An investigation of student nurses' experiences of learning within the Clinical Learning Environment

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Abstract

Student nurses in the United Kingdom spend approximately half of their nursing education programme in the practical setting, learning to nurse. This practical setting is commonly referred to as the Clinical Learning Environment (CLE). High quality placement experiences are essential in supporting the development of knowledge, skills, values and attitudes required of a Registered Nurse. However, the literature suggests that many students describe their clinical placements as being punctuated by negative experiences. Given the importance of learning in practice for the profession, and the pervasive negative reports from students, this study investigates the critical question of how student nurses experience learning within the CLE. A qualitative methodological approach was taken, with interviews and focus groups conducted with forty-six student nurses. The focus of the discussions was to specifically elicit the students' experiences of learning in this environment.

Theories of situated learning (Lave and Wenger, 1991) and power (Lukes, 1974) were used to support the analysis. Analysis of the data highlighted three key themes: i) Educational realities associated with the CLE; ii); the influence of Mentorship iii) Power and powerlessness. It was found that care delivery requirements are consistently prioritised above the learning needs of students; coined 'the clinical imperative' in this thesis. Given the extent of clinical pressures, mentors are relatively powerless to advocate for students' learning needs. Under such circumstances, students have a propensity to take up non-supernumerary 'worker', rather than peripheral 'learner' roles, often 'supervised' by Healthcare Assistants. The students described their learning experiences as typified by patterns of inadequate supervision and ubiquitous poor practice.

Student powerlessness within the hierarchical structure, compounded by risk of failure or poor treatment, creates student vulnerability. Such vulnerability means that students are often willing to exchange learning for work, to reduce risks and ingratiate themselves with mentors. Positive mentoring relationships may ameliorate the pressures inflicted by the conditions of the CLE. Conversely,

negative mentoring experiences may exacerbate the risks associated with learning in this environment. Despite such challenges, students are still required to demonstrate their increasing competence, which can become problematic if they have not been afforded appropriate learning opportunities.

Analysis of the data reveals that students frequently experience mentors (and others) utilising their power to coerce. Students often feel unable to challenge (either compromised learning experiences or poor practice) because they fear reprisals. The influence of power can lead to the suppression of students in the CLE, and in the worst cases may lead to attrition.

This thesis demonstrates that students experience significant challenges to learning within the CLE, challenges which are poorly understood. Greater understanding of how student nurses experience learning within the CLE can inform those responsible for nurse education how to improve and optimise learning in this challenging environment.

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Glossary of terms

Approved Education Institution (AEI)

British Educational Research Association (BERA)

Clinical Learning Environment (CLE)

Healthcare Assistant (HCA)

Health Education England (HEE)

Institutional Focused Study (IFS)

International Council of Nurses (ICN)

Learning Environmental Leads (LELs)

Link Lecturers (LLs)

Multidisciplinary Team (MDT)

National Health Service (NHS)

Nursing and Midwifery Council (NMC)

Private, Voluntary and Independent (PVI)

Research Based Thesis (RBT)

Royal College of Nursing (RCN)

The World Health Organisation (WHO)

United Kingdom (UK)

Chapter 1: Introduction

Aims and rationale of the study

In undertaking this Research Based Thesis (RBT), my primary aim was to better understand student nurses' experiences of learning within the Clinical Learning Environment. Student nurses spend significant time in clinical environments, learning how to nurse in practice, applying theoretical knowledge (gained within the University setting). Nursing is fundamentally a practice based profession, therefore the experiences gained within the practice setting have a significant influence in shaping students' development into competent Registered nurses. Understanding students' experiences within the clinical environment is therefore important for identifying the factors which impact on the quality of their learning experiences and ultimately influence their preparedness to practise as nurse registrants.

Although there have been significant enhancements in nurse education within the last 20 years, literature indicates that many students still describe their clinical placements as being characterised by negative experiences (Randle *et al.,* 2007; Eick *et al.,* 2012; Thomas *et al.,* 2012; Ion *et al.,* 2016; Wilson, 2016). Much of the extant nursing literature has a relatively narrow remit, for example focussing on issues relating to mentorship, belongingness, bullying and conformity to poor practice within the CLE. While these are important topics, a focus on such discrete issues may fail to fully explore the often subtle interplay at work within certain experiences and relationships in the CLE and the subsequent impact on students' experiences of learning in this environment. As a result it is likely that we fail to understand how and why students may experience the CLE as a challenging place to learn, and how these challenges can lead to a number of negative consequences. For example, there is reason to believe that compromised learning experiences within the CLE may contribute to high pre-qualifying attrition rates (Health Education England, 2018) and a lack of preparedness at qualification – a common criticism levelled at the profession (Willis Commission 2012).

Pressures within contemporary health care environments are well recognised (Maben, 2013; Royal College of Nursing, 2013; Appleby *et al*., 2014). This research aims to provide a deeper level of understanding and new insights into how student nurses experience learning within this pressured environment, and the particular challenges involved in negotiating their learning needs set within the relationships, norms, expectations and behaviours in clinical settings. Given concerns about attrition rates, preparedness and general student welfare, this new knowledge would be significant anyway, however recent changes within supervision and assessment regulations (NMC, 2018a), published since the commencement of the study, provide an added impetus for this thesis. I will briefly refer to some of the implications for the new Standards; however this thesis is not instrumentally focused on informing them.

