and training wise, it's not a question of knowledge base or anything like that, but it is a system that is different and I think for a lot of the staff they haven't experienced that so therefore if somebody... in the workforce that feel very hierarchical, if the Matron knows something and [it's] not for you to be part of a team. ... And breaking down those barriers and preconceived ideas has actually been quite difficult, to get a team that's gelled and feel that yes, you can challenge, you can approach, you can do all of those things, and that's never really been an issue for me. You go up to the Ward Sister, you talk to her, believe you me in our day when we trained some of them were pretty scary people, but you would go up and you would approach and you'd be part of a team; and that's been quite difficult for some of our staff and I know that's been a difficulty.

Four: I think there's a huge under-estimation of differences in communication terms, everything. I think there are huge differences and it makes a hell of a difference to the care we're delivering, and I don't think people take that on board".

As can be seen from this long extract, different systems of learning co-exist and the system these experienced nurses have been used to, where the student asks questions of the ward manager and the latter challenges students' knowledge in handover, is no longer accepted by all. These observations on multiculturalism and learning were sometimes made after the tape was turned off or in an embarrassed way and participants said that they had no forum for discussing these difficult issues. This lack of discussion of multiculturalism has been observed by Allan & Smith (in press) elsewhere, that health managers and mentors have a limited understanding of equal opportunities and ignore the difficulties evoked through working in a multicultural workforce.

In Site B, comments were made by practice educators about the differences and potential difficulties between diploma students' and degree students' attitudes to learning:

"I was going to say they're very much students. The attitude and the culture, especially I mean the diploma students are the same, but very much the university students...they're very, very...students. Same as every other student at university. There's a laissez faire attitude with the degree students if they're a bit late or it's no big deal because that's the nature of university isn't it?" (PE2GNCB).

Conclusions

Much of the data presented here suggests that there have indeed been changes to both education and practice which have altered but perhaps not radically changed the leadership

for learning in the clinical areas; leadership continues to be led by ward managers and to an extent by lead nurses/modern matrons while students' everyday learning is undertaken by their mentors who are themselves supported by the ward managers. However what is new about student nurse learning in clinical areas in 2008 is the position of the student and the link lecturer in between education and practice; for both it raises uncomfortable feelings which need to be addressed. These uncomfortable feelings appear to reflect an *uncoupling* of learning and teaching from clinical practice and student nurse learning has been fragmented by the move to higher education. This fragmentation and split between practice and education is, if anything, greater than before the introduction of Project 2000 and the Fitness for Practice curricula.

The key themes which have been presented in this chapter are summarised in Figure 2. We used these themes to inform our curriculum analysis, using the following concepts:

- Linking theory/practice
- Mentoring systems/training
- Supernumerary status
- Student support

We conclude our analysis by presenting the curriculum analysis in Chapter 5 and discuss our findings in Chapter 6.

Figure 3. Summary of key themes in qualitative data.

Fieldwork data:	
Negotiating supernumerary status	Professional learning in nursing Ward atmosphere Ward learning opportunities
Working in clinical areas	Ward atmosphere Ward learning opportunities Nature of nursing
Emotions	Stress Ward atmosphere - nature of patient care e.g. care of dying Support for students and mentors
What is nursing?	Role models Reality of practice Stress Curriculum
Leadership roles	Most important – ward manager/mentors/ lead nurses Least important –specialist/nurse practitioners/consultants Role of link lecturer
Learning not teaching	Professional learning in nursing Role of mentor/link lecturer Stress
Diversity and multicultural learning environment	How is nursing taught?

Chapter 5 - Curriculum analysis

The key themes which have been presented in this chapter are summarized in Figure 2. Using these themes to inform our curriculum analysis, we developed the following concepts:

- Linking theory/practice
- Mentoring systems/training
- Supernumerary status
- Student support

Documents accessed online included curriculum documents, mentoring training documents, QAA reports. These were read by one researcher.

Linking theory/practice

With the new curriculum (Making a Difference) came a different ratio of theory to practice. The previous 60/40 ratio in favour of theory was modified to become 50/50. The learning that takes place in practice was given due credit through this and each university uses portfolios to link theory and practice learning. University D states that the portfolio provides 'a record of significant learning experiences' and 'provides the basis for discussion with the student's mentor'. University B states that 'the student portfolio was designed and developed to assist students to gain optimal learning in practice' and that the portfolio is to provide evidence of learning.

University A places more emphasis on the role of the theoretical assessment such as essays, examinations and practical examinations in drawing together practice experiences to link theory and practice.

Although all the university QAA reports suggest that they deliver online learning and teaching, University A emphasises e-learning technologies such as their Virtual learning Environment, to enable the student to link theory/practice and students are provided with access to online communities of learning. In addition, each student chooses a Community of Practice which is a group of health care practitioners who share specific professional interests; this enables students to develop local knowledge about local communities' health needs. This community of practice communicates current developments online and the student has access to this mode of communication and learning.

All of the Universities have a system of curriculum development, implementation and monitoring of the pre-registration curriculum e.g.: through Practice Education Committees.

Mentoring systems/training

The mentor is the key to practice learning in each of the university curricula. For example, in terms of locating responsibility for student success, University B reiterates the Making a Difference Curriculum position on mentors "the mentor is the arbiter of the students' success or otherwise in practice". The student should produce the evidence with the assistance of the mentor and the personal teacher no longer 'verifies' the evidence. However each university acknowledges the limitations of the mentoring system such as allocation of shifts. For example, University A acknowledges that students will not always "spend all of their time with their allocated mentor."

Supernumerary status

There are clear guidelines on exactly what each university defines as supernumerary status. University A states that it does 'not include the students being counted in the number of nurses required to deliver the service; the Trust does not pay for the student to work; the student's educational needs are considered paramount and take precedence over service needs'.

Having said that, it then goes on to say that 'it is important to understand that you [the student] are not an onlooker. The experience of giving care as a helpful participant, and being part of a team of health professionals is vital to your learning'. This phrase is most telling given the data presented in this report about the tensions around supernumerary status; and yet it seems that the university itself finds the concept of supernumerary status troubling and difficult to balance. On the one hand it states firmly that the student is a learner and on the other suggests that learning as part of a team while delivering care is *vital* to learning.

Student support

Ranges of student support interventions are described in the documents reviewed and include pastoral support by personal tutors to university wide student support agencies. However there are some differences in the emphasis that each university places on the type of support offered. For example, university B states that in placements mentors are 1st line of support followed by clinical placement facilitators and clinical placement development managers; ward manager is not referred to. In contrast, University A's first statement about student support states that the personal tutor is the main student support; along with academic support via Dyslexia Support Unit and Student Advice Centre. It makes no statement about placement support in the same way as University B. Nor does university D's handbook states that the personal tutor is the point of pastoral and academic welfare and makes no mention of the mentor. The guidance about placements does mention the mentor as a student support. University C mentions that 'practical skills will be taught by nurses working in the area for placement along with lecturers from the College who have a formal link with the placements'. This is the only reference to the link lecturer role.

Conclusions

It is clear from reading these documents, that the universities themselves reflect the tension we have highlighted in our report around linking theory/practice, mentoring systems/training, supernumerary status and student support. Some of the universities have attempted to address the issue of the student's position between practice and the HEI through the provision of online learning opportunities, access to online communities of practice and clear guidance on being a student. However our empirical data from the survey and the fieldwork show that the systems may be in place but students, mentors and staff continue to experience the tensions borne out of the shifts in the provision of nurse education and changes to clinical leadership. It seems to us that these local schemes have failed to address the underlying problems of nursing education – namely, the uncoupling of education and practice.

Chapter 6 - Discussion

Our main finding is that the policy changes in both the education of nurses, such as the move to the higher education sector, and the workforce changes in nursing, such as the changes to students' and health care assistants' roles brought about by these very same educational developments, have had profound effects for both student nurses and staff who mentor and work with them both in practice and in the higher education setting. These effects are evident in the literature and illustrated in great depth by the empirical data from this study.

One of the effects for students has been an *uncoupling* of their learning in clinical practice from their theoretical learning. For students, one of the signs of this uncoupling has been that their so-called supernumerary status has become a hurdle which the more successful can negotiate in order to learn effectively in practice; for those students who do not learn to negotiate this status, learning can be difficult and their status as students rather than workers acts as a barrier to learning in a ward team.

For lecturers, there has also been an uncoupling from practice brought about partly as other authors (Andrews et al 2006, Ramage 2004; May & Veitch 1998) have suggested by the demands made on link tutors which have led to their lack of presence in the clinical areas. We argue that this lack of presence leads to their feeling of a lack of skills and identity with practice. The uncoupling from practice is also shaped by the lack of clinical academic career pathways – lecturers are employed within a structure which does not effectively encourage a connection with practice. This is experienced in some cases as a sense of loss and lack of identity, what might be described as a lack of clinical academic confidence, which is yet to be effectively resolved. The uncoupling of link lecturers from practice has led to a lack of student support in the clinical area. Our data suggests that the need for reflection to manage emotions is largely unmet, yet other authors (Lofmark & Wikblad 2001) have found that students appreciate reflective sessions because they help them process and make sense of their emotional learning. This is what Eraut (2008) calls their immersive experiences.

Perhaps this is part of a wider shift to skills and competency based education and practice which Scott (2008) identifies and a move from relational caring where emotions are not identified as a key component of nursing and therefore not taught or assessed in education or practice. Our data suggests that emotions remain a strong feature of both learning, mentoring and practice and that support is required to focus on how to manage feelings and learn from them.

The leadership of clinical learning continues to be the remit of the ward managers (and to an extent the lead nurses or modern matrons) who maintain overall responsibility for ensuring that the learning environment including mentor training and support is provided at a ward level. The consequences for the ward managers of the shifts in student learning has been a continued responsibility for learning while at the same time an increase in their workload and their NHS Trust wide responsibilities which have taken their presence and attention away from the ward and students in many ways.

For the mentors, who have effectively been left with the daily responsibility for learning, if not the leadership, the effects of these policy shifts have been to make teaching and learning a requirement for promotion whether one has the inclination or not to teach and work with students effectively (as Watson S [2000] also found). Our survey data showed that the ward

atmosphere and staff relations, continue to shape learning and our fieldwork data suggested that getting on with mentors through negotiating their expectations around supernumerary status also shaped the student's learning. Negotiating supernumerary status successfully may be the flashpoint for working relationships between trained staff and students and an indicator of a hidden curriculum. The hidden curriculum is defined as "the unstated norms, values and beliefs that are transmitted to students through the underlying educational structure" (Finnerty 2008). Margolis (2001) and Magill-Cuerden (2004) argue that managing the hidden curriculum is a potential barrier to effective learning. Magill-Cuerden (2004) has written how rituals and routines enable the teacher (in this case the mentor) to establish a regime which leads to the cultural conditioning of the student. In these data, the basic work so resisted by the students may be seen as the routine through which the mentors and staff enforce the regime of learning. This work is seen as low status and associated with HCAs whereas the trained staff are perceived to do high status, technical work. Our data shows that some students struggle with these regimes which contain the unwritten rules of practice. For Margolis (2001) the mentor is the primary agent in socialising students and their role is to maintain the hierarchy of institutions; if the student wishes to succeed they have to negotiate this. Supernumerary status is inherently at odds with the mentoring system as it takes the student out of the traditional relationship with the hierarchy.⁸

These findings have led us to ask three fundamental questions. Firstly, "what is nursing?" is a question that has bedevilled nursing as an occupation since its inception (Baly 1995). While the arguments between Nightingale and Bedford Fenwick were political, empirical studies have repeatedly shown that there is little agreement as to the nature of nursing work. For example, Goddard (1953) argued that nursing could be defined as technical, affective and basic work and subsequent studies (Fretwell 1982; Melia 1982 Alexander 1983) all found that nurses and student nurses valued these components of nursing work differently; each was assigned low or high status. Smith (1988:3) argues that there are differences between a "professional rhetoric of caring and nurses' own work priorities". This is borne out by more recent work done by Smith et al (2006) into the delivery of caring work by overseas-trained nurses (Allan 2007). Our data suggest that technical work is valued more highly than caring work by students because they see trained nurses undertaking this technical work. While trained nurses may value caring work, their values are somehow not being transmitted to students who, and more significantly, feel devalued themselves because of the work they, as untrained students, do on the wards. This is partly because students do not feel treated as members of ward teams consistently. As one of our stakeholders said:

"Doctors see their students as junior colleagues whereas nurses see students as labour."

This relationship between students and trained staff has perhaps deteriorated as a result of the uncoupling of students and their academic role models from practice because neither see themselves as part of the same workforce.

Secondly, what should student nurses learn? Both the literature reviewed and the stakeholder interviews suggested that the nature of nursing should inform the curriculum and should reflect what trained nurses do. But the literature also suggested that trained nurses focus more on technical rather than affective or basic (or essential) tasks and this discrepancy between what trained nurses say they do and what they *actually* do continues to confuse

⁸ Our thanks to our colleague Gina Finnerty for a useful discussion of mentoring which progressed our analysis here.

students. The stakeholders felt that student nurses should learn basic and affective as well as technical care in order to supervise holistic care as trained nurses. They thought that trained nurses should also continue to practise these skills in their careers. Our data from fieldwork showed a marked tension as discussed above in how students valued basic care and how trained staff valued basic care.

Thirdly, whom should student nurses be learning from? The literature suggested that student nurses may be learning essential care from health care assistants and not nurses because trained nurses, as we've seen, are not delivering essential care. Our data confirmed this trend as trained nurses deliver technical care while students and HCAs provided the basic care. The potential for trained nurses to role model essential care is therefore reduced while role modelling and socialisation within professions remains key to professional identity formation. In addition to this, the papers reviewed also suggested that existing interpretations of new nursing roles do not place student nurse learning at the heart of their leadership function.

The strength of our data and our findings is that we have used multiple methods and innovative and in-depth data collection to confirm and test our working hypotheses. Sadly though, our findings reflect findings from other empirical work. Longley et al (2007) argue that funding of nurse training/education is under funded and that successive governments have failed to truly resolve this problem. We argue that our data show a fundamental theory/practice split which cannot be reconciled in the current policy framework; this focuses on structures of nursing (Longley et al 2007) nursing roles and nursing education rather than understanding the underlying beliefs and cultures of learning in the nursing profession. For example, Longley et al (2007) recommend that nurse educators need to keep up to date and nurse education should be service led. But if service, as represented by trained nurses, have attitudes which are 'anti-education', then the profession will continue to place students and mentors in the invidious position of negotiating between two opposing value systems. As Watson R (2006) has argued, we need to understand and operationalise how educational values can become part of nursing practice.

The current 50/50 curriculum has reinforced the split between theory and practice by (again as Melia [2006] says) not mapping academic qualifications to practice skills. We would suggest that our data show that there is great reluctance to do this among trained staff who do not see the value of an education as opposed to a training. As Melia (2006) argues, the student nursing workforce is largely seen as pool of labour rather than a potential solution to workforce and health problems in the future. As a consequence, the trained nurse workforce is exploited in its mentoring responsibilities and students and lecturers feel displaced and uncomfortable.

Chapter 7 - Conclusions and recommendations

Our recommendations are written within the context of the current constraints of funding and the lack of clinical academic career pathways as well as the agenda on modernizing nursing careers and the Darzi review of the NHS (2007). We recognise that structural change is necessary to change nursing education as well as cultural changes to alter attitudes to education within the profession. And we acknowledge the efforts of others who have lobbied hard for these structural changes to be brought to successive government's attention.

However we believe that change can also start locally in small ways and therefore recommend closer scrutiny of the ways in which the hidden curriculum works in practice.

Our findings suggest indicators to assess leadership for learning in clinical practice. These indicators should be evident in the working curriculum and in the working relationship between the clinical practice area and the HEI. By working we mean the formal, informal and hidden curriculum which may be evident in the documents and student evaluations which record student nurse learning. These indicators would include evidence of:

- Good leadership for learning in clinical practice e.g. ward managers actively co-mentoring and contributing to mentoring systems; taking a lead on bringing education and research into practice.
- Explicit linkages between theory and practice in learning among clinical staff e.g. reflective sessions; teaching sessions; research activity.
- Link lecturers are supported to maintain an effective and regular presence in practice in areas where they can draw recent practice exemplars.
- Support of mentors through regular support sessions with link lecturers and co-mentoring.
- Student support in practice e.g. regular support sessions run by practice educators, mentors, link lecturers.
- Commitment to supernumerary status.
- Adequate staff/workload ratio.

Implementing these indicators would resolve the tensions arising from the identified practice education split and empower ward managers and sisters to use systems already in place to support effectively mentors and students. They would also assist in strengthening the role of the link lecturer and in finding a clinical competent and credible role to embed higher education in practice.

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Appendix 1 Stakeholder interview schedule

An investigation into changes in nursing leadership roles and their impact on how student nurses learn in practice in the new NHS

Interview: Areas for exploration

Background

The background to our research suggests that an investigation into the impact of the move into higher education and how student nurses learn in practice is timely given the introduction of the NHS plan and recent adverse publicity about standards of nursing. Our study will update the research undertaken prior to the introduction of Project 2000 (NMC 2004) when students were apprentices and the ward sister had direct responsibility for student nurse learning in practice. Furthermore, the study will deepen our understanding of who student nurses identify as their role models and how the emergence of new clinical and nursing leadership roles impact on learning in the new NHS.

The research aims are:

- To investigate the impact of the move into higher education and changes in ward management, new practice roles and clinical leadership on student nurse learning in practice
- To identify factors in the new NHS which facilitate and impede learning in practice

In your view:

- What impact has educational change such as the introduction of Project 2000, Fitness for Practice and university based education had on practice learning?
- What is the status of care in current nurse education?
- Which philosophies of learning are evident in curricula, which reflect changes in nurse education?
- Who facilitates student nurse learning?
- What leadership roles for student nurse learning are evident?
- What approaches to learning are evident in practice?
- What is the impact of changes in ward management, new practice roles and clinical leadership on student nurse learning in practice?
- What is your vision for the future of nurse education?

Appendix 2 Interview schedule

26/01/07

An investigation into changes in nursing leadership roles and their impact on how student nurses learn in practice in the new NHS.

Schedule for focus group and individual interviews

Starting background:

Age

Gender

Year qualified

Role

Ward

Specialty

Mentor/Associate mentor

Mentor prep. Completed

Number students currently

- How do mentoring relationships work? What makes them work well? What stops them from working?
- Who is responsible for their learning? Do students take responsibility for their own learning?
- Who is responsible for teaching? Do trained nurses teach as they work with student nurses?
- What approaches to learning are used in practice? How do students learn in practice?
- Who do student nurses learn from?
- Who are their role models?
- How do learn to become nurses?
- What leadership roles for learning are used? Who takes the key role for leadership for learning in the Trust?

- What changes to leadership roles have taken place in the last 15 years?
- What has been the effect of these changes on student nurse learning in practice?
- What impact did the introduction of Project 2000 have on practice learning for student nurses?
- What impact has the introduction of Fitness for practice had on practice learning for student nurses and university based education?
- What impact has the introduction of university based education had on learning in practice for student nurses?
- How have relationships between HEIs (nursing schools) developed during these periods of curriculum change

Appendix 3 Online questionnaire

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PRIVATE AND CONFIDENTIAL

LEARNING ENVIRONMENT QUESTIONNAIRE

Placement

Student Trained Nurse

(Please tick)

The following statements are concerned with nurse training in the clinical placements. For each statement please indicate your opinion by placing a tick [✓] in one of the five boxes. There are no right or wrong answers, but please try to avoid the ‘uncertain’ column unless you really cannot agree or disagree. If you wish to clarify or explain your choice, make your comments in the box provided.

Note: The term ‘learner’ is intended to refer to student nurses. Placement or clinical placement manager applies to G grades.

SECTION A <i>(Questions 1 to 3 to be answered by student nurses only)</i>	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Comments
1. This was a good placement for student learning.						
2. I am happy with the experience I have had on this placement.						
3. I learnt a lot on this placement.						
<i>(Remaining questions to be answered by everyone)</i>						
4. The number of staff is adequate for the workload.						
5. There is much to learn on this placement.						
6. There are enough trained nurses in relation to learners and health care assistants.						
7. The workload does not interfere with teaching or learning.						

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University of Warwick, Coventry

1984: Permission given to P A Smith to use the questionnaire.

SECTION B. PLACEMENT ATMOSPHERE/ STAFF RELATIONS	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Comments
On this placement, the ward/placement manager and trained nurses:						
8. Provide an atmosphere which is good to work in.						
9. Are concerned about what a student is thinking or feeling.						
10. Are available and approachable.						
11. Give reprimands in private.						
12. Praise and encourage the learner in her work.						
13. Work as a team with learners.						
14. Keep staff and learners well informed about placement activities.						

SECTION C. PLACEMENT TEACHING						
15. Ward/Placement manager devotes a lot of her time to teaching learners.						
16. Trained nurses in the placement teach regularly.						
17. Mentors in the placement teach regularly						
18. Clinical placement facilitators/practice educators support learning during the placement.						
19. Clinical nurse specialists teach regularly in the placement.						
20. Nurse consultants teach regularly in the placement.						
21. Modern matrons teach regularly in the placement.						
22. Consultants are interested in teaching.						

23. There are regular sessions, in which trained nurses discuss the nursing care of patients.						
24. The ward handover is used as an occasion for teaching learners.						
25. Trained nurses teach as they work with learners.						
26. The ward/placement manager initiates teaching.						
27. Learning objectives are in use on this placement.						
28. Teaching and learning activities are routine in the routine.						

SECTION D. PROVISION OF LEARNING OPPORTUNITIES	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Comments
29. Trained and learner nurses work together giving a full range of care, eg. bathing and dressing; drug rounds; aseptic dressings.						
30. The placement manager and trained nurses give learners an opportunity to watch or perform new procedures.						
31. The placement manager attaches great importance to the learning needs of student nurses.						
32. The placement manager gives learners the opportunity to read case notes and text books.						
33. Learners are given an opportunity to use their initiative and discretion.						
34. Learners are taught on doctors' rounds.						
35. The placement manager promotes good staff/patient relationships.						
36. Patients receive the best attention and nursing care.						
37. Patients get plenty of opportunity to discuss their feelings and anxieties.						
38. Nursing care is tailored to meet the individual needs of patients.						

SECTION F. ANXIETY AND STRESS

40. Do/did you experience anxiety or stress whilst working on this placement?

Frequently

Occasionally

Not very often

Never

(Please tick)

41. Identify the main cause(s) of any stress or anxiety on this placement.

42. What work and other experiences on this placement were most valuable for your education?

43. What work and other experiences were least valuable for your education?

44. Have you any suggestions for improving teaching and learning on this placement? If so, please give details.

45. In case you have any other comments to make about the placement, would you write them below.

THANK YOU FOR YOUR CO-OPERATION.

Appendix 4 - Dissemination

Throughout this study we have actively engaged in disseminating our findings through conference papers, a published paper and leading a symposium at an international teaching and learning conference.

Published peer reviewed paper:

Allan H T, Smith P A & Lorentzon (2008) Leadership for learning: a literature study of leadership for learning in clinical practice. Online early article: Journal of Nursing Management

2007 Conference/Symposia

At the Nurse Education Today 2007 International Conference we led a symposium exploring the theory/practice split and gave a paper entitled 'Some uncomfortable data: nurse lecturers' experiences of the link lecturers' role'. We discussed the experience of being on the periphery of practice for lecturers and how this produces an anxiety which makes bearing the patient almost intolerable creating the anomaly of nurse educators who do not practice nursing. In this paper we argued that their new roles have reinforced a split in nursing between education and practice.

We have been invited to lead a Master class at the University of Salford, School of Nursing on Leadership for Learning: the link lecturers' role.

This work has been presented to the PhD group at University of Surrey and used as the basis for teaching at MSc and Doctoral level seminars.

Our intention is to publish a paper on the link lecturer role and a more general paper on the study findings.

2008 Conferences/Symposia

We have also had an abstract accepted for the Nurse Education Today 2008 International Conference which is titled 'Dissonance between theory and practice in nursing, midwifery and mental health: the influence of the hidden curriculum. Our paper will be 'The importance of students' nurses' ability to negotiate supernumerary status.'

There will also be a new edition of Pam Smith's original ground breaking book "The emotional labour of Nursing" to be published during 2008/09 by Palgrave Macmillan which uses the data to update the original argument for today's NHS.