A phenomenological insight into the motivations, approaches, and knowledge of final year pre-registration nursing students

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Declaration

This thesis results entirely from my own work and has not been offered previously for any other degree or diploma.

The following publications have arisen directly or indirectly from the work that led to this PhD.

Peer reviewed journal articles:

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Morrell-Scott, N. (2017) New academic staff to an institution's perceptions of acceptance. *Journal of Further and Higher Education*. 1-16

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Conference presentations:

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Morrell, N. (2015) Exploring 2nd year pre-registration student nurses perceptions of understanding nursing as practice and theory. *RCN Educational conference,* Nottingham.

Morrell, N. Herin, M. (2014) Appropriate Assessment Strategy for Student Nurses: Practice and Theory? *Dubai International Conference for Advanced Research in Business*, 8-9 December 2014.

Signature

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I would like to dedicate this PhD to my much-missed uncle James, who always encouraged me to aim high.

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Abstract

This thesis illuminates final year student nurses' perceptions of their nurse education, and contributes both to the nursing and Higher Education (HE) literature. This thesis highlights both the approaches and motivations to learning student nurses take, the implications of this for wider public protection, and the role of the nurse. A qualitative phenomenological insider research study is undertaken, utilising a sample size of eighteen final year student nurses as the data source, undertaking semi-structured interviews from a United Kingdom (UK) Higher Education Institution (HEI). Data analysis is undertaken by using Interpretative Phenomenological Analysis (IPA).

I argue that based upon the assumptions that student nurses make, in terms of their perceptions of what is and is not important from the curriculum, this changes approaches and motivations to learn. Subsequently, this causes gaps in the students' knowledge. The perception of the role of the nurse is also found to be somewhat misjudged, and the holistic role of the nurse has been diminished. The theory practice gap is perceived by student nurses to not exist, yet whilst underpinning theoretical knowledge is limited there is a level of confidence. Furthermore, student nurses demonstrate a blissful ignorance towards the importance of knowledge for professional practice. Future practice as registrants may be affected, alongside the holistic role of the nurse being lost. Subsequent implications may be that patient care is adversely affected due to the approaches and motivations to learning that student nurses take.

Chapter One

Introduction

Through undertaking this research, I endeavour to illuminate final year student nurses' perceptions of their undergraduate experience. This will allow for key insights into understanding student nurses' education, in turn knowledge will be gained which can be transferred to general education and other disciplines. My personal interest is around understanding what can assist with the delivery of high quality patient care, to keep patients safe and improve standards delivered. By examining students' perceptions of their nursing education, this can then affect how nurses are educated, and so would fit in with achieving the future aim of improving patient care. This research will answer the following research questions:

- What skills and theoretical knowledge do final year student nurses value, and what are the implications for: (a) their approaches to learning and, (b) their practice?
- To what extent do final year student nurses perceive there to be a 'theory–practice gap', and what are the implications for their understanding of nursing as a professional practice?
- To what extent do student nurses report any changes, or developments, in their perceptions of the nursing role over the course of their degree?
- What are the implications of these findings for the design and teaching of the nursing curriculum?

The aims of this thesis are to explore the perceptions of nurse education for final year student nurses, in terms of both their approaches to learning, and to

discover how this may affect their future practice when they enter the professional register as a Registered Nurse (RN). Exploring how students perceive their education could not only allow for an insight into how students nurses learn, but could also assist with enhancing patient safety and improving care. Gaining an understanding of how students perceive their education can allow for a greater insight into their future practice.

1.1 The contribution to knowledge that I intend to make

This thesis examines: student nurses' understanding of the role of the nurse, which skills and theoretical knowledge are perceived to be essential to practice, and how this influences their approach to learning. I illuminate the theory practice gap concept from a previously untapped research source, final year student nurses. Most importantly, asking these questions can allow an understanding of the implications on the design and teaching of the pre-registration nursing curriculum. Fundamentally, allowing conclusions to be drawn as to how further to prepare student nurses for professional practice, and to develop the curriculum positively. This thesis will highlight the implications of the perceptions of student nurses, in terms of their learning and future professional practices. My research will allow for a greater understanding of the perceptions of student nurses, and may then positively influence patient care through curriculum development.

The findings of this research are timely in view of a major review of the Nursing and Midwifery Council (NMC) (2010) standards for pre-registration nursing education, beginning in 2017. The research will contribute to knowledge for nurse education, and has importance to nurse educators, both within the United

Kingdom (UK) and internationally, and to general educationalists of other disciplines in gaining an understanding of how students learn. This research provides a valuable contribution to support the development of the nursing curriculum, because it allows an insight from the final year student nurse perspective. This is important to ascertain what final year student nurses' perceptions of their education are, in view of them soon becoming registrants, to capture a real insight as to how their nurse education prepares them for professional registration. Equally, this research will contribute to knowledge through the generation of new ideas, and is of interest to the wider nurse education community through enabling changes to be made to the pre-registration nurse curriculum.

The research takes places in a single Higher Education Institution (HEI) with one cohort of final year student nurses. Each university and each cohort of student nurses have their own characteristics, and therefore, generalising the findings would not be possible to suit every other UK and international HEI. However, some similarities can be drawn to other cohorts of student nurses and, likewise, to other academic disciplines. This thesis challenges nurse educators to review the current pre-registration nursing curriculum, to ensure that student nurses are therefore fit to meet the needs of the challenges that face them within the future. This is an underexplored area and findings in terms of what motivates students to learn, how they learn and why, are of use in any educational context. I base this assumption on the limited research that has taken place to examine final year student nurses' perceptions on the research questions asked. This research delivers a unique contribution to knowledge through the sample that I have utilised, and the research questions that I ask.

I feel that it is important to discuss how I became interested in the subject area, which is driven by my background in nursing, and how the genesis of the research idea arose.

1.2 Background to the Study

I had always wanted to become a nurse as far back as I could remember, as I always knew that I wanted to care for people and make a difference. Although, upon reflection, my insight into this career was limited in terms of the role and scope of the modern nurse. Following my A-Level completion at eighteen, I enrolled on a pre-registration nursing degree at a local university. I was within a group of students who were the first group of pre-registration degree nurses at the university.

Having graduated with my degree and Registered Nurse Adult (RNA) status, at twenty-one, I went to work within a busy cardiothoracic critical care unit at a National Health Service (NHS) trust as a staff nurse, and then I moved to a general critical care unit. At which point I was co-ordinating the student nurses' experience as part of my role. The mentoring of student nurses within this area ignited the passion that I have for developing future nurses, and teaching. Whilst undertaking a Masters in Professional Education (MEd) I began to teach ad hoc sessions within a local university. I believed then, as I still do now, that as teachers, we have the ability to make a difference, as patient care and the improvement of standards has always been what drives me. I was then successful in obtaining a lecturer's post at a local HEI.

The first role that I took up was as a Clinical Education Lecturer, and involved, amongst other things, largely teaching undergraduates clinical skills. It was

early on in this role that I gained the MEd. Whilst undertaking this, I completed a piece of research which examined if student nurses felt prepared to practice, and this triggered my passion for examining this phenomenon, and for research in general.

I never anticipated being able to undertake a PhD, but my manager at the time felt that I should, and so I embarked upon this research journey. Through undertaking part one of this programme I examined several different areas of pre-registration curricula, and how this related to student nurses. It was through undertaking these previous studies, that I noted how there was a gap within the literature examining the notion of student nurses' preparation for practice, and the implications of their learning in relation to the 21st century healthcare context. Specifically, how student nurses are prepared to meet the demands of it, and how they themselves perceive their education. The notion of the 21st century healthcare context will be debated within the following literature review chapter. The 21st century healthcare system is a rapidly moving and evolving system of healthcare, which is also facing significant financial cuts, technological advances, challenges from patients in terms of acuity of illness, and the demands of delivering services to an expanding and ageing population, both within primary and secondary care. Running alongside this changing and unpredictable healthcare system, there are also changes within the Higher Education (HE) system and nurse education, which I will discuss further in the following literature review chapter.

I have worked in three different HEIs and I have taught many pre-registration nursing students, I have always been interested in hearing their experiences of nursing education. This thesis is informed by my continuing clinical practice. I

often hear, when working in clinical practice and collaborating with practice partners, how RNs of varying grades and experiences pass comments, which are largely negative, on the undergraduates and have many opinions on the education of pre-registration nurses. This is despite the pre-registration curriculum now being at an all-graduate level, as opposed to its previous diploma level of academic study. Whilst nurse education has changed, so has the NHS and healthcare, this will no doubt continue to change in the future, and this is the reason why I aim to explore this area through this thesis.

Based upon my role as a nurse, academic, researcher, and as someone who uses the NHS, I have a stake in improving nurse education positively. The experience I have allows me to have an insight into the phenomenon that I am examining of nurse education. Therefore, this affords understanding of the context of nurse education. Due to the reflective nature of this thesis, I am writing in the first person. I will now provide an overview of each chapter within the thesis.

1.3 Overview of the thesis

In chapter one I have lain the foundations for this thesis, by outlining the research questions to be answered, and demonstrating the aim of the thesis. Within this chapter, I provide an outline of the contribution to knowledge that I intend to make, the background to the study and where my interest in the phenomenon arose from, along with an overview of each chapter of the thesis; as such, I will now move to chapter two.

Chapter two presents the literature which is relevant to the thesis and the research questions. This chapter surveys the literature in relation to the current

context of nurse education and how this is delivered. I provide an overview of the history of nurse education from its origin to the present date, and this is important to allow the current context to be understood and allows for an understanding of the importance of the research questions. I explore the current challenges for staff delivering the pre-registration nursing curriculum. I also deliver an overview of the literature in relation to the engagement of students in curriculum development. I provide a review of professional socialisation within the practice environment for student nurses, and a discussion takes place of the literature in relation to learning through working in practice. I consider mentorship and the clinical learning environment, in relation to pre-registration student nurses, through a detailed discussion. I explore the theory practice gap that is said to exist with pre-registration nurse education. Finally, I examine the literature around the transition from student nurse to registrant. The literature review discusses challenges and factors that influence nurse education and the preparation for registration. The importance of conducting this research is supported by the literature review, in terms of the necessity to adequately prepare student nurses to become competent, knowledgeable registrants.

Within chapter three, I discuss the methodological approaches that I adopt for this research. This includes a discussion of how this study utilises insider research, with an associated discussion of the benefits and challenges that this can bring. A discussion of the theoretical framework that was employed takes place, with rationale and justification for its use. The chapter also includes a rationale and justification for this being qualitative research. I explain the nature of phenomenological research, and discuss why I feel this to be the most appropriate approach. I explain the methods and process of sample selection

and recruitment, and justify the sample size of eighteen utilised. Ethical issues are discussed and the methods I employ for minimising these, along with the plans I had in place to support participants. I provide a summary of how I gained ethical approval for the study within both the university that I am studying for the PhD, and the site in which the data collection took place. I demonstrate and justify the method of data collection that I utilised, and provide an overview as to the process of data analysis that I undertook. I reflect upon issues that arose, challenges that I faced and how I dealt with them.

Chapter four presents the findings of the research from the semi-structured interviews, through displaying the seven themes that were generated following data analysis. The seven themes were: “what is the role of the nurse?”, “student perceptions of the benefits of prior healthcare experience”, “skills perceived as important for practice”, “theoretical knowledge perceived as important for practice”, “the theory practice gap”, “learning to care”, and “emotional transitions to registrant”.

Chapter five discusses the findings of the previous chapter in combination with the literature review from chapter one to answer the research questions. Each research question is answered in turn. The first research question will explore which skills and knowledge are perceived to be essential to practice by final year student nurses. I explore the reasons why those viewed as essential are deemed to be so. I also discuss which skills and knowledge are perceived as non-essential. I also debate the approaches and motivations to learning by student nurses. The second research question examines the notion of the theory practice gap, and if student nurses perceive there to be one. I discuss previous literature in relation to the theory practice gap, and discuss factors

which may have minimised this. When answering research question three, I examine how student nurses perceive the role of the nurse to change during their nurse education. When answering research question four I discuss the implications of the findings of this research to nurse education, patient care, and also what can be contributed to general education in terms of the approaches to learning.

Chapter six presents the key conclusions drawn from the thesis, I also offer recommendations for future practice in line with the constructivist nature of the research. Furthermore, I explore limitations of this research study and provide an overall conclusion to the thesis.

Chapter Two

Literature review

The following literature was collected and explored on an iterative basis before data collection, and was then revisited and the review updated. To aid clarity of reading, the literature has been separated under its headings to allow for a full and clear engagement of it. The headings and links between each will now be demonstrated. The move between hospital and formal training (section 2.1), discusses the evolution of nurse education from its beginnings to the present day, and the significant government changes to both nurse education and healthcare. Current regulatory directives upon nurse education (section 2.2), discusses NMC policy in terms of the standards and objectives that new registrants should meet. I then discuss the global context of nursing and nurse education (section 2.3), and follow with the current UK context of nursing and nurse education (section 2.4). Engaging the student in curriculum delivery (section 2.5), discusses how HEIs attempt to enhance curricula and the student experience by working in partnership with students. Student learning within HE (section 2.6), examines what is known already concerning how students learn and what motivates them within HE. Professional socialisation within the practice area (section 2.7), discusses an aspect of the curriculum that can prove to be a challenge for both educational staff to include within the curriculum, and for students when in the clinical learning environment. Learning through working in practice (section 2.8), discusses practice learning, the theory of communities of practice, mentorship within the clinical learning environment, and how this affects student nurses. Simulated practice within pre-registration nurse

education (section 2.9) provides an overview as to the use of simulated practice as an educational tool. The theory practice gap within nurse education (section 2.10), discusses the suggested theory practice gap that exists within nurse education and examines literature surrounding this. The transition from student nurse to registrant (section 2.11), explores the theory of student nurse transition to registrant. I will now move into an overview of the background of nursing education.

The regulatory body for nurses and midwives within the UK, the NMC (2010), describe 'Pre-registration nursing education' as the programme that a UK nursing student undertakes, in order to acquire the competencies needed to meet the criteria for registration. Nurses have a duty to promote and maintain clinical standards, to ensure safe and effective patient care (Thomas and Davies, 2006). This process begins as a pre-registration student nurse, and as such, the foundations for future practice should be set at this point. This signifies the importance for understanding student nurses as a group and how they learn, what they perceive as important to learn, their understanding of nursing as a profession, and most importantly what the implications of these factors are. The implications of not examining this group could be significant in terms of future nursing practice and the delivery of quality patient care.

Currently, the NHS is under the highest amount of pressure it has ever faced since its conception in 1948 (NHS England, 2013). This is due to illnesses that are more chronic, a growing and ageing population, and staffing shortages (NHS England, 2013). In addition to this, there are new technologies and treatments which are advancing on a daily basis. This melting pot of change

and advancement can create challenges in adequately preparing pre-registration student nurses for their transition to registrant, as an RN.

The health needs of any nation are said to be critically dependent on the relevant and appropriate education of its nurses (Turale, 2011). Therefore, this research is important, particularly when faced with the complexities of providing care for the public within the 21st century and onwards, as highlighted within the NMC standards for pre-registration nurse education (NMC, 2010). The role of the nurse is vast and wide in its range. The International Council of Nurses (ICN) defines nursing as:

> *"Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles."* (ICN, 2016).

Whilst it is essential that new registrants are adequately prepared for the technical and social complexities of the healthcare system, fundamentally nurses are required to provide holistic care to patients. It is difficult to define 'care' and it has been for many years, as each person has differing criteria as to what 'care' should be. Difficulties of defining care have been acknowledged, "Care as a concept is complex. It is referred to on a number of different levels. Nursing leaders exhort nurses to care, but their definitions are limited because they fail to take into account the emotional complexities of caring" (Smith, 1992, p. 135). Providing care for patients is extremely important, as it is the

fundamental component of what a good nurse is, which then forms the foundations of any technical ability and physical tasks (Smith, 1992).

Holistic care was at the centre of the Willis (2015) review, and is central to the Department of Health (DH) (2015). Often the holistic role of the nurse has been overtaken in view of undertaking day-to-day tasks that are required for the modern healthcare system. However, through this thesis I maintain that the nexus of nursing is about providing safe and efficient care to patients, to allow them to be protected when at their most vulnerable, and by undertaking care in a holistic way to support the embodiment of what being a nurse is. Although the adequate preparation of nurses is paramount to the study, I want to ensure that the holistic nature of nursing is central to my work as it is to nursing. Holistic nursing was the basis of nursing since it began as a profession, and was always central to nurse education, even with new technologies and demands that are faced by nurses. Holistic care should be central to pre-registration nurse education and any registrants practice, and this is why I maintain a holistic focus throughout this thesis, in terms of the role of the nurse and in my care for the participants. In order to fully understand the current context of nursing, it is necessary to examine the way in which nurse education has been delivered within the past.

2.1 The move between hospital and formal training

Nurse training historically took place over a two-year training programme within hospitals (Abel-Smith, 1960). With the most famous being the Florence Nightingale School within St Thomas's Hospital in London, which was set up in 1860, and was the model training school that others around the UK used as

their benchmark. This style of hospital based apprenticeship continued to be used until fairly recently. There was no set entry criteria that was publicly known, as this was often undertaken in private (Dingwall, Rafferty and Webster, 1988). This is in contrast to today's entry criteria, which is explicit and has to meet both NMC requirements and university entry criteria. This style of nurse education continued for a hundred years until the 1960s with largely no changes made, which some may find surprising considering the clear advancements in healthcare.

In the 1960s and 1970s, the delivery of nurse education moved to a more formal classroom based model, with nurse tutors and clinical teachers providing placement tuition in clinical areas (Barrett, 2007). This signalled the beginning of the move towards an emphasis on pre-registration nurse training, to which we are currently accustomed. The significance of examining the 1960s and 1970s, in relation to this thesis, is due to this being the first steps of the move towards the educational model that is currently in place; however, this was further developed in the 1980s.

In the mid-1980s a major review of nurse education delivery took place (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1986), and this has signalled the biggest change that nurse education has faced. This transfer came on the back of the Judge Report (Royal College of Nursing (RCN) 1985), which evaluated pre-registration nursing and the challenges it faced at that time. Changes made resulted from key points in the report, which were that attrition rates were at a fifth of the student numbers, with almost a third of nursing students then at the point of qualifying not meeting the required standard. Additionally, there were also concerns about the high

numbers of students out in practice needing to be supervised; these issues caused a tension, and so recommendations were made. These included: the transfer of education to the university setting, a broader curriculum, students having full student status i.e. being supernumerary, and the programme to be three years in total. This consisted of a foundation year, and year two and three focusing on specialising and refining skills which were field specific. This shifted nurse education to a 50:50 split between practice and classroom theory, as opposed to the majority being delivered in the clinical area with a small amount delivered in the classroom. Following the historic pattern of student nurses being educated within the practice environment, there was a substantial call by the DH to move nurse training to predominantly within the university setting, signalling a significant change in the education of nurses.

This move to HEIs in the 1990s for the delivery of UK nursing programmes, subsequently meant there was debate about the clinical credibility and role of nurse lecturers (Fisher, 2005; Kenny, 2003). In the 1990s there was a call to recruit more nurses through the Project 2000 initiative (UKCC, 1986). This was due to it being apparent, to the DH and NHS managers, that there were current staffing shortages, and to plan for the future nursing workforce. Implications of this were that patient safety would be compromised. Following the first decade of Project 2000 nurses within the 1990s, there has been much academic debate that new registrants possessed insufficient levels of clinical skills (Carlisle et al, 1999; DH, 1999; UKCC, 1999). This was attributed in part to the nurse lecturers themselves being insufficiently skilled and out of practice (Fisher, 2005; Kenny, 2003), and the move to nurse education being controlled by HEIs rather than the hospital trusts (O'Driscoll, Allan and Smith, 2010). Implications of this were

that there were accusations that nursing standards were dropping, with infection rates across the country increasing (O'Driscoll, Allan and Smith, 2010; Scott, 2004).

Following these changes there was academic debate around the practice setting and mentorship process, including: the time constraints which affect the student–mentor relationship (Lloyd-Jones, Walters and Akehurst, 2001), RN attitudes towards mentoring student nurses (Hyde and Brady, 2002), and the support required for student's preceptorship (Allen, 2002). "A High Quality Workforce" (DH, 2008a) was published and summarised how the NHS should improve the quality of their services for staff. The recommendations focused upon, but were not exclusive just to, improvements to pre-registration nurse education, a period of preceptorship for new nursing registrants, and guidance for the encouragement for NHS trusts to ensure there is continuing professional development for its nursing staff. Lord Darzi within the key DH document "High Quality Care for All" (2008b) outlined the strategies for a sustainable, flexible workforce; an important aspect of this was the importance of the preparation for the education of nurses. Significantly, since 2013 pre-registration nursing courses have moved to a minimum requirement of a degree profession from one that was largely diploma. This highlights the move forward that the profession has made and the emphasis on educating the workforce to a higher academic level. Consistent with the NMC's vision to have the minimum educational award as a degree for all pre-registration new registrants to the profession, the DH in 2012, also recommended that all nurses who are in specialist and management roles must have a degree by 2020. I will now outline the NMC's regulatory directives that affect nurse education.

2.2 Current regulatory directives upon nurse education

The NMC currently regulates both nurse education and nursing practice within the UK, and the obligation of the NMC is to protect the public (NMC, 2010). Regulation by the NMC oversees organisations and nurses who provide teaching and assess the teaching of student nurses, in both the university environment and clinical practice. The NMC recognises the necessity for a curriculum, which ensures that nurses are able to meet the needs of the future; this was laid out in their 2010 standards for pre-registration nursing education.

> *"Nursing education across the UK is responding to changing needs, developments, priorities and expectations in health and healthcare. Nurses who acquire the knowledge, skills and behaviours that meet our standards will be equipped to meet these present and future challenges, improve health and wellbeing and drive up standards and quality, working in a range of roles including practitioner, educator, leader and researcher. As autonomous practitioners, nurses will provide essential care to a very high standard and provide complex care using the best available evidence and technology where appropriate.*
>
> *Our standards aim to enable nurses to give and support high quality care in rapidly changing environments. They reflect how future services are likely to be delivered, acknowledge future public health priorities and address the challenges of long-term conditions, an ageing population, and providing more care outside hospitals. Nurses must be equipped to lead, delegate, supervise and challenge other nurses and healthcare professionals. They must be able to develop practice, and promote and sustain change. As graduates they must be able to think analytically, use*

problem solving approaches and evidence in decision-making, keep up with technical advances and meet future expectations." (NMC, 2010, p. 4)

The above expectations are met through standards for nurse education being set by the NMC (NMC, 2010). Upon completion of an approved programme the NMC (2010) are confident that all new registrants will possess the following characteristics for effective practice:

- *"deliver high quality essential care to all*
- *deliver complex care to service users in their field of practice*
- *act to safeguard the public, and be responsible and accountable for safe, person centred, evidence-based nursing practice*
- *act with professionalism and integrity, and work within agreed professional, ethical and legal frameworks and processes to maintain and improve standards*
- *practise in a compassionate, respectful way, maintaining dignity and wellbeing and communicating effectively*
- *act on their understanding of how people's lifestyles, environments and the location of care delivery influence their health and wellbeing*
- *seek out every opportunity to promote health and prevent illness*
- *work in partnership with other health and social care professionals and agencies, service users, carers and families ensuring that decisions about care are shared*
- *use leadership skills to supervise and manage others and contribute to planning, designing, delivering and improving future services." (NMC, 2010, p. 5)*

Pre-registration nurse education within the UK currently consists of fifty percent of time taking place within the university setting, and fifty percent taking place within the clinical environment (NMC, 2010). This split is thought to produce well-rounded registered nurses at the end of the programme. Student nurses must complete a minimum of 2300 hours of both theory and practice time, totalling 4600 hours, in a minimum of three years and achieve the the agreed NMC criteria in order to gain their professional registration (NMC, 2010). The NMC set their standards for nursing education, which university providers have to abide by, and the last standards were set in 2010. Some minor amendments were made to the standards since they were published in 2010, but the NMC, recognising that the healthcare and education landscape was shifting rapidly, announced in 2015 that the standards would be reviewed. This commenced in 2017 and the new standards are suggested to be published in 2018. Therefore, the timing of this research is important to add to existing and future discussions. The recent Willis review (2012) and its subsequent report (Willis, 2015) documents how crucial it is to get pre-registration nurse education right, and highlights several key points to allow nurse education to develop. This includes points that nurse education should keep core values such as: how the delivery of patient centred care should be at the centre of all pre-registration nursing, safety and dignity should be embedded as a top priority, and nurses should be prepared to work within a variety of settings for now and the future.

Whilst Willis (2015, 2012) highlighted that nurse education could not be held directly responsible for poor standards of care, it was acknowledged that there was a loss of public confidence and a poor perception of the professional role of the nurse, which the profession should work to improve. It was also indicated

that healthcare providers should fully support nursing education, and this is a potential nod to the idea that student nurses are not supernumerary within the practice area. There is acknowledgement that since the Willis commission (2015, 2012) there has been little change on issues that were highlighted then. A further interesting point raised within the Willis review (2015, 2012) is that there should be better evaluation of, and research into, nurse education programmes to ensure that programmes are fit for purpose, and that careful attention should be paid to understanding nurses as a strategic workforce within the UK as a resource. Clearly, this links to the research that I am undertaking and further reinforces my points that this is an area for exploration, which should begin with understanding student nurses' perceptions of their experience.

As the NMC's standards have been discussed, it is essential to now discuss the current global situation in terms of nursing and nurse education.

2.3 The current global context of nursing and nurse education

The 21st century brought significant changes to the health needs of the world (Andre and Barnes, 2010). In 2002, the World Health Organisation stated that sixty percent of global diseases were attributed to chronic conditions, and that by the year 2020 this was expected to rise to eighty percent. As such, it is necessary for this research to be undertaken, to enable development in nurse education, and allow future nurses to be adequately prepared for professional practice. Nurses of the 21st century need to be able to have the relevant knowledge and skills to be able to safely and competently care for a diverse array of patients (Nielsen et al, 2013), again supporting the rationale for this research to assist with curriculum enhancement.

Global challenges in relation to the healthcare system are similar between the UK and many other countries, such as Canada, USA, and Ireland (Scott, Matthews and Kirwan, 2014; Pringle, Green and Johnson, 2004) and these issues have been long debated within the literature. Contextual similarities between the UK and other countries are: more acutely unwell patients than the healthcare system has ever faced, workforce shortages, financial restraints, the explosion of technology within healthcare, and the evolution of the nursing role (Wolff, Pesut and Regan, 2010).

The global HE terrain and landscape of nurse education, in which nurse academics work to prepare student nurses to be sufficiently prepared to practice for professional practice, is constantly changing and has been identified to be an international issue (Darbyshire, 2014; Nielsen et al, 2013; Grealish and Smale, 2011; Lindahl, Dagborn and Nilsson, 2009). Therefore, educators should be flexible and respond to change, based upon current demands or what policy makers decide.

It has been suggested that on an international scale pre-registration programmes are not changing (Andre and Barnes, 2010; Forbes and Hickey, 2009). It has been identified that within Ireland there are significant deficits within the curriculum, when considering the needs of the population and how healthcare services are provided (Scott, Matthews and Kirwan, 2014). Furthermore, this provides a rationale for the necessity of this research, to add to the existing pool of knowledge and illuminate any potential specifics which could enhance the curriculum.

Within the American context, it has been recommended that in order to meet the needs of the 21st century healthcare system and associated challenges, the

current outdated curriculum needs to be enhanced to ensure it is responsive to change, is culturally relevant and appropriate to what is needed (Turale, 2011). Drawing upon Turale's (2011) work concerning America is useful, as there are significant similarities in both their healthcare and nursing education system to the UK. Having an awareness of other countries' healthcare and education systems, can be useful when examining the current UK situation, and to enable change to be made to enhance the curriculum. This may allow for a cross pollination of ideas and developments to the curriculum. My research examines student nurses' perceptions of their nursing education, to gain an insight into their experiences and perceptions. As such if changes to curricula were made, then this may allow future RNs to be better prepared to face the challenges of today's, and the future, healthcare system. Turale (2011) states that there is evidence that from a global perspective, nurses are not being currently prepared to meet the needs of caring for patients, which concurs with other evidence such as Willis (2015, 2012). This is a challenging situation for the profession to be in. As the global context has been examined, it is only fitting to discuss the UK context.

2.4 The current UK context of nursing and nurse education

The world of nursing has changed dramatically over the past decade with targets being set, more patients being diagnosed with long term conditions, and increasing staffing pressures (Willis Commission, 2012). It is due to this change that the aims of this research has significance. It was highlighted nearly twenty-five years ago that there were budget cuts which were leaving nurses with increasing workloads, subsequently detracting from allowing nurses to provide

care, as physical and technical activities overruled anything else (Smith, 1992). Issues that were highlighted twenty-five years ago, remain along with the new additional challenges, again highlighting the necessity of this research.

Within the health service, there are changing priorities; staff are being faced with austerity measures and more acutely unwell patients. This is also in the shadow of several damning reports regarding healthcare services such as: Keogh mortality review (Keogh, 2013), Mid Staffordshire report (Francis, 2013), Winterbourne View Report (DH, 2012), and the Willis Commission (2012) which highlighted instances of poor standards of care from nursing staff. In view of the perceived failings of nurses from the recent inquiries, it is clear that there needs to be an identification and re-evaluation of nursing programmes, to assist in avoiding the catastrophic errors and failures in care that have recently been reported upon. The changing complexities of caring for patients, inadequate staffing, budget constraints, a lack of practice placement sites, and more community based care, have all been identified (Nielsen et al, 2013; Spence et al, 2012; Ironside and McNelis, 2010) as issues which will negatively impact on student nurses' learning.

It was emphasised by the DH in 2010 that the pre-registration nurse education standards should reflect the changes of the healthcare context, and should allow for all new nurses qualifying to have the skills to be able to work with competence, across differing healthcare settings. The 21st century provides challenges in terms of educating undergraduate nurses (McNamara, 2014). There is a tension faced by nurse lecturers, programme managers and HEIs, as they are directed by both their role as an RN, having a duty to act as set out within their rules and obligations by the NMC, and to employers to provide a

good student experience, and retain students on the programme. The role of the nurse educator is a difficult one, due to the points discussed above (Curtis, 2013; Rolfe, 2012).

Bartles (2005) describes how nurses are being taught to work in clinical settings in which they may not be working in the near future, and undertaking roles that may not exist in the future. In view of this point, it is clear that as nursing roles evolve and advance, tasks that were once advanced skills are now perceived to be essential skills required for a new registrant, such as the ability to undertake venepuncture and catheterise patients. Therefore, nurse education is not evolving as fast as the role of the nurse is, and subsequently creating a dissonance between the evolving nursing role and the needs of the public.

Nurse educators face the challenging task of ensuring that student nurses are adequately prepared for the contemporary realities of practice, and ensuring that they have the correct knowledge, values and attributes, which reflect what is required by the healthcare system and the public. Nurse educators are faced with the challenges and expectations of what is required for current practice, but also have to respond to the necessity to prepare nurses to be compassionate (Curtis, 2013). Nursing faculty are exposed to the expectations of educating for compassionate nursing, and to current anxieties about the quality of UK nursing practice.

It is not only UK nurse academics that face these challenges (Curtis, 2013; Rich and Nugent, 2010) as this is a global challenge. The USA are also dealing with similar issues, such as the drive to achieve student satisfaction both through university and practice experience, and challenges to increase the quality of nursing, and it is these outcomes that must all be achieved which create a

tension for nurse educators. Whilst working within these environments and facing these challenges, nurse educators should prepare student nurses to face the challenges of meeting the expectations of the profession, and public, within the 21st century. However, Curtis (2013) and Rolfe (2012) also add a further challenge, which is that the recruitment and retention of students and the necessity to promote student satisfaction, along with the drive to work in line with the universities corporate agenda and drive for research, provides yet more tension on the role.

Challenges faced by academic staff within nurse education are not only in terms of patient care and medicine, but also in relation to the challenges due to the advancement in communication, technology, social media, and education to connect staff and students together (Stott and Mozer, 2016). A further pressure for academics who are providing nursing education is to uphold both their professional and academic credibility (Rolfe, 2012), and it is often difficult for nurse educators to maintain this.

Changes in policy relating to pre-registration nurse education and the NHS, have led to a dissonance between education and practice (O'Driscoll, Allan and Smith, 2010). However, it has been highlighted that this is not just a UK challenge but also occurs internationally (Salminen et al, 2010; Saarikoski and Leino-Kilpi, 2007). It is perceived that this issue within the UK is due to the NHS not being a learning focused organisation but actually a target driven workforce organisation (Melia, 2006; McGowan, 2006). Whilst this is a valid point, it should be acknowledged that the NHS does not wholly drive nurse education, but it is the stakeholders who drive it, such as the NMC, HEIs, and the public. It may be that student nurses perceive theory and practice as totally separate entities, and

this may be due to the clear 50:50 nature of the programme, rather than there being an understanding that both inherently link to one another. If the pre-registration curriculum is not based around the seamless, coherent nature of theory and practice it has been suggested that this can result in the 'de-professionalisation' of student nurses; a subsequent implication of this is that this would also then transfer to a students' registrant status (Lambert, 1992) and so may influence upon patient care. Practice placements bring associated problems due to high throughput and pressures (Curtis, Horton and Smith, 2012). This can negatively impact upon patients and students, through care delivered, in particular relating to students being socialised to develop compassionate practice. This is a particular challenge at present, following on from damning reports such as the Healthcare Commission (2009) which discussed the investigation into the Mid Staffordshire NHS Trust that suggested there is a lack of care and compassion in nursing. Student engagement will now be discussed, as this is a potential way of enhancing the curriculum.

2.5 Engaging the student in curriculum development

Student engagement is increasingly part of the day-to-day working of HEIs. There is a current drive for staff–student partnerships within HE to assist with student engagement and pedagogic development (Healey, Flint and Harrington, 2014; Higher Education Academy (HEA), 2014). Engaging students is perceived to be of benefit in overcoming many of the challenges faced by HEIs currently, and has been attributed to meeting equality objectives (Berry and Loke, 2011), improving retention (Thomas, 2012), encouraging transition (Vinson et al, 2010), refining existing curricula (Bovill, Bulley and Morss, 2011),

and enhancing student performance (Kuh et al, 2010). As such, the notion of student engagement has been noted within policy documents to enable quality enhancement, such as the Quality Assurance Agency (QAA). The QAA urged HEIs to ensure that students were engaged in the assurance and enhancement of their experience, both as individuals and as a collective (QAA, 2012).

In relation to answering the research questions for this thesis, gaining student perceptions is important to develop future curricula through the illumination of their perceptions and experiences. It is anticipated that working with students to gain insight and perceptions will become a common feature of nurse education, in line with current policy agendas to enhance future curricula further. Gillies (2011) discusses how students can assist with validating and outlining the expectations of the HEI. In terms of this research and examining student nurses' perceptions of a curriculum, this is imperative as they can guide the curriculum for the future, both in terms of examining the curriculum and by assisting the enhancement of it. Student engagement has been said to be inextricably linked to student satisfaction (Hardy and Bryson, 2010). This, furthermore, consists of additional aspects such as student and staff interaction, employability, collaborative learning, transitions, personal development, and curriculum design.

Trowler's (2010) work on student engagement illuminates the prevalent themes within the literature pertaining to student engagement, which fundamentally overlap. The themes from the literature are governance, learning, and identity. In terms of engaging students, it should also be acknowledged that the level of engagement that students can be involved with would depend on their place within the HEI, from a power perspective. The power differential in relation to

student engagement has been identified (Mann, 2008; Grant, 1997). Within the world of HEIs there are four key roles that students have: students as participants; students as partners, co-creators and experts; students as evaluators; and students as change agents (Kay, Dunne and Hutchinson, 2010). This has resonance for this research as students are, in my opinion, all of the above and their evaluations of this research will allow them to inform the future curriculum.

The student perspective within HE is extremely topical, and many institutions attempt to engage with students from a teaching and learning perspective to enhance curriculums (Bovill, Cook-Sather and Felten, 2011). Within pre-registration nursing, this is often adopted from the perspective of how the curriculum is delivered, such as the utilisation of small groups in classes, and different methods of providing feedback. However, in terms of the actual specifics of the curriculum, this is not the case, due to the outline of the curriculum being set by the nursing regulatory body, the NMC. Whilst standards are set by the NMC, these are largely broad outlines of what a curriculum should include, and it does depend on the enactment of the standards by each HEI as to what the specifics of each programme includes. Whilst this research does not intend to debate the issue of whether the NMC are correct or incorrect, it should be highlighted that the students can determine what they perceive to be missing from the curriculum, and what curriculum priorities should be to allow for enhancements to be made; this is in line with the constructive nature of the research. Student engagement on this issue may well provide a deeper insight as to what could be developed within the curriculum to support students, ease the transition to registrant, and most importantly allow for improved patient care.

In their final year, pre-registration student nurses will have had a variety of placements and will be able to shed light on their current thoughts, emotions, and feelings. It is for this reason that final year students are the sample recruited for this study.

Discussing student engagement and how this can develop the curriculum was necessary in order to answer the research questions, and provide some underpinning theoretical understanding of how to move forward. I will now discuss how students learn, firstly as HE students and then as student nurses.

2.6 Student learning within HE

It is important to examine the literature around how students learn within the HE context, and the approaches to learning that students may take. A surface learning approach is said to be common in HE (Gibbs, 1994). Diploma and degree nursing students' approaches to learning have been examined, and it has been suggested that student nurses demonstrate a deep approach to learning, in subjects that would have a direct correlation to their academic success (Snellgrove, 2004). Student engagement towards deep and surface learning can influence performance in the academic context (Morton and Booth, 1997). Whilst this is important, I believe that it should not be academic performance that should be considered, but practice performance within the professional arena, and the impact upon this that learning, and the approach to learning, has. It has been identified, how much of the work around student learning has had a focus upon the different levels in which students engage with formal learning, and ways in which learning can impact upon students (Tomlinson, 2014). In terms of my research, I examine the perceptions of

student nurses of their nursing education and through this will uncover their approach to learning and what impact this has upon their practice.

Entwistle (2007) considers how much of the research into the relationship between approaches to learning has examined the perceptions of teaching that student nurses have experienced. However, the uniqueness of my research is not concerned with the teaching that students have experienced, but instead their perception of the curriculum, approaches to learning, what is needed to practice, and the implications that arise from this. It is recognised that students from all disciplines within HE share similar approaches to their learning (Entwistle, 1991). Entwistle (1991) discusses approaches to learning in terms of what provokes their approach; he describes this as coming from the context and the content. This research should clarify what student nurses perceive as essential to practice, through examining the content and context. It has been suggested that during a programme of study an individual student's approach to learning can differ and is often dependent on their interest in the subject (Richardson, 2007). This suggests that students may take a deeper or proactive approach to their studies, if the subject matter appeals to them.

The idea of how students learn in HE has been examined, and it is noted that students use strategy in terms of how to tackle individual tasks (Entwistle, 1991). It is the idea of strategy that will be examined through this research, in terms of what student nurses perceive to be useful in their education, and why they feel this. Whilst learning styles are important from the perspective of teaching and learning, I am more concerned with the approaches and motivations, and any subsequent implications that arise from this. Ramsden (1981) also discusses strategic approaches to learning. If student nurses do

use a strategic approach to their nurse education, it is important to ascertain which skills and knowledge they are strategic in learning in a deep or surface fashion, and if this coincides with the assumption by the NMC and the public of what nurses should know. Strategic learning has been further expanded upon by Entwistle (1997), when considering three domains of strategic approaches to learning which are, surface level (to cope), strategic (to achieve) and deep (to understand).

It is the function of university education to introduce students into how to think in the way of the competent professionals that they are to become (Entwistle, 2007), and it is the preparation of student nurses that this thesis explores. Patricia Benner, whose seminal work in 1984 famously created her novice to expert theory of teaching student nurses, which is still widely used today within practice areas, advocated this structure of systems of learning as being able to embed the fundamentals of good nursing practice, which would eventually become customary practices. The work of Benner (1984) has been extremely influential in nursing education, and has been utilised to encourage and assess knowledge, skills, and competence, and is used as a theory of experiential learning. Benner (1984) highlighted the stages of competence that she proposed practitioners display, and should be measured by, and suggested that as practitioners develop they move up the scale from novice to expert. Student nurses are often assessed against the underpinning theory of Benner's (1984) scale. At the point of registration, students are seen as competent, i.e. at the middle of the scale and able to work independently. The subsequent two points to Benner's (1984) theory are proficient and expert. This would occur through working within a fixed clinical area for a period of time post-registration. As part

of the pre-registration curriculum, challenges that educational staff face is the professional socialisation which should take place; this will now be discussed.

2.7 Professional socialisation within the practice area

Professional socialisation is necessary to be discussed, to build upon possible theoretical components of what is required to prepare nurses for professional practice, and therefore answer the research questions. Student nurses, whilst undertaking a pre-registration nursing course, have vast demands placed upon them, from learning both the theory and practice elements of the programme, developing care and compassion within their practice, working with patients and multidisciplinary teams, as well as dealing with the stress and demands of the programme itself (Curtis, Horton and Smith, 2012). Professional socialisation has long been discussed within the literature as a legitimate aspect of nursing education (Gray and Smith, 1999; Luker, 1984; Cohen, 1981; Olesen and Whittaker, 1967; Davis, 1966). Olesen and Whittaker (1968) coined the term studentmanship, in which they describe the learning of behaviours and practices which shape students professional role as a nurse. Interestingly Olesen and Whittaker (1968) acknowledge this is an implicit part of professional practice and the education of student nurses, equally they note how important peer relationships upon professional socialisation.

Professional socialisation is a process where an individual gains the knowledge, skills, experience, and professional identity which are characteristics of that profession (Cohen, 1981). This process also includes acquiring values necessary to perform in that role, and it is the emphasis on nurses' values that is of interest to nurse academics and NHS recruitment teams at present. To

develop a person with limited experience and knowledge into a well-rounded, knowledgeable, and caring professional within three years is undoubtedly a challenge. Professional socialisation, as noted by Cohen (1981), is a key area that occurs within the hidden curriculum in pre-registration nursing. The hidden curriculum is described as implicit values, which underpin the curriculum and which influence students' learning (Gidman, 2011).

Melia's (1987) seminal work found that student nurse socialisation occurs through two descriptions of nursing, one in the classroom and one within the practice setting. Due to the disparity between what students experience with the different ideologies, this causes significant confusion for the students, along with a lack of commitment to both versions, and to a career within the profession (Melia, 1987).

The work by Melia (1981) and Luker (1984) highlighted the insight of student nurses within the 1980's and their experiences of the professional socialisation that takes place, whilst Gray and Smith's (1999) work explored students within the 1990's. Yet it should be noted that nursing and healthcare has changed considerably since this time, and as such further current identification into this areas is warranted. Luker's (1984) work highlighted how professional socialisation and the acquisition of tasks is primary to gaining knowledge for the group that she interviewed. A commonality between these studies is the identification by the students that they learn the behaviours and practices from ward staff. Ultimately this then leads the students to get involved with delivering direct patient care along with the wider team to enable them to feel that they fit in, as fitting in this was deemed to be important to the participants, and their mentors in practice.

Caring behaviour has been suggested to lessen as students move towards the end of the programme (Curtis, Horton and Smith, 2012; Murphy et al, 2009; Mackintosh, 2006). However, these are not new points, as this was noted as long ago as Smith (1992) who described how student nurses commence programmes with enthusiasm, but by the end of the programme they display cynicism and disillusionment. Along with these traits, students also become less focused on the patient and more focused on the illness, along with not demonstrating an emotional side to caring. It could be argued that had these points been taken on board when they were first written, and noted subsequently each time, the professional crisis which has taken place within the past five years, and harm that has occurred to patients that have been noted in reports such as Mid Staffordshire report (Francis, 2013), Winterbourne (DH, 2012), and the Keogh (2013) reviews, could have been avoided, or minimised. This is not to say that if these points were taken on board there would never be patient harm, neglect or a lack of care again, but they may be less frequent than they are now. It has been suggested that care diminishes for student nurses towards the end of their programme (Maben, Latter and Macleod Clark, 2007). This then leads to students becoming dissatisfied and disappointed about the profession that they are entering into because the realities of practice pressure hits them (Maben, Latter and Macleod Clark, 2007).

The retention of students and RN within Ireland has been enhanced by effective socialisation whilst students are on the pre-registration programme (Mooney, 2007). New registrants need to have skills to be able to adapt quickly, and should be socialised into the role (Pennbrant et al, 2013). Student nurses currently have many different practice placements throughout their programme.

Therefore, the socialisation and ability to adapt has been overlooked by curriculum managers, and there may be a perception that students are taught this through part of the hidden curriculum, rather than making this a key point in preparing students for coping within today's clinical world, where change occurs almost continually.

Professional socialisation can assist with the development of skills to provide safe and effective care, in line with the expectations of the public and the NMC (2015, 2010). Professional socialisation can also assist with the development of understanding the role of the nurse (Curtis, 2013), therefore, it is clear that as a component of a student nurses' education professional socialisation is extremely important. Equally important, is that student nurses are socialised in the correct practices of nursing, and have positive experiences from mentors. As professional socialisation occurs largely within the practice environment, learning through working in practice will now be discussed.

2.8 Learning through working in practice

A significant amount of a student nurses programme will be spent within the practice environment, and so it is essential to explore the literature around how student nurses learn within this environment. The attainment of new knowledge, through learning in work, has long been acknowledged and discussed within the literature (Andrew, Tolson and Ferguson, 2008; Billett, 2004; Evans, Hodkinson and Unwin, 2002; Hutchins, 1999; Boud and Garrick, 1999; Guile and Young, 1999; Engestrom, 1993). Learning through community engagement, i.e. within the practice area, has been taken on board by academics who realise its importance in the HE world (Bond and Paterson,

2005). Whilst challenges to learning in practice have been noted in relation to student nurses and their practice learning, it has been highlighted that the positive effects of this are how students become critical thinkers and professionally socialised (Morley, 2016).

Within nursing, as a professional learning area, the clinical context is recognised as the most significant area for students to learn about practice within the 'real' world (Egan and Jaye, 2009). Clinical practice may be arguably the most important part of the pre-registration curriculum (Henderson et al, 2011; Clarke, Gibb and Ramprogas, 2003; Papp, Markkanen and Von Bonsdorff, 2003). This in turn would assist with shaping the student to learn and practice their profession, and develop their attitudes and behaviours, which as discussed within this chapter are extremely important.

Clinical practice has many strands of importance which pertain not only to the acquisition and reinforcement of clinical skills, but also to learning attitudes, norms, and processes of how to deliver care (Eraut, 2000), however, as previously discussed this sometimes can fail. There is a body of literature which advocates how students should be integrated into the practice teams (Henderson et al, 2011; Twentyman, Eaton and Henderson, 2006; Henderson, Fox and Malko, 2006). Best practice for learning may be for student nurses to join established teams of nurses to learn (Egan and Jaye, 2009), and this is the model that many pre-registration programmes attempt to use. Although, sometimes this can fail in the realities of the current healthcare system, due to a shortage of mentors and placement areas amongst other things.

Nursing could be thought of as a community of practice. Over 20 years ago, Lave and Wenger developed the concept of community of practice in their 1991

book, Situated Learning: Legitimate Peripheral Participation, as a notion of how learning occurs through their situated learning theory. Whilst defining community of practice as “a set of relations among persons, activity and world, over time and in relation with other tangential and overlapping communities of practice. A community of practice is an intrinsic condition for the existence of knowledge” (Lave and Wenger, 1991, p. 98). The community of practice model demonstrates how learning occurs in practice, through collaboration between peers, with individuals working to a common purpose which is defined by knowledge not task (Wenger, 1998). The Lave and Wenger (1991) theory, focused on the learning of “newcomer’s” moving into a community of practice and “old-timers”, in order for them to become “full participants” through legitimate peripheral participation. Legitimate peripheral participation was defined as “a way to speak about the relations between ‘newcomers’ and ‘old-timers’, and about activities, identities, artefacts, and communities of knowledge and practice” (Lave and Wenger, 1991, p. 29).

However, it has been suggested that community of practice has never existed within nursing (Andrew, Tolson and Ferguson, 2008). It could be argued that nursing as a profession and the individual teams make up their own community of practice. This is based upon the notion that the community of practice consists of members having a common purpose, shared repertoire of methods, language, technologies, and behaviours (Wenger, 1998). In view of what communities of practice is, it is surprising that there could be an argument that community of practice does not exist within nursing.

Lave and Wenger (1991) focus their situated learning theory upon the premise that when “newcomers”, who could be seen as student nurses, engage in a new

community, such as the clinical learning environment in which they undertake their placements, they will increase their learning of how the community works, or how to fulfil their role by the process of legitimate peripheral participation. Through this process the “newcomer”, or student, will learn how to “become a nurse” through participation from the periphery of practice into full engagement. This could be perceived as students on a placement, ready to learn their role. However, within nursing, student nurses have reported episodes of incivility from practice areas, which can inhibit their learning. There is evidence relating to high incidences of incivility within nursing as a discipline, and research suggests this is not just a UK issue but also an international one (Andrew, Tolson and Ferguson, 2008), yet there is no firm rationale for why this may be the case. The tight bonds of the community in practice can be positive and enhance the community (Wenger, 1998). There are challenges to entry to the community, and occasionally these tight bonds can inhibit the participation that newcomers experience (Morley, 2015).

Learning in work, ultimately is the process of student nurses learning the day-to-day actions and behaviours of being a nurse, which coincides with the earlier discussion on professional socialisation. Although sometimes this could be inhibited by academic staff, who stop student nurses from learning in work by not having a reasonable insight into current practices and the curriculum. This links to earlier points on the challenges to educational staff who provide the curriculum. Academic staff should ensure their teaching prepares student nurses sufficiently for the world of work (Elliot and Wall, 2008). However, this can prove to be a challenge by academics who have not worked in practice for a period of time. This may be enhanced if the academic staff spent time working

in practice alongside their academic role as previously noted. It has been said previously that nurse lecturers have different values to clinical staff, and that this is noted by student nurses and can cause confusion and differing behaviours (Corlett, 2000).

An important consideration of the pre-registration curriculum, is not only how students learn in practice but also how mentors support them, and as students spend fifty percent of the programme within clinical practice this is important. Clinical placements should allow students to put into practice what theory they have learned at university. With student numbers being higher, there has been a reduction in the quality and quantity of clinical placements available to HEIs to provide for their student nurses (McNamara, 2014; Levett-Jones et al, 2011; Cangelosi, 2008; Wilford and Doyle, 2006) and clearly, this is a challenge. However, this is a global issue, and not just one applicable to the UK. It is believed that clinical placements are the most important element of the success of the pre-registration nursing programme (Nash, Lemcke and Sacre, 2009; Pearcey and Elliott, 2004). Although, it should be remembered that the remaining fifty percent of theoretical knowledge provides the student with the theory to practice, and may be of more importance, yet this may not be considered by students. The areas where students learn in practice have been altered due to the healthcare changes that have occurred, in the form of a shift from secondary care to primary (Midgley, 2006). Working with an RN as a mentor, forms the basis of how students are taught in clinical practice, although, the quality of the mentorship experience does depend on many factors, including the student and mentor relationship.

Before changes occurred to job roles and nurse education in the 1990s, it was the ward managers who played the largest part in assisting with learning for student nurses, due to them giving the emotional support required (Smith, 1992). Whereas, following this move ward managers were not able to give as much support to the students. The 1990s saw changes to the healthcare system within the UK, which predominantly focused on the new roles of ward sisters and leadership (DH, 2000); these changes also affected the learning of student nurses within the clinical environment (O'Driscoll, Allan and Smith, 2010).

Largely, the changes to pre-registration nursing education, involved the move to allow student nurses supernumerary status. This involved not counting the students within the numbers of staff within the clinical area. This meant that there was greater significance on the students primarily learning whilst working alongside an RN, rather than the students being thought of as apprentices whose first role was to care for patients and learn second. When this was implemented, there was a disparity between the clinical areas embracing this (Elcock, Curtis and Sharples, 2007). It may still be questionable if this still happens, as many student's report that they are simply used as "an extra pair of hands" within clinical areas today (Morrell and Ridgway, 2014).

Mentors are perceived to be extremely important in supporting student nurses through the pre-registration programme, through the change in role into registrant, and then post registration into the preceptorship phase, again this highlights the nature of students as part of the community of practice. Whilst an essential element of a student nurse's education is practice, a tension is its reliance upon mentors who have large workloads whilst feeling often unprepared and unsupported for the role itself (Watson, 2006). Whilst this point

has validity, it should be acknowledged that all mentors prior to mentoring student nurses must have attained a formal mentorship qualification. The mentor–student relationship is pivotal to a positive learning experience (O'Driscoll, Allen and Smith, 2010). However, they also found that some mentors struggle with letting go of that role.

Shulman (2005) discusses how, within the American context, the clinical practice aspect of nurse education is one of the key components to the education itself; whilst this is correct, issues that as educators we are faced with is the mentorship process within the practice setting sometimes failing the student. Potential causes of this may be due to some mentors not fully engaging with the process, students not being seen as supernumerary, or staff not embracing current practices due to long-standing practices. Therefore, sometimes students are at risk when out in practice of not getting the most from their practice placements. This is also the case within the American context (Nielsen et al, 2013); therefore, this is not just an issue solely for the UK. Hinshaw (2008) labels the current context of nursing as a "perfect storm", due to the shortage of RNs. Therefore, this suggests there are limited numbers of trained staff with an additional mentorship qualification in practice who could support and preceptor new registrants and student nurses.