Threaded throughout both my clinical and academic career has been a desire to understand and improve students' experiences of learning, particularly within practice. This passion influenced the choice of subject area for both my Institutional Focused Study (IFS) (appendix A) and this RBT. The IFS was entitled: '*A qualitative examination of nurse link lecturers' perceptions of the challenges facing student nurses in clinical learning environments'*. This study revealed that Link Lecturers perceive the mentor/mentee relationship to have a fundamental impact on the quality of students' learning experiences within the CLE. The link lecturers reported that students commonly find themselves located in polarised positions of either 'fitting in' with mentors, thereby potentially gaining access to available learning opportunities, or 'falling out' and merely learning how to 'get through' their placement (Harrison-White and Owens, 2018).

These IFS findings motivated me to explore students' experiences of learning within the CLE; the RBT was intentionally formulated to build on and complement the knowledge gained through interviewing Link Lecturers. Furthermore, I am an Associate Head of School/ Associate Professor and lead for nurse education in a School of Nursing. Whist it is hoped that this RBT will

inform change at my institution, and elsewhere, my primary aim is to better understand students' experiences of learning within the CLE. With this aim in mind, I set the following research question:

How do student nurses experience learning within the CLE?

I aim to highlight particular elements of this broad question through the following sub questions:

> ***To what extent are student nurses able to engage in practice based learning within the CLE?***
>
> ***How do relationships within the CLE affect student nurses' learning experiences?***

In what remains of this chapter I will provide a brief outline of how the study proceeded to meet these aims.

Methodology

The empirical research at the centre of this study was undertaken at a University in the South of England, and involved second and third year student nurse participants. I chose a qualitative methodology because this approach enabled me to better understand students' experiences of learning. This research was conducted within the hermeneutic tradition, focusing on combining student nurses' and my own experiences, and on establishing key discourses from the literature. I utilised Ricoeur's (1974) hermeneutic interpretative theory to understand and interpret the student stories of their learning in practice. This theory enabled me to acknowledge and integrate my own views, as a practitioner, and seek to interpret the students' views in the context of this. Based on my extensive experience as a clinical nurse and educator, this unification yielded considerable depth of understanding of the phenomenon under consideration.

The literature

To understand both the extant literature and my data, I drew on theoretical frameworks to provide analytical lenses. In addition to Ricoeur's (1974) hermeneutic interpretative theory, which informed my methodology, I drew on the work of Jean Lave and Etienne Wenger (1991), to make sense of how student nurses experience learning within the CLE. I utilised Lave and Wenger's (1991) situated learning theory in my IFS and, based on that experience, I realised that it would be a useful theoretical framework for this RBT. I used the work of Steven Lukes (1974) as a second theoretical lens to help me understand the extant literature and analyse the data, specifically relating to power dynamics operating within the CLE. Together this material enabled me to understand the position of student nurse learners in this environment. In line with the hermeneutic perspective, my approach to the literature review is based on establishing the prevailing narrative within the literature. I prioritised an approach that would best enable me to develop an awareness of student nurses' experiences, in line with my chosen theoretical perspectives, over a more strictly systematic approach.

Lave and Wenger (1991) argue that it is through the varying social relations that learning can be best understood, thus placing learning as socially, rather than individually grounded. For students, one of the most significant relationships is, arguably, between the mentor and mentee. When that relationship functions effectively learning is more likely to be optimised. Lave and Wenger (1991, p 29) claim that 'situated learning', as occurs in the CLE, has '*legitimate peripheral participation'* as its defining feature. It is from this peripheral position that learners are given the time and space to legitimately learn as a non-essential part of the workforce.

Understanding the importance of *legitimate peripheral participation* enabled me to appreciate the negative consequences for learning, where this status is eroded. There is good reason to think that such erosion may occur whenever student nurses are asked to undertake Healthcare Assistant (HCA) work related

activities in the clinical environment. Such requests mean that learners are typically prevented from participating within a community of expert practitioners, enabling them to gain mastery in nursing. If students are acting as a HCA, this removes or relocates them away from the community of experts. Lave and Wenger (1991) assert that exclusion from such participation may prevent 'newcomers', i.e. student nurses, from moving towards becoming full participants (competent Registered nurses) within the community of practitioners.

Although Lave and Wenger recognise the potential impact of power within communities of practice, theirs is principally a learning theory and not a theory of power. To fully understand my data, I needed a more nuanced appreciation of the power relationships operating within the CLE. I therefore utilised the work of Lukes (1974) as a complementary theoretical lens. Lukes sets out a three-dimensional view of how power operates. The first two dimensions were helpful in enabling me to understand the power dynamics operating within the CLE. It is the third dimension which suggests that for power to function most effectively there needs to be a general acceptance of an underpinning ideology. Applying this third dimension of power to the CLE reveals how students learn in an environment in which their learning needs are perceived as a secondary consideration, because of a general acceptance that attending to care requirements must take precedence over providing or taking up learning opportunities. I refer to this ideology as the 'clinical imperative', which takes a key position in the analysis of the findings. I argue that the clinical imperative is seen to operate a source of power that governs relationships and experiences of learning in the CLE. It helps to explain how and why mentors and students negotiate learning opportunities in an environment where learning needs are viewed as a secondary and comparatively insignificant consideration.

Analysis

The presentation of these findings is centred on three key themes, which emerged from the data. These are: i) Educational realities associated with the

CLE ii); The influence of mentorship iii) Power and Powerlessness. Analysis of the data reveal serious concerns about the suppression of some students within the CLE. To understand these concerns, issues of power and relationships need to be considered. Set against the pervasive strength exerted by the 'clinical imperative', students and mentors are often relatively powerless to advocate for learning needs. Within this context, mentors are often unavailable to students due to clinical pressures. Unavailability forces mentors to allocate (particularly junior) students to 'work' with HCAs, under the premise that they are 'learning' the 'basics'. Healthcare Assistants are orientated towards care work tasks rather than learning, therefore students are readily exploited as 'workers' