UNIVERSITY OF Southampton

The Higher Education Academy

Appendix 4c Southampton Nursing Qualitative Data (Staff and Students)

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31 October 2012

Background to the Nursing Qualitative Data Report

Acknowledgements

This report draws on nine individual student interviews and one student focus group with first year nursing students regarding their experiences of early clinical placements. The section also reports on nine interviews with clinical teachers.

The individual nursing student interviews, preliminary analysis and analysis report were undertaken by Stuart Ekberg. The focus group was conducted by Stuart Ekberg. Further analysis and development was undertaken by Anja Timm.

The clinical staff interviews were conducted by Stuart Ekberg and Regina Karousou. They were analysed by Sarah Bignold, who also wrote the preliminary report.

The final report presented here was written by Anja Timm.

Methodology

All of the interviews were conducted with volunteer students who had responded to an open invitation to take part. All volunteers were interviewed, where possible. At the time of interview, all of the students were on their first clinical placement (P1). The interviews were semi-structured and followed protocols developed by the project team. They were fully transcribed and entered into NVivo. Analysis included in-depth coding of the interview data using framework analysis and further development of themes using the coded data.

Context

At the time of interview, the undergraduate adult nursing programme was a three year programme that could lead to a variety of qualifications (degree and diploma). Students would frequently change between these different tracks, depending on their circumstances. However, differences only occurred at the later stages of training, the first year was identical. Nursing students started their first clinical placement in January of Year 1. Nursing programmes across the UK are identical in that the Nursing and Midwifery Council specifies that at least 50% of the degree has to be undertaken within clinical settings. This means that all of the time between the start of university (September/October) and the first placement could be considered preparatory – it involves both classroom-based teaching and clinical skills sessions. It is also important to note that many nursing students have worked for extended periods within healthcare prior to attending university.

Year 1 in nursing starts with a Theory block and students then move into Placement 1 (or P1), which consists of ten weeks and includes shift work (full-time). Students then return to the university for a further block of Theory. P2 starts in June and lasts another ten weeks. Placements can be in a range of environments where nursing provision takes place, including managed care wards, operating theatres and community settings. When on placement, students work closely with a dedicated clinical teacher, their mentor. The expectation is that they will work the same shifts and that at least 40% of the student's time on a placement is spent with this person. When the mentor is not available, adult nursing students might work with a 'buddy', i.e. a substitute mentor who is also a trained nurse. However, students may work with a range of individuals, including healthcare assistants (HCAs) and other members of the multi-professional team.

For recent changes to the nursing programme, please refer to the section reporting on staff data.

Duration of project: August 2010 to October 2012

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Findings from Nursing students

Working with and learning from staff

All nursing students on the Southampton programme are allocated a supervisor, who is a nurse at their placement site and their 'mentor'. Some students also discussed their 'buddy,' who stepped in if their mentor was unavailable. Students supposedly spend 40% of their time working alongside their mentor. However, according to the data collected, practice varied, as did relationships between students and their supervisors. Variation appeared due to inexplicable personality differences with several students invoking the notion of 'luck'.

> *It's not a guarantee. You don't get a good mentor every time. It's just you've got to work with what you've got. And you just hope there's not a personality clash, because it will happen. And in that case, that's where I think it will be challenging and difficult.* (Angela)

Students considered it an inevitability that they would be allocated to supervisors with whom they might struggle to interact at a professional level – at some point. The ensuing 'personality clashes' might make the placement experience very difficult indeed. Here, another student explains the impact of her relationship with her buddy.

> *My buddy... was supposed to help me, but she didn't. She just wasn't a very nice person at all (…). Even if I asked her something, she'd be like rolling her eyes up to heaven and like trying to make the biggest deal out of nothing, when all I was doing was just asking a simple question.* (Lauren)

The student goes on to refer to friends' advice about encountering such people no matter where you work. This was mirrored in another interview, where a student's decision to leave the nursing programme was attributed to poor relationships on placement. Several students' accounts illustrate the challenges that can arise when students are unable to engage in amenable working relationships with their supervisor.

In the data, establishing good working relationship with the supervisor emerges as a key component that enables nursing students to gain access to learning opportunities whilst on placement. One student explained how her supervisor was able to appraise her capacity to learn and engage in particular tasks. Practically, this meant that she could identify appropriate learning opportunities:

> *…as the placement got on, she'd – we got to know each other a bit more, so then she'd know what I was capable of and what I wasn't, whether I was, you know, really untrustworthy or a capable student. And then so that's when she started showing me like the IV stuff and the drugs and that. But if I was – if she wasn't there and I was just put with anyone, that was like – that was when you had really rubbish days, because they don't know you.* (Lisa)

Later in the interview, Lisa goes on to contrast this relationship with those that she had with other nurses. She explains that without them knowing her personal stage of learning they were unable to provide tailored learning opportunities. Another interviewee described how lack of mentor training can limit students' experience of initial placements:

> *Your mentor has like a set of guidelines that they should follow, with you under their care, while if you were just put with someone else they might not necessarily know what those are. So you could be asked to do stuff by that person that doesn't actually realise that you're not meant to do that, or you're not allowed to do that.* (Heather)

One major restriction that is placed on students on the Southampton programme is that they are not allowed to administer intravenous drugs to patients; Heather described how staff who are not mentors may be

unaware of such regulations. Another student remarked on how some mentors are simply unavailable to students due to other work priorities, for example in the case of a very busy matron. As discussed above, having a close working relationship with a supervisor can be important, as that person can appraise a student's ability at any one time, and customise learning opportunities to suit their competence. Another advantage of a close working relationship is that supervisors can identify good learning opportunities, even if that means taking them out of their immediate work context:

> *If there was something more interesting going on with someone else in the afternoon, they'd be like, 'Oh go with them because you'll get to see this.' So it wasn't just you were stuck with one person... when you're out with different people, you get to see how different people work as well. Rather than just with your mentor who does it their way, you then do exactly the same thing with someone else who would do it different because that's their way. So it's nice to see all the different ways and then you can sort of choose your own (bits) and put it all together yourself.* (Amber)

According to students, there are advantages to working with different people: it allows them to observe and engage in different approaches to particular care tasks, and to integrate their experiences in order to develop their own professional judgement of best practice. Amber's particular situation may be an outcome of her placement type. She worked with community nurses, who would meet for two hours at lunchtime to complete paperwork and discuss patients. This arrangement meant Amber's supervisor could identify potential learning opportunities that would be of use to her. In fact, several students also described such arrangements occurring informally in a ward setting. Once they themselves have established good working relationships with other staff, students report accessing additional of learning opportunities even without their supervisor(s):

> *…when my mentor wasn't there I'd work with somebody else, and all the nurses were absolutely lovely, really nice. But it's important that you get on with them – well not – you don't have to be buddies, but as long as you respect them, I think they'll teach you, and as long as you show willing then they're willing to teach you and have you there.*

It seems many of the tasks that nursing students undertake with their supervisors could be done with other nursing staff, but that the success of this can be improved if a supervisor is able to identify the best learning opportunities for a student to engage in, irrespective of whether those opportunities come from working with them, or with another member of staff.

Accessing learning

Staff facilitated

When describing how they came to access particular learning opportunities on their initial placements, participants predominantly identified members of staff – as opposed to the students themselves, or other students – as being the people that identified those opportunities. Below are two interview excerpts, the first reporting on a community setting, the second on the hospital.

> *They'd be like... 'Oh have you seen this? Have you taken the staples out of someone's knee?' Like, 'No.' 'Go and do that.' So they were pushing the opportunities towards you, so that was really good... And also, when you're out with different people, you get to see how different people work as well.* (Amber)

> *…one of them said, 'Have you done your sterile technique yet?' And I said – I wasn't expecting to – and I said, 'No.' And they said, 'Oh we'll get you to do that.' So one of them, Mark, wasn't a mentor or a buddy to anyone, just a really enthusiastic nurse, he said, 'Right, the next stitches that come in, you take them out.' So I did. And then he signed me off in my book.* (Kim)

Across placement types, then, students report benefiting from working alongside staff willing and able to identify learning opportunities. However, not all placement sites offer these types of experiences. Below, a couple of students describe more limiting workplace setting:

> *...they just seemed, on our ward, they were like worn down, overloaded, underpaid, overworked, moaned all the time.* (Lisa)

> *...I was quite surprised that we were used as HCAs by some staff. And other staff really wanted you to learn as much as you could, and they explained everything they were doing, let me shadow them, and you worked as a team with them. Rather than being, 'Well you can do that.' And that really works...my buddy was one of the ones who would use me as an HCA. But there were other staff nurses on the ward who were very much more, 'Come and see this. Do you want to help me do this wound dressing? Have you seen aseptic technique before? Do you want to come and do this catheterisation?' And they were much more proactive.* (Samantha)

Such participant reports highlight the dependence of student learning on the individual qualities of the staff they encounter. In addition to their enthusiasm for teaching, it also seems that staff need to be able to discern the individual needs of their students. Some of the participants spoke of their mentors as actively appraising their individual aptitude, at varying points of their placement, and customising learning opportunities to suit their particular abilities at that time.

> *...I think the minute she realised that I could do quite a lot of stuff, and I was quite sensible and had common sense, I was really left there for the day doing everything, apart from the drugs. (*Samantha)

Students reported that their prior work experience in healthcare mattered in this context, irrespective of whether they chose to declare it or not. Below they describe how their mentors came to evaluate their individual aptitude, and adjust their learning opportunities on the basis of their evaluation.

> *...I think it allowed her to take a little step back, I think, just to see what I can and can't do, for her own – and that's good for a mentor to do that. Because they need to see where your limitations are, they need to see what level they need to work at you with, and it allows them to bring their expectations probably down a bit or up a bit, you know, being flexible.* (Angela)

> *For me personally, I've got quite a good background, and I was – I didn't want to go in seem the arrogant student, but I also wanted to go in and learn, but not sort of overstep the mark. But as I went in they were brilliant, they worked to what I could do, they sussed out my level and they worked with that. Rather than starting from scratch, they knew where I was and they worked from that.* (Amber)

Several participants described a contrary experience where staff assumed they were able to complete care tasks that they had no experience or competence in.

> *Yeah some of them made you feel a bit stupid. Like when she told me to take that catheter out and I was like, 'Oh I've never done that before,' she just kind of gave me a two sentence explanation of how to do it and then walked off. And I was just stood there like, 'Oh my God.'* (Sophie)

Staff inappropriately assuming student competence was not a commonly reported experience, but it does illustrate the importance of staff appropriately evaluating the individual aptitude of their students. Below, one student explains her strategy for dealing with such situations. This approach could be used as a model for how students can address inappropriate assumptions of aptitude when on placement.

> *…I just ask. Yeah, or if they – say – they ask me to get some things to do a wash, I'd get everything that I know I needed, and then if I – I'd say, 'Have I forgotten anything?' Or they'd say, 'Oh you need to get this,' or, 'Oh you don't need this,' things like that.* (Christina)

Via another student

Although it was not a common theme in the data, some participants reported that students were helpful in and supportive of each other in their learning. For example, students might offer one another the opportunity to come along and participate in a care task which would clearly be a learning opportunity. Or they might teach each other.

> *...you're kind of learning off each other. Like one of the students had never – she hadn't taken a cannula out. And I sort of said to the nurse, I was like – and she wanted to do it – and I was like, 'Shall I show her?' I was like, 'or do you want to show her?' She was like, 'No, you might as well show her,' she was like, 'you know how to do it.' So I was kind of like teaching her how to take a cannula out. She was like...'can you do it?' I was like, 'No, you do it.'...on the day after, my mentor, she was like, 'How about you two going together and you can help each other do it, sort of thing, and learn?' And she was, 'The only way you learn is by doing it.' So we sort of went in and did that. So it was really nice to have other students on that.*

A final way in which students described identifying learning opportunities was through their own initiative, i.e. by 'asking to do everything'. Some students recalled that they were told, during preparation at university, to use their own initiative to seek our learning opportunities once placements would start. Below, a participant described the personal realisation of this as difficult:

> *...you self-learn academically, which takes a little while to get used to. At college we were spoon-fed, so it's a bit different. But the realisation of the self-learning practically is a big thing.* (Laura)

The student continues to explain that she does not understand whether it is her responsibility to identify learning opportunities, or whether her mentor should be responsible for this. As discussed above, there appears to be specific learning opportunities that staff are best placed to identify on behalf of students. But nursing students also have access to their AoP portfolio that specifies the competencies they are expected to attain. On their initial placements, students may not realise the need to chase opportunities, e.g. to practise measuring blood pressure. It seems that students themselves should be able to identify such elemental competencies. At the same time, the above analysis highlights the key role staff play in identifying a diverse range of learning opportunities. In turn, this appears to set up the students for identifying these on their own later.

Additional learning opportunities: Teaching sessions

Very few participants from nursing reported learning opportunities that were not immediately tied to the routine business of the workplace. Below, a student described an impromptu teaching session:

> *…obviously you don't have people having caesarean sections 24/7, so the times that we weren't doing anything we used to go and have like classroom sessions in the theatre, with the ODP [Operating Department Practitioner] students as well. So we like spent like 3-4 hours some days just going through anatomy, physiology stuff, going through different like instruments and stuff like that, which was really good.* (Dave)

Dave felt that there were considerable advantages to having such learning opportunities alongside practice. He reported observing that medical students appeared to get more teaching sessions on placement than students in nursing. Dave went on to refer to the teaching of practical skills that might then be utilised on placement. Such sessions could presumably be used to teach skills that students might rarely get an opportunity to learn on actual patients, and yet are important to be competent in.

Only one of the participants reported attending regular teaching sessions:

> *...every Wednesday afternoon they had teachings in one of the rooms, where they had nurses from different wards teaching you all different things. So we had one on fluid balance, we had one on malnutrition, we had one on heart failure, we had one on like the outreach team. So they were good. And they always said to me, 'Go to that, go to that,' so I was always like pushed to go to the teachings.*

Learning

Learning by observing

Most participants described the beginning of their first placement as taken up by essentially observing what others were doing on the placement site. However, most participants also described progressing beyond this phase fairly quickly:

> *You're literally a shadow, you know, shadow to somebody.* (Heather)

> *My first week I was just watching to start with.* (Amber)

> *Sometimes it was a little bit dull when you're in the theatre and they just sort of expected you to just sit and watch.* (Christina)

Many of the participants constructed learning by observing as less than complete. For example, it is described as 'just' observing, indicating that there is something minimal about that practice. Moreover, Christina explicitly associates this with her lack of engagement. Heather described her role on the first day as a shadow. Her use of 'literally' emphasises the minimal nature of this role. Although the observation phase of learning was portrayed as minimal, it could also be described as an important phase to progress from.

There were some tasks for which observing formed an integral part of the participant's reported learning experience. For instance, one student described how what she had learned from observing scrub nurses in neuroscience theatres – laying out the trolley (and being talked through it) – was later displayed to her mentor when she moved on to work in recovery.

Observation appeared to be the optimal approach to learning in situations where students were, for whatever reason, unable to gain more practical experience themselves. One student described learning about the difficulty of protecting patients' rights to privacy. She discovered that this could be particularly difficult when patients were being discharged, as patients might not necessarily want their medical details divulged to the people that come to collect them from the hospital.

In contrast to earlier descriptions of learning by observation as limited, the student presents observing as a 'next best' option to having practiced something herself. The analytic label 'learning by observation' does not entirely capture what is required for learning to occur. In this case, the student was learning how to deal with patient confidentiality by watching and listening to how other nurses dealt with such situations. That is, she was observing an interaction.

Other nursing skills, however, that are not of an interactional nature but involve the cognition of an individual nurse require more active involvement of staff if students are to learn. Below, a student described the limitations of observing drug rounds in a nursing home:

> *I did go on drugs rounds... the problem is with that placement, is the nurses know their patients inside out, they know their drugs inside out. Sometimes they don't – not that it's bad practice, but they can just open the drugs trolley and reach for the drugs without even looking to see what drugs they – do you understand what I mean? They know them so well. So you're just following and watching the same repetitive thing and not actually – I was never given the – I don't know at what point you're allowed, but for me to do the drugs round and maybe them watch me, I know certain parts of it legally you can't do. But to stand and watch someone repeat the same thing when they know what they're doing and they could do it blindfolded is really different to being on a hospital ward and not knowing your patient and not knowing.* (Laura)

Laura's account described the nurses that she worked with as having developed a mental routine. This routine, unless articulated, is a private one, and therefore not available to an observing student. Learning by observation, then, is not necessarily a practice that simply involves a student following a practitioner. It may require a more active stance on the part of the practitioner, who must articulate the rationale of what it is that they are doing. It is only once the student can listen in on the mental routine that such a situation becomes a learning opportunity.

The predominant way in which observing was described in the interviews was as the groundwork (step one) that needed to take place before more practical learning – by doing – could be attempted.

> *...for my first week most of my time my mentor, I would go to her and say, 'What would you like me to do today?' and she could then say, 'Follow me, I'm doing this, it's quite interesting,'...And you literally would follow them for the first day, and they would get you to do stuff, and watch them a certain number of times... So watch one, do one and then independently as well.* (Heather)

This type of account indicates a hierarchy of learning in which a student begins by observing some element of professional practice, before progressing to attempting that task themself whilst under supervision. Learning could then culminate in a student practising the task independently, without direct supervision. Clearly, students were not always able to progress in this way. There were some tasks for which students were not able to move beyond observing, particularly on surgical placements. There were also some tasks which students were able to practise themselves, but always under direct or close observation. So, although there was a hierarchy of learning described by participants, this was not a path that every student would progress through for every clinical task.

It is also the case that participants described some tasks as being better learnt through practice, even in instances where they had never observed that practice before. Below, a student contrasts the approaches of observing then practicing, with practicing under guidance:

> *I think it's good to see it and then do whilst under instruction. But in a sense, with some things I think you're best getting your hands dirty, getting stuck in and actually doing it, having a step by step instruction. And then kind of going from there, you know.* (Emily)

There is a fuzzy boundary, then, between learning by observation and learning by practice. In some instances this progresses in a hierarchical fashion, whilst in others it does not. This will be considered further in the next section.

Learning by practice

Participants were unanimous that many things were best learnt through hands-on experience; by doing something hands-on, things were 'falling into place'. Below, one student shares her experience whilst being on a community placement:

> *Unless you're really squeamish, never say no. Just get stuck in, go for it. While you've got a mentor there you've got someone looking over your shoulder permanently, you can't go wrong, just give it a go... It's things that you've never done before, like injections, and where if you get it wrong and the wrong amount in it you could mess up someone's blood sugars completely. So to start with when you're sort of pulling it up, you know, like weird like the check system, I'd be like, '10 check,' and then just sort of you give the injection. So yeah, to have someone, you're not responsible as such for that then, so you've got two of you, you don't have the responsibility of doing it but you're still doing it. So yeah, it's quite nice to have someone to fall back on... if it goes wrong you've got someone there behind you to put it right straight away. Whereas if you didn't have that person there you'd be like, 'Have I done that right?' So yeah, 'Can you come and check this?' So yeah, it's quite nice to have someone there instantly.* (Amber)

Amber highlights the benefits of learning under supervision. She explains how it is possible to learn something new by practising on patients, even if the task being attempted is one that could potentially harm that patient, because there is a qualified professional monitoring to ensure accuracy and safety. Community placements are likely to offer a greater number of such opportunities, by virtue of the fact that students must work closely with nurses all of the time. This is not necessarily the case on other placements. Nevertheless, participants on these other types of placements described learning under supervision positively, including those on day surgery and in outpatients (described below).

> *...I was just being taught all the time. And like I went from just watching the endoscopies to actually being able to like assist, and then going and setting up the room, and really getting involved by the end of it. And just felt like – and they made me feel like really part of the team, so yeah very good.* (Sophie)

As discussed above, progression from learning by observation to learning by practice was not the uniform way in which participants described learning new skills whilst on placement. Below, one student described learning how to remove a cannula on the first day of her placement in a general medical ward.

> *...on my first day like one of the nurses were like, 'Oh this patient needs a cannula taken out, do you want to do it?' And like she didn't show me, she was like, 'No I'm just going to talk you through.' So it was like you were literally just learning as you were doing it, and you're like, 'There's a real patient there, and like it's the first time I've ever done it.'... And then by about the third or fourth week I was just, if they were like, 'Oh so and so needs a cannula,' I'd just go and do it on my own, rather than them having to like come with me. 'Cos like for the first few times you kind of want someone there for support. But after like two or three weeks that was just OK on my own.* (Megan)

In spite of having no prior experience, even experience of having observed the procedure being conducted before, Megan described being able to learn how to remove a cannula through practising on a patient. She described direct supervision and instruction from a qualified practitioner as what enables her to learn in this way. She then described this sort of direct experience leading to her increasingly independent practice of, and therefore competence in, this clinical task.

It was apparent that this was a rich learning experience for Megan. In the interview she went on to describe her learning in a very detailed way. From this account, it is clear that Megan learnt from more than just being able to practise on an actual patient. In addition to that, she was offered an emerging commentary from her supervisor on the rationale for conducting each stage of the clinical task in a particular way. She culminates her telling by explaining that she finds this the best way to learn something new.

The process of close supervision can enable practice by learning, even in circumstances where it is not possible for students to practise directly themselves. As discussed earlier, students are unable to administer drugs to patients, and yet the following fragment, taken from the nursing focus group, illustrates how supervisors can assist students to learn and practise skills in relation to drug rounds:

> *Samantha: Yeah my very last shift, doing the drug round with the staff nurse, she kept sort of testing me, so, 'What does this group of drugs do? What does this group of drugs do?' You know, really trying to get it to sink in. Which was – you know, that was the first shift I'd worked for somebody where I felt like we were both working as a team, and that she was very interested in educating me, and she was checking that I'd understood.*

Shortly after Samantha's turn, the following comments were made.

> Sophie: *My mentor... he'd explain everything and then he was like, 'Do you remember what this does? Do you remember what this does?' and he'd get me to say it all. And he was really good at teaching.*

Julie: *I think that's a good way of learning actually yeah.*

Dave: *It's how you remember it as well isn't it?*

Samantha: *Absolutely. The quality of teaching that I got when they gave you the input was very, very good. It was just lacking in quantity. You know, for a 13 hour shift I'd maybe get half an hour input, on average.*

These fragments illustrate the different ways in which students can learn by practice. What is common to all of the accounts studied here is the close involvement of a supervisor, and often a supervisor who is willing to articulate the basis for particular clinical practices. However, as Samantha's comment illustrates, these sorts of learning opportunities require investment on the part of qualified practitioners, and the availability of this on placement can be scarce. The reasons behind why this is the case need to be probed. Two factors that can exacerbate getting few learning opportunities can be identified in accounts offered by the participants: being unengaged, and contributing to the workload, rather than learning.

'Not learning': Unengaged

A few participants described scenarios where they were not actively involved in what was going on in their placement site, but rather found themselves as passive bystanders. One student quote emphasised the importance of a particular care context on students' experience of their first placement, here a managed care ward where patients were largely able to care for themselves, and therefore not in need of significant nursing.

> *...I can't wait for my next placement because then I get to do so much more. And like even on drug rounds and stuff, the patients had their medication themselves so we didn't have to do anything. You just had to go around, like I went around a few times to watch to make sure that they had taken the right stuff, medicines and stuff, but that was it. It was only like on my last few days that I got to like refer patients to like say physiotherapists and stuff, but there wasn't nothing major. Like I spent the majority of my time like reading notes of patients.*

The student above experienced the type of placement setting she has been allocated as problematic. She described the ward as atypical, a place where the types of nursing practices she might learn as a novice were limited. Unlike other participants, who described participating in the administration of medication on drug rounds, this student described her role as merely ensuring the patients took the correct medications. Her role, then, is represented as being more passive than in other participant's accounts of comparable situations described earlier.

In the interviews, students seemed to think of hospital settings as standard. Below, another student contrasted the 'busyness' of a hospital ward with the availability of a relatively larger number of learning opportunities - with her community setting:

> *I think the hustle and bustle of a busy ward would probably suit me. Because there are times on the community placement where you're sitting in a car going from place to place, so you're not actually doing that much.* (Emily)

However, earlier interview excerpts indicated that another student on community placement felt it offered experiences that were richer than those on a ward. Some students considered travelling with colleagues as an opportunity to talk (and to learn), although Emily considered it a disadvantage.

Several participants described fellow students as being unengaged – they described it as an inherent possibility on placements. Some places were seen as more likely than others for this to happen, especially managed care wards (as described above) and theatres:

> *Yeah, theatres was definitely like that. You could do nothing if you wanted, just sit in the corner on a chair all day if you could. And they said a lot of people do. They said it was really nice to have a student for a change that actually wanted to get involved and do stuff. They said a lot of the time they did just come and sit in the corner, which I would guess is probably why people hate theatres. Because you literally would just sit and do nothing, and you would get nothing out of it that way as well.* (Dave)

It seems likely that some placement types pose greater risks for student passivity than others. However, with the possible exception of Lauren, no participants were able (or willing) to describe the personal consequences of sustained disengagement, and it is therefore difficult to reach any firm conclusions about this matter, based on the available data.

Some students described feeling passive during parts of their placements as an initial stage that they eventually overcame once they had adjusted to being on placement.

> *[I felt in the way] mostly in the anaesthetic and theatre bit, just sometimes like say when I was in the anaesthetic room... I was just put on the monitoring and there's not a lot else I felt I could do, and I'd just sort of feel a bit of a spare part watching all the time... when I was in theatre, there's like healthcare assistants who go and fetch things... and sometimes they'd ask me to go and get something and I wouldn't know where it was or what it was...I felt a bit useless like 'cos I didn't know where it was or what it was... after I'd been through going through the same things over and over I felt more useful, 'cos I could do things... I mean obviously you can't help that, but at first you kind of – I did feel a little bit like a spare part, or a bit useless, just because I didn't know some of the things. But it can't really be helped, I guess.* (Christina)

This student attributes feeling 'like a spare part' – and her passivity – as resulting from being uninitiated with a particular environment. As she learnt more about that environment, she was able to engage more. Contrast this with Dave's account, above, of being in theatre. Throughout his interview, he never discussed feeling passive, but rather talked about the range of tasks he was able to engage in. Christina's experience was quite different from Dave's, and also different from Lauren's experience of being on a managed care ward from which she felt she could not progress.

The process of adjusting to a placement environment can occasion unique learning opportunities for students. One student reported on a situation that occurred very early on in placement that she was clearly insufficiently experienced to deal with.

> [Asked about difficult aspects of placements] *Yeah when you have absolutely no idea what you're meant to do and everyone around you is doing something. So like there was my fourth day, I still was kind of like, 'Eek,' and there's a patient and they had a massive vasovagal... I was taking the patient's relative to see them, and as I walked in, and I was aware that they were feeling quite sick, and then they went unconscious as they were throwing up. And the relative was there watching it like, 'Help him.' And I was like, 'You need to move.' And I couldn't get them – and I rang the emergency buzzer and then everybody ran in and they were like, 'Bleep the doctor. Start suction.' I didn't know what I was doing, I just sort of stood there like, 'Um I'm not helpful, I'm going to go.'... I had done the right thing, in hindsight. But it was like that was completely alien, I had no idea what to do, I had no idea how to handle that.* (Heather)

This account described the opportunity of learning what to do when something happens that is beyond a student's personal competence.

'Not learning': Contributing to the workload

In the interviews, participants often distinguished between tasks that they felt were educational, and those that they felt were explicit contributions to the workload of the placement site. Participants referred to these as 'menial tasks'; frequent examples given were bed making and running errands.

While bed making was described as a menial chore by some, various participants described tasks commonly associated with HCAs as important learning opportunities, at least initially. The big issue for all students was how to progress towards tasks associated with the nursing profession specifically.

> *At the beginning of the placement it was OK to do that with the healthcare assistants, because it was basic, like basic knowledge really, like and basic care... But then towards the end of the placement I wanted to learn more about, now that I'd learnt the basic running, I wanted to learn more about the drugs they were giving and things like that. But then most nurses would say, 'Oh I don't like students coming on a drug round with me.' I don't know why. They'd say, 'No you just do what you're doing.'* (Lisa)

Lisa legitimated, albeit without strong positive assessment, working with HCAs on the basis that she could learn about basic patient care from them. She then moved on to describe wanting to learn from nurses. As was observed earlier in the report, several students described going on drug rounds with nurses. Here, Lisa reports being denied that opportunity.

Below, Kath's story provides another example: rather than moving on to new learning opportunities, she is instructed to continue doing 'basic care':

> *...I found in the first couple of weeks, working with the HCAs, as opposed to my mentor, actually helped me like just to get settled into like a routine. But then after that it was kind of frustrating, because I felt I learnt as much as I could learn in that sort of area and then felt like I wanted to move on a bit more in the time I had left.* (Kath)

Students do not necessarily seem to object to working with and learning from HCAs, but over time they find that this limits other learning opportunities. In the focus group, there was a lengthy discussion of how students felt 'used as the errand boy', i.e. asked to fetch equipment and supplies. Below, one student described her experience, which appears somewhat extreme for a first placement:

> *To be honest, I did feel very used. One night shift I basically did the whole of the work for the whole of the night for a six bed bay. And I did feel that I wasn't, certainly wasn't supernumerary. I did feel like I was a very important part of the numbers for that ward. I'd say three or four shifts out of the ones I did in that four week period I went home almost in tears because of the frustration of feeling quite used. (…) [I felt] quite kind of bottom of the pecking order, 'You do everything and we're not going to teach you anything.' But then I had other days where it was completely flipped on its head and I'd go, 'This is why I'm doing it.'... I think the moment they sort of sniffed I was a hard worker it was, 'Go on, off you go, you can do that, that and the other.' ... It's very much you've got to be a bit more assertive and try not to fall into lackey mode.* (Samantha)

This student described being 'used' and 'included in the numbers' (of staff in the workload), and how this happened at the expense of new learning opportunities. But she also highlights her role in this situation, and described what she learnt about approaching these situations, i.e. how to maximise the likelihood of accessing learning opportunities in future.

Below, another student described being sent off to work on her own with a designated number of patients, rather than engaging in learning opportunities. She continues to invoke an imperative of care: the needs of patients are described as of greater importance, and more urgent, than her need to engage in learning opportunities.

> *Because I sort of knew the job myself anyway because I'd done it for a little bit, and it's all very much the same in a nursing home. I did feel that I got lost, over the whole placement I got lost in being a carer's – I wasn't used as a member of staff, that would be too strong – but I did get lost (…) – and I just did the same as everything. (…) But I wasn't there to be a carer. Not that I mind doing that, but it was – it was when the light bulb came on, 'Hey, oh my God, I've got this portfolio of 40 odd skills to be signed off, and shouldn't I not be doing more of what the nurse was doing?' But then you wouldn't refuse because – I wouldn't refuse because*

you know you've got 16 patients to get out of bed and you don't want them to be doing it on their own. (Laura)

The student described how it occurred to her – midway through her placement – that working as part of the care team was having a detrimental impact on her training as a nurse. Elsewhere in the interview she described how she changed her approach partway through her placement, and dedicated more energy to engaging in learning opportunities. However, she also reported that she felt she was behind most other students in her cohort.

It is important to emphasise that not all participants reported being included in the workload, and some explicitly noted that they were not. Another student's story makes that point below. She had four years HCA experience on an acute ward before starting the nursing programme:

I was worried that they'd see that I'd got a bit of experience and confidence and they'd use that. 'Cos I'm from [City], and the university there, well the hospital isn't a university hospital, so the students almost get used as health care assistants. (…) But I really noticed the difference. I noticed that I was a student nurse, and I thought I was just going to be a healthcare assistant, they were going to use that, but I really noticed the difference... I was taught loads, loads and loads, much more than I thought. (Kim)

Learning by studying

There was very little discussion by the nursing participants of learning by researching and studying some topic whilst they were on placement. Many students did, however, mention that they had kept a notebook of particular types of things – usually types of drugs or medical conditions – that they had either learnt about or encountered whilst on placement. Making notes allowed them to follow up later if necessary, and to refer back to.

...I had like a little notepad in my pocket and I was like, 'Sorry, can I just write that word down?' So I was just like writing things down as I went, so I sort of remembered... some patients, with the illnesses they had, like within the notes obviously it didn't really describe what they were, and I was like, 'Never heard of that,' so I'd like write it down. And I'd go home and like look it up. So you kind of get a bit more of an understanding about what it is. (Megan)

The note-taking that Megan described enabled her to engage in deferred learning, using her record as a point of reference for later study. Below, another student described notes as a memory aid during her first placement, which was split across two sites, beginning in orthopaedic surgery before moving to orthopaedic recovery.

I'd make notes of some of the things they told me. I made notes of drugs and things like that. And, to some extent, I like kept a diary, to some extent. Sort of when I remembered I'd try and write down things that were significant, things I'd seen yeah, yeah I think that's a really useful thing to have though, to go back and read over it, just so you can remember. 'Cos so much happens and you think, you know, it's just easy to forget everything that happened.... Say one day I saw somebody and I'd think, 'Oh I think I've seen that before,' and then I might look through notes and try and remember.... Like they do an operation where they go up the nose into the brain, and like you can expect a lot of bleeding down the back of the throat and stuff like that, so when they come into recovery it's good to know that and have seen it and sort of understand when you're caring for the person. (Christina)

Christina went on to explain another strategy for learning something new that she described within her account of how she spent a typical day on placement.

> *And then you go through the crash trolleys and check them, and quite often I'd do that, because it's quite good to learn, go over and over and over what's in the crash trolley. 'Cos they had the list, and then I'd go through it and I'd be like, 'Right, what's this?' and try and find it.* (Christina)

Here, Christina described a learning opportunity that could be both incorporated in her daily work on the ward, and also did not require supervision from a member of staff. The method she described is similar to the learning by repetition that participants elsewhere describe in relation to working with patients and staff, but here it is a learning opportunity that Christina has apparently occasioned, independently, for herself. Other students describe opportunities to study that were facilitated by staff.

> *I'd never seen a syringe driver before in my life, I didn't know what the hell it was... and they went, 'OK what do you think that is?' 'I haven't got a clue.' 'OK go away and find out.' So, you know, trying to find out what it was for myself. (…) They had this massive book that they've kind of compiled for their students, you know, everything that they do is in there. So I went away and had a look and said, 'OK this is what it is.' And, 'We're going to go and do one of those now.'* (Emily)

Learning by research and study, as one might do in university, were not described by the participants as being common on nursing placements. However, those instances that did occur were uniformly appraised by the participants as enhancing their learning.

Learning about the nursing profession from being on placement

Some students talked about learning, on placement, what was involved in being a nurse. They often provided this account in response to a question from the interviewer about whether their idea of being a nurse had changed since they started placement. Although many students commented on this issue, there was no uniformity that could be discerned amongst the Southampton interview data. That is, different students made observations about different aspects of the profession. Take, for instance, the comments that Kim made in response to the interviewer's question. Kim had experience of healthcare prior to beginning her first placement, having worked for four years as a HCA at a hospital in another city.

> [Asked whether her ideas about what it might be like to be a nurse changed in any way] *Definitely. But I think that's hospital rather than – 'cos the knowledge that these nurses had was amazing compared - I'm not saying the nurses in [City] are stupid, but it just seemed very limited to the nurses that I've worked with. And I think that's because of the university [Southampton], it's such a better university than [City]... I don't know, the nurses here just seem to know everything. I don't know if that's because it's orthopaedic and they know what orthopaedic procedures are. But I just felt, especially my mentor, she was really, really knowledgeable. She taught me so much.... And I was really happy to think that one day I'm going to be as knowledgeable as them.* (Kim)

In her account, Kim described her surprise at discovering the level of knowledge that the nurses she worked with displayed. She seems to imply, then, that the profession involves a lot more knowledge than she previously realised. However, her observation is tentative, because her observation is made in comparison with her previous experience of nurses at a different hospital. As a student who has only undertaken a single placement, then, it may be the case that participants like Kim are yet to be immersed in the profession for a sufficient length of time to be able to comment on the nature of the profession in general. Angela, who had also only completed a single placement in day surgery prior to being interviewed, appears to be in a similar situation:

> *When I first started the hospital went into the black because of the flu situation, so it was very tight for beds. And they were going to make the day surgery [unit] into an inpatient ward, which went down like a lead balloon. Because the first thing is, thinking, the skill base, 99% of it is day surgery, and they wouldn't have any idea of what would be coming in as an inpatient.... And it made you realise, 'oh I don't want to be like that, I want to keep my skill base up to date.'* (Angela)

Angela, here, described the problem of the day surgery in which she worked becoming a temporary inpatient ward as that the staff that worked there would not have the requisite skills to tend to such patients. She represents an atrophy of skills amongst staff working in this area, and speculates that this may be a consequence of specialisation. However, having only completed a single placement, Angela cannot comment more definitively on this matter. She has no experience of other areas of nursing practice and, in particular, specialisation.

The variation exhibited in the way that participants discussed the nursing profession may result from them only having completed a single placement at the time of being interviewed. Because nursing placements can vary considerably, from community placements, to nursing homes, to wards, to theatres and so on, these participants be may yet to gain sufficient exposure to the profession to be able to comment on it in a way that would enable discernible themes to be identified in the data.

Comments on the university

Analysis of the student interviews highlighted several areas where students thought the university could help to make placements run more smoothly. Three areas were commented on by more than one student: policies on what students could be involved with, the timing of assessment tasks, and the placement feedback system.

There are policies in place that stipulate what students can and cannot do whilst on placement. For instance, students on the Southampton programme are not allowed to administer intravenous drugs. However, several students reported a poor understanding of these policies by both themselves and placement staff. Amber's comments illustrate the nature of this situation:

> *...the only thing that I found strange was that no one knew what you could and can't do, or can and can't do.... So there's no clear guidelines as to whether you can or can't do it. So like with blood sugar someone would be like, 'Oh I think you can,' and someone else, 'No you definitely can't.'* (Amber)

Several participants also complained about the timing of assessment tasks, scheduled during their first placement. Students reported having to sit for an examination in the first few weeks of their first placement, on lecture material presented beforehand. They also reported being given a reflective assignment that had to be submitted midway through their placement. These students complained that it was difficult to manage revision and essay writing whilst adjusting to being on placement for the first time.

The third university practice that several students commented on was the placement feedback system. Students are required to give feedback at the end of their placement, and are not informed of the details of their next placement until submitting it online. This feedback is then passed onto the placement sites. Students felt that it was impossible to give anonymous advice, given that there are usually less than four students at one placement site at a time. One student suggested that student anonymity could be established by collating feedback before passing it to the placement site.

Summary of nursing students' findings

- Nursing students recognise the relationship with their mentor as vital, but also experience it as variable.
- Students think themselves 'lucky' if they end up with a good mentor, i.e. one that welcomes them, takes an interest and draws on their experience, expertise and networks to benefit the student.
- Initial placement learning was often described as being mentor-dependent or essentially staff-facilitated. Without the mentors' interest and involvement in the learning process of the novice, it was much harder for students to progress.
- Some staff appraise a student's stage of learning on an individual basis (taking into account their background and prior experience). Other staff seem to make assumptions about students' experience and or level of competence, which can be stressful to novices/neophytes.

- Students consider continuous re-appraisal – and feedback – as particularly helpful aspects of placement learning (when it happens).
- Students value and appreciate mentors' thinking ahead and ensuring that learning opportunities with them – or alongside other staff – are utilised.
- Students enjoy learning with or from another student.
- They can (and do) use their own initiative to identify learning opportunities, often based on their AoP portfolio.
- However – as students see it – staff have a key role to play in identifying learning opportunities; these also tend to be more diverse.
- Early guidance by the mentor is crucial as it sets up the students to go on identifying learning opportunities for themselves later.
- Few students reported attending teaching sessions (within placements). Those that did found them to be a helpful way of learning about less frequently occurring situations and procedures.
- Ad hoc in-placement teaching sessions that students found helpful included anatomy and physiology / familiarisation with specialised equipment and instruments / inter-professional teaching (e.g. from Operating Department Practitioners) and practical skills.
- Only one student reported attending a regular schedule of taught sessions whilst on placement; they found these to be of benefit to their learning. Sessions offered: malnutrition / fluid balance / heart failure and learning about the work of the outreach team.
- Students appear to operate with the notion of a hierarchy, where learning by watching or observation is associated with basic or initial stages of learning only.
- Learning by doing (with instruction and under observation) comes next and finally leads to independent practice. In students reported experiences, however, there is no uniform progression from one to the next.
- As the project focused on initial placements – most of students' reflections focused on the first two stages. Nursing students' accounts of instances of learning by doing tended to be relatively unproblematic. When students were deemed to be ready, staff was available to observe their practice, they were willing to instruct and tended to provide feedback to the student. This contrasts with the data from other professions and is likely to be a feature of the close student-mentor relationship.
- Students tend to portray shadowing as minimal or early stage learning, but they nevertheless report significant benefits from observing – especially in the case of professional interactions (such as dealing with difficult situations).
- Students report significant differences in their learning between: a. watching a practical or clinical skill being performed and b. hearing a practitioner articulate the rationale for doing a particular practical skill in a particular way whilst it is being done.
- Students also report 'not learning' (or missing opportunities) either due to difficulties with engaging with a particular site or set up or because they are feeling used / contributing to the workload (rather than engaging in educational activities).
- For their initial placements, some students report struggling in particular settings. They describe first placements in theatres, community settings and managed care wards as particularly difficult. This may be in part because these setting do not meet newcomers' expectations of 'a nursing placement', i.e. on a hospital ward. It may also be due to the fact that at this stage, the student simply does not know enough about these settings to make any sense of them, or to find a role for themselves within it.
- Some students do report thriving in such settings – particularly community settings – though this may be down to their previous experience and / or a particular teaching approach.
- Many students report benefitting from working along healthcare assistants, especially on initial placements. However, some students – who have considerable prior experience of working in an assisting role – do wonder how continuing to perform HCA tasks will enable them to progress with their nurse training.
- Nursing students tend to think of bed making and running errands as menial tasks.
- Oftentimes students understand they need to perform these tasks – they want to contribute to the workload of the unit. At other times, they simply feel used.

- Moreover, they worry about the cumulative impact this may have on their education, i.e. not keeping up / not progressing / not completing their AoP.
- Some students also recognise an implicit exchange involved in clinical teaching, i.e. the more they are willing to contribute to routine tasks, the more likely it is that the team will support them in their learning.
- A few students described how they continued to learn through studying after their shifts. Several reported taking notes to look up specific procedures, conditions, drugs or equipment. Some students keep a diary of events or skills to refer to later (for reflection and or revision. Several students reported using lists for memorisation and/or to rehearse protocols and procedures (on-site or at home).
- Fewer students still reported being asked to research new skills by using on-site materials and guidance before learning how to perform these. Those that did found it useful. It also meant that they were more aware of the resources available to them in a particular setting.
- Finally, few nursing students reflected on wider professionalism issues – though this is perhaps unsurprising, given that the project sought to capture their experience of initial placements. Those that did were concerned with the nature of specialist nursing training (learning more about the profession, including limitations). Others were starting to appreciate (and differentiate) between different levels of nursing care.

Findings from Nursing staff

Factors that influence early clinical placements

Analysis of the data shows that three major factors are perceived as influencing the success or otherwise of early clinical placements. For the purposes of this report, 'a successful placement' can be understood as one in which a student is seen to be thriving and enjoying the experience, meeting their learning outcomes and internalising the 'norms and values' of the nursing profession. First, all interviewees stressed the importance of the relationship between mentor and student and for most this was felt to be the most significant factor in the success or otherwise of the placement. Second, it was perceived that the wider clinical environment could affect the student experience, either independently or through its impact on the mentor-student relationship. Third, student variables were seen as playing a significant part. Student variables are discussed in terms of personality traits and motivation for nursing, student expectations and preparation, and other more external factors that can affect the student experience, e.g. adjusting to shifts, travel, living away from home, managing childcare arrangements, etc.

The relationship between mentor and student

On each clinical placement the student is allocated a mentor as well as one or two buddies. As far as possible students are given the same shifts as their mentor, but when the mentor is unavailable they may attach themselves to their buddies. There was little reference made to the role of the buddy and the emphasis was overwhelmingly placed on the relationship between mentor and student. This was seen by virtually all interviewees as the major influence on the success or otherwise of the placement.

> *The mentor absolutely. It all seems to come down to individual mentors. Students will come and say, 'My mentor was fantastic and I had a good time', or 'my mentor wasn't...' But it always seems to be one or the other.* (James, p3)

> *The mentor, yeah. The physical environment can be as shoddy as you like... but if the people they work with are kind and nice to them they have a great first placement... but if their mentor is nasty to them they have a horrible first placement. So it's absolutely all about the person.* (Linda, p1)

> *So the student's experience is closely linked to the interpersonal relationship that they have with the mentor, the time the mentor can spend with them, their sort of ability to facilitate and to assess the students* (Michael, p1)

In early clinical placements the mentor works closely with the student, supervising most of their activities, facilitating learning and assessing their practice and passing or failing them in the competencies laid out in their AoP document. As part of their training mentors are taught that their role is in *directing learning,* rather than in *teaching* students.

Mentors are taught strategies for directing students' learning. These include asking students to investigate an area and present their findings, perhaps at the hand-over between shifts, or to investigate an individual patient or a piece of research and present it in one or two minutes. Another learning strategy suggested to the mentors was to ask students to learn about a couple of drugs a week, so that they gradually built up their pharmaceutical knowledge.

There was also a sense in which learning took place through less direct strategies that could not be taught to mentors. This learning included not only the acquisition of knowledge and skills but the acculturation into nursing through the internalisation of the 'norms and values' associated with the profession. These processes were seen as difficult to articulate as they happened automatically and spontaneously. It was as if learning took place through osmosis. One interviewee described this type of learning as 'situational learning'.

> *...a lot of the understanding about professional – the culture, the boundaries, the way that we behave, the reasons we do things, comes out of moments of learning. I couldn't prepare you a teaching package for that. But if we worked on a ward together looking after a person, in short moments of being with that patient, that's where the powerful learning happens. And whether the mentors recognise that or not doesn't really matter, it's still happening you know, that situational learning is going on all the time.* (Linda, p3)

Interviewees were able to identify the characteristics that made for a 'good mentor'. This included a mentor that was enthusiastic, valued student learning as opposed to seeing the student as just another 'pair of hands' and acted as a good 'role model'. It was felt to be important that students could admire their mentors and hence wish to emulate them.

> *Ones who are a good role model, you know, sort of showing good caring attitudes to patients and good standards of nursing care, I think enhances the student experience. They want to be with somebody they admire really.* (Lisa, p2)

The support provided by the mentor was seen from both a learning perspective and from a more personal 'befriending' role. A number of interviewees referred to the importance of the 'nurturing' role of the mentor and of the clinical area in general.

> *...this year we have put two first ward placement students into a critical care unit. We've never done that before. And there was a kind of anxiety that it might be too much for them, that very intense nature of clinical work. But in fact the manager has reported that the students are doing very well. And again because they are very closely supervised and supported – the nurturing is strong.* (Michael, p1)

Implicit within much of the data from the interviews with nursing staff was that learning, certainly in the earlier placements, was mentor-directed rather than self-directed learning. Mentors serve as a gateway to learning opportunities and what the student does is largely controlled by the mentor as, ultimately, the mentor is responsible and accountable for the students' actions.

> *And if the mentor is happy to allow a student to do something, they take the responsibility, and they are accountable for that skill or that kind of procedure that the student is going to do. But the student will do it under the supervision of the mentor.* (Michael, p5)

> *Sometimes they feel that they are just not being allowed to do the things that they think they could do* (James, P5)

> *...so one of the recent first year gripes was, 'so and so gets to leave the ward and go and see this sort of thing, but I don't, and it's not fair. And it's because their mentor is really paying attention, and my mentor is not paying attention.'* (Linda, p8/9)

These quotes show the control that the mentor holds over student learning and helps to explain why the success or otherwise of the placement is so heavily tied up with this relationship. Indeed, if students acted independently or tried to take control of their own learning, heavy sanctions were applied, including fitness to practice panels.

However, one interviewee indicated that, although student learning might be mentor-directed rather than self-directed, it was not an active/passive partnership. Although the mentor might be the one to create and control the learning experience, the student was expected to respond actively.

Student learning within the clinical environment is therefore heavily dependent on the role of the mentor and students cannot be placed in a clinical area unless there are adequate numbers of trained mentors. Interviewees pointed out that mentors do not receive any remuneration or extra time for carrying out this role and the university relies on the goodwill of qualified staff. Enlisting and retaining enough mentors was an

on-going challenge. Some interviewees felt that pressure should be put upon qualified staff to act as mentors and that they had a duty to perform this role:

> *I have seen some people (…) take an extraordinary robust approach, to say, 'Yes this is your code of conduct, it's in your policy, it's in your job description. It's a performance management issue if you refuse to do it. And you will not get through your next KSF gateway unless you do a mentorship course.'* (James, p15/16)

> *I mean some people do sort of opt out. And I mean it's that rewarding bad behaviour thing, of the fact that somebody doesn't want to do it, do you give in to them and not make them do it?* (Lisa, p2)

However, there is a clear tension between forcing reluctant staff into becoming mentors and the need to have mentors who are enthusiastic and welcoming towards students and who value student learning. The following quotes show how interviewees recognised the difficulties involved.

> *...we talk about toxic mentors who really don't want students. (*Caroline, p8)

> *...and some of them view students as being a bit of a burden and they detract from patient care. I mean the majority don't, the majority are very keen and want to have students there. But it's unfortunate, you know, we get students coming back sort of saying that they felt a nuisance, either because they were given non-verbal feedback that they were, or sometimes even verbally. And that makes them feel really – if that's a first warder that could make them feel really really devalued.* (Lisa, p2)

Impact of the clinical environment

The relationship between mentor and student is enacted within the wider clinical environment: according to the interviewees, the 'ward culture' was largely shaped by the ward sister.

> *...the culture which influences what the mentor is like with the student is heavily influenced by the sister. The way the mentor is with the student will be directly influenced by the way the sister is with the mentors*. (Linda, p3)

Becoming a part of the clinical environment and feeling they had a role within the ward team was also seen as an important factor in the success or otherwise of the placement. Students could feel very isolated if they did not feel part of the team. Again, both the ward culture and the mentor were seen as playing a significant part in helping the student to integrate into the team.

> *Some students have a natural ability to become integrated into particularly if you've got a very close-knit team and they feel they're outside of it. And so it can be really hard. And that's where their mentor is a key, is key in allowing them to have that degree of integration.* (Victoria, p19)

> *Oh yeah, certainly, they need to feel part of the team. If they don't feel part of the team then they find it very isolating.... And recognising what part you play in the team, that whilst you may be there in a very junior capacity doesn't mean you're not part of the team.* (Mary, p10)

> *It's about the culture on the ward. And I would say sometimes in the longer term rehab type of wards, they do find that difficult. It's a recurring theme, I think, that students can find that hard. Because they, you know, they're not sure, they're trying to fit in, they're trying to become part of a team, and however nice they are and however much they try, sometimes it's really difficult. I think, what I've perceived as the problem is the leadership on the ward. If the leadership on the ward is not strong, then it falls apart all the way down.* (Karen, p5)

Students were felt to be very susceptible to the ward culture and would quickly pick up and internalise the attitudes and feelings of the permanent staff:

> *...they're getting 'acculturated' very quickly, and if a culture is one of moaning the student will learn to moan. And they learn that sort of thing from the people they work with.* (Linda, p1)

A further area of concern discussed quite widely by the interviewees was the tension between students having a supernumerary status on the one hand, and yet on the other being used as healthcare assistants. This was felt to be particularly acute in earlier placements.

> *that's often one of our biggest problems students start getting used as another pair of hands on the ward.* (Victoria, p6)

> *I think probably they end up doing far more healthcare support work than they should be doing, particularly in Year 1 and possibly half of Year 2. And that's an education issue for us and that constantly comes up in student feedback.* (Victoria, p12)

One interviewee pointed out, however, that although students should be treated as supernumerary, the exigencies of the clinical environment meant that sometimes they just had to put this to one side.

Another interviewee argued that the most basic tasks, where students could feel that they were being used as 'a pair of hands', could be transformed into a learning experience if it was presented in a certain way. In effect, she argued that any experience, no matter how banal, could be turned into a learning experience:

> *…it's how you ask the student to do it. So if you ask them to go and do the afternoon teas they might feel dumped on, but if you tell them it's about looking at fluid balance and different techniques to ensure people drink then they start to see some relevance in it.* (Victoria, p7)

Student variables

Interviewees identified a number of student variables contributing to the success of early placements and these, in turn, affected the mentor-student relationship and the interaction between student and the wider clinical environment. Student variables identified were personality traits and motivation for nursing, student expectations and preparation, and other more external factors.

'Good students' were described as enthusiastic, motivated, showing initiative and 'engaged with the learning'. 'Bad students' lacked these capacities, failed to engage with the learning process and might behave unprofessionally.

> *Students who are not doing so well are those that behave unprofessionally – they turn up late for their shift, they're rude, arrogant, unpleasant to people – they're what you might call lairy, gobby, answering people back.* (Michael, p3/4)

> *...someone who is engaged with it, someone who is motivated, interested, shows initiative and has got the kind of characteristics of what an academic might call adult leaning.* (Michael, p2)

Moreover, 'good students' were sensitive to their environment and knew how and when to pursue learning opportunities. Interviewees explained that students needed to know when it was appropriate to pursue learning opportunities and ask questions and when it was more appropriate to refrain from such activities and become more self-effacing. Another interviewee pointed out the potential rewards of being considered to be a 'good student':

> *So there is a kind of feel that they have done well, the mentors have responded to them positively, seen them as a developing member of the team and would like to offer them a job at the end.* (Michael, p7)

The data suggest that a 'good student' 'tows the line' in accepting established nursing norms and values. The importance of time keeping – arriving on time for shifts and returning promptly from breaks – was prominent in the data and staff considered it a visible marker of thriving students (see below under 'The Support System').

Whilst conforming to accepted standards and internalising professional values was part of students' successful acculturation, a 'good student' should also be willing to challenge 'bad' practice. This was accorded very high value by university staff.

> *...it's a very very difficult thing to challenge people who are your seniors... but we're encouraging the students to challenge [bad practice] and if they can't challenge it at the time with that person, either challenge it in a very positive way with someone else or come back to us to support them to challenge it.* (Caroline, p14)

The personality of the student and their enthusiasm for nursing was therefore seen to play an important part in the success or otherwise of early clinical placements. Alongside this there was a perception that students were more likely to thrive if they had realistic expectations about what to expect.

> *in Year 1 it's very much about survival. It's about finding their feet. And the messages I hear most are that it was very different from what they expected, that it was very busy, that they feel that everyone else knows what they're doing except for them.* (Philippa, p3)

Previous life experience, and particularly previous experience as a healthcare assistant, was seen as having some influence on the success or otherwise of early placements. It was generally agreed that previous work as a healthcare assistant (HCA) made the transition to the clinical environment much easier for students because they knew what to expect and the environment was familiar. However, some interviewees saw previous HCA experience as a double-edged sword. First, it was felt that students could feel frustrated at the similarities between the work they had done previously and the work expected of first year student nurses. Second, they may too easily slip back into the role of a healthcare assistant without realising the need to approach their activities differently. There was a need for them to see basic care as learning opportunities rather than tasks carried out passively and as an end in themselves:

> *And if a student has had experience as a healthcare worker beforehand, it can sometimes make the transition easier. But again it can also sometimes work against them, because they may easily slip back into that role, and we want them to move forward to being a student nurse.* (Caroline, p3)

> *Because what they are physically doing will be very like what the healthcare support workers are doing, but they should be doing it with a very different mindset, and reappraising and re-evaluating anything they've done before, and seeing things through a different lens.* (James, p7/8)

It was felt to be important that students were prepared as far as possible for the clinical environment. Prior to their clinical placements students were encouraged to find out about the clinical area both in terms of work shifts, commuting and also their expectations and their AoP portfolio. Within the first week students were supposed to have a meeting with their mentor, to talk about what they felt were their strengths and weaknesses, their expectations and to express any concerns.

Finally, it was recognised by interviewees that the students' external circumstances could influence the success or otherwise of the clinical placements. Students had to adjust to working shifts, travelling to and from work, possibly leaving home for the first time or managing childcare and other home commitments. In addition, relationship problems or other personal crises could affect their experiences and performance in the clinical environment.

And the other time when things are emotionally difficult for the student is when external factors start hitting home. So boyfriend break-up, financial problems, travel, just the tiredness and the stressiness of working in a clinical area. (Linda, p11)

The recognition of how students' personal circumstances, along with other student variables, could affect their clinical placement experience was further shown through interviewees' discussion of the micro functions of the support system.

The support system

Interviews with nursing staff highlighted the importance attached to the clinical aspects of nurse training and described the complex support system set up to ensure appropriate and successful clinical placements throughout the three year training.

We have a big team. Practice is 50% of the curriculum and about a third for other professions, so we have a really strong team to make sure we're giving as much resource to supporting practice as we are to academic work, because that's a large part of the students' curricula. (Victoria, p9)

The support system is not static; it has evolved and continues to evolve, particularly in terms of the different roles set up within the system. Staff working within the support system are based either in a university or within the NHS/Trusts, although occasionally staff may have joint appointments where they work within both a university and NHS.

The support system can be seen to operate at two levels. First, at a macro-level, the support system is a formal structure with personnel in place to ensure that clinical placements are well organised and provide students with suitable experiences. Second, at a more micro-level, the system aims to support individual students whilst on placement and to resolve any personal and inter-personal difficulties that may arise.

Macro-functions

One of the main functions of the support system is to find suitable clinical placements for students that provide appropriate learning opportunities alongside trained mentors. Once established, staff monitor placement quality through regular clinical audits and through student evaluation. At the end of each placement students are asked to fill in an evaluation form. To ensure a high response rate students are not informed of their next placement until the evaluation for the previous placement is completed.

Each Practice Academic Co-ordinator (PAC) is responsible for looking at the student evaluation for their clinical area:

If it's just one poor evaluation then you think maybe there is a personality clash.... If you get a couple you're starting to think, 'Is something not right here?' So you might go and visit that ward and just see, you know, talk to the Locality Environment Lead, you might just investigate a little bit more to see if problems are starting to develop. It might be that there is a changeover of staff, it might be the ward somehow is understaffed. (Karen, p10)

Within the university an administration team ensures that each student has an appropriate range of different placements throughout their training, covering the main specialities. In addition, the team looks at individual students to see where they are living and to try and place them in an area that is convenient. There is a particular concern with first year students, who are also having to adjust to the clinical environment, shift patterns and possibly living away from home for the first time.

The support system recruits and trains mentors and ensures that they receive regular updates. At the start of each clinical placement students have an induction day that introduces them to the area and provides them with contact people in case they should experience problems whilst on placement.

This comprehensive structural support system functions to provide an optimal clinical environment in which the novice student can be transformed into professional nurse. It serves as the bedrock for the transition between university and the clinical environment, as well as a firm base on which the relationship between student nurse, mentor and the wider clinical area can be enacted. The report now turns to this more personal and interpersonal level.

Micro-functions

Whilst the support system aims to put in place an optimal learning environment for students, it also recognises that difficulties may arise for individual students through personal issues or inter-personal problems between themselves, their mentors and/or the clinical environment. Students are encouraged to seek help if they cannot resolve these difficulties. The student's academic tutor is generally regarded as the most appropriate person for the student to turn to for help as they will remain with the student throughout their three year training.

> *We see them in learning groups every four weeks, so that's our opportunity to really start exploring what is happening in placements. And the academic tutor who runs the learning group has seen that student throughout their journey, and you build up a relationship where you know if something's not right. Hopefully it hasn't got to that point. And all students are encouraged to keep in contact with their academic tutors. And the majority of academic tutors will also contact the student either by email or phone to say, 'How are things?' a week in, you know 'Make sure you remember that I'm here if you need me'. So we build up that relationship throughout the programme.* (Caroline, p12)

At the induction day students are also informed of other members of staff that they may contact if they are having problems. This includes the link tutors, the PACs and Trust Education Teams. The Education Teams were felt to be another invaluable layer of support.

> *And then some of the Trusts, I mean Southampton in particular has got education teams dotted around the hospital, and I think that's something that really helps as well. So that if a student is struggling, or maybe not finding their mentor to be particularly helpful, they've got somebody else in the Trust that they can go to, who is there in uniform, you know, around all week. And they can just have a quiet word with them, and sort of I think it just adds an extra safety net really.* (Lisa, p3)

The data show how members of the support team would make informal contact with both students and clinical staff throughout their clinical placements, e.g. through casual 'chats' or 'walk arounds' that provided another opportunity for students or staff to raise issues or concerns and for university staff to monitor student progress.

> *I do tend to wander around whenever I can and go and visit the students when they're on these placements, just to check they're OK and things are working.* (Michel, p4)

> *And if I see any of the students in the hospital they quite often come and have a cup of coffee with me or just sit and chat and we get feedback from them as to how well they've been getting on.* (Michael, p6)

The data indicate that the most common problems were students experiencing difficulties with their mentors, or poor attendance or time keeping on the part of the student. The former was usually reported by the student and the latter by the clinical staff. Interviewees showed how problems were approached with tact and sensitivity and in the use of terms such as 'exploratory conversations'.

> *...sometimes I trust the student to tell me exactly what's going on, and if it rings true I'll try a softly, softly approach. And if the student tells me it's fixed, then I'll trust them that it's fixed. Sometimes students tell us stuff that isn't necessarily true, or is a misconception. And then you have to work with the mentor to try and get the student to understand what is really going on.* (Linda, p7)

Interviewees identified that one of the most frequent signs of a student not thriving in the clinical environment was poor attendance or poor time keeping. These behaviours were also regarded as the student failing to conform to accepted standards and professional behaviour. Initially, however, it was felt that students may not understand the need for good attendance and good time keeping or they may push at the boundaries to ascertain what is and is not acceptable.

> *...you tend to have a few issues with the first years where they think they can arrive late because their buses arrive late, and those kind of things. And so a lot of those problems can be nipped in the bud by the ward manager, a strong mentor or myself. So sometimes I am brought in to reinforce what the clinical staff are saying to them and just to lay down that things aren't acceptable.* (Mary, p6)

One interviewee showed how measures had been brought in to ensure that professional standards were enforced by monitoring students' time keeping; requiring them to sign in and out.

A student who continued to arrive late or had poor attendance was often deemed as one who was struggling in the clinical environment. Interviewees showed how staff would try to explore any issues with the student in an attempt to discover whether there were difficulties in their personal life or whether they were having problems with the course or with their mentor.

> *It might reveal that the student has got things like childminding difficulties and that they can't manage the shift patterns. So you might have a conversation about that and give them some options about childminding arrangements. You might have a conversation with a student who says, 'Actually having gone on to these wards, nursing is not what I thought it was and it's not for me. I can't do this.' Or it might be a conversation with the fact that they just don't get on with their mentor.* (Michael, p3)

However, in spite of the sensitivity shown towards students, good attendance and good time keeping remained paramount and, as the following quote shows, failure to conform eventually to these standards could not be tolerated. At a micro-level the support system therefore operates on a day to day basis in an attempt to maximise a successful outcome to the clinical placement. It is both pro-active in its monitoring of student progress and reactive when problems arise. In spite of these apparently sophisticated measures, some interviewees still felt that students could fail to report the difficulties they were experiencing or did not receive the degree of support that was required:

> *And you know I think sometimes students are not good at coming forward and telling us about problems early enough. Sometimes perhaps we're not good at picking up what they are not saying as what they are saying and intervening or realising the gravity of what it's like for them. And so they might come and say, 'Oh I've got a bit of a problem' and we'll try and encourage them to go back and sort it out, but actually I don't think sometimes we appreciate how difficult it is for them to go and sort it out. You know, it's about professionalism, and they do have to learn to address problems, but I think sometimes they need a bit of a holding hand and I'm not sure how consistent we are at doing that, or at appreciating the difficulties.* (Karen, p6)

Future developments in nurse education

There was some discussion with interviewees about future developments in nurse education. Five themes predominated. First, there was concern about future recruitment of student nurses. At Southampton, the diploma and advanced diploma in nursing is to be withdrawn from September 2011 and the only route into nursing will be via a degree course. The rest of the country will follow by 2013. The bursaries currently available for diploma and advanced diploma courses will therefore be withdrawn. It is not clear whether anything will replace them and whether student nurses will have to pay fees like other university students. It was felt that these changes in the funding of nurse education could affect future recruitment.

Second, once training becomes totally degree-based, mentors will be expected to grade students in their clinical placements rather than simply pass or fail them on their competencies. There will also be new methods of recording student assessments. This will require considerable staff development.

Third, at least 70% of clinical placements are at present in an acute setting and less than 30% are in the community. The NMC propose that, in future, half of all placements are to be in the community. This raises concern about whether students will have enough acute experience and whether the community has the capacity to take the increased number of students.

Fourth, interviewees indicated that there had been some suggestion that Trusts would be paid for having students and if this was the case there would be a much greater interest in having students and a concomitant increase in capacity.

Fifth, interviewees spoke about changes to the student experience in either enabling the student to follow patients' journeys and move with them through the different clinical areas, or through a 'hub and spoke' approach where they had a base area but spent time in different related areas.

Summary staff perspectives

- On each clinical placement a student is allocated a trained mentor and one or two buddies. The key relationship is with the mentor.
- The major influence on the success or otherwise or early clinical placements is the quality of the relationship between mentor and student.
- The wider clinical environment impacts upon the student experience but this is largely mediated through the mentor and student relationship.
- Student variables also influence the success or otherwise of early clinical placements. These variables include the personality of the student, their motivation to become a nurse, their expectations of what it involves and external circumstances, such as home commitments, travel arrangements, adjusting to shift working, financial difficulties or relationship problems.
- The transition from university-based to clinical-based education is made easier when students have a healthcare background. However, such students can feel frustrated in early placements by the repetition of what they were doing as healthcare assistants or by failing to realise the learning opportunities in simple nursing tasks.
- In early clinical placements learning is mentor directed rather than student directed.
- In early clinical placements students learn nursing skills and begin to integrate knowledge but they also have to learn to conform to professional standards and internalise the 'norms and values' of the profession.
- There is a complex support system to help facilitate the successful outcome of clinical placements. It is composed of both university staff and NHS staff. It operates at a formal macro-level and a more informal micro-level.
- At a macro-level, systems are in place to ensure that students are allocated to clinical placements of high quality and that they are suitable on both a practical level and a learning level.

- At a micro-level, the support system operates on a more personal level to monitor student progress and to intervene if problems arise.
- Most mentors and students work well together, but when problems arise in the relationship the support system often becomes involved.
- In early placements students must learn to conform to professional standards. Time keeping is one standard that the support system may be called upon by clinical staff to reinforce.
- One of the challenges for nurse education is ensuring there are enough trained mentors in the clinical areas.
- There is a tension between the perception of the student as supernumerary and of the student being seen as part of the workforce. The latter perception can serve to eclipse the student's role as learner.

Duration of project: August 2010 to October 2012

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