Learning in practice in the professional context will occur when there is experience and independent thinking (Henderson et al, 2011). The major components of clinical learning areas working effectively is that the learners are: enthusiastic, motivated, believe that they are included within the team, have professional relationships with the team members, and feel confident to ask

questions (Henderson et al, 2011; Senge, 2006; Henderson, Fox and Malko, 2006; Chan, 2001).

It has been widely acknowledged that the student–mentor relationship has been said to affect students' working life, professional growth, and self-esteem (Kaihlanen, Lakanmaa and Salminen, 2013; Holland, 2010; Shen and Spouse, 2007; Kim, 2007; Saarikoski and Leino-Kilpi, 2007; Theobald and Mitchell, 2002; Spouse, 2001; Löfmark and Wikblad, 2001; Crawford, Dresen and Tschikota 2000) and, therefore, establishing good relationships for students and mentors are important. Kaihlanen, Lakanmaa and Salminen (2013), discuss the qualities that student nurses appreciate a mentor to have: fairness, expertise, patience, and understanding. These traits would not be out of place when mentoring in any discipline. Cantrell and Browne (2005) highlight that working with an RN in the capacity of mentorship enhances the student transition in a positive manner. It could be suggested that this would only be the case if the mentor had the above listed qualities, as the transition experience could be very different if mentors did not.

The transition process of student nurses is a process which is individual to each student, non-linear and very unpredictable (Kaihlanen, Lakanmaa and Salminen, 2013). This is likely to be due to every student having varied placements and mentors. This process of transition for some students may be easier than others, and this could be due to the clinical mentors' support and experience dealing with students. Exploring mentorship and the clinical learning environment within this thesis is of paramount importance to highlight what pre-registration nursing students experience within fifty percent of the programme. I will now discuss the use of simulated practice within nurse education.

2.9 Simulated practice within pre-registration nurse education

As previously discussed, there are many challenges to the clinical learning environments, such as placement pressures because of high demand, the ability to be able to assess students properly, and the reinforcement of clinical placements. A way of attempting to resolve some of these practice issues, has been the use of clinical simulation. The use of simulated practice has been advocated as a strategy that is being utilised globally to attempt to lessen the issue of a potential reduction in quality and quantity of placements, and higher student numbers (McNamara, 2014; Adamson, 2010). Simulation has been said to be a representation of a real clinical environment and situation that involves some role-play within a scenario (Jeffries, 2005). Although, this is not always the case as undertaking simple clinical skills can also be perceived as simulation.

Clinical simulation within nursing has always been undertaken in some degree by teaching clinical skills. However, this is now somewhat more in vogue through the utilisation of high fidelity simulation, involving the use of mannequins and often the recording of students, with students often being able to view their performance following the simulation scenario taking place. The NMC (2010) identify the use of clinical simulation within nursing education, and their educational standards now include the use of up to 100 hours per year as formal simulated time. There is a body of knowledge which is beginning to support the use of simulation within nurse education, as a teaching and learning strategy, and it is agreed that the use of simulation provides students with a safe environment in which to practice their learned skills, and develop clinical decision making (Au et al, 2016; McNamara, 2014; Oberleitner, Broussard and

Bourque, 2011; Sanford, 2010). This occurs through the actual scenario and the debrief that follows.

Often clinical simulations occur with other members of the multidisciplinary team, to aid the realism of the scenario, but also to develop the skills of the student nurses and other disciplines to work with one another, as clinical staff within hospitals will very rarely work in isolation. As such, simulation is a key component of how students can learn, and this is both through the working with other multidisciplinary team members and also as a way of academic staff observing students working in practice, albeit in a simulated environment. McKimm et al (2010) highlighted the importance of educating future health professionals to work in collaboration with others, although collaborative and multidisciplinary working as a concept has been acknowledged for decades. Due to the separateness of each healthcare profession, the healthcare system is failing and it may be necessary for a more generic training for each profession (Duckett, 2005). However, this would bring in much role boundary crossing, and would only serve to potentially create a generic healthcare practitioner and alienate each profession's role. I will now discuss the notion of the theory practice gap, to allow for a full exploration of the subject when answering the research question.

2.10 The theory practice gap within nurse education

Within nursing literature, there has been a suggested theory practice gap, which has been repeatedly discussed both internationally and within the UK for decades, and again recently (Elliot and Wall, 2008; Chapman and Clegg, 2007; Brasell-Brian and Vallance, 2002; Landers, 2000; Crane, 1991). The theory

practice gap can be defined as a discrepancy between what student nurses are taught in the classroom setting, the theoretical aspects of nursing, and the practical aspects that are taught on placement (Jones, 1997).

It has been said, that theory can only offer generalisations as to what may happen in practice, with the practical element of nurse training essentially plugging the gaps to provide a rounded view of what nursing is (McCaugherty, 1991). Whilst this may be the case, it has been identified how some studies had found discrepancies between what student nurses are taught in theory, and what has been observed in practice (Corlett, 2000). The theory practice gap has been an issue that has disgruntled nurse lecturers for many years (Baxter, 2007). It is nurse educators' job to ensure that the curriculum reflects the contemporary realities of the practice setting; however, it often does not. The shift of pre-registration nursing education to HEIs from the practice setting has been said to further widen the theory practice gap (Chapman and Clegg, 2007; Hewison and Wildman, 1996; Crotty, 1993). It may be that this is due to there being a perception that theory and practice are detached, because of the physical move of the teaching environment.

Whilst many academics perceive there to be a theory practice gap, from examining research of Midgley (2006); Papastavrou et al (2009); and O'Driscoll, Allan and Smith (2010), it would appear that students also perceive there are deficits within the practice setting for their learning. It has been identified that student nurses identify a gap within their knowledge, and struggle to link taught theory into clinical practice (Kaihlanenm, Lakanmaa and Salminen, 2013). Although, once again these issues are nothing new as there has always been theory and practice taught in differing formats. It has been said that student

nurses who are about to qualify, identify the need to increase clinical practice experience and develop their clinical skills, and that they also feel they need more information into the role of being a nurse, before they can practice effectively (Ross and Clifford, 2002). This point is somewhat alarming due to students studying nursing for three years, and spending fifty percent of their time in clinical practice working with RNs as their mentors. However, this point may arise from students claiming in the past that they do not work with their mentors as much as they should do when on clinical placement, and are utilised largely as an “extra pair of hands” (Morrell and Ridgway, 2014). It may also be the case that the students have not reflected upon their experiences, and this is something that has also been identified in newly qualified nurses (Allan et al, 2017).

It has been suggested that globally, new registrants feel that their pre-registration education has not prepared them adequately for their new working life, and that this could have been rectified by developing critical thinking skills and clinical skills (Pennbrant et al, 2013; Pike and O'Donnell, 2010; Kelly and Courts, 2007). The necessity to ‘hit the ground running’ and the associated ability for new registrants to be equipped with the skills and knowledge to practice effectively, has been long discussed within nursing literature (Wolff, Pesut and Regan, 2010; McKenna et al, 2006; Greenwood, 2000).

New registrants have long reported the emotional issues related to being unprepared to meet their new role, with feelings such as self-doubt, an anxiety about making a mistake and not being able to do the job properly (Higgins, Spencer and Kane, 2010; Goodwin-Esola, Deely and Powell, 2009). New registrants worry about being uncovered as incompetent, and not being able to

cope (Duchscher, 2009), and this is a concern in relation to their fitness to practice. The tension and stress that new registrants feel, can lead them to suffer health problems, and to decide to leave the profession due to feelings of lack of competence (Rudman and Gustavsson, 2011; Kovner et al, 2007). A key feature of the role of a nurse is to have confidence and competence in undertaking basic practical skills (Jeffries, 2007). It could be argued that what nursing students are seeking is competence. Competence within healthcare may be thought to be a common conception, however, there is minimal in terms of a common universally accepted understanding of what it is, this was also noted by Scott-Tilley (2008). It has been suggested that new registrants need more time and resources to develop their ability to meet the expectations of their role (Goodwin-Esola, Deely and Powell, 2009).

Research in Sweden found that different universities providing nurse education, meant that there were differences between student nurses' perceptions of whether they were equipped to progress into registrant status (Schüldt Håård, Öhlén and Gustavsson, 2008). The dissonance between perceptions of preparedness by nursing students who attend different educational establishments within the UK has never been explored. However, anecdotally there may be perceptions that different universities provide a different education to each other. As one of the research questions directly relates to the theory practice gap, this was necessary to be discussed, both to set the context and to allow for understanding when answering the research questions. Student nurses transition occurs as a natural part through the programme and will now be discussed.

2.11 The transition from student nurse to registrant

The experience of progressing from student to RN is described as a transition; it is said all newly qualified nurses undergo this. The transition to registrant is an important area to be explored and understood by nurse academics, who are the gatekeepers of the profession, and those who assist with imparting large amounts of theoretical knowledge to students. It has been suggested that the transition period begins prior to qualification (Duchscher, 2009) therefore, it is important for nurse educators to understand the support student nurses may require when moving into the role of registrant. There has been considerable research focusing on newly qualified nurses' role transition (Mooney, 2007; Gerrish, 2000; Kramer, 1974) and it is acknowledged that this is an important aspect of becoming a nurse. Debates about newly qualified nurses' preparation for qualification have been topical within the literature for many years (Lauder et al, 2008; Charnley, 1999; Darcy, 1995). Whilst Kramer's (1974) work was developed before the degree system came into play, the understanding of students transitioning from student to registrant status can still be applied and related. A key finding from Kramer's (1974) seminal work indicated the issues around student nurse to registrant transition, this work has become the foundation for many exploring transition theory. When discussing transition, Kramer coined the term "reality shock" meaning how difficult student nurses find this process, which links to issues raised when discussing theory practice gap. Following on from Kramer's (1974) work there has been research into transition, yet this is sporadic (Mooney, 2007; Ross and Clifford, 2002; Whitehead, 2001; Gerrish, 2000; Baillie, 1999; Maben and Macleod Clark, 1998; Jasper, 1996),

and common themes within these papers could be subdivided into four areas such as: support, coping, preparation and transition, and responsibility.

The transition period Kramer (1974) suggested for nurses has been described as similar to feelings of, but not exclusive to, inadequacy, stress, anxiety, panic, and frustration, and this impacts upon the student performance in both theory and practice (Clancy, Oyefeso and Ghodes, 2007; Reising, 2002; Whitehead, 2001). The quality of the transition experience may have important consequences for the staff member, the workplace, and the wider workforce (Nash, Lemcke and Sacre, 2009) and this should be acknowledged. Registrant transition within the Canadian context was explored by examining newly qualified registrants (Wolff, Pesut and Regan, 2010), this found that newly qualified nurses felt unprepared for qualification, inadequacy, and stress, and this is similar to the feelings of UK newly qualified registrants. There is still a necessity for new registrants to “hit the ground running” the world over (Wolff, Pesut and Regan, 2010). Whilst it is acknowledged that new registrants should be able to hit the ground running, there is still a clear contrast between what is required, and how newly qualified nurses actually feel. Therefore, based upon the findings of this research an insight will be gained, and this can allow my findings to be used to support curriculum development to achieve this global requirement.

It is identified that sixty percent of the nursing workforce consists of newly qualified nurses (Higgins, Spencer and Kane, 2010). Based upon this figure, the findings of my research are important to assist with the effective preparation of registrants, who make up a significant amount of the workforce for now and the future. There is a necessity to ensure that these potentially vulnerable new

registrants should be cared for appropriately. It has been suggested that the transition process for newly registered nurses actually occurs prior to them completing their training, as it is at this point that students would begin to fully understand their roles and responsibilities (Nash, Lemcke and Sacre, 2009).

It has been found when examining the issues surrounding student nurse transition to registrant, that this is an extremely stressful time (Whitehead and Holmes, 2011). The stress student nurses face is not only due to their new role, but also due to them starting a new job. The issues of student nurses facing stress and finding the transition difficult in not only a UK issue, but is faced internationally (Whitehead and Holmes, 2011; Pellico, Brewer and Kovner, 2009; Morrow, 2009; Kelly and Ahern, 2008).

Some of the negative effects of stress felt by student nurses are that there may be health and wellbeing issues, and issues around patient safety (Vasiliadis, Forget, and Préville, 2012). However, Gibbons (2010) suggests that the stress that student nurses face can actually enhance their university experience. It is well documented within the literature that students suffer stress; however, student nurses are well documented to experience high levels of stress. This has been highlighted by Jones and Johnston (2000) to be at higher levels than senior medical students face, and other members of the general population. This stress could then potentially cause errors, which may have catastrophic effects, both on patients and staff. Stress is said to be, for student nurses, a manifestation upon the person, when they cannot cope with what demands are placed upon them (Cohen, Kessler and Gordon, 1995). Stress for student nurses has been largely attributed to the demands of the course, both academic and practically, financial worries, and the effects of coping for ill patients and

dealing with patients who are dying (Galbraith, Brown and Clifton, 2014; Stewart-Brown et al, 2000; Rhead, 1995).

From as far back as 2000, there have been recommendations for healthcare employers to provide stress management programmes for nursing staff and students (Jones and Johnston, 2000). Although, this appears to have been, largely, only paid lip service. Within the HE context for student nurses, whilst students are provided pastoral support, there is minimal support offered to all students as a standard part of their university experience, often with referrals to occupational health, counselling, or advising to attend their own General Practitioner. It appears that stress has become commonplace in nurse education. Whilst the causes of student nurses' stress are well researched, there is a gap within the literature as to why student nurses do not actively seek stress support (Galbraith, Brown and Clifton, 2014). Based upon the literature examined, there may be an argument that not only would students have a better university experience, but students who are actively taught stress management techniques may provide improved patient care, and make less errors in practice. However, this does not detract from the point that the reason for the stress may be that students are being ill prepared to practice effectively, coinciding with the transition to registrant.

The transition of nursing students is a period of stress, adjustments, and growth (Holland, 1999). The transition process of nursing students has been described as a period of learning the culture and routine, that makes up the healthcare system (Nash, Lemcke and Sacre, 2009; Cantrell and Browne, 2005; Walker, 1998), equally this could be perceived as professional socialisation. It is also said that student nurses who are about to graduate, worry about how they will

ensure patient safety, and about the increase in responsibility when qualified (Kaihlanen, Lakanmaa and Salminen, 2013).

It is said that the most important part of the transition process is the transformation at the end (Nash, Lemcke and Sacre, 2009). The final part of nurse education is a period of the student consolidating their knowledge, developing competence and confidence, and identifying areas to which they are lacking, whilst accepting the professional responsibilities they will have (Kaihlanen, Lakanmaa and Salminen, 2013; Cooper, Taft and Thele, 2005; Mills, Jenkins and Waltz, 2000). It is also identified that within the final parts of the programme nursing students' emotions will all be very different, due to different levels of competence, and the students own realisation of discrepancies between what they know, and need to know, to practice effectively (Cooper, Taft and Thele, 2005).

It is at this point of qualification that students may begin to perceive that their skills and knowledge are insufficient to meet that of RNs (Nash, Lemcke and Sacre, 2009; Cantrell and Browne, 2005). Interestingly, from an educator's perspective if the students are meeting all of the criteria from practice placements, and are passing the academic demands of the programme, this may be an element of self-doubt and a lack of confidence, as opposed to an actual lack of ability. It is suggested that the lack of confidence that is reported by students, may have significant implications for the wider workforce and the individual themselves (Nash, Lemcke and Sacre, 2009). Therefore, due to the huge focus on accountability student nurses face, it is important that they are able to provide safe high quality care (DeBourgh and Prion, 2011). Student nurse transition was an important aspect to be discussed through this thesis,

due to this being a process that students experience before becoming a registrant. Therefore, in line with answering the research questions this was a necessary point to consider, as participants will be experiencing transition when taking part in this study.

2.12 Conclusion

In conclusion, this chapter has explained the relevant literature which was necessary to provide a background of what has brought nurse education to where it is at now, to set the context of the current nursing education system, and to explore the relevant literature which surrounds the research questions. This discussion will then allow the research questions to be effectively answered, and conclusions drawn later on within the thesis. The following chapter discusses the methodological approach that will be utilised for this research, and I provide a comprehensive explanation for the research approaches that I took.

Chapter Three

Methodology and methods

The aims of this research are to investigate the perceptions of student nurses, to gain an insight into their nursing education, in terms of how they approach their learning, and how they will practice within the future as registrants. Within this chapter, a detailed outline of how the research was conducted is provided, along with justification for my research approaches. I will firstly discuss the notion of reflexivity, and then move on to how this was insider research. I will then discuss how the theoretical framework of constructivism was adopted. The research was qualitative in nature and utilises a phenomenological approach, and I will explore why I took these approaches. Furthermore, I discuss the strategy used for sample recruitment and selection, and how I came to have a sample size of eighteen participants. In order to achieve the aims of the research and answer the research questions appropriately, the method of data collection chosen was semi-structured interviews, and I will discuss this within the chapter. The process of gaining ethical approval and potential ethical issues are also discussed, as are strategies I had in place to minimise these. I further explain how the storage of data complied with the UK Data Protection Act (1998). I then discuss the data analysis approach, which was Interpretative Phenomenological Analysis (IPA) and how I undertook this, including any challenges I faced and how I overcame them.

Following completion of this study, I intend to contribute to the knowledge in this area to enhance future curricula, and to the research process in general. This research focuses on data collected from one UK HEI through a small scale yet

detailed study, to allow an illumination of final year student nurses' perceptions. This will contribute to development of future curricula and ensure that theory and practice are strengthened. Linking theory to practice is important. Crotty (1998) advocates the linking of research theory to practice, as he asserts that practice is a broad and rich source of questions and problems which require answers. It is the new knowledge generated from this research that may improve the preparedness of future student nurses, by enhancing the curriculum and understanding how student nurses learn. I will firstly discuss the reflexive approach that I adopt.

3.1 Reflexivity

As discussed in chapter one, I take a reflective approach in my exploration of this research. Reflexivity relates to a process of continual reflective self-appraisal and self-critique (Dowling, 2006). Throughout this chapter, I discuss the approach that I used, examining and explaining why, and exploring options and choices that I had, along with a justification as to my actions. The process of reflexivity through understanding is something that I undertake as a practising nurse, hence, it comes naturally to me. The notion of reflection and being a reflexive practitioner was initiated during my nurse training, as we were encouraged to undertake this process based upon many different associated models (Johns, 1994; Gibbs, 1988; Kolb, 1984; Schon, 1983). However, reflection is acknowledged to be a skill that nurses do struggle with (Burton, 2000).

3.2 Insider Research

The research was conducted within an HEI that I had links to, therefore this research was “insider research” (Trowler, 2012). Insider research is described as projects where the researcher is involved with the research setting (Robson, 2002), such as I was. Trowler (2012, 2011) has advocated the use of insider research, due to its supply of recruits, naturalistic data, and the ability to examine specific or under-represented groups. In relation to this research, the group examined are both specific and under-represented as a group within research, and so would fit with Trowler’s (2012) view. This also correlates with the phenomenological perspective as discussed later, due to this group being a phenomenon. A benefit of using insider research is that it can produce richer data due to understanding the context of the environment (Mercer, 2007), as such this links to phenomenology and the lived experience of participants, as I could understand their context more. I was an insider to the setting and this aided my contextual awareness of the experiences of the students and what they were living, yet I do not claim to be an insider to understand exactly the phenomenon that they are part of as I am no longer a student nurse.

Insider researchers are described as the “natives” of the research setting, and so can shed light on the lived experiences of the situation (Brannick and Coghlan, 2007). This is something that I considered and attempted to minimise, as discussed further within this chapter, when considering bracketing during the analysis phase of the research. Whilst I could be classed as a “native”, I believe this allows the contextual awareness required of the phenomenon being investigated. Although I had links with the HEI, I had little association with the students, therefore I felt assured that I could be unbiased within the research.

Undoubtedly, this could have affected my position in the research, and my identity as to how I perceive myself, and how the participants would perceive me. The notion of conducting insider research, yet not fully being an insider, also coincides with the idea of bracketing the data analysis, in terms of my thoughts, opinions, and preconceived ideas for objectivity and to provide findings as natural as they can be. I believe that this detached approach begins from the start of the research process, and this was something I endeavoured to do.

Newton (2000) discusses the rapidly changing landscape of HE, and, with this in mind, asserts the usefulness of insider research. With the changing HE landscape, I feel this is further support for the utilisation of adopting this method, in view also of gaining student nurses' perceptions as the student body changes frequently. The considerable benefits of insider research have not been fully accepted by others within the research community (Mercer, 2007; Newton, 2000), and it was purely for pragmatic reasons such as ease of access and understanding the context, that insider research was utilised as an approach. Trowler (2012) notes that insider research may have disadvantages such as: the institution being identifiable, outcomes which could negatively impact upon the institution, the researcher being compromised by their findings or their position, and even the researcher being biased in their views, either positively or negatively, due to their closeness to the area being examined. However, as previously discussed, I have attempted to minimise these issues and acknowledge them. The system of disguising details can actually alter the transparency of the research (Ezzy, 2002). This is something that I was mindful of throughout the research process in order to maintain the integrity of the

findings. Therefore, based upon Trowler's (2012) and Ezzy's (2002) points for future publications, a system of smoke and mirrors would be used to divert readers attention away from the institution, whilst not detracting from the context of the subject matter to allow participants protection.

Insider research within the academic arena can assist with improving the quality of education (Newton, 2000). Fundamentally the reason for this research is to contribute to the wider nursing education literature, and to enhance the pre-registration programme that student nurses undertake, and so on a bigger scale to improve the care that patients receive. Next, I will discuss the theoretical framework adopted.

3.3 Theoretical Framework

Epistemology is described as a way of understanding and explaining how we know what we know (Gray, 2014; Crotty, 1998). Epistemology has also been described as the relationship between the knower, or somebody who will know, and what can actually be known (Guba and Lincoln, 1998). Having an epistemological stance is important for a researcher (Gray, 2014; Easterby-Smith, Thorpe and Lowe, 2002). This is important for many differing reasons, one being that it can assist with clarifying a research design, and it would also enable the researcher to have a knowledge of different philosophies. Therefore, this would enable researchers to identify which designs would and would not work, depending on the research objectives.

Ontology, as discussed by Crotty (1998) is the study of being and what "is". Ontology is the nature of reality (Guba and Lincoln, 1989) and there is an interrelationship between both ontology and epistemology (Crotty, 1998). This

implies that a particular epistemological stance would indicate a certain ontological stance, and vice-versa, which could complement one another. In view of these points, and to establish credibility as a researcher at a high level, it was important to consider and recognise both my epistemological and ontological perspectives.

Utilisation was made of a framework from a constructivist position. In essence, constructivism is a process of idea sharing amongst individuals who learn through appraising and embracing knowledge (Fosnot and Perry, 2005). This is congruent with the research aims of examining the student perspective and developing the curriculum, whilst also acknowledging my own philosophical values. All have pre-constructed perceptions of reality located in time and place (Guba and Lincoln, 1989; Lincoln and Guba, 1985). Gray (2014) suggests that constructivists create meaning from and about the world, rather than discovering it. Tashakkori and Teddlie (2003) echo this, suggesting that viewpoints and perspectives uncovered through research are influenced by the surrounding world. When undertaking constructivist research, an aim of this is to produce a sophisticated or detailed description of a research setting (Guba and Lincoln, 1989). This is in addition to developing a process which is interactive between the participants and researcher, with the addition of there likely being many different perceptions and perspectives of situations.

A key product of constructivism is that following the research, action should be encouraged from it (Brown Wilson and Clisset, 2010), and this is a longer-term aim following this research being completed, to allow positive changes to the curriculum. The use of constructivism within nursing is encouraged as the values of the profession are reflected within the principles of constructivism

(Rodwell, 1998). This further supports my constructivist stance, in alignment to the principles of nursing, which therefore relates directly to this research.

Constructivism, due to its nature of constructing meaning, links with the qualitative phenomenological approach that was used, as uncovering the layers of meaning was my intention. Knight and Saunders (1999), who illustrate the use of constructivism in gaining a “thick description” of a situation, have discussed this. It is the thick description and richness of data that is required to fully answer the research questions. Further aligning with the approach of undertaking a small-scale study, which then allows appropriate conclusions to be drawn and recommendations to be made. The in-depth description that I aim to gather will also be aided by utilising a qualitative approach.

Constructivism encourages subjectivity (Harvey and Land, 2017; Polit and Beck, 2014), and no single interpretation of truth or meaning that is correct (Harvey and Land, 2017), yet there is an emphasis on understanding the meaning that individuals give to their experiences, thoughts, and feelings (Denzin and Lincoln, 2011; Weaver and Olson, 2006). This guided my research choices in terms of utilising a qualitative, phenomenological, semi-structured interview approach. Furthermore, constructivists refuse to accept that truth can only be established by quantifiable methods (Robson, 2011), again supporting the qualitative approach undertaken.

Constructivist researchers often work closely with participants and are sometimes referred to as being “inside” (Harvey and Land, 2017); subsequently I did undertake insider research. By taking this insider research approach to constructivist research, there is a relationship that occurs between researchers and participants, with mutual respect being gained (Harvey and Land, 2017;

Birks et al, 2008; Birks, Chapman and Francis, 2008; Weaver and Olson, 2006) and as such, the products of this interaction are the research findings (Harvey and Land, 2017; Polit and Beck, 2014).

The use of flexible qualitative methods is appropriate in constructivism (Weaver and Olson, 2006), and this supports my approach to qualitative, semi-structured interviews. Constructivists also argue that knowledge generated should occur in the settings in which they happen; to help understand an individual's perspectives and behaviours (Denzin and Lincoln, 2011; Dykes, 2004) to support the approach of insider research with semi-structured interviews.

3.4 Qualitative Approach

In order to answer the research questions and gain student nurses' perceptions of the curriculum, this research was conducted using a qualitative approach. Over a number of years, qualitative methods have grown in popularity (Silverman, 2011; Saks and Allsop, 2011; Cousin, 2009; Denzin and Lincoln, 2003; Bryman and Burgess, 1994). Qualitative research suits exploration of lived experiences; providing a detailed, rich picture of the phenomenon, that allows the researcher to get closer to what is being researched (Punch, 2005; Taylor et al, 1995). This underpins why I chose to use this method as opposed to a quantitative approach, in terms of gaining the experiences of the students. From this, I could unpick and understand more about the students' perceptions, and therefore the findings would be accurate and conclusions would be reflective of the phenomenon.

Qualitative data is concerned with sense making, meaning, and subjective experience (Willig, 2001). This links to the constructivist phenomenological

approach (Todres and Holloway, 2010), that I have adopted. Qualitative methods are increasingly being used to reach areas of insight that other methods cannot reach (Pope and Mays, 2006) and as such, will assist with providing a detailed insight into the perceptions and experiences of the participants. In terms of this research, interviews were undertaken to generate thick data.

As qualitative research focuses on subjective information, the advantage is that it does not attempt to predict or control the phenomenon of interest (Rebar et al, 2011). Furthermore, this underpins the use of qualitative data within this research. Grossoehme (2014) discusses the robust nature of utilising the qualitative approach, and this was something that I aimed to achieve. The aim is to gather 'real' data, demonstrating perceptions and lived experiences, linking with the phenomenological approach that I have utilised which will now be discussed.

3.5 Phenomenology

I wanted to undertake a research approach that would examine participants' lived experiences, to allow conclusions to be drawn when answering the research questions, hence the employment of a phenomenological approach. The theoretical lens for this research is constructivism, correlating with the use of phenomenology, due to both having an emphasis on how the meaning and thoughts are understood. Husserl, often recognised as the founder of phenomenology, believed this to be the science of pure 'phenomena' (Eagleton, 1983, p. 55). Phenomenology aims to discover and develop understanding of experiences as identified by those living the experience (Rebar et al, 2011; Polit

and Beck, 2010). An advantage of conducting phenomenological research is that, through its heavy emphasis on inductive data collection, it can reveal other information that was not part of the original research focus (Gray, 2014). Whilst this can be advantageous, as more detailed data can be collected, there may be a downside, in that other information can detract from the original aim and this could cloud the findings.

Phenomenology is said to put a value on experience and consider the whole person, examining resarch in a very holistic manner (Oiler, 1982), mirroring nursing which examines patients from a holistic view. Phenomenology is suited to research in social sciences, health, and education (Cresswell, 2007, 1998), further supporting why this was used due to the research being nursing education. Another rationale for using a phenomenological approach is that the lived experiences of the participants, both positive and negative, are important (Liu et al, 2010). In terms of this research, the aim is for curriculum amendments to be made to positively enhance the curriculum, and to identify negative areas of the curriculum, again to make a positive contribution to the curriculum. Equally, this would also recognise positive aspects of the existing curriculum which could be further enhanced. I also endeavour to share good practices for other relevant disciplines and general educational practice, such as how student nurses learn, including approaches, attitudes, and motivations, through the dissemination of this study. Cohen, Manion and Morrison (2007) suggest that research can succeed or fail on both the appropriateness of the methodological approach undertaken, and the sampling strategy adopted, and this will now be discussed.

3.6 Sample selection and recruitment

The method of sampling must be appropriate to ensure that the research is of a good quality (Gray, 2014; Streubert and Carpenter, 2011). A purposive sample technique was used, from a population of ninety-eight final year pre-registration nursing students from one UK HEI. Purposive sampling is a sampling strategy in which participants are selected as being representative of a larger population (Gray, 2014), and this is applicable to this sample used. Purposive samples have been used in many studies relating to nursing and nurse education from large cohorts (Laurencelle, Scanlan and Brett, 2016; Watts and Davies, 2014), and this assured my understanding that this was an appropriate method of sampling strategy. The purposive sample accessed the students who had the knowledge of what I wished to explore, and so this allows participants to discuss their thoughts and perspectives upon the subject (Cohen, Manion, and Morrison 2007; Ball, 1990). This was essential for this study, in order to gain the rich information associated with qualitative phenomenological research, and necessary for the constructivist approach. Qualitative researchers mainly employ purposive, not random sampling methods, to seek out the population of people who will be experiencing the processes that are being studied (Denzin and Lincoln, 1994). Justification for using this group of participants was due both to their knowledge and experience of being a pre-registration student nurse. Participants were currently 'living' both the curriculum and the hospital experience through placements. Therefore, they had the knowledge and experience of what they felt was needed to practice, and what was being taught. Final year student nurses as a group, have been

utilised in previous research to examine experiences and perspectives (Watts and Davies, 2014).

I decided to examine the perceptions of final year student nurses, as they could reflect back against their journey as a student nurse over the programme, and because they were almost registrants and so could highlight key aspects of their curriculum as they were still living this. Similarly, previous research studies also found the benefits of utilising final year student nurses, to consider experience of curricula and clinical practice (Felstead and Springett, 2016 Watts and Davies, 2014). As opposed to perceptions of students who are either too junior, i.e. first and second years, or perceptions of qualified staff, whose views may be altered, or may have an agenda. It is not to say that this group of participants may not have an agenda.

When undertaking constructivist research it is important to gain all views of the potential research population, to ensure that accurate representation takes place (Brown Wilson and Clisset, 2010). In order to apply this point to my research, I attempted to be as inclusive as possible to all students within the cohort; to give all participants a voice should they wish to participate.

I emailed a recruitment poster to all students who met the criteria. A poster was also placed on the relevant year group's notice board. The recruitment poster clearly stated my contact details and a brief description of the study (Krueger and Casey, 2009). A face-to-face meeting was set with any interested participants, during which the full information was given alongside a Participant Information Sheet and a formal letter of invitation for their perusal. Participant Information Sheets allow potential participants to make an informed decision regarding taking part in research (Harvey and Land, 2017). During this meeting,

I ensured that participants were made to feel both “personally needed and wanted at the interview” (Krueger and Casey, 2009, p. 74). Participants had two weeks to make their decision, and could ask any further questions, before self-selecting and consenting to take part in the research. Other studies (Valizadeh et al, 2016; Laurencelle, Scanlan and Brett, 2016) have used a similar method of recruitment which I felt strengthened the justification for my approach.

3.7 Sample size

Qualitative sample sizes are often small (Punch, 2005). This is evidenced with the small sample size of eighteen used for this study. However, I wanted to undertake a small-scale study to allow for depth and richness. An important, but often neglected, facet of undertaking qualitative research worth consideration is sample size (Gray, 2014). I carefully considered this component of the research approach due to understanding its importance. Sample size in qualitative research is much more than quantity, it is about quality and richness of data, suggesting fewer than fifty participants is adequate (Rebar et al, 2011; Davis and Scott, 2011; Morse, 2000). Similarly, this links with the phenomenological approach adopted, to gain thick descriptions. I feel it necessary to note that a smaller sample size aligns with my method of data analysis, which will be discussed later in this chapter. However, my aim was to continue to recruit students and undertake data collection until data saturation occurred. Data saturation refers to information gained which becomes repetitive and confirms previously collected information (Streubert and Carpenter, 2011; Morse, 1994). Polit and Beck (2010) assert that in terms of qualitative research there are no real rules in place, and this should be decided when data saturation occurs.

Phenomenologists use small samples of participants, usually ten or fewer; the guiding principle for this phenomenological research is that all participants must have lived the same experience (Polit and Beck, 2010). I was able to guarantee this as my research only considers final year student nurses. Although, I hoped for a minimum of ten participants to add validity to my research, I aimed for a sample of around fifteen to twenty. The rationale for a sample size of fifteen to twenty participants was that, as this is the students' final year of study, uptake and compliance could have been low. The students were extremely willing and receptive to take part in the research, and this was something that I had not anticipated. Following data analysis, I did have another two students who asked if they could also take part. However, as data collection had taken place, data saturation had occurred, and data had been analyzed, I did not take up their offer. In total, I interviewed eighteen members of the cohort; this in turn meant that there was an eighteen percent respondent rate. Whilst this figure was low, data saturation had been reached at seventeen participants, yet I decided to undertake one more interview to confirm to myself that saturation had definitely been reached. A study by Valizadeh et al (2016) also used this method with a much smaller sample size as a method of ensuring validity.

The majority of participants were female and under twenty-five years of age. There was a varied mix of participants who had previous experience, and those who would be deemed typical undergraduates. The following table (Table 1) demonstrates the names allocated to each participant and their demographic details, which includes their age, sex, and whether they had previous healthcare experience, whether it be in the NHS or private sector. There were five

participants who had care experience within either the NHS or private sector, and thirteen participants who did not.

Participant name	Sex	Current Age	Previous care experience
Marilyn	Female	21	No
Audrey	Female	21	No
Katherine	Female	41	Yes
Judy	Female	25	No
Lana	Female	24	No
Errol	Male	21	No
Elizabeth	Female	25	No
Greta	Female	23	No
Ava	Female	21	No
Bette	Female	45	Yes
Clark	Male	23	No
Joan	Female	37	Yes
Marlene	Female	25	Yes
Jean	Female	35	No
Rita	Female	21	Yes
Grace	Female	21	No
Vivien	Female	22	No
Mae	Female	40	No

Table 1. Participants' demographic table

3.8 Process of gaining ethical approval

The term ethics was defined by Polit and Beck (2010, p. 553) as "a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants". Ethical issues relating to the undertaking of research have been well documented within the literature (Gerrish and Lacey, 2006; Lankshear and Knobel, 2006; Parahoo, 2006; Butler, 2003), and this is an extremely important

aspect of any research. This research accessed pre-registration student nurses through the university setting; therefore, NHS ethics were not required.

Ethical approval was granted firstly through Lancaster University, approval reference no: RS2014/95. Then the HEI in which the research took place granted ethical approval. I not only adhered to local ethical policy but also the British Education Research Association (BERA) (2011), NMC (2015) Professional Code, and RCN (2011) research guidelines. To comply with BERA (2011) guidelines, professionalism was maintained and was at the forefront of my mind, participants were treated with sensitivity, fairness and dignity. Coincidentally, these are some of the underlying principles of nursing practice, as stated within the NMC (2015) Professional Code.

3.8.1 Ethical considerations

It is essential that I discuss the ethical considerations made, how I minimised these and the plans in place to maintain to ethical safety. Long and Johnson (2006) discuss how any research could be potentially harmful both to the researcher and participants. Whilst I am aware that any research could have the potential to cause harm, strategies were in place to minimise risks to both the participants and myself. There was minimal potential for discomfort, distress, inconvenience, or change in lifestyle for the participants. There were no particular abstentions or requirements that were imposed on the participants in order to undertake this research. Participants were not knowingly identified as having any vulnerability, or were from any vulnerable groups, such as patients, children, or those lacking capacity (Streubert and Carpenter, 2011). As the research was conducted in the students' final year this would make all

participants at least twenty years of age, as nursing programmes will only accept those who are a minimum of eighteen years at commencement of the course. This is congruent to other studies (Watt and Davies, 2014; Clucas and Chapman, 2014) exploring student nurses' perceptions. I will now discuss the following ethical considerations in detail; power, sensitive information and confidentiality, and access, which are important to me as both a nurse and a researcher.

3.8.1.1 Ethical considerations: Power

As I was a nurse and had some links to the HEI in which this research took place, there were potential issues due to the natural power differential that exists between a lecturer and a student, regardless of whether the lecturer and student belong to the same institution or not. There was a possibility that participants could feel manipulated or coerced due to the power differential that exists (Gerrish and Lacey, 2006). Johnson (2004) has noted this within nursing education research as something that does occur. This coercion could mean that participants would participate when they did not wish to, as they may feel pressurised. It could also mean that opinions may have been produced that were not truly reflective of what participants actually both felt or have experienced, due to participants believing that this may be what I wanted to hear. I had an awareness of the Hawthorn effect and how this could influence participants answers and behaviours (McCambridge, Witton and Elbourne, 2014), and so I attempted to minimize this. This important point was considered, and was at the forefront of my mind when conducting this research.

Participants and researchers enter into a special relationship, and through this, it is important that there is no exploitation (Polit and Beck, 2010). Participants

fully understood that they could withdraw at any time of the process, as is consistent with many other studies (Valizadeh et al, 2016; Watts and Davies, 2014), to aid their feeling of having power.

In relation to the issue of power, Polit and Beck (2010) also discuss how researchers when undertaking qualitative research are actually in a valuable position to do good. This is due to the close relationship that can develop with participants and researchers, and the cathartic nature of qualitative research (Streubert and Carpenter, 2011). Equally, I also aimed for a reflective approach within the research, this is a valid point and whilst I wanted my participants to feel comfortable, I ensured a professional, courteous relationship was maintained, through conducting the interviews in a quiet room on a mutually agreed time and date. Laurencelle et al (2016) and Valizadeh et al (2016) used a similar approach with quiet rooms for interviews to allow for participants to feel comfortable.

3.8.1.2 Ethical considerations: Confidentiality and sensitive information

Participants signed to provide their informed consent, which included their understanding that I would protect their anonymity and maintain confidentiality; I used pseudonyms to ensure this. Anonymity relates to ensuring that the participant is not identifiable to the information that they provided (Parahoo, 2006), this was guaranteed to all participants. However, it was made clear that should a participant have disclosed an issue, which raised questions around patient care being compromised, or anything else that could be perceived as breaching the NMC Professional Code (2015), this would then have to be acted upon. This would mean that personal tutors would be informed; the fitness to practice process and/or the raising concerns policy would be commenced.

When signing to consent, participants were made aware that this was the case, and that they could withdraw at any time with no repercussions. Whilst it was not intended that any information provided might be seen as detrimental, a potential issue could have been if a participant disclosed, intentionally or unintentionally, sensitive information. This sensitive information could be, for example, issues around harm to patients that they have witnessed or disclosures around poor practice.

Educational research can be regarded as sensitive (Cohen, Manion and Morrison, 2007). Exploring pre-registration student nurses' thoughts, feelings, and emotions could be perceived as being sensitive and this was something that I was aware of in view of my own duty of care to the participants. Due to the reflective nature of the research, in which participants were discussing their thoughts, feelings, and emotions, this may have been a potential area for students to become distressed or upset. The distress or upset that could have been evoked by the participants, may have arisen from them drawing upon particular experiences from the practice setting whilst on placement, or through concerns for the future that they may have. Jack (2010) recently discussed how resilience could develop through self-examining these experiences and thoughts, she furthermore identifies that this is something that research ethics committees should consider, and that whilst potential harm could occur there can be real value to participants. If participants were distressed during the interview then this would have been stopped immediately and they could consider if they wished to continue. Should any distress occur, participants would have been signposted to personal tutors for pastoral support or the university counselling service, which provides free confidential support. In terms

of the potential ethical issues that may have arisen and my duty of care, I must highlight that no participants withdrew following interviews and none required counselling or a referral to their personal tutor.

3.8.1.3 Ethical considerations: Access

Whilst access should not have been an issue in simple terms, there could have been an access issue from the HEIs perspective, as they may not have wanted their students to be researched. Walford (2001) suggests a four-stage process to gaining access to participants and this process was applied to this research. The process involved: approach, interest, desire, and sale. With the HEI being approached firstly and gaining their interest, discussing the researcher's desire to undertake the research, and finally selling the research to participants to get them on board. This research could have been potentially damaging to the HEI if the participants were to criticise the programme and their preparation for RN status. I acknowledged this and as part of a measure to negate this potential issue, the HEI was assured that any publications arising from the research would not allow them to be identified or named. I also reiterated to the institution that they would be able to benefit from the outcomes of this research to develop their programme, if they wished, in line with the constructivist nature of the research.

3.9 Identity

Due to the reflective nature of this research, I feel that it is important to discuss the issue of identity at this point. The need for reflection is important in terms of considering one's identity within the research process (Alvesson and Skoldberg, 2000). This is a multifaceted issue in terms of my position within the

research in terms of, how I view myself, how the participants view their own identity and how they view me. In respect of my position in the research, I kept myself as far away from the sample population as I could so that I did not skew any results. I did not know the participants and I feel this protected the trustworthiness of the research; trustworthiness of the data is discussed later within the chapter.

In terms of how I viewed myself this was difficult, as I am a nurse, lecturer, and researcher combined, I am neither one or the other, and I feel it important to make this point of how I view myself within the research. Wenger (2000) discussed how we define ourselves and how we can move from different communities. In essence, this is part of who I am, with myriad roles within different situations. I did set boundaries out at the beginning of each interview to express that I was all three, but that in the context of this research whilst I had links with the HEI, I did seek to gain truthful answers from participants.

Whilst I tried to mitigate issues of power and the inevitable power differential that exists, the participants would view me differently, and as I mentioned when discussing power earlier within the chapter, I attempted to minimise this. Regardless of this, I would still be seen as being different whether the participants viewed me as an RN, a lecturer, or researcher. This was something that through the interviews I kept at the forefront of my mind and reiterated to participants as the interviews began. This coincides with Letherby (2003) and the perspective that some things cannot be disguised. I further reiterated to participants that their accounts should be their beliefs, views, and experiences and not what they thought that I would want to hear under any of these three

identities, as previously discussed which could occur due to the Hawthorne effect.

The anonymity of the participants in the research was also important. This is further rationale for the reasoning of the demographic table (Table 1) earlier within the chapter. As within chapter four, I wanted to tell the participants' stories and provide the contextualisation of their history. By doing this, it may inform why they do have particular opinions or perspectives, and by giving this background, I feel this adds a realness to the findings. The sense of realness is a key reason why I chose a qualitative phenomenological approach, and this was something that I strived to maintain.

3.10 Data collection

The depth and detail required to answer the research questions, meant that semi-structured interviews were chosen as the data collection method for this research (Gray, 2014). This is linked to the qualitative phenomenological approach, which also sought to gain detailed, rich data of lived experiences. There are several valid methods of data collection that could have been utilised for this study, such as: interviews, questionnaires, and focus groups. Questionnaires were considered due to ease of deployment, and for the simplicity for participants to answer them (Oppenheim, 1996). However, there would be no opportunity to further explore in more depth the participants answers (Oppenheim, 1996). Likewise, the use of focus groups was considered. Although, this may not have provided information which could have answered the research question, due to some participants not being as candid in a focus group compared to during semi-structured interviews (Parahoo,

2014), and as such I considered this to be a benefit of gaining richer data from the use of interviews.

Within qualitative research, the use of interviews as a data collection method can be adopted in many differing ways. Gray (2014) separates interviews into structured, unstructured or semi-structured. Structured interviews often produce quantitative data, whereas unstructured and semi-structured often produce qualitative data (DiCicco-Bloom and Crabtree, 2006), my approach was semi-structured. Healthcare researchers (DiCicco-Bloom and Crabtree, 2006) often use individual in-depth interviews, this allows a further exploration of attitudes and experiences which can be expanded upon during the interview, which allows for a rich insight. Whilst this research is education focused, the subject matter is nursing and so has pertinence. Importantly the use of interviews correlates with the use of the underpinning constructivist perspective (Mojtahed et al, 2014).

Interviews are a way of people discussing their interpretations of the world in which they live (Cohen, Manion and Morrison, 2007). This closely aligns to the principles of phenomenology, supporting why interviews were used as the method of data collection. As a theoretical perspective, phenomenology uses relatively unstructured methods of data collection (Gray, 2014); this allows the individual to expand on their responses to highlight their lived experience, without being constrained by set questions. This would account for the semi-structured interviews I used, as there is a base structure but the rest of the interview is conversational and can develop freely. Using semi-structured interviews is a means of exposing the perspectives of participants when

examining a phenomenon of interest (Marshall and Rossman, 2006). This links to the phenomenological approach utilised for the research.

Interviews can be described as an interchange of views between two people who have a mutual interest in a subject (McCracken, 1998; Kvale, 1996). This is reiterated more recently by Gray (2014) who describes interviews as an exchange of information, in which an interviewer attempts to ascertain information from another person and gain a view on their understanding. Interviews are widely used across many different disciplines as a data collection strategy (DiCicco-Bloom and Crabtree, 2006). Having previously used semi-structured interviews in the past I felt comfortable in using them as the tool for data collection, although, I was equally aware of the advantages of them over other data collection tools. Such advantages of semi-structured interviews have been documented (Robson, 2002; Patton, 2002; Mason, 1996; Barriball and While, 1994).

Interviews are said to require high-level interpersonal skills (Oppenheim, 1996), which is akin to nursing. Part of the skill of interviewing includes the ability to give support without adding bias, putting the respondent at ease and asking questions in an interested manner (Oppenheim, 1996). Clucas and Chapman (2014) in a study which utilised final year student nurses, also noted how the use of interviews allowed for a flexible, yet thorough, approach to exploring responses.

It should be acknowledged that interviews are not a normal conversation as they are pre-arranged, question based, and have a specific purpose (Cohen, Manion and Morrison, 2007; Dyer, 1995). The use of methods such as interviews and observation involves a considerable investment of both time and

energy in building up access and trust. These methods can either alter the behaviour of the participants which the researcher wants to observe, or compromise the researcher (Alaszewski, 2006). I considered these points, and did not want to compromise or alter any participant's answers. Whilst interviews are an 'abnormal' situation, I made the participants feel as comfortable and relaxed as possible to answer questions honestly.

Interviews are more costly and time-consuming than other methods of data collection such as questionnaires, and responses may be influenced by the relationship between the interviewer and the respondent (Polgar and Thomas, 2008; Hulley, Cimmings and Browner, 2001). I decided to undertake the interviews myself to allow the opportunity for any points to be clarified by the participant or myself, as this would not be possible with other methods of data collection such as questionnaires. This is also a strength of using interviews as a data collection method. Whilst interviews can be costly, I minimised costs through undertaking my own transcription.

I followed the interview schedule (Figure 1) to guide my questioning. The interviews began with each participant confirming their cohort and field of practice, and then with myself asking the participant, in a conversational manner, if they had any healthcare experience. This was to allow the participants to feel relaxed and to be eased into the interview (Kvale, 1996). However, I was conscious not to lose the conversational nature of the interviews. Throughout the interviews, any additional questions that came to mind were also asked, which improved the flow of the conversation, and hence more probing questions could be asked.

Interview schedule

Did you have experience in healthcare before commencing your nurse education, if so please explain? If not, why not?
What was your understanding of the role of the nurse prior to starting the course?
What is your understanding of what the role of the nurse is three years on?
In terms of the curriculum that you have been taught from, do you feel that this prepares you for both the theory and practice of nursing?
Do you feel that theory and practice are taught at the right time?
What skills and knowledge do you feel are essential to be taught in university to prepare you for registration?
Are there any skills and knowledge that you have been taught that you believe to be irrelevant to current nursing practices?
Do you feel that the skills and knowledge that you have been taught in theory and practice time link together?
As a student who is near to qualification, what do you think are the current challenges that are faced by nurses on a daily basis in practice?
How do you foresee the role of the nurse in the future?
How do you feel about qualifying, do you feel ready?
Please explain if/how you feel prepared for your role as a new registrant (Qualified nurse)?
Do you have any other questions/comments?

Figure 1. Interview schedule for semi-structured interviews

3.10.1 Genesis of the interview questions

The interview questions that I asked were devised based upon examining the existing literature, unpicking both the research questions, and the overall aim of the research. The questions asked within any research study are central to the design of the research (Oppenheim, 1996), and I carefully considered these, once I had fully explored the literature and research questions. Following the initial questions being developed, I refined the questions that were to be asked, and at this point changed any words and phrases that I felt would not be understood. I was also conscious that I wanted the interviews to have the same feeling as a normal conversation, and was well aware that my participants may not understand terminology and phrases that I may use, and so this was something I considered when refining and rewording the questions. Oppenheim (1996) suggests that questions need to be composed and improved in order to

yield the answers that are required, which is why I took my time to develop these. When developing the interview schedule, I firstly examined the literature to develop a bank of potential questions and sent these to other academics at a variety of other HEIs, not connected with the study or participants, and asked them to feedback which questions they perceived were the most appropriate to gather the data for the research aims. Therefore, this ensured content validity (Parahoo, 2014). Content validity, discusses the extent to which the questions in a questionnaire sufficiently embody the phenomenon being studied (Parahoo, 2014). In remaining true to the tenets of the qualitative paradigm, a pilot interview schedule was not undertaken. Guidance in this process is established in qualitative research literature (Oppenheim, 1996). I will now discuss how the data was stored.

3.10.2 Data Storage

The necessary arrangements were made to comply with the UK Data Protection Act (1998) with regard to computer storage and confidentiality. The data collected was stored on a password protected computer. The hardcopy data was shredded in the confidential waste upon being thematically analysed by myself. Participants were anonymised through being given randomly allocated pseudonyms, by myself. Hence, I was the only person to know their true identities, to ensure anonymity, this also brought the participants' experiences alive within the thesis. Valizadeh et al (2016) used a similar approach by providing pseudonyms, and this reasurred me that my approach was legitimate. The table demographics (Table 1) which contains the pseudonym names, is located earlier within this chapter under the section entitled Sample size.

3.11 Data Analysis

There are different methods of qualitative data analysis which could have each been utilised for the study, such as: Interpretative Phenomenological Analysis (IPA) (Smith, 1996), discourse analysis (Potter and Wetherell, 1987), and conversational analysis (Hutchby and Wooffitt, 1998). However, this research used IPA as the method of data analysis. The main aim of IPA is to explore in detail the personal and lived experiences of participants (Lyons and Coyle, 2007). This closely aligns with the phenomenological lens used within this study, and so makes it the most appropriate method of data analysis for the study. The aim of IPA is an exploration of how participants make sense of the personal and social world, including particular experiences or events for participants (Smith and Osborn, 2008). It is the examination of final year student nurses' perception that is the purpose of this research. The use of IPA is growing within qualitative research, particularly within social and health sciences, due to its commitment to examining how people make sense of life experiences (Smith, Flowers and Larkin, 2009) and this correlates with my approach to investigating this phenomenon.

Small sample sizes suit the use of IPA (Lyons and Coyle, 2007); this coincides with my small sample size of eighteen participants. IPA's theoretical underpinnings arise from phenomenology, and this further supported the rationale for why this method of data analysis was pertinent to this study. Sample sizes of one, when using IPA, are becoming more common (Bramley and Eatough, 2005; Smith, 2004; Weille, 2002; Smith et al, 2000), although the use of sample sizes this small have been contested (Smith, 1993; Yin, 1989).

IPA consists of a four-stage approach to data analysis. I have presented this in diagrammatic format below in Figure 2 for ease.

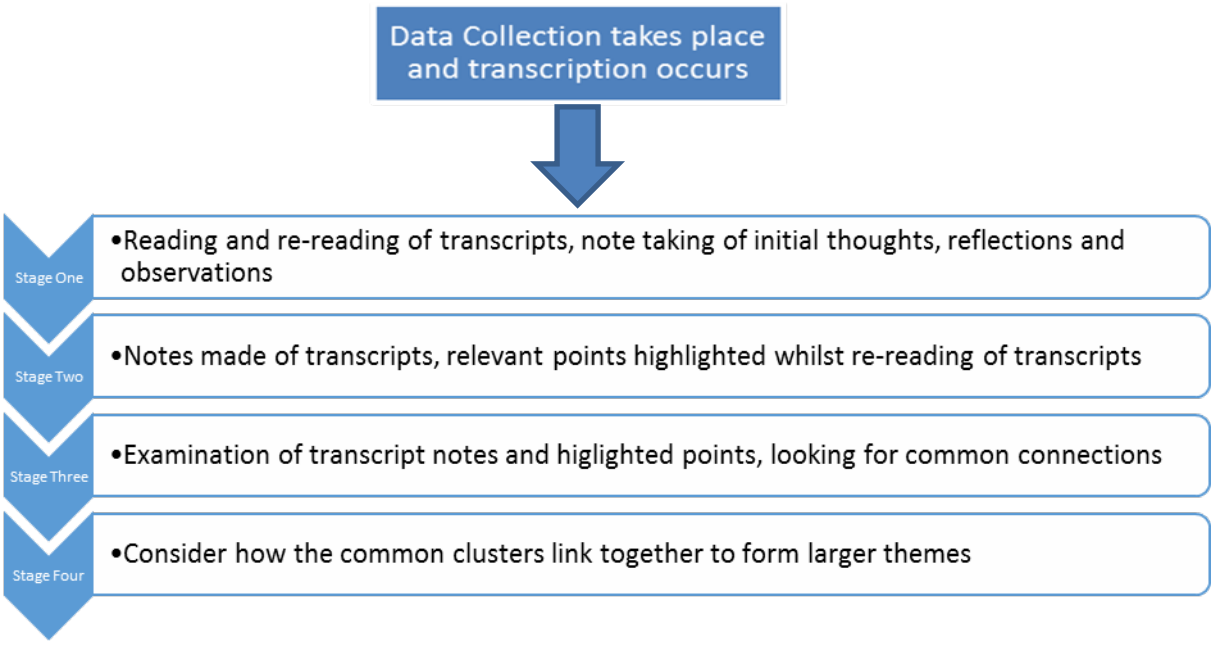

Figure 2. Four-stage data analysis process

3.11.1 Process of Analysis

In terms of the data collected for my research, I undertook eighteen audio-recorded semi-structured interviews, ranging from a duration of twenty minutes to one hour in length of time. Other nursing research studies (Felstead and Springett, 2016; Valizadeh et al, 2016; Clucas and Chapman, 2014) have used this approach with similar durations of interviews, and this provided me with assurance that the interview timings were appropriate. Over a period of two weeks, I transcribed all the interviews to minimise costs. Following the last interview being completed, I waited a period of one week before commencing analysis. Rationale for this was that if participants decided to withdraw then this would mean that I had not included their data. Equally, this would not

contaminate the themes should I have used their data in the process of analysis, and then had to withdraw it. I decided to take this pragmatic approach to keep to the time frame. I also felt that if participants were going to withdraw then they would likely do this soon after the interviews took place, although no participants withdrew. Laurencelle et al (2016) used a period of three days for participants to withdraw following their semi-structured interviews, however, I considered how the students may be busy with other commitments and so gave them slightly longer to withdraw. IPA consists of a multi stage approach, with each stage building upon the next as demonstrated in Figure 2.

The process of analysis is an iterative and inductive cycle (Smith, 2007). Smith, Flowers and Larkin (2009) suggest that whilst there is a general stage by stage approach for IPA, this can be used flexibly depending upon sample size and the experience of the researcher. Flexibility and innovation of the researcher is welcomed through IPA to adapt this process to suit the level of expertise and experience. This was reassuring considering I perceived myself as a novice researcher. I will now discuss how I involved participants following data analysis.

3.11.1.1 Participant involvement following data collection

To ensure that there was an accurate transcription of the semi-structured interviews, I provided all participants with the opportunity to review their interview transcript, this occurred immediately following transcription and before data analysis took place. In total, three of the eighteen participants responded. All three stated that this was an accurate account of what they had said and a fair representation of their views. It is good practice within research to allow

participants to examine their transcripts should they wish, in order to demonstrate validity within qualitative research (Yardley, 2015). This process has been called “respondent validation”, (Silverman, 2011, 1993) and “participant feedback” (Yardley, 2015). In essence, this is the same process and has the same aims and outcomes, which is to display integrity and validity within the research, and to further engage the research participants. The stages of data analysis will now be discussed.

3.11.1.2 Stage one

The process of IPA occurred after all interviews had been undertaken. This ensured that there was no time to be influenced by some ideas and not all, and to ensure that the process was undertaken with all information to not bias the themes that emerged. According to Smith (1999) stage one of IPA involves the researcher reading and re-reading the text. To complete this part of the process, I initially read the transcripts of the semi-structured interviews undertaken. At this point, it is important to listen to the original recording, whilst reading the transcript for the first time to allow the participant’s voice to be heard (Smith, Flowers and Larkin, 2009), therefore, I did this. Smith, Flowers and Larkin (2009) suggest this allows for a more complete analysis of the data. Through listening to the pauses, and tone of the participant’s voice, this allowed me to become immersed in the data, and get a feel for the realness of the data within the transcript.

Whilst undertaking this part of the analysis, I made notes on the transcription sheet of any initial thoughts, reflections or observations. IPA assesses data from the interviews, notes are made, and themes are highlighted which are recurring (Biggerstaff and Thompson, 2008). This involved underlining specific words

which I felt were important and writing the first thing that I thought when reading the transcripts. I felt that this initial read through and note making process was a key part of the analysis to allow an immersion into the data by myself. This part of the process was time-consuming, however, I believed it necessary to allow myself to gain a true feeling of how participants' felt, and to gain their perspectives. This is key to phenomenological research. It was important to me that I kept the perceptions of the participants at the centre of what I was doing, in order to ensure that I fully aligned with the phenomenological approach. Nevertheless, it was also important, in gaining the perceptions of this unique group, as this was the key aim of the research (Felstead and Springett, 2016).

3.11.1.3 Stage two

Stage two is widely regarded as the most detailed and time-consuming (Smith, 2007). This stage consists of mostly making initial notes, and is when the researcher would make notes on anything that they feel is of interest within the transcript. The difference here between the first and second stage is that the initial notes in stage one were the brief first thoughts of the issue, and here there are more detailed notes. I found this part both time-consuming and the most difficult, as there was a tendency initially to be restrained in highlighting points. However, after reading each transcript more than once I did then feel that more points were justifiable in being highlighted, as I became further immersed in the data, and I felt some points warranted a place in the analysis.

Stages one and two do in fact merge, due to notes being made when the initial reading of the transcript and listening of the audio recording takes place (Smith, Flowers and Larkin, 2009). As the notes are then further read and re-read, then more notes will follow. This was evident, as initially after the first read through

the pages were sparse, then the pages were crammed with notes and markings I made upon the third re-read. In terms of guidance from the literature as to what should be commented upon, how much and the type of comments made, this is a process with no rules, apart from that the aim is to have thorough notes and comments on the data. These were generated through involving myself with data closely through the reading and re-reading process.

Included within stage two is the process of bracketing. This is the end of critical judgements by the researcher, to ensure they do not bring in their own assumptions or experience into the data analysis (Spinelli, 2005). Due to human nature, this proved to be the most difficult part. According to Moustakas (1994) the idea of bracketing is concerned with preventing as much emotion and perceptions as possible of a phenomenon that is in question. It could be said as nurses bracketing forms part of the nurses' role of being non-judgmental as unbiased as advocated by the NMC (2015). Whilst I could never remove my experiences, thoughts, or opinions, the use of bracketing, as Tufford and Newman (2012) suggest, does allow my research to not be tainted. This is important when focusing on my identity in terms of what I would expect of participants and their answers to the semi-structured interviews.

Following the initial read through I reviewed the transcripts three times in total. This meant that after completing the read through of the whole set of transcripts; I then began the process again of making notes, highlighting key words and phrases. Rationale for reading each transcript three times over and making comments on each transcript on each time of reading, was that I wanted to ensure that I did not miss any key points on any other read through. Therefore, this was my own attempt at assuring the validity and reliability of the analysis

that I undertook, which would then positively affect upon the themes that were generated later on.

3.11.1.4 Stage three

Stage three of IPA focuses on the development of emergent themes. This took place through examining the notes made from all the transcripts and looking for common connections, patterns and interrelationships between the notes made. This was the part that I found most enjoyable through the data analysis process. At this stage I re-read the text and identified themes from the within each section of the transcript and looked for likely connections between themes. This has been highlighted by Biggerstaff and Thompson (2008) as an important part of conducting research using IPA. This stage, in short was to consider the strong themes emerging from each individual transcript. I did find that some themes were more obvious to see than others were, and it felt as though some did jump off the page. This aspect of the process did involve the breaking up of quotes from the transcripts. However, I did not want to lose the meaning of what the participants said and this was something that I was conscious of. The themes were a reflection of the quotes from the participants, but were bound together by my interpretation of their meaning. This involved a mixture of both participant's original thoughts and words, but also of my interpretation of the meaning, this aligns with the interpretative aspect of IPA.

Whilst the notes of each transcript can feel quite loose in terms of meaning, the themes as a whole should feel that they have accurately reflected the phenomena, to ensure the phenomenological aspect of IPA (Smith, Flowers and Larkin, 2009). In terms of the developing themes, I examined transcripts looking for common connections in clusters.

3.11.1.5 Stage four

Following the emergence of initial common connections from the data in stage three, stage four usually involves the researcher examining how the common clusters link together to form larger themes. It is important to note that at this stage, the small clusters may not all fit into groups and some may in fact be discarded (Smith, Flowers and Larkin, 2009), I did not have to discard any. This stage explored how the smaller clusters fitted into the larger grouped themes, through examining patterns and connections between each smaller theme. The aim at this point is to re-order the categories in a hierarchical relationship (Biggerstaff and Thompson, 2008). When demonstrating the hierarchical relationship between the themes I do not believe that any themes are more important that another, as my findings are all significant. Although, I have demonstrated these in a logical way.

3.12 Trustworthiness of the data

An important aspect of this resarch that I must pay attention to is the issue of trustworthiness of the data.

According to Graneheim and Lundman (2004) research findings should be trustworthy, in relation to the procedures used to generate the themes, this was something that I was aware of and tried to ensure had occurred. Lauckner, Paterson and Krupa (2012) discuss that the trustworthiness of a study, is essential to accurately capture the phenomenon of interest. This links to the use of the phenomenological approach, as it was this accuracy of the phenomenon that was what I intended to gain. Three strategies suggested by Lauckner, Paterson and Krupa (2012) to ensure trustworthiness of data, are to have a

prolonged engagement within the field, in addition to undertaking a process of member checking and to include thick description. However, not all IPA advocates feel that member checking is essential (Goldblatt, Karnieli-Miller and Neumann, 2011). The prolonged engagement within the field was achieved through the duration of the interviews taking place. For example, I did not undertake them over a very short time frame, but over a period of weeks, with breaks in between each.

Member checking by colleagues was a potential option, however, I felt that in line with the constructivist paradigm there would be no right and no wrong interpretation, and multiple interpretations would bring multiple perspectives. I did attempt to minimise the multiple perspectives through self-checking my own analysis three times for each transcript. I also included the thick description of each theme and the background of the participant. I felt that adding the demographic details of the participant as located within Table 1 would add to the realness of the data and provide contextualisation. This would also coincide with the thick description added in from the participants' excerpt quotes. The use of the excerpt quotes would strengthen the demonstration of themes that I have generated. This would coincide with the demographic table to allow for an understanding of the participants viewpoints and perspectives, as their reasoning and responses may have been deemed by factors such as age, sex and background.

Through the process of analysing the data, I did review each transcript three times to attempt to ensure that the findings were accurate and to assess that the same themes were coming through. I feel that this not only ensured trustworthiness but also added to the rigour of the process that I had

undertaken. I also reassessed later on for outliers and inconsistencies. To ensure trustworthiness of data, the participant construction of meaning must be understood, for example by a number of ways such as culture and context (Morrow, 2009). This was a key aspect of my undertaking this research, in line with the constructivist phenomenological perspective, as I do have an understanding of the participants' context and culture. Although, I would never be able to fully understand every participants' perspective, but I can construct meaning from the findings and I do have an insight into the phenomenon that is their experience.

3.13 Use of participants' experiences within the data

In order to demonstrate the points made by each participant and to exhibit how these comprise the themes, I have provided some quotes to justify the themes and demonstrate participants' feelings and points made. Each quote demonstrated has the participant's name next to it and this can be used in conjunction with Table 1, located in chapter three, to allow for a more personal approach to reading the excerpts of the transcripts, and add context and understanding for each participant. Similarly, the use of excerpts within the following chapter, I feel, also allows confirmation that the themes are an accurate representation of students' views, and as such act as a further method of ensuring validity to my research. Other recent studies (Felstead and Springett, 2016) have also highlighted the use of quotations for this purpose. The theme excerpts are located within the following findings chapter, chapter four.

3.14 Themes

The subsequent discussion of the themes that were produced, represented what final year student nurses perceived about their nurse education. Seven themes arose through analysing the data; these are presented within chapter four. I discuss these findings with relevant information such as how strong each theme was, in terms of the number of participants.

Themes
What is the role of the nurse?
Student perceptions of the benefits of prior healthcare experience
Skills perceived as important for practice
Theoretical knowledge perceived as important for practice
The theory practice gap
Learning to care
Emotional transitions to registrant

Table 2. Themes derived from data analysis

3.15 Conclusion

In conclusion, I have provided a thorough overview as to how I conducted the research, coinciding with justification for how I came to decisions made, citing rationales along the way. I explained how the theoretical framework dictated the approaches that I took, and discussed the ethical considerations I made and how data was protected, stored, and analysed.

The next chapter, chapter four, presents the findings of this research, demonstrated within each theme, and displays excerpts from participants' quotes to justify the findings and demonstrate validity.

Chapter Four

Findings

Chapter three demonstrated the methodological approach I employed for this research. I demonstrated how the different components of the methodological process each align, and discussed in depth the rationale for taking the approaches I took. This was an important aspect of discussing the methodological approaches utilised, to strengthen the thesis, aid clarity when reading, and to set out my capability as a researcher.

In this chapter, I will discuss the data I have collected, and provide an outline of the key findings. As previously discussed in chapter three, section 3.83 page 99, I use quotes within this chapter to illustrate the themes, and as embodiments of statements by respondents. The process of data analysis led me to detect seven themes within the data. The themes are: “what is the role of the nurse?”, “student perceptions of the benefits of prior healthcare experience”, “skills perceived as important to practice”, “theoretical knowledge perceived as important to practice”, “the theory practice gap”, “learning to care” and “emotional transitions to registrant”. Table 2, chapter three, demonstrates the themes; I will now discuss the first theme.

4.1 What is the role of the nurse?

This theme discusses the findings, of the understanding that participants had into the role of the nurse when reflecting back upon commencing the programme, and what their current perception of the role of the nurse is now. An important aspect of the findings, was the insight into the roles of the

registered and student nurse that participants had before commencing the course. In terms of examining this, it appears that the role of the student nurse and RN, is something that many final year participants had little insight into when beginning the programme. Participants throughout the sample, described how they did not have understanding into what the role of the nurse actually was, when commencing the programme. Interestingly there was also no difference between those who had healthcare experience and those who did not, in terms of their assumption of the role of the nurse. One participant, Rita, who did have previous healthcare experience, stated,

> *"I am still as shocked as to how much there was to learn and how many subjects there are…science, law, ethics, maths, clinical skills. I think honestly I thought that the biggest thing I may learn was how to do an injection, nobody told me that there would be so many things involved in being a nurse and what the role consisted of" (Rita)*

Considering Rita did have healthcare experience, it is surprising her lack of insight as to the role of the nurse. This is interesting as to what participants believed that the role of the nurse actually was, when applying for the programme, and what drew them to the profession in the first place. Vivien, who had no healthcare experience, highlights not only her lack of knowledge of the role of the nurse, but also the programme,

> *"I remember back on the open day and someone said this course is hard and we need dedicated people to be the future, I can honestly say that comment is not even the tip of the iceberg, I never even realised that I would have to work shifts…my god back then I really was clueless" (Vivien)*

The lack of understanding may question the recruitment and selection process in terms of explaining the awareness of the role, and the programme, that participants had. The level of insight participants had towards the role of the nurse, may cause some concern as to what the participants thought they were applying for, when applying to join the programme. Equally, this is interesting as to what the public perception of the role of the nurse actually is; specifically linking to what draws people to the profession. Joan reiterates this,

> *"even after working as a senior healthcare assistant on one ward for 10 years, I don't think I had any idea of the bigger picture, I suppose I just saw the nurses as people who were always busy and spoke a lot to the doctors, I just didn't realise that different settings have different demands, and the amount of pressure and responsibility that you have as a nurse…thinking back whilst I have loved every minute of my training, I don't know if I had the insight would I actually want to do this as it's just so much responsibility" (Joan)*

Overall, the findings suggest that participants, regardless of their healthcare experience, demonstrate they had little appreciation of the role of the nurse when commencing the programme. Participants discussed their socialisation, implicitly and explicitly, to the clinical practice area, and findings pertaining to this will be discussed. Through the data analysis process I found that many participants suggested that they underwent a period of socialisation, in terms of working with the staff in the clinical areas. It appears that they used this as a way of understanding what the role of the nurse was. Nine participants demonstrated this, Mae highlights her thoughts,

"The good thing about going onto so many different placements is that I feel that we benefit from getting involved with all of the different staff and learn how they work" (Mae)

Bette discusses how she not only learns how to be a nurse from working with nursing staff, but that she also learns other skills such as how to work in a team. Teamwork was discussed and participants highlight that this is something that is not taught within university, but is learned whilst working within clinical teams in practice. Bette, who had previous clinical experience, discusses this,

"you quickly learn from all of these placements how to become part of the team, being part of the nursing team is a massive deal and can make you learn very quickly about how to be a nurse…this is the type of thing that you don't get in university…they can teach you all the knowledge but being a nurse comes from working with nurses" (Bette)

This demonstrates the approach to learning and working in practice that participants use, to understand what the role of the nurse is, and to gain the professional socialisation that comes from working in practice. Audrey states,

"I have found the best thing to do is to find yourself a good new staff nurse or a good nursing assistant and they show you the ropes and after a while you're fine because let's face it you can learn from them how wards work and how to be a nurse, and doing tasks, you know like giving care is basically the same thing on every ward isn't it" (Audrey)

Equally, Ava highlights a valuable finding which many other participants discussed, around their lack of insight into the depth of knowledge required to be a nurse,

"A big part of being a nurse is not actually about knowing loads, because as long as you know how ward areas operate and who to ask, and basic things about how to do certain stuff then you're fine, you really don't need to know a lot just more about how the ward works and then you're fine" (Ava)

Findings around socialisation suggest that it is not just learning the process and skills from mentors to be able to do the job of the nurse, but also about how to behave and portray the role of the nurse, that is important to participants within their education. Marilyn demonstrates this,

"you know what I think the more you work with nursing staff the better because it's from them that you learn to act, maybe it's about acting and portraying yourself as a nurse that helps me to feel ready and have more confidence, rather than the stuff I learn at university" (Marilyn)

As highlighted, learned behaviours are important and participants appear to learn the role of the nurse from practice colleagues. Furthermore, this appears to be beneficial to participants, in view of developing confidence. However, Greta made a valid point relating to how socialisation and learning in the clinical area can sometimes go wrong,

"Well I have seen some people have really bad mentors and really bad wards and then what I have found is that often it either breaks them and they report it to the university or they start acting like the staff…you know like actually forgetting why they came into nursing in the first place. It's like, oh what's it called… behaviour breeds behaviour, and that really worries me" (Greta)

A potential issue that could cause concern, is if participants work within teams who do not function appropriately. Participants could then be exposed to poor practice, or could miss the opportunity to learn how to work within a fully functioning team.

It is clear that there was a lack of understanding of the role of the nurse at the beginning of the programme, and this does continue for some participants as they move towards their registrant status. However, for others there does appear to be a realistic and appropriate view of the role of the nurse, and how this may become a challenge for the future. Seven participants describe what they perceive the role of the nurse as now, and what they believe the role of the nurse to be in the future. Ava demonstrates how she perceives that the role of the nurse is misunderstood,

> *"I just don't think that people know what nurses do, and I actually think that this is a challenge within modern working…loads of people say about us assisting doctors, like seriously, we do not there is so much more that we do than be a doctor's handmaiden!" (Ava)*

Bette reinforces the need for a curriculum, to ensure that nurses are prepared adequately for the challenges of the role, to effectively prepare nurses for practice, and describes what the potential implications of ineffective preparation may mean. Bette discusses,

> *"it's quite scary really how much we do, and loads of people are saying that you don't start to learn until you qualify, you know like when you pass your driving test, but the thing is this seriously worries me because if we're dealing with real human beings then we need to know everything*

before we qualify before we potentially kill someone, and this is the reality of the situation" (Bette)

Rita highlights that she believes the role of the nurse has evolved from what it was in the past, and that the profession is challenging in terms of accountability and responsibility, although she suggests this has not been realised by the public,

"I don't think the role of the nurse, from what I can see, is ever going to be really like it was 50 years ago, we have so much responsibility that the general public don't realise, all this stuff in the papers and these reports damage the reputation of the profession and that in itself is a challenge, we're out trying to do good and we are being sabotaged by the press" (Rita)

Katherine suggests that due to the ever-changing role of the nurse, nurses find it difficult to fully understand their role, as there are often additional aspects added within their remit. Likewise, many tasks and skills that are currently perceived as advanced, were not undertaken by nurses or were only ever undertaken by nurses in specialist roles. Participants also describe nurses as "cheap labour" and this is an interesting finding. This is in relation to the frustration of the student role, and in terms of their future role as a registrant. This may be a reference to the advancement of the nursing roles, and their perception that some nurse's roles are in place of doctors. Katherine highlights this,

"I know everyone says you won't ever stop learning and you will have to keep studying even when you're qualified, but with the way that we do lots of the doctor's jobs I think this will be the case more than ever

actually, I should have just trained to be a doctor at least then I would know what my scope of practice was and would be paid for it, it's sometimes like we're just very very cheap labour" (Katherine)

Whilst the findings are significant in terms of what student nurses perceive the role of the nurse to be, Clark also highlights that nurses have multiple roles, and predicts it will change in the future,

"Our job roles are so diverse, and I am not sure how the roles are going to develop further within the next 20 years or so, and this worries me" (Clark)

This point is interesting in terms of students having an awareness of the wider nursing professional landscape, and how nurses fit into the future healthcare system. As such, this would mean that the curriculum should be flexible and responsive.

This theme has presented the findings from this research, around what participants believe the role of the nurse to be. Participants demonstrated they had little understanding of the role of the nurse when commencing the programme, and this was no different between participants who did, and did not, have healthcare experience. I have also identified that to assist with understanding what the role of the nurse is, participants undergo a period of socialisation, through this, participants also used this as a time to learn the role of the nurse. Participants then demonstrated that they have a reasonable understanding of the role of the nurse at the point of qualification, and that they understand the potential future nurses' role.

4.2 Student perceptions of the benefits of prior healthcare experience

This theme displays the findings of whether students perceive health care experience to be beneficial prior to commencing the programme, and how this affects their progress on the programme. It was interesting to ascertain if participants perceived prior healthcare experience as being either necessary, advantageous, or of no benefit at all. It should be noted that whilst some participants state they have healthcare experience, this could be very different in terms of the duration, location and experience, all of these factors would undoubtedly vary. The five participants who did have healthcare experience, felt that they were at a clinical advantage over those who did not have any healthcare experience within the cohort. This is surprising that those who felt clinically at an advantage with healthcare experience, yet did not fully understand the role of the nurse, and had little insight into the nursing programme. Katherine, who did have healthcare experience, demonstrates this,

> *"I had experience, which I think stood me in good stead compared to those who didn't, it was more in terms of things like knowing the systems and how the wards function, that gives you a helping hand" (Katherine)*

Typically, when discussing experience participants infer task acquisition, suggesting that this would demonstrate experience and preparedness for registration. Participants also perceived that in first year, if they were given the opportunity to undertake and practice extensively a range of clinical tasks within university, they would feel adequately prepared and this would negate the need for previous experience. Ava, a student with no healthcare experience before entering the programme, highlights this,

"I wished I had experience before coming into this...I mean some of the things that we are expected to do is so personal and you can see the patients, particularly some of the old men looking and thinking there's this little 18 year old girl wanting to wash me and it's embarrassing for them and us… I think if I had had some experience even my demeanour would have been different and so it wouldn't have been so bad" (Ava)

It appears that those who had experience felt at an advantage, as they largely understood the processes of the ward areas, although this may be that the students are already professionally socialised into the healthcare environment. Those participants who did not have care experience, stated that they typically used their first six months as a period of developing skill acquisition, and understanding how clinical areas function as they did not have this experience,

"The first six months was really just about finding my feet and knowing how things happen" (Lana)

Fifteen participants believed that gaining experience of around three months of placement learning was sufficient. All participants attributed this to the undertaking of clinical tasks and how clinical areas operate, as opposed to developing and refining their nursing skills in relation to, for example, communication. In terms of experience, it appears that students who have previous clinical experience will provide support for their peers in order to support them through clinical practice, as a way of showing them the ropes. Bette, who was a mature student with previous healthcare experience, demonstrates this and she displays the support given to her peers,

“Those poor kids who came straight from school and started their training, you could see the look of fear in their faces when we were on placement; I took a few under my wing to help them” (Bette)

Another participant, Greta, who had no experience, demonstrates a key point that links with areas around emotions, around when students have no experience they feel less confident and more vulnerable. Consequently, when experience is gained I have found that students’ will fully participate and engage in providing patient care, as prior to this due to a lack of confidence they were hesitant to participate. However, at the point of registration, student nurses acknowledge that they are able to undertake their role and will get involved with clinical tasks. Whereas, at the beginning of the programme those who had no experience, suggested they needed around one to six months to be able to match their counterparts with clinical experience abilities, although this was largely due to understanding how the clinical areas work.

“Well I had no experience whatsoever; at first I was so frightened I just hid in the toilets…now though with all the experience I have had I’m willing to do anything it’s just a case of rolling up your sleeves isn’t it?” (Greta)

Those who had experience, felt more prepared to go out into clinical practice, and at an advantage to their peers to those who had no clinical experience. It is worth considering if this perception is due to the participants having an insight into the operational aspects of the clinical area, as opposed to them having greater experience. This insight into the profession and the socialisation of the clinical environments appears to be what participants who did not have experience felt that they were lacking, as opposed to having the ability to

undertake clinical tasks. It appears that participants with experience, support and even informally mentor their peers, who do not have any previous healthcare experience, to assist with them gaining confidence and experience.

4.3 Skills perceived as important for practice

This theme demonstrates which skills were perceived as important for clinical practice and why this may be the case. There were no skills within the curriculum which were perceived as unimportant for practice. All skills were perceived as important, overwhelmingly, medicines management, particularly intravenous medications (IV), were perceived as the most important for clinical practice. Fourteen participants discussed IV drug administration as an important yet under explored skill. Katherine highlights this point and further describes the assumption of what is required as a nurse when qualified,

> *"we need to know about IV drugs, it's like the elephant in the room, the thing is literally one day we are a student and the next we are qualified and then it's like, well go on, but we don't get taught about this, fair enough if we can't administer the drugs but even practising using the equipment would give us a head start, this is important for us to keep patients alive when we qualify" (Katherine)*

Many participants suggested that this is a necessary skill, which may aid confidence, competence, and transition to registrant. Jean further reiterates this,

> *"I just don't see why we can't do IV drugs...well I know why actually, but the thing is the university staff say that they teach us everything properly, so why not teach us properly and then do the study day when we qualify,*

at least then we have an idea, I think we're more likely to make a mistake or pick up bad habits from the trained staff once we are qualified, and then we have more to lose. I mean it's also about being able to give proper treatments to patients so that they don't deteriorate, and if that happens and I make a mistake well that's my registration gone isn't it?" (Jean)

This potentially highlights how if students were taught about IV drug administration, and were familiar with the equipment, they would be able to undertake this task correctly at the point of registration. All fourteen participants who raised this as an issue, stated they felt this would allow them to feel prepared and confident. Participants could not understand why they would not be allowed to administer IV drugs as student nurses. However, many highlighted that when qualified, there was an immediate expectation that they would understand and be able to administer these drugs after a trust study day. Many of the participants who discussed this believed that they would be less at risk of making errors, and would feel more confident and competent in administering the drugs, if they were given the knowledge and exposure during their programme of study. They further provide an insight as to how this is about their level of accountability. Mae discusses this,

"Even taking the needle and attaching it to the syringe is like a big deal to me, it's just so fiddly, maybe the lecturers should let students play with the equipment…sometimes the staff on the wards forget that they were ever students and are like, can't you do that? But if university helped us we wouldn't feel like such fools and quite inadequate" (Mae)

Rita demonstrates how practising using equipment associated for this skill would improve confidence. Rita highlights how her mentor allowed her to practice safely within the clinical environment. Whilst students are not allowed by the university to administer IV medications in practice, they do gain confidence from simply practising with the equipment, which may also assist with the transition to registrant,

> *"my mentor was great and asked me to practice drawing up drugs from water ampules in the treatment room, even using the syringe and needle was difficult, I felt such an idiot…if university would even let us practice in the skills labs then we would be feel a bit more confident" (Rita)*

General drug administration, such as oral, subcutaneous and intramuscular injections, and topical medications, were another area that participants discussed as being an area in which they felt a lack of confidence and exposure, yet were all perceived as important. Although the participants stated they had met their learning outcomes for placement, they wanted more experience with medications management and felt vulnerable moving onto the professional register. In terms of skills and skills acquisition, it appears that the two major concerns from students do relate to medications. This pertains to both IV drug administration and having a knowledge and experience of simple drug administration. Elizabeth shows her concern,

> *"I think even though I have passed my medicines management learning outcomes, I don't feel safe to do these on my own actually, I think more support and even maybe testing from university would be good, as if I am going to be administering potentially life threatening drugs to patients I want to know that I am not going to harm them…they say look the drugs*

up, but it's the process that I want more help with, because what if I do something wrong?" (Elizabeth)

Participants understand the potential consequences of making a drug error, Vivien, describes the fear of making a mistake through drug administration,

"I need more help with my medicines management; I just worry about doing medications in case I make a mistake" (Vivien)

Other skills mentioned, that participants did perceive they had limited experience with, were venepuncture, cannulation and catheterisation as Joan explains,

"the thing I would feel so much more ready to be able to do my job when I qualify if I could do all these skills, like venepuncture, cannulation and catheterisation, then I don't think it would be so hard when I qualify, I would just feel so much more confident and less of a burden than I know I am going to" (Joan)

It could be argued that students should be able to undertake more advanced skills before qualification. This would be to aid transition to RN, improve confidence and develop what are now deemed essential skills for practising within the 21st century. However, it is clear that participants over emphasise the reliance on technical skill acquisition, and downplay the care aspect of the role. This may create a tension between what student nurses, academics, RNs, and the public may perceive as important. Grace demonstrates her confidence and competence, whilst emphasising the acquisition of clinical skills,

"Because we get taught skills that can be applied to lots of different areas that really helps you know, trained staff seem to think that you're an okay

student if you can do skills without hounding them, this makes you feel that you can take anything on" (Grace)

Participants appear to place a value on skills teaching sessions, putting emphasis on their "survival" in clinical practice through being able to undertake skills. It is clear that participants want recaps every year, as they fear that what skills they learned early on in the programme they worry that they will lose their skills. Jean a mature student with no healthcare experience demonstrates this,

"The first year skills sessions really are so important for our survival on the placements" (Jean)

Eight participants discussed how some skills and knowledge, which had been taught early on within the programme and then had not been used again, had been lost. Greta explains this,

"They taught us how to do things in first year and I did it on one placement and now if you asked me how to do it I swear I wouldn't be able to tell you how" (Greta)

Joan further elaborates and provides a suggestion to academic staff,

"Seriously if you don't do something for ages then you forget don't you…the university staff need to remember that if we don't have recaps on subjects and skills then we will forget…it's a case of if you snooze you lose isn't it in terms of knowledge?…I really think that we should have recaps from each year or on each subject" (Joan)

Jean also discusses this,

"I do worry you know that I've forgotten so much information and skills…the thing is I have really enjoyed my training and learned so much, but particularly the skills that I haven't used in ages worries me, I just

have the feeling that the staff when I qualify won't be so able to perform these skills…and what if I do something wrong and harm a patient?" (Jean)

Through this theme, I have presented the findings of which skills participants perceived are important for practice, which are all clinical skills, particularly medicines management. Students have an appreciation for these skills due to their ability to then be able to use them in clinical practice.

4.4 Theoretical knowledge perceived as important for practice

Theory makes up fifty percent of any UK nursing programme, and an interesting finding was what participants believed they would have been taught upon commencing the programme. Overwhelmingly, participants suggested that the science based subjects such as anatomy, physiology, and pathophysiology, are the most important theoretical subjects for clinical practice, when they reflected back upon what subjects they believed the programme would consist of, many also thought it would be science based. Sixteen out of eighteen participants believed when commencing the programme that it would be very much science based. Katherine, who did have previous healthcare experience, demonstrates this,

"I honestly just thought I would be taught about how the body functions and diseases, and to be honest not much more than that" (Katherine)

Mae, a mature student with no previous healthcare experience, displays insight into what she expected to be taught, and a realistic view on how and when learning will occur,

"I thought the course would be all medical and scientific…, I suppose in some ways there was a lot of science at the beginning, with none towards the end of it, but then again thinking back on this, there is so much to cram into a relatively short space of time, and so we should really be reading things at home and learning ourselves but I just don't have the time" (Mae)

In terms of what the participants expected of the programme, from a theoretical subject perspective, it transpires that there was no insight but a presumption that it would be heavily focused upon subjects such as anatomy, physiology, and pathophysiology. This signals a lack of insight into the programme and the role of the nurse when participants are applying for their place. Participants clearly expected a different programme, rather than what they actually received, based upon these findings. Clark suggests he was shocked as to how many science based subjects there were,

"It sounds crazy now that I think about it but I really didn't think there would be much science in this course, I remember saying that when I first got the timetable and everyone looked at me like I was strange…Now I can see why they did but back then I just didn't think about it and it did genuinely shock me" (Clark)

Another participant, Marilyn, stated she did not know what to expect and that the content of the course has surprised her. Marilyn was eighteen years old on commencing the programme with no healthcare experience,

"I had no idea at all what would be taught, I'd never even really thought about it" (Marilyn)

Participants displayed a lack of insight when commencing the programme, in terms of which theoretical subjects would be taught. Therefore, the level of insight into the theoretical aspects of what the programme consists of, may be necessary to be examined when candidates are interviewed for their place on the programme. Audrey, who was also eighteen when joining the programme and had no healthcare experience, further reinforces this. Audrey discusses in an honest way that she had a lack of insight into the programme when starting, in terms of what she expected to be taught,

> *"I can honestly say that I thought the biggest thing I thought I would learn would be how to do an injection…boy did I soon come back to earth with a bang!" (Audrey)*

When students reflected upon the subjects they had studied during the programme, such as mental health nursing, health promotion, law, ethics, management, leadership, research, sociology, and psychology, they asserted that they had not learned much in detail that they could remember about these specialisms. When probed as to why this would be the case, the majority of students' answers pertained to these subjects not being useful in clinical practice, as such they approached the assessments to get a pass mark, and approached their learning in a superficial surface manner. Rationale for this was that participants perceived these subjects as irrelevant to their practice, and so approached their learning in this surface way. The following excerpts from Vivien, Marilyn and Marlene demonstrate this significant finding,

> *"Oh all that stuff about research and leadership it's of no use to me all I want is to be a nurse. So when assignments came in, I did them, got a*

pass and concentrated on the important stuff, you know like learning medications" (Vivien)

"All these other subjects I just do to pass to get through the course, you know the stuff like health promotion and sociology, it's a case of passing the assignment and moving on" (Marilyn)

"Seriously I have too much more relevant stuff to learn about than rubbish like public health and health promotion, so I got that done and moved on" (Marlene)

Audrey suggests that occasionally there is a dissonance between what students understand as valuable to nursing practice and what is not,

"The only real modules that I remember really helping me with my practice were the skills and the anatomy and physiology, the rest of it was all just a bit pointless" (Audrey)

Sixteen participants discussed how, within first year and second year, there was a strong component in the curriculum of anatomy, physiology, and pathophysiology. However, participants felt that although this was not a strong enough component in the final year, they wanted more. Of these sixteen participants, fourteen discussed how they believed there should be a strong link to anatomy, physiology, and pathophysiology in the final year as a way of consolidating learning. It was suggested that this would assist with feelings of preparedness and confidence for registration. Marilyn expresses her anxiety and demonstrates this,

"The thing is we had anatomy, physiology and pathophysiology in both years one and two, and now I think that we really need it more so than ever" (Marilyn)

Grace recognises the use of anatomy and physiology taught in university, and its relevance to clinical practice,

> *"Anatomy and physiology in the first year was so hard, but I can see now why it was, as I needed to know this stuff before going onto placement where I had people's lives to deal with I knew I tried harder to learn these subjects over the other stuff" (Grace)*

Again, the necessity for a stronger emphasis on anatomy and physiology within the programme was found, and is highlighted by a mature student Katherine,

> *"well we had it in the first few years and that was good but actually now that I'm ready to qualify I'm thinking ok so I want to try and link things myself to illnesses and I'm wondering why these are happening, but I just don't know, I just think that I need more physiology and pathophysiology…the role of the nurse is now so medical and we need to know this stuff" (Katherine)*

The apparent need for more anatomy and physiology within the final year is reiterated, although participants do identify their responsibility for adult learning, and self-directed learning. Marlene further echoes this,

> *"I would feel more settled and ready to qualify if I knew more in depth about these conditions, even little recaps would be nice, and I suppose that it's sort of about me going to learn at home" (Marlene)*

Errol further adds to this,

> *"Let's face it, all we need on a day to day basis is to know how to survive each shift and make sure that we don't harm patients, as long as no one unexpectedly dies on my shift or I don't make an error which will get me into trouble, then I can go home and sleep at night. All we need are the*

anatomy, physiology, and medications management subjects. All the rest are nonsense, you know like management, leadership, research and ethics. All I want to do is to keep my patients' safe on a day to day basis." (Errol)

Participants place significant value on theoretical subjects they perceive will directly support their nursing practice and patient care. Therefore, this may be why anatomy, physiology, and pathophysiology are frequently mentioned. This is reiterated by Judy, who rationalises why she believes anatomy, physiology, and pathophysiology would support her learning,

"The thing is I'm not saying that the other subjects aren't important because they are, but everything that we do as adult nurses is about patients with illnesses and a better understanding of these illnesses would be helpful to say the least because we need to keep the patients' safe and our registration in fact, I will have just got it and don't want to lose it" (Judy)

Katherine adds to this,

"I need the subjects that will help me on the shop floor, the rest of the stuff like, Mental Health nursing, management, leadership and sociology etc. don't help me when I'm trying to save someone's life" (Katherine)

Comments such as these were extremely common in the interviews, when discussing subjects, and the majority of participants believe they simply need theoretical subjects which they can use in practice immediately. This highlights what the students perceive useful, and why, and is a significant insight into their perceptions of useful theoretical subjects. There were no other theoretical subjects that participants felt the curriculum needed in order to support them.

This demonstrates how participants place a low value on the other theoretical subjects such as, for example, law, ethics, and health promotion, in comparison to anatomy, physiology, and pathophysiology which are perceived to be more important. This may be due to its use of application in clinical practice which would assist with student nurses undertaking their role, and prepare them for the role of the registrant. Furthermore, whilst participants do suggest they require more anatomy, physiology, and pathophysiology at the latter end of the programme, they do identify that they should take account of their own learning to support any deficits. This demonstrates how students understand the need to take control of their learning, as part of being professional final year students. Whilst participants suggest they understand they should undertake their own private study, many confess to not doing this. Often the rationale for this was a lack of extra time, as the full time nature of the programme appears to inhibit the ability study.

4.5 The theory practice gap

This theme presents the findings from this research around the theory practice gap which is an enduring issue within nurse education. Participants primarily see theory and practice link together through the programme. All eighteen participants felt that the curriculum aligned to practice requirements, and that placements and theory complemented one another. Participants did not feel there was a gap between theory and practice, as Audrey explains,

> *"No there's no gaps there, I feel everything is matched well and I don't think I have gaps between theory and practice in my knowledge and I*

feel fully confident that I can work in practice by applying the theory I have to my practice to keep my patents safe" (Audrey)

Lana demonstrates how she does not understand the theory practice gap concept,

"I can't see where anyone would think that theory and practice don't link, that's just nonsense of course they do, surely people can see that the theory we learn, you know like the anatomy and physiology and medications supports our practice" (Lana)

Lana was not the only participant who demonstrated these opinions. Clark, Judy, and Marlene demonstrate this,

"I think all my placements seemed to fit well with the stuff that we learned in university" (Clark)

"I can't say that any of my placements have been too hard, what I mean by that is that whilst they have been tiring and have pushed me I haven't felt totally out of my depth in terms of knowledge, everything seems to be fitting into place at the moment" (Judy)

"I'd say that everything seems to have just connected…obviously I know that the lecturers have planned it so it does" (Marlene)

Participants also discussed positively, how they felt that the mandatory clinical simulation they undertook, was effective in linking practice and theory. A further positive aspect of the curriculum mentioned by participants was an optional advanced resuscitation course, which included the use of clinical simulation, which all final year students took part in. It was highlighted that these sessions had tested both clinical ability and enabled participants' critical thinking, in a safe environment. Bette explains further,

"The advanced resuscitation course was amazing, I was petrified before doing it, but after it I just felt such a sense of achievement, I really felt at that point that everything had come together, don't get me wrong it is horrible being examined by your Lecturers, but it was such a good experience, and most people only do this after qualifying so that was really good for us" (Bette)

Errol and Rita discuss their experience in the use of the simulated practice,

"I know I was really nervous, but I think the thing that I enjoyed most about doing the simulations and the resuscitation course was that I really felt that everything sort of was coming together, as I had to show that I could do certain skills and had to back up and reason why I wanted to do certain things" (Errol)

"Throughout the whole programme simulation has helped me so much, I feel that it has helped to consolidate my learning, for instance if I haven't experienced something that my colleagues had and I had wondered about it, then if I had it in simulation it really helped me link the theory to the practice" (Rita)

The majority of participants expressed how these opportunities were perceived to be beneficial to their feelings of preparedness to register. Participants did suggest they felt anxious throughout the simulation process, but all reaffirmed how this aided their confidence for the future when practising as registrants. It was noted how participants felt simulation was beneficial through working with the wider multidisciplinary team, such as medical and pharmacy students. Participants also stated they found it easier to link the theory and practice in the simulation. It appears that the inter-professional simulation assists with this,

whilst also allowing the student to demonstrate theory and practice linking. Marlene shows her confidence through undertaking clinical simulation,

> *"It's nice you know to know that your tutors will be there and you can perform well and put all of the things that you have learned together, especially when you can show off to other disciplines about how much you know, when the expectation is that they, like the Doctors will know more than you, it's quite liberating actually" (Marlene)*

This theme explored the findings around student perceptions of there not being a theory practice gap. Findings also suggest that students perceive clinical simulation as a tool, which allows them to demonstrate their linking of theory to practice, and how this develops their confidence.

4.6 Learning to care

This theme demonstrates what I found, in terms of what participants' perceptions of care are, and where this is learned. Many participants discussed care as the application of practical skills, rather than communication, compassion, and empathy. Fifteen participants stated that they believed that they would have been taught more whilst in university about how to care. Participants did state they learned more in practice about care rather than at university. It was specifically identified that this occurred within the first half of the first year when they were in placement. I have found that participants perceptions of learning what care was, is actually about the undertaking of clinical tasks, rather than providing holistic care to patients. The different tasks perceived as care were, medications administration, clinical observations, and documentation.

Grace, who was eighteen when commencing the programme with no clinical experience, discussed how she perceived being a carer in her first year as an unimportant task. This demonstrates how participants put a low emphasis on providing care to patients. Providing fundamental care appears to be a downplayed aspect of being a student nurse. The role of a student nurse appears to be to complete technical tasks, as demonstrated,

"I liked the first year, don't get me wrong but it was often very much being a carer for patients…I wanted to be doing more important jobs" (Grace)

Errol, who was eighteen years old with no healthcare experience, discusses the first year, and suggests this is when student nurses learn their trade, in terms of skill acquisition. Errol did not elaborate fully, but suggests that "easy jobs" are providing personal care, and maintaining hygiene needs for patients. Whereas some RNs may perceive providing personal care to patients as being a fundamental aspect of being a nurse and providing care,

"I felt like in my first year, I really was learning my trade, staff would just say 'oh can you do this or that', about things that were really easy jobs, you know like getting patients up out of bed and washing them" (Errol)

Marlene was twenty-two when she commenced the programme with healthcare experience, and felt she learned how to be a nurse during first year. This contradicts other participants' experiences of the first year. It is unclear if Marlene discusses this in terms of the art of being a nurse, which can be said to include developing care and compassion, or how to practice as a nurse through skill acquisition,

"I learned how to be a nurse during my first year" (Marlene)

Ten participants perceived the support for learning to care for patients, mostly came from the nursing assistants on placement, as opposed to the RNs themselves, or the university academic staff. One participant, Clark, who had no previous care experience, demonstrates his anxieties within the first six months of the course when going onto placement, what he believed his expectations of the course would be, and where he perceived his learning to have come from and when,

> *"I thought I would have learned the nursey kind of jobs in university, going onto placement so soon after starting with no experience was so scary...I was genuinely petrified when I knew I would have to wash a patient, I learned from the healthcare support staff" (Clark)*

Whilst participants expected to learn how to undertake clinical tasks at university, it is clear they learned these practical skills out in practice from nursing assistants, rather than RNs. The nursing assistants on placement appear to have been a big support and students learned a lot from them. It appears that students work on a closer level with the nursing assistants, than the RNs who act in the capacity of mentors. This is particularly during the early parts of their course, such as in year one. Two participants, Judy and Ava, both who did not have healthcare experience, display this. Judy inadvertently demonstrates the powerful nature of who facilitates learning for students during the early phases of their programme, and that socialisation of student nurses is an important aspect, when considering their views of how to care for patients,

> *"I tagged onto the nice healthcare assistants on placement and they showed me the ropes initially, I knew if I had a good one then I would be ok, I think in my first 12 months I saw my mentors minimally" (Judy)*

"I think the first year really is just a care year, maybe it would be better if we just worked with health care assistants for the first 6 months" (Ava)

This was not an uncommon comment, and is interesting, as the students should be working alongside their mentors and under direct supervision, in accordance with the NMC standards for pre-registration education (NMC, 2010). It appears that the students are largely unsupported by RNs during the early parts of the programme, yet nursing assistants often informally mentor them. Lana implies that mentors will only teach students when they are able to complete tasks which are beneficial to the mentors. In terms of learning to care, it may be that participants perceive this as both learning the ropes of how a clinical area functions, and the ability to undertake clinical tasks,

"Until I knew what I was doing I kind of got the feeling that my mentors didn't want to know me until I could be of use to them…then once you know what you're doing, mentors can't wait to teach you things, I sort of think that it's a case of you scratch my back and I'll scratch yours, which isn't right but that's how it is" (Lana)

In this sense, it appears that there is a trade-off, with students' providing their mentors with the ability to assist with tasks, and mentors facilitating students learning for practice, and as such is a new finding.

Moving on, in terms of participants experiences as a final year student, six participants felt they could not provide care, and undertake their role effectively. Rationale included the lack of staff within the ward areas, and the amount of documentation that has to be completed, which participants perceive as inhibiting the ability to provide care. This is a significant finding and is likely to

cause concern particularly in view of the past reports around patient care. Mae discusses,

> *"I really don't think that we can do our job properly, the problem really does start and finish with the amount of staff on the wards" (Mae)*

Participants did not suggest that patients are neglected, but they do highlight that they feel care is limited. However, participants do not discuss who actually provides the care to patients. Greta echoes this,

> *"It bothers me all of this, I wanted to be a nurse to help people, but now I see how much we don't do and it makes me sad… I was told on a ward when I first started by a charge nurse, 'you should go and do something other than this, you can't do your job properly because there isn't enough staff' at the time I thought oh he must just be disillusioned, but actually he may have been right…although I don't think he should have said that to me at the beginning of my course, it's always stuck in my mind that" (Greta)*

Whilst highlighting that staffing is an issue, Rita did suggest that she believes care is compromised, due to the amounts of written documentation required as part of the nurses' role,

> *"Part of the problem for me is not always about things like staffing or too many patient's, it's the sheer repetitive nature of the paperwork…why are we duplicating everything in this day and age?" (Rita)*

This aspect of paperwork that participants stated they undertake, clearly causes participants concern, in terms of participants feeling they cannot deliver care. Joan demonstrates this,

"Oh the paperwork, I tell you when friends say about all these headlines saying nurses can't do their job, I say it's right because we have so much paperwork to do, and I mean it just takes you away from the patients and delivering care to them" (Joan)

A key part of nursing practice, to demonstrate that care has taken place, is to ensure that documentation is completed. When discussing care, participants frequently stated they did not have the time to provide care. Interestingly, a significant finding is that participants often mean 'tasks', rather than holistic care. Therefore, it is clear that even as students who are about to move onto the professional register, there is a clear misunderstanding as to what care is. This was a frequent comment by participants. Bette highlights this when asked about how she defines care,

"Well care to me is about making sure that patients have had medications, dressings changed, new bed linen etc. I don't have time to sit there talking to patients and holding their hands or feeding them, that's what the nursing assistants are for or even visiting times with family. I bet if you ask every student in the cohort they will give the same answer" (Bette)

Surprisingly, participants did give very similar answers in terms of definitions of care, and how they feel care should be provided. Phrases such as dignity, compassion, and holism did not enter the conversation during the interview, which may surprise many, as the perception of care was simply about tasks and task acquisition.

To summarise, participants believed they would be taught how to care in university, those students who had experience found it useful, and those who

did not have experience when commencing the programme lacked confidence. It has been demonstrated that participants expect to be taught how to care at university but largely feel that they are not, particularly in the early parts of their course. It would be presumed that this occurs in practice from mentors. However, this actually occurs from nursing assistants. Students perceive this learning occurs when they become useful to their mentors, and then an exchange of tasks for knowledge takes place. It is clear to see that participants view care as simply as how to undertake clinical skills, as opposed to the other aspects of care such as developing caring skills, communication, and compassion.

4.7 Emotional transitions to registrant

This theme presents the findings from the research around participants' emotions as they move onto the professional register, and their emotional experiences from undertaking the programme. All participants discussed their progression towards registration with emotions, these ranged from being scared, excited, and anxious. All eighteen participants discussed how they felt scared about finishing the programme and becoming an RN. Other words used which had similar connotations such as, petrified, nervous, afraid, or worried. Lana and Clark demonstrated this very simply,

"I am absolutely petrified" (Lana)

"Oh it's just so scary, nothing frightens me as much as this at all" (Clark)

Judy maintains that whilst she is scared, she is also pleased about the course finishing and the prospect of qualifying,

"Of course you know I feel happy about coming to the end, but I am genuinely so scared it's untrue" (Judy)

When participants were asked why they felt these emotions, responses were mixed. This included the realisation that they would be solely accountable for their actions, with no mentor to share accountability. Another rationale for this response, was due to participants believing that they did not have enough knowledge to feel comfortable to practice. Subsequently this appears to increase stress levels which Marilyn, Vivien and Ava demonstrate,

"The fear and anxiety at the moment is making me not sleep, I'm sure though soon I will settle down, and surely everyone must be feeling the same? It's because I will be on my own" (Marilyn)

"The thing is I am now responsible for everything…it's me and me only who is accountable" (Vivien)

"It's because now I am accountable" (Ava)

Although participants demonstrated confidence, there was an insight as to participants fearing that they did not know enough. The combination of anxieties over qualifying, and the loneliness about not having a mentor when qualified are demonstrated. Marlene expresses her anxieties,

"I worry about the fact that I am going to be on my own really, what if the staff on the new ward don't like me or think that I'm thick" (Marlene)

Twelve participants discussed how they perceived the format of the nursing programme made them more adaptable, and able to work to the demands of modern nursing, and as such made them feel confident to transition to registrant. This was for several different reasons, such as clinical placements being so varied, standardisation of paperwork, and skills taught which were

applicable to a variety of placements. The variety and quantity of placements appears to be advantageous to students learning. Errol, Katherine, and Joan discuss their thoughts on the number of placements being of benefit and how this affects their confidence,

> *"I think that because we had so many placements in so many different areas this helps you to deal with different situations and become more adaptable" (Errol)*
>
> *"I'm definitely more adaptable, I have worked with some students from other local universities and they can't do half the things that we can at XXXX, I think the difference is because we constantly have short placements so have to be able to just crack on with things and get involved, they have big long placements and that stops them from being adaptable" (Katherine)*
>
> *"the paperwork helps you know because things like the NEWS charts are the same everywhere…I mean the most basic thing that we can do from a paperwork point of view is a set of observations, so to be able to walk onto a ward and do them helps you to feel good and quite confident but always gets you brownie points from the staff…now if everything was the same for paperwork in all trusts then that would be great" (Joan)*

However, Errol demonstrates how he feels that his knowledge is lacking,

> *"I just don't feel that I know enough" (Errol)*

Whilst some participants stated that they were questioning their knowledge, this contradicts earlier points in which many participants state they feel ready to qualify. Many participants suggested excitement and positivity about qualification. This is a positive finding, as the participants are clearly happy

about the choices that they have made, and the profession that they are entering into, whilst acknowledging the responsibility that comes with the role of the nurse. Audrey and Elizabeth excitedly discuss,

> *"I can't believe it, it's going to be amazing, I'm just so excited…I know it is so much responsibility but it will be worth it so much" (Audrey)*
>
> *"I'm so excited to put my staff nurse uniform on, my family will be so proud, I will be so proud, it's been so tough but the excitement at the moment is just so much" (Elizabeth)*

Participants demonstrate positive emotions in terms of their transition and confidence, yet the issue around staffing has caused significant stress to participants. This is in view of participants observing their mentors and the teams around them being short staffed and stressed, equally they also demonstrate they feel stress because they fear the care provided is not what they want to provide for their patients, and they fear for their own professional registrations. Eleven participants discussed how they perceived there were poor staffing levels within clinical areas. This is both interesting and concerning, considering current agendas have been based upon the findings of previous reports, which have highlighted staffing issues. Some participants appear to find that this is normal practice within the healthcare system. Participants discussed the effects of short staffing upon patient care, which led to staff and students feeling stress, and the anxieties they then have due to the fear of potentially making errors. This finding highlights the pressures that RNs face, and that student nurses have awareness of this. Additional concerns about staffing by participants, also add to the student's stress at what could be perceived to be

an already stressful time within their programme, and for the future. Judy whose anxiety can be felt highlighted this,

> *"The thing is you watch how some staff are so stressed from the sheer fact that there is so few staff, and they can't do their jobs properly…But equally I'm worrying that I will get my registration and then lose it because I will make an error" (Judy)*

The issue of short staffing was clear to see through the findings. This demonstrates how this affects the student experience in a negative way. Participants appear to be worried about making errors now and in the future due to poor staffing levels, and also have concerns around the level of support they may receive, as it appears they do not believe it to be in place for them. Grace and Audrey discuss this,

> *"I just hope that there will be some good staff who will help me when I start on my ward and not some who are so stressed because there's no staff" (Grace)*
>
> *"I know it's common sense but it really would solve a lot of problems if there were enough staff on the wards, care would be delivered, there would be less stress and we would be able to do things properly…I know it's easier said than done, and there is no money for staff but there must be surely" (Audrey)*

Lana discusses her concerns around making a potential error, due to not having enough staff on the ward, and displays her anxiety,

> *"I worry about if the big wigs come around, I mean how can I defend myself really if I make an error because there isn't enough staff, it's not like this is a new problem" (Lana)*

In addition to the stress that participants have highlighted, it has also been made clear that participants perceive they have become more assertive and resilient throughout their programme. Ten participants demonstrated this, Judy discusses this,

> *"I am definitely more assertive…I had to be, I think I'm a very different person now to when I started" (Judy)*

Six participants felt that their assertiveness arose from dealing with difficult situations from their programme. Elizabeth and Ava demonstrated this,

> *"I had to become more assertive through the course mainly because of the people I was working with such as the nurses and healthcare assistants, particularly actually the healthcare assistants, sometimes they try and be pushy, but I thought no I'm not here to do your job, so I just became a bit mouthy, I'd say it was more about saying no I'm here to learn and train to be a nurse…so I think it is assertiveness" (Elizabeth)*
>
> *"At first I used to be bothered when I made mistakes or people didn't like me. I have to say now though I am very much of the opinion of whatever, it is not to say that I don't care but basically if you let them then these people will eat you up and its survival of the fittest, so that's why I have this attitude and my friends do too…bad isn't it" (Ava)*

This finding signifies the attitudes and behaviours by colleagues students may be exposed to whilst out in clinical practice. The assertiveness that participants discuss, could be perceived as a defensive mechanism to cope. However, it may also be that participants simply mirror the behaviours of clinical staff. Greta displays this assertiveness,

"sometimes it's like you have to fight a bit for your patients, so yes I'm probably more assertive than when I started because otherwise who will stick up for them" (Greta)

Participants' passion for patient protection, and the nursing profession, was demonstrated through this statement. This highlights participants' professional values, in terms of wanting to protect the patients and so they develop assertiveness. Joan rationalises why she found it necessary to develop this assertiveness,

"I think I'm definitely more assertive than when I started…you have to be don't you? Otherwise that's it and people will walk all over you" (Joan)

Others suggested that assertiveness training within university would be helpful, to feel prepared in dealing with many different potential situations. Eight participants did not feel that they were assertive. It was suggested this was due to their personality, being 'shy', not being mature enough, and lacking in knowledge and experience to 'defend' themselves against older, more experienced colleagues. Audrey summarises,

"no I'm not assertive at all, I just try and people please, I don't want to come across as all bolshie…and I think there's a very fine line between the two, I mean I'm nice and polite and try to just communicate well…I suppose really it's about communication not about assertiveness, maybe this will come with time, maturity and experience, although it hasn't come yet…" (Audrey)

Vivien highlights that she did not need to develop assertiveness skills. This was felt due to her perception she was competent and confident in her practice,

“my gosh now because I can defend my actions and provide a rationale and this has only come through knowing what I am doing, and then to say out loud, I think I’m so much more confident” (Vivien)

The assertiveness and resilience that participants have demonstrated may be a by-product of the stress and staffing issues that participants discussed, and as such, participants became confident.

4.8 Conclusion

Throughout this chapter, I have presented the findings of the seven themes that were discovered during data analysis. The themes presented were: “what is the role of the nurse?” “student perceptions of the benefits of prior healthcare experience”, “skills perceived as important for practice”, “theoretical knowledge perceived as important for practice”, “the theory practice gap”, “learning to care”, and “emotional transitions to registrant”.

The discussion that follows in chapter five, will build upon these findings to provide a thorough discussion of the prominent issues, and the outcomes in relation to the research questions, in conjunction with existing literature to demonstrate the relationship, with the findings presented in this chapter.

Chapter Five

Discussion

This research explores final year student nurses' perceptions of their nursing education. I examine perceptions of the skills and theoretical knowledge that student nurses are taught, and what they perceive are, and are not, essential for clinical practice. Following examination of this, I then investigate the implications for this, on student nurses' approaches to learning and their practice. I also explore student nurses' perceptions of the notion of the theory practice gap, and what the implications are for their understanding of nursing as a professional practice. I further illuminate the extent to which student nurses report any changes, or developments, in their perceptions of the nursing role over the course of their degree. Finally, I explore the implications of these findings for the design and teaching of the nursing curriculum. It is critical that the needs of the students, and subsequently registrants, are met to ensure that the healthcare system is prepared for future challenges, and to ensure that patients are safe at their most vulnerable.

To explore the aims of this research, I conducted eighteen semi-structured interviews, from a cohort of final year students, to examine this phenomenon. The previous chapter presented and demonstrated the findings of the research. Throughout this chapter I will draw upon the findings within chapter four, and from literature discussed within the literature review in chapter two.

5.1 The skills and knowledge perceived as essential to practice

I have found that the student nurses in this study perceive that medications management is the most important skill, and the sciences, such as anatomy, physiology, and pathophysiology, are the most important theoretical subjects that are essential to practice. By having these particular knowledge and skills, student nurses perceive they are equipped to practice competently when moving onto the professional register, yet they do acknowledge that they could have more of this content within their programme. This perspective from student nurses contests previous literature (Pennbrant et al, 2013; Pike and O'Donnell, 2010; Wolff, Pesut and Regan, 2010; Kelly and Courts, 2007; McKenna et al, 2006; Greenwood, 2000) which explored both student nurses' perceptions of practice preparedness and that of registrants. It is interesting and important to understand why the findings of this research contests previous literature, and the NMC's view, in terms of student nurses' perceptions of what is needed to practice. The NMC drives and controls the standards for nurse education in the UK, and it is essential to ascertain if the perceptions of final year student nurses mirror the view of the NMC, or if there is a contrast in opinion, and if so, what the rationale for this is. It is equally important to examine if the views of student nurses concurs or contrasts against previous literature. This research illuminates this area and allows for insight and potential changes in pre-registration nurse education, which fits with the constructivist approach of this research.

The findings of this research demonstrate how important to student nurses the skill of medicines administration is, this is also the case with RNs as Wright (2012) and Dilles et al (2011) suggest. I have found that the following are

reasons as to why student nurses place emphasis on the administration of medications as opposed to other skills. The reasons are: the perception that medications management is the most important part of nursing practice, and an awareness that there may be consequences to both the patients' health and the individual nurses' registration should an error be made. According to Armitage and Knapman (2003), a nurse spends forty percent of the clinical shift administering medication; this may be the reason as to why student nurses perceive this skill to be the most important, as they observe RNs spending a large part of their time undertaking this particular skill.

King (2004) reiterates not only the importance of a nurse's full knowledge of medications, in terms of pharmacology and potential effects, but also the accountability that nurses hold for their actions and omissions. It appears from the findings of this research, that participants were very aware of the accountability issues in terms of medications administration, and so it was perceived to be more important than other skills. Yet participants are more concerned with understanding how to undertake the skills correctly. This implies that students are task driven, and that the underpinning theory may be lacking. The NMC (2010) highlight medication administration as being an essential skill that student nurses should demonstrate competence in prior to qualification. It was clear from the findings that participants were well aware of the need to demonstrate competence in this skill, often implying this was the only skill that mattered.

The only theoretical subjects that participants perceived to be essential to practice were the science based subjects, such as anatomy, physiology, and pathophysiology. McVicar, Clancy and Mayes (2010) note how it has been

recognised internationally that the sciences are problematic for student nurses to learn. It has further been suggested that registrants in Sweden (Danielson and Berntsson, 2007) and Ireland (Mooney, 2007) have perceived their knowledge of the sciences, including pharmacology, were lacking. I have found that students within this research did not consider difficulty an issue in relation to their understanding of the sciences. It has previously been suggested that student nurses do not enjoy learning the sciences (Dunn, Osborne and Rakes, 2013; Salamonson and Lantz, 2005; Elberson et al, 2001). However, the findings of my research contradict this, as participants stated they craved more science within the curriculum, due to the perception that this was of more use in direct clinical practice, and would also support their move to registrant. Equally, it was perceived that through understanding the sciences this allows patients to be unharmed through having the knowledge to provide care, as opposed to other subjects, which will be discussed later.

Participants suggested they would make more of an effort to learn these subjects in a more meaningful way, because of their perceived relevance to practice and delivering direct patient care. The perception by patients, doctors, and the public is that nurses should have an advanced level of understanding of the sciences (Davis, 2010; Friedel and Treagust, 2005; Jordan et al, 2000; Wilson, 1975). In terms of learning the sciences, the participants appear to understand and mirror the literature in relation to sciences being needed within clinical practice. However, potentially more important is that it appears there is a lapse in understanding of the importance of the other components of nursing education. Willis (2015) highlighted how skills and knowledge once considered

advanced or post-registration, should now be taught within the pre-registration curriculum, due to them now being essential for nurses in practice.

Findings from this research have identified that student nurses perceive all clinical skills taught to be essential to practice, although medicines management was overwhelmingly the most important, and none are perceived to be non-essential for practice. In contrast, there were some theoretical subjects which students did not find of direct use within clinical practice. These subjects were, law, ethics, sociology, health promotion, research, leadership and management. I have found that for these subjects the participants' motivation to learn was to simply pass the assessment. As stated within the literature review, there is a clear outline of what the NMC (2010) expects newly qualified nurses to be able to have as a skill set, and this includes subjects such as leadership, management, health promotion, and sociology. The students in this study demonstrated that they approach their learning of these subjects in a superficial manner, and this is potentially concerning due to a lack of understanding of their importance. Coincidentally, it was also highlighted by Willis (2015) that very few new registrants understand the use of research and apply it to practice, highlighting that there should be a heavy focus within the new standards, as it makes a significant difference to patient care. It is important for student nurses to understand that whilst delivering direct care to patients in clinical practice is essential, there is a requirement to have an awareness and appreciation of other aspects of knowledge which support clinical practice in a non-direct way. These subjects do not appear to be important for final year student nurses when delivering patient care, or when discussing providing

nursing care. This means that there are potentially gaps in care provided, and that the holistic role of the nurse is not accounted for.

5.2 Student nurses' motivations and approaches to learning

Throughout examination of the findings, it was extremely clear as to why participants perceived that skills such as medications administration, and knowledge such as the science-based subjects were essential to practice. There appears to be three motivating factors for how student nurses approach learning. These are: practice relevance, patient safety, and professional protection. My rationale for this is that it was clear that student nurses wanted knowledge and skills which they perceived would have practice relevance, in order to allow them to be equipped to undertake their role on a daily basis without any issues. Patient safety was an important factor for student nurses, as they did not want to cause harm to patients. Professional protection was equally important as a motivation to learn, to ensure participants had a deep level of understanding of the skills and knowledge which they perceived would not allow them to cause patients harm, and so there would be no ramifications in terms of their professional registration. Furthermore, motivations for paying special attention to these particular skills and knowledge would ensure that patients were unharmed, and so professional registration would be kept intact.

Nurses are the last point in the process to be able to avert a medication error (Rainboth and DeMasi, 2006). The student nurses in this study demonstrated an awareness of the importance of correctly administering medications, and how this can cause anxiety to them for fear of making an error. The annual cost to in-patients each year who have been harmed by medication errors is around

£774 million (The National Patient Safety Agency, 2007). This reiterates the importance of ensuring that student nurses are adequately prepared for their future role of registrant, in terms of patient safety, cost, and the legal aspects of medicines administration. It was unclear during the semi-structured interviews if it were particularly patient safety, potential harm to registration, or cost to the NHS which motivated student nurses to ensure they correctly administer medications, but appears to be a combination of the three factors. It appears that the motivation for students' learning is not the academic success, but as discussed previously it is practice relevance, patient safety, and professional protection.

Taking a deep or surface approach to learning is dictated by the motivation of how important student nurses perceive the learning to be. Motivation to learn, in a deep or a surface way, is judged upon how useful the subject would be in clinical practice by the student. The motivation to learn by student nurses within this research is to practice safely on a day-to-day basis. Student nurses are motivated by the need to feel safe in their practice, without any repercussions or reprimands which may affect their registration. This is in terms of them making errors, which could harm patients, causing professional implications, and as such, they will take a deep approach to learning skills and the sciences. I have found that the motivation to take a surface learning approach appears to be driven by the need to pass assessments, rather than perceptions of usefulness to practice. This mirrors the existing literature (Entwistle, 1991) on deep and surface learning as discussed within the literature review chapter. Whilst Entwistle (1991) discussed the idea of strategy for student approaches to learning, my research highlights that the surface approach is taken for

assessments in subjects deemed non-essential for student nurses practice, and in nursing the implications of this approach could be significant. Gibbs (1994) discusses how a surface learning approach is common in HE. It is widely known that students are assessment driven and the demands of a pre-registration nursing degree are high, furthermore suggesting surface learning takes place. It is concerning that the student nurses in this study feel that there are components of their nurse education which are essentially tick box exercises, and that once these subjects have been assessed they can almost forget about them and move on. This is not what the public or the NMC would expect from a newly qualified registrant in terms of having gaps in their knowledge. This means that there may be practising registrants who do not have the full understanding of what is needed to practice, and who appear to misunderstand the role of the nurse as purely a task driven role, rather than the all-encompassing holistic nature of the knowledgeable nurse. There is undoubtedly a lack of appreciation for many theoretical components of the pre-registration curriculum by student nurses, due to the lack of acknowledgement of relevance to clinical practice.

I have found that the student nurses in this study take a surface approach to learning the theoretical subjects, which they perceive to be non-essential in clinical practice. Surface learning takes place as an active process by student nurses to subjects they perceive are not going to benefit the care they directly provide to patients. It appears that the student nurses in this study do not have the breadth of understanding that all components of the curriculum are equally important, even though they may not understand the use of some knowledge components when they practice. The surface approach to learning was

attributed to meeting module learning outcomes, in order to pass academic work.

Whilst participants described how they had a deeper level of understanding of medications, it appears that much of this was in terms of undertaking the task itself safely. An important aspect discussed by Dilles et al (2011) in terms of the administration of medications, is the involvement of nurses through the extra activities involved with medication administration. There were advanced aspects of the medications administration process that were not discussed such as effect monitoring, medications information, the use of health promotion, and therapy adherence, all of which appeared to be insignificant for student nurses. This highlights that whilst student nurses perceive they undertake the task competently, they are not thorough in their approach. Furthermore, this suggests that a task orientated, superficial way of performing exists.

As there was a clear identification of subjects which were deemed essential to practice, this affected the attitudes, motivations, and approach to learning that student nurses made. The findings of this research suggest that student nurses take a deep approach to learning theoretical knowledge that they perceive to be of value to themselves in clinical practice. This meant that students did pay more attention to these subjects when learning and endeavoured to have a greater knowledge and understanding of these. Yet whilst participants demonstrate they are taking a deeper approach to these subjects, there are still significant gaps in their knowledge and understanding, and as such, this may have significant implications in terms of the practice that they undertake as registrants. Whilst participants felt that their abilities to practice were effective,

and there was no reason to question this, equally there does appear to be a level of confidence by participants rather than competence.

Snellgrove (2004) and Cowman (1998) identify that student nurses approach to learning is generally “to just get through”. I have found that medications administration and the sciences are approached in a deeper fashion, compared to the subjects highlighted earlier which are perceived to be less essential. However, for the less essential subjects students do take the approach of Snellgrove (2004) and Cowman (1998), and in this respect the findings concur with this previous literature. However, Snellgrove’s (2004) study, which examines approaches to learning, suggests that student nurses demonstrate a deep approach to learning in subjects that would have a direct correlation to academic success. Whereas, within this research I have identified that students approach learning in a more positive, deeper fashion in subjects which would aid them in clinical practice, such as medications and the sciences. Becoming a safe practitioner far outweighs the degree classification for the students in this study, in terms of their approach and motivation to learning, and as such, the findings of this research shed new light upon the motivations and approaches to student nurses’ learning.

5.3 Implications for practice

Due to the perception that some subjects are important and some not important, which subsequently alters student nurses’ approaches to learning, there are implications for participants practice as registrants. The implications for practice are that student nurses may have significant gaps in their knowledge and understanding. Following this there are potential implications in terms of the

care that patients receive. There are therefore potential concerns around patient care and safe practice. This aligns to work undertaken exploring issues around newly qualified nurses and the potential implications of insufficient preparation for practice and poor delegation skills (Johnson et al, 2015; Cipriano, 2010; Mohr and Batalden, 2002). Whilst their mentors had signed off all the students as competent to practice, it could be questioned as to participants' level of deep understanding and underpinning knowledge. This then raises more questions relating to if, as registrants, the participants would ever build upon their knowledge to fill the gaps that they have, or if they continue as they are. Potential implications from this may be that as this process continues with registrants becoming mentors and then teaching new students, nursing knowledge and skills may be further depleted. This could have serious effects upon patient care and the nursing profession for the future.

5.4 The theory practice gap

The findings of this research suggest that participants perceive there not to be a theory practice gap. There is a significant body of literature which demonstrates how experienced registrants perceive there to be a theory practice gap (Elliot and Wall, 2008; Landers, 2000; Crane, 1991). It has been suggested that a theory practice gap exists within nurse education in both the UK and internationally (Elliot and Wall, 2008; Chapman and Clegg, 2007; Hewison and Wildman, 1996; Crotty, 1993). The preparation of nurses is one of the most significant aspects of the healthcare system. Ascertaining if the theory practice gap exists is of extreme importance as theory and practice inform one another, and student nurses spend equal time in both. The link

between theory and practice in nursing education is essential to adequately prepare student nurses for registrant status. Hence it is essential to answer this question, to inform potential curriculum enhancement and the generation of new knowledge in line with the constructivist perspective. Corlett (2000) suggests that theory and practice are essentially the differences between what students are taught in the classroom, and what they experience whilst out in clinical placement. Existing literature has largely come from the perspective of experienced registrants, whether it be academics or those working in clinical practice.

Whilst there has been lengthy debate in the literature (Elliot and Wall, 2008; Landers, 2000; Crane, 1991) about theory and practice not linking, the findings of this research demonstrate that final year students perceive the curriculum to complement practice, and they perceive there to be no theory practice gap. Equally, as previously discussed, the participants also simply devalue other subjects within their nurse education, and as such, there are potential significant implications for this for their professional practice and patient care. This challenges Kaihlanen, Lakanmaa and Salminen (2013) who suggest that student nurses often identify gaps within their knowledge, and find it difficult to apply theory and practice together.

This further supports the conclusions drawn from the previous research question, as participants approach learning in a manner in which, as long as they do not make errors or cause patients harm, they perceive their knowledge is adequate. Ross and Clifford (2002) discussed how student nurses who are about to qualify often feel the need to increase their clinical skills and knowledge as there is a theory practice gap. The responses of the participants suggest

they have an over confidence in ability and a lack of insight, awareness, and deep knowledge of the nursing role, that causes their perception of there being no theory practice gap.

Whilst participants do not perceive there to be a theory practice gap, they have also suggested that they were taught less than expected about how to care. However, their meaning of care is actually about skills acquisition, rather than the delivery of holistic care which may account for things such as caring for spiritual needs, dealing with emotional issues, and communication. Previous literature (O'Driscoll, Allan and Smith, 2010; Papastavrou et al, 2010; Midgley, 2006) which examines the theory practice gap has considered the perspectives of experienced academics and practitioners examining new registrants' performance. It is worth noting that academics and registrants who work within clinical practice may have differing expectations as to how much knowledge newly qualified registrants would have, and whilst both have differing perceptions there is a significant amount of literature which demonstrates that the theory practice gap exists. Whilst student nurses do not perceive there to be a theory practice gap, experienced registrants do perceive one, causing a contrast in perceptions, and demonstrating the limited insight into the holistic view of nursing that student nurses have. This further highlights the lack of appreciation that student nurses have for the wider curriculum and its relevance to practice.

5.5 The use of clinical simulation to support theory and practice

Findings from this research indicate that student nurses perceive clinical simulation to assist them in linking theory and practice. The findings

demonstrated student nurses enjoyed their learning through clinical simulation, due to it being undertaken in a safe environment, allowing them to ask questions and be involved in situations that they may not have seen, or have had limited experience with. By undertaking the simulated experiences, this afforded student nurses an opportunity to reflect upon their previous experiences and ask questions, which they may not have had the opportunity to do before. According to the NMC (2010) guidance, student nurses can undertake 100 hours of simulated practice per year, and this has been a relatively new addition to many curricula. The use of simulation within nursing education is growing (Sundler, Petterson and Berglund, 2015) and this coincides with the evolving complexity of healthcare, and many technological advances.

Recent research (Berragan, 2014, 2011; Arthur, Levett-Jones and Kable, 2013; Moule, 2011) into clinical simulation for nursing undergraduates, found that the simulated sessions provided the opportunity for students to develop clinical skills, solve problems, and reflect upon their practice. The findings of this research links with previous literature (Haraldseid, Friberg and Aase, 2015; Stokes and Kost, 2009) in terms of participants stating they felt more able to problem solve, reflect, and work in difficult situations, alongside the link between theory and practice being evident for them once they had completed their simulation. The use of simulation has been said to improve the ability to critically think, and participate in clinical decision-making (Haraldseid, Friberg and Aase, 2015; Stokes and Kost, 2009) and the findings of this research highlighted how participants stated they enjoyed being tested to think in real life scenarios, and as such they perceived that this aided their theory and practice linking. In terms

of clinical simulations developing the critical thinking nurse, this aligns with the NMC's (2010) requirements, which is extremely positive.

Participants approached simulation as a tool to learn positively, as an addition to their normal university teaching and clinical placements. Participants discussed how this was because they were aware the patients, and they, were safe in the environment, and that they could reflect upon their performance with an expert, who could then guide them as to how to improve in the future. Haraldseid, Friberg and Aase (2015) discuss how simulation should work as part of the link between theory and practice, and should complement both. Students demonstrated it was due to the realness of the simulation that allowed them to learn. The students' approach to learning was to ensure that they did learn in a deep way, as they could enact the theory and practice that had been learned at university into the clinical setting, whilst still being guided and supervised by a professional.

The findings of this research support the use of simulation to support theory and practice linking, as participants state it assists with supporting their clinical practice, through not only the method of teaching that it uses, but also because of the way that they can see how the theory they learn directly supports their practice. This is an interesting and pertinent finding due to the participants understanding that they have enough of the right knowledge to practice, and because of their naivety that there is not a theory practice gap. The notion of the theory practice gap has been debated within the literature, and is largely perceived to exist by experienced nurses who are already on the professional register.

5.6 Role of the nurse

The findings of this research demonstrate how, when commencing the nursing programme, many participants had a limited understanding of what the role of the nurse was. Despite this, participants applied for the programme and were successful in attaining their place. This was apparent even with participants who had healthcare experience.

Even at the point of registration, some participants still demonstrate how they have a restricted view of the role of the nurse. This is apparent by the nature of participants' responses within the findings, who discuss nursing and care simply as undertaking tasks, and holistic nursing is discussed minimally. Simply undertaking tasks appears to be what many participants believe the role of the nurse to be. It is concerning that this is the perception of what the role of the nurse is, and whilst there may be an element of realism in terms of the need to undertake tasks, to conduct investigations, and provide treatments for patients, this is not simply the role of the nurse. As the literature review discusses (ICN, 2016; Willis, 2015; DH, 2015; NMC, 2010; Smith, 1992) nursing is so much more than simply completing tasks, and is fundamentally about providing holistic care to patients and their families. Caring for patients holistically is not central to the modern nurses' role from the perspective of the participants.

Looking to the future, participants do discuss how they feel the role of the nurse will change, and nurses will have a different role, which leaves participants unsettled. Perceptions by participants regarding the future role of the nurse refers to undertaking skills, rather than providing the holistic care.

Whilst nursing as a role has changed to mean that nurses undertake more skills and tasks which were once considered advanced skills, it is highly concerning

that the holistic nature of nursing as part of the role has been lost. This necessity to simply undertake tasks may have derived from: staffing shortages, the complexities of patients' illnesses, coinciding with the need to deliver rapid care to patients, and driven by the demands of the current healthcare system (NHS England, 2013). Previous conceptions of the nurses' role may have come from ideas formulated from past idylls. It is not to say that nursing as a profession should not be advancing, as the healthcare system requires, but that the central premise of being a nurse, based upon the perceptions of this group, is that nurses are members of the healthcare system who simply undertake clinical tasks, rather than providing care.

5.7 Becoming a professional and being socialised

Part of a student's understanding of what nurses do comes from mentors and the socialisation from learning in clinical practice. The student nurses in this study perceive that as long as they can undertake their role on a day-to-day basis, without harming a patient, then they are doing a 'good job' and acting in the role of the nurse. Based upon the previous research questions' findings, whilst this group of student nurses perceive they are prepared for practice, they actually have a limited understanding of what the role of the nurse is. Half of the time students spend on their programme is within clinical practice, and it is here that professional learning occurs, which is where they formulate their understanding of what the role of the nurse is. This is based upon working with their mentors and observing other RNs' practice. The RNs who act as mentors to student nurses, and who assess student performance, are pivotal in allowing students to understand the nursing role.

Part of the preparation that student nurses undertake to practice is the professional socialisation within clinical areas, that occurs during the practice time. This implicit aspect of the curriculum exposes students to the skills and knowledge which cannot be taught, such as behaviours and role modelling. Cohen (1981) discussed how professional socialisation is important; as this is the part of the curriculum where the student will both gain the professional knowledge and skills and will form their professional identity. Cohen (1981) does not identify for student nurses transitioning to registrant, it is the day to day workings of how clinical areas function that are perceived by students as important to allow them to succeed in their role. I have found that this is very important to student nurses, in terms of their pre-registration education. Rationale for this is that participants perceived that if they could simply get through a shift without a patient being harmed or making an error, then they perceived that they were doing a ‘good job’ and succeeding. Much of their assumption that they were doing a ‘good job’ was based upon them understanding how clinical areas work, and being able to complete necessary required tasks. Again, whilst student nurses become exposed to what they perceive to be the role of the nurse, it seems that they observe tasks being completed and how staff interact, and this forms the basis of their understanding of what a nurse does, and is. This is significant in terms of students understanding what the role of the nurse actually is, which is not about simply undertaking tasks, but actually about providing holistic care to patients. Their perception of nursing simply being a task orientated role is concerning because nursing requires more skill, knowledge, and finesse than simply undertaking tasks. It appears that these attitudes are being perpetuated by the socialisation

that students undergo, but it was unclear from the interviews where these behaviours arose from, i.e. the RNs, the nursing assistants, or the wider multidisciplinary team. The participants did note that they spent a significant amount of their early programme time with nursing assistants, and that many mentors made them feel that unless they had the competence to complete clinical tasks, they were of no use to them. As such, there was a perception from students that their mentors would not teach them.

Eraut (1994) explains how there are several methods of preparatory training by professions, such as nursing, which lead to academic qualification following study at university and learning from experts in practice. The mix of studying theory at university and learning in practice is intended to allow students to register with a good level of competence. The NMC (2010) believe that this model ensures student nurses would then leave university following education as a professional nurse with an adequate standard of clinical competence. However, what may not have been noted previously is the significance of the socialisation that student nurses undergo when in the practice arena. This is in order to allow students to build their knowledge and skills, and develop the tacit knowledge learned through practice time. Working within clinical practice consists of not only gaining professional knowledge, but also understanding the cultural practices of each clinical area.

I have found that student nurses spend a lot of time learning from nursing assistants whilst in clinical practice, learning essential skills and understanding how clinical areas work. Student nurses gain much experience from these members of the wider team, in terms of clinical cultural practices and the delivery of fundamental care. The acquisition of knowledge and delivery of

fundamental care, which has come from unqualified nursing assistants, was an unexpected and significant finding in terms of the education of student nurses. Willis (2015) acknowledges that unqualified nursing assistants with little access to formal training, provide sixty percent of hands on care to patients, yet it is largely un-acknowledged that student nurses learn so much from these untrained staff. Student nurses should be gaining the underpinning knowledge and skills to practice effectively from RNs. Working the majority of their time with nursing assistants, who do not have the underpinning knowledge that an RN has, may be why student nurses perceive nursing to be a task orientated role. Therefore, supporting the reason why the approach to learning is in such a way. Eraut (1994) discussed how the period in practice contributes to a person's knowledge base and socialisation to the occupation. The significance of this may not have been fully recognised in nursing, in terms of who within the healthcare team it is that student nurses learn from.

5.8 Confidence and assertiveness

The findings of this research demonstrate that participants are confident in their own abilities to practice as registrants, and perceive they are prepared for practice. Although participants exude confidence and perceive they are ready for professional practice, they do not acknowledge that they have large gaps of nursing knowledge due to their approaches to learning which is to survive each shift safely, without causing harm. The confidence participants suggest, demonstrates a serious lack of understanding of the holistic role of the nurse, and this could cause concern due to a combination of over confidence and superficial knowledge.

From examining the findings, it appears that, the confidence that the students have is due to the amount of clinical experiences that they are given within the programme. Previous literature (DeBourgh and Prion, 2011; Rudman and Gustavsson, 2011; Nash, Lemcke and Sacre, 2009; Kovner et al, 2007; Goodwin-Esola, Deely and Powell, 2009 Cantrell and Browne, 2005) suggests that student nurses lack confidence, particularly when they are in the final stages of the pre-registration programme before they become registrants. Yet this group of students largely demonstrate a high level of confidence. This is not to suggest though that the participants in this research whilst confident in their ability were mavericks, as they all demonstrated awareness of their limitations in clinical practice and stated they would ask for help if needed. However, due to the way that they explain their approach to learning, there are gaps in their knowledge. The NMC's (2010) standards for pre-registration nursing state there should be a comprehensive knowledge of all aspects of the curriculum when student nurses qualify, although participants perceived that much of the curriculum was irrelevant for clinical practice.

On a positive note, the confidence that student nurses demonstrated within the findings implies that students can integrate into the placements quickly and adapt to new environments. Jeffries (2007) suggested that a key feature of a nurse is that they have confidence in undertaking basic skills, and I have found that they do. The findings of this research also demonstrate that alongside confidence, participants developed assertiveness and became resilient through their programme.

The participants suggested that the assertiveness and resilience was due to their desire to ask for help and learn within the clinical environment, to ensure

that they were knowledgeable to move into registrant status. This may also link with the professional socialisation that student nurses undergo whilst on clinical placement, in which they learn from RNs. The resilience that was demonstrated within the findings was shown through the student experiences when working with colleagues. As previously discussed, this was due to working with other members of the healthcare team, and how students sometimes felt that they had to defend their patients, in order to ensure that the best care was delivered. I demonstrated through the findings that often students felt more resilient as they progressed through the programme, and developed confidence.

A further factor for this level of confidence that I have found, is that student nurses perceive they are more confident and prepared for practice, through the undertaking of clinical simulation within their programme. This builds upon previous research (Sundler, Petterson and Berglund, 2015; Ricketts, 2011). A recent study by Sundler, Petterson and Berglund (2015) suggested that the benefits of simulation were that students learned to work as part of a team, and developed their skills and competence. Simulation may be key to ensuring that the students feel not only confident to prepare for registration, but also ease transition to registration. Participants perceive they are confident and ready to register, as simulation has assisted them in linking theory and practice.

McCallum (2007) suggested that simulation brings a level of real world experience to those who use it, and it is this real world experience that I have found that provides students with more confidence to practice, and allows feelings of preparedness. This is regardless of whether they do have the underpinning knowledge and skills to practice competently.

I have found that student nurses do report changes and developments in their perceptions of the nurses' role over the course of their degree. However, I have found that there was a lack of initial insight as to the role of the nurse when commencing the programme, regardless of whether participants had healthcare experience or not. In view of this, there are therefore potential implications in terms of the participants becoming registrants who have high confidence levels, but limited knowledge and understanding to support this. This is because the students have had experiences of being socialised into the role of the nurse through clinical practice, in turn, this has allowed developing confidence and assertiveness in their practice. However, whilst students do perceive that their understanding of the role of the nurse has changed through their progression and that they are ready to qualify, participants' perceptions of the role of the nurse may be misaligned to that of the public. Participants perceive nurses to be task orientated rather than holistically focused.

5.9 Curriculum implications

There are several implications of these findings for the design and teaching of the nursing curriculum, which will now be discussed. The perceptions of student nurses which subsequently affects how they approach their learning have implications, and this is based upon what student nurses believe to be essential and non-essential for their practice. Due to student nurses making these assumptions this then affects how they approach their learning, in terms of surface and deep approaches. Implications of this are that there are gaps within their knowledge, and as such, these gaps would mean that patients do not receive the holistic approach to care that they require. Equally, there is a

dissonance between the expectation of a new registrant's knowledge and skill, and the reality. This is because of the approaches and motivations to learning affecting which theoretical knowledge is perceived to be essential for practice, which is then learned in a deeper way. Likewise, the subjects perceived as not important are approached in a surface way, which would then cause potential deficits upon patient care. Therefore, attention needs to be paid to demonstrate the relevance, and significance, of these subjects to clinical practice within the nursing curriculum. Implications of attention not being paid to this, are that future generations of nurses may have a minimal appreciation of the knowledge required for delivering safe effective nursing care in practice.

I have found that there is a clear perception by student nurses that the undertaking of tasks is the most important aspect of the nurses' role. Therefore, for future curricula, there is a necessity to reinforce the importance of the holistic nature of nursing, and that task orientated approaches to care are inappropriate. It appears that there is little motivation to care from student nurses, as they perceive that caring is not what the role of the nurse is. These attitudes and behaviours are indicated to have been developed through the professional socialisation that occurs through learning in practice, and by spending large amounts of time with non-registered nurses.

The perpetuation of focusing solely on tasks may be due to the increasing demands of the healthcare system. However, it seems that the role of what a nurse is, is being diminished to ensure tasks are completed, and hence a potential future problem lies, both in terms of the role of the nurse and also the level of care that patients receive. Therefore, the implications of this are that there is a dissonance between what the public and NMC require from nurses,

in terms of attitudes to care, due to both the approaches to learning that student nurses take, and the socialisation that they undergo from learning in practice.

Whilst the NMC (2010) guidance is not prescriptive in terms of the specifics of what student nurses should be taught, the standards are comprehensive, and do demonstrate that all nurses at the point of registration should have the same general capabilities and level of understanding. Equally, the NMC is specific in the amount of time that students spend working with a mentor RN learning in practice, which is a minimum of forty percent (NMC, 2010). Therefore, whilst student nurses are achieving a minimum of forty percent, potentially the other sixty percent may be spent with non-registered staff. Subsequently, in terms of the future curriculum, it may be advantageous to increase the minimum time spent with RNs as mentors to a higher amount. My rationale for this is that the small amount of limited time that is suggested may cause the student nurses to perceive the role of the nurse to be different to what it actually is, due to the limited professional socialisation that is occurring with the RNs. This would allow all RNs to enter the register with very similar foundations for future practice. However, I have found that this group of student nurses actually decide what they want to learn, and in how much depth, based upon what they perceive as important and not important to practice. Therefore, there could be a situation where some components of the curriculum are largely ignored due to the approach and motivation to undertaking superficial study, and as such, patients would not receive full holistic care by knowledgeable competent nurses.

There are significant implications of student nurses' perceptions of their nursing education for their future practice as registrants. As discussed previously, the approaches to learning, and the learning that occurs would undoubtedly affect

how participants practice as registrants. Firstly, if student nurses have gaps within their knowledge then this would directly affect patients and the healthcare system in the first instance. Following on from this, due to what is understood about how learning occurs within practice, the model of mentorship that is currently utilised within nurse education would need to be re-evaluated for effectiveness. As such, and because this model of learning in practice is used, nursing knowledge and practice may become insufficient to meet the needs of patients. Incidentally, whilst it is known that the demands from the healthcare system, with more unwell patients and a greater need to deliver effective care, students nurses appear to be taking away from their future skills and knowledge due to the way that they approach their learning. This may also fundamentally change the role of the nurse forever.

Another important consideration is to ensure that nurses who become mentors themselves have the correct knowledge and skills to support future generations of students' learning, and as such there is a potential urgency in ensuring that students have the correct knowledge and skills to support their practice. Undoubtedly, this means that patients would not receive a full holistic approach to their care. Further implications are that student nurses perceive that the role is medical and less about holistic care. This may then mean that the role is more task orientated, and less about the professional values and foundations of what nursing is, and so this will affect future practices, which is concerning. In order to combat this misunderstanding in the future it may be beneficial if holistic nursing practice was re-emphasised within the curriculum. It is clear that the professional socialisation that students are undergoing, coinciding with the work-based learning that they are undergoing are creating a tension.

McLaughlin (2011) suggests that encouraging an experiential or work-based learning approach for student nurses should be of benefit, yet it appears that the approaches to learning that students are taking are dictated by those who should be supporting them in practice. Holland (2011) supports the use of practice teaching yet does highlight it can be affected, positively or negatively, by the culture within the area. This links to the community of practice idea (Lave and Wenger, 1991) and whilst this is positive, there is a potential for issues relating to who students are working with which will also drive their approach to learning.

As participants perceive there not to be a theory practice gap, and subsequently they perceive their practice is effective, they have a blissful ignorance of their capabilities. I make this claim based upon their understanding of the knowledge and skills that they perceive as essential to practice, and how they approach their learning. Implications of this for the nursing curriculum may be that there is a deficit in knowledge and skills and as such, patient care may be compromised. Based upon the findings that much of the components of the curriculum are perceived as irrelevant, this demonstrates that the theory practice gap is actually as wide as it ever was. The perceived non-essential subjects therefore, for future curricula, need to be further highlighted in terms of their relevance to clinical practice. Stakeholder involvement in the preparation of the curriculum may also be useful to ascertain if clinical areas perceive that students are performing to their expectations. Gidman (2011) and Lawson (2004) advocate using stakeholders to ensure that a curriculum is both dynamic and fit for purpose. Furthermore, for curriculum development, the combination

of engaging the students and stakeholders in this instance for nurse education would be beneficial.

In terms of the findings pertaining to the nurses' role, whilst there is a change in students' understanding of the role of the nurse over the duration of their programme, there is still a clear misinterpretation of what the role of the nurse is by student nurses. Subsequently, student nurses appear to believe that the role of the nurse is about undertaking tasks and have a minimal view as to what care is. Seemingly, students working in practice, with mentors who portray a task orientated approach to their practice, are perpetuating this view of the role of the nurse. Implications of this for the design and teaching of the nursing curriculum may be that at the start, prospective students apply for a place when they do not fully understand the role of the nurse. This could cause potential issues in relation to future students applying and taking a place on a programme that they now have to self-fund for. Considering students who are on the programme who have an altered perception of the role of the nurse, the implications of this to the nursing curriculum are that the nursing curriculum may need to be realigned to the developing role of the nurse. Furthermore, the holistic role of the nurse is being lost and as such, there is a discrepancy.

The implications of these findings matter to nurse education because, at the end of any student nurse pre-registration programme, HEIs should feel confident that they have produced registrants who are fit for purpose. This involves being able to deliver care which is holistic, yet safe. This is the basic expectation of the public and the NMC (2010). However, due to the approaches and implications to learning that students make, in terms of their surface and

deep approaches to subjects that they perceive to be important, patients may well be at risk.

Incidentally, the findings of my research are congruent with those highlighted by the Willis report (2012, 2015), yet my findings are based upon the perceptions of final year student nurses. Similarly, since my data has been collected and analysed the Council of Health Deans (2016) have recently published proposals for the education of the future nursing workforce, and likewise there are distinct similarities to both what I have found, and points that I have made. I feel that this adds significant weight to the validity of my research. Points raised by the Council of Health Deans (2016) include: ensuring nurses promote health and wellbeing, caring flexibly for the whole person regardless of the setting, having higher-level skills, and having a broad underpinning knowledge drawn from evidence-based practice, leadership, research, and developing resilience. This highlights that whilst the sample utilised was from one cohort of students, at one HEI, there are comparisons that can be drawn to other HEIs and other students, as the findings of my research have been realised on a wider scale within nurse education as needing attention.

5.10 Overview of the findings

Following a review of the findings and examining the literature, I have ascertained which skills and knowledge student nurses perceive to be most important for practice. These were medicines management and the sciences, which includes anatomy, physiology, and pathophysiology. I have also found

that those perceived by student nurses to be of less use to them were, health promotion, sociology, law and ethics, research, leadership, and management.

The findings of this research suggest that this group of student nurses do not perceive there to be a theory practice gap, yet they do express that they were taught less about how to care than expected. This does not mean that the theory practice gap does not exist, yet it does mean that the student nurses in this study do not perceive one. Importantly, these findings signify a naivety by student nurses in terms of their perceptions of how theory and practice link, and provides a useful insight from the student perspective as to what their understanding is, whilst contributing to the literature around the subject.

Student nurses' perceptions of the role of the nurse does change over the course of their programme. However, students' understanding as to what the role of the nurse actually is, appears to be in some cases different to what registrants may believe it to be. Findings of this research suggest that students place little emphasis on the caring role of the nurse, and place a great significance on the tasks that a nurse undertakes. As such, based upon these findings, there are clearly areas of development for the future nursing curriculum in order to ensure that student nurses are prepared for the current and future realities of professional practice, and to ensure that patients are kept safe.

5.11 Conclusion

In conclusion, this chapter has examined the findings demonstrated in chapter four, utilising the literature review in chapter two, and other pertinent literature. I have highlighted the significance of the findings and debated the potential implications of my findings. The following chapter will conclude the thesis,

suggest recommendations for future curriculum practices, and will discuss limitations of the research.

Chapter Six

Conclusions and limitations

This chapter articulates the conclusions drawn, provides a detailed account of the contribution to knowledge that I have made from this research, offers recommendations for the nursing curriculum in line with the constructivist nature of the research approach, and highlights any limitations.

This research answered the following research questions:

- What skills and theoretical knowledge do final year student nurses value, and what are the implications for: (a) their approaches to learning and, (b) their practice?
- To what extent do final year student nurses perceive there to be a 'theory–practice gap', and what are the implications for their understanding of nursing as a professional practice?
- To what extent do student nurses report any changes, or developments, in their perceptions of the nursing role over the course of their degree?
- What are the implications of these findings for the design and teaching of the nursing curriculum?

The findings from this thesis contribute to the existing knowledge base for nurse education, through the insight of eighteen final year student nurses' perspectives of their pre-registration nursing programme. The value of the research findings suggest that this group of final year student nurses perceive they are prepared for practice when they register, and are confident in their abilities. Yet, there appears to be gaps in underpinning theoretical knowledge,

based upon the approach to learning taken, and this has many potentially significant implications. Through examination of this issue, I have made a positive contribution to the literature, which can inform the future curriculum through gaining the perspectives of this insufficiently examined group.

The first research question that I addressed:

- What skills and theoretical knowledge do final year student nurses value, and what are the implications for: (a) their approaches to learning and, (b) their practice?

When examining and answering the first research question, it is important to consider the implications for nurse education and the professional practice of the participants. Whilst it is clear to see why students perceive that some skills and knowledge are more important than others, the implications of this will undoubtedly mean that there is a gap between their perception and the reality of nursing, in terms of what is needed to practice and why. Although it is well documented and accepted within the literature (Entwistle, 1991) that HE students have a deep and surface approach to learning, for nursing this can have significant implications upon their practice and patient care. As such, the consequences to patients receiving care from nurses who have taken this approach could be catastrophic. Equally, it must be considered if there is ever an appreciation for the subjects that are perceived not important to practice, and if the gaps in knowledge are ever filled.

In respect of the first research question, the findings of this research suggest that this group of student nurses perceive medicines management skills and science-based subjects such as, anatomy, physiology, and pathophysiology, to be what are needed to practice. Whilst highlighting these issues, and discussing

this, I have also found that there were elements of the curriculum that were perceived to be less essential to practice, and as such approaches to learning also changed considerably. These findings are significant in terms of the level of understanding that student nurses have, of both the holistic nature of nursing and general knowledge required.

The findings of this research question are both unexpected and significant, because it exposes both the approaches to learning, and the level of knowledge that final year student nurses have. As nurses are critical to the NHS in caring for patients, it is imperative that they are educated appropriately to meet the needs of the current and future population. Therefore, based upon these findings and the acknowledgement that student nurses have gaps in their knowledge, there is a potential gap in the care of patients, through a lack of knowledge, and in the limited holistic approach that student nurses take.

The specific contribution to knowledge that I have made will allow for a greater understanding of students' motivations and approaches to learning, and the subjects that students believe are, and are not, essential for practice. This will allow for future curricula, teaching, and learning strategies to be developed, to ensure that future student nurses have an appreciation of all aspects of the curriculum, and as such are adequately prepared. Recommendations for the future would be to highlight to student nurses how all elements of the curriculum are equally important, to ensure that an appreciation for all theoretical subjects will develop.

The second research question that I addressed:

- To what extent do final year student nurses perceive there to be a 'theory–practice gap', and what are the implications for their understanding of nursing as a professional practice?

This research offers a unique insight into the perceptions of student nurses around this area, and as such should be utilised in the future in conjunction with existing literature, as there has been very little research examining this group's opinion of this subject. I propose that theory and practice are perceived to link by student nurses, because they have a significant naivety in terms of what is required to be the holistic, knowledgeable nurse that the NMC and the public require. These findings are significant because student nurses who become RNs, are shown to have a lack of understanding of the wider knowledge needed to be a nurse, and this contrasts with what the NMC expect within their professional standards (NMC, 2010), for newly qualified nurses.

There are significant implications of these findings, as it is clear that this group of final year student nurses do believe that their practice is sufficient, this is in light of their admission of how they approach their learning, and an identification that their underpinning knowledge has significant deficits. This demonstrates that students are blissfully unaware of the gaps between their theory and practice, and as such, the implications are that patient care may be compromised due to these gaps. I have also found how significant the use of clinical simulation is for the education of pre-registration student nurses. I have found how simulation provides students with an opportunity to learn, refine new skills, and enhance confidence.

Recommendations to be made include highlighting how all theoretical components of the curriculum support everyday practice.

The third research question that I answered:

- To what extent do student nurses report any changes, or developments, in their perceptions of the nursing role over the course of their degree?

I discussed my findings in relation to the extent to which final year student nurses perceive the role of the nurse to have changed over the course of their programme. Student nurses do observe a change, however, they still do not demonstrate that they fully understand the role of the nurse as a holistic caregiver, instead they perceive the nurse as somebody who completes tasks. It is perceived that nurses undertake a very task orientated role, and holistic care was all but never mentioned. Implications of this potentially mean that the role of the nurse may be forever changed, if this perception continues with each new generation of nurses. A subsequent implication from the findings around this research question is the level of supervision that takes place, and by whom, in clinical practice for student nurses. It appears that particularly in the early parts of the programme students are mentored by nursing assistants, and potential implications of this may be that students are missing out on learning opportunities from RNs, as they are largely working with the nursing assistants. In terms of the high level of confidence that students appear to demonstrate, this is concerning due to student nurses not having the underpinning theoretical knowledge for their practice to warrant this confidence. A further significant contribution to knowledge is the level of professional learning and socialisation that takes place, particularly in terms of where and who the learning occurs from. A recommendation would be to ensure that student nurses work the

majority of their practice time with an RN mentor, as opposed to a minimum of forty percent.

The final research question that I addressed:

- What are the implications of these findings for the design and teaching of the nursing curriculum?

There are several significant implications from the findings of this research. These include the notion that student nurses appear to demonstrate a significant lack of underpinning theoretical knowledge due to the way they approach their learning. It has also become clear that as students spend much of their practice time with nursing assistants, they appear to misjudge the role of the nurse, because of who they are supported by in practice, which also means that they develop a task orientated approach to care.

The findings of this research question are important because they demonstrate the significant implications of the approaches to learning of student nurses, and their future practice as registrants. The implication of this is that there may be future nurses who are not embodying the vision of what a nurse should be by the NMC and the public. Equally, the implication of the approaches to learning that student nurses have taken has meant that student nurses have significant gaps in knowledge, and so patient care would undoubtedly be compromised. Future nurses who are mentored by registrants who have taken this approach to their learning would, therefore, continue in this cycle, and so the cycle of a diminishing understanding of the holistic role of the nurse would be perpetuated. This is because student nurses appear to take an approach of wanting to survive each shift on a daily basis, and this is their benchmark for what knowledge is needed to practice. All other knowledge, which can assist them in

the delivery of holistic nursing care, is learned on a very superficial level, and further widens the theory practice gap, yet this is perceived as not to exist by student nurses. A recommendation is that in the future there should be a stronger emphasis on the theoretical subjects that are deemed not important to clinical practice. It may also be useful to reconsider how the role of the nurse is portrayed to student nurses.

The implications of what I have identified within this research corresponds with the new ideas from the NMC for the potential design of the new nursing educational standards which have recently been announced (NMC, 2016), what has been highlighted by the Council of Health Deans (2016), and key points that arose from the Willis review (2012, 2015), which aids my assurance that this research is legitimate and valid. The NMC (2016) have suggested that theory and practice should be more strongly linked, and that the application and emphasis of research should be emphasised. In light of the findings of my research, they should be used in conjunction with other existing literature to assist with future pre-registration curriculum development.

6.1 Limitations

Limitations to this study have commonalities with any other research that uses qualitative approaches. The limitations of this research are that the sample was a small size from one institution, therefore, this study does provide an in-depth snapshot of the phenomenon of what final year student nurses experience, and perceive, in relation to their pre-registration education. With a purposive sample of final year student nurses, who have volunteered to take part in the research, I do not make claims that the sample is representative of the entire study

population. However, this does provide an insight into a cross section of the entire population's perceptions.

I acknowledge that I used a small sample size, yet I have acknowledged my rationale for this, and discussed how this group have also been used in small numbers in previous nursing research studies (Watts and Davies, 2014). I feel this adds to justification that this sample size is acceptable. Equally, I have acknowledged that data saturation occurred within the sample, yet I also took the opportunity to undertake another interview to ensure that this was the case. I argued for the use of the insider research approach within this research, and clearly articulated my position within the field of the research study to the participants. Whilst this research was undertaken as insider research, I feel that I minimised any potential interference by myself, by choosing a site of study and participants who I had limited connection to. I feel that whilst I had a connection to the site and a good understanding of the research area and context, I had no connection to the participants, and therefore this also minimised the amount of potential interference and altering of accounts by the participants for my benefit. The knowledge of the context that the research took place in and of, I feel allowed for a greater understanding, and less of a potential bias by myself, when examining the results. This also allowed for more meaningful questions as part of the semi-structured interviews. Within this research, I examined the perceptions of participants. Examining perceptions can have limitations, and it should be acknowledged that I took this on board. Potential limitations of examining perceptions, particularly from this small unique group, could be that there is an altered view by them in their outlook. However, it is important to

consider what can be learned from this group, in terms of how they perceive their nurse education, and establish why this may be the case.

6.2 Conclusion

The aim of the study was to explore the implications of student nurses' perceptions of their nursing education, for their approaches to learning and their future practice as registrants. Integral to this aim was to understand how student nurses learn, and what motivates them. While some comparisons can be made between the works of others, the perspective of this study is different because it focuses upon the perceptions of final year student nurses. This thesis contributes to the knowledge, theory and practice of nurse education. An insight has been gained into what the motivations and approaches to learning are that student nurses undertake, and what skills and knowledge they value for their practice. It is clear that for this group of student nurses the motivations for learning are to ensure that they have superficial knowledge to be able to survive within clinical practice when on duty, without causing harm to patients and equally to ensure that their ability to practice is not affected. This approach of learning has highlighted potential gaps within the knowledge that student nurses possess which may affect their future practice. Furthermore, this thesis has highlighted that student nurses do not perceive there to be a theory practice gap, which contradicts previous existing literature, and their inadvertent answers to how they approach learning. This research has also highlighted the perceptions of this group of student nurses perceptions of what the role of the modern nurse is. The findings illuminate students' understanding of nursing, how they approach learning and their motivations for learning. Therefore, if

future student nurses, locally, nationally, or globally, take the approach to learning that I have exposed within this thesis, then nursing knowledge, practice, and patient care would be diminished, and the implications of this could be detrimental for patients. Therefore, in view of making a positive contribution to nurse education, the timing of this research is extremely important in view of the expected consultation of the new standards, which will begin imminently.

The preparation of nurses to become a professional encompasses a range of knowledge and skills and this research has illuminated this. Gidman (2011) explains how there are many different components of creating a professional which must make them fit for practice at the point of qualification. Eraut (2005) discusses how students who undertake professional programmes must meet a number of different agendas. This includes learning the correct skills and knowledge for practice, understanding how theory and practice link, and meeting the prescribed curricula in terms of regulatory bodies. This is the case for nursing students who have to meet the intended standards of the NMC (2010). It is imperative that student nurses are adequately prepared with the skills, knowledge, and experience to practice, not only now but also for the future, and that the philosophy and ethos of nursing as a holistic profession continues for the future. This is in terms of providing holistic, compassionate, and sensitive care for patients when they are vulnerable. This is necessary to protect the public and also to protect the essence of what being a nurse is.

"The character of the nurse is as important

as the knowledge she possesses"

Prof Carolyn Jarvis

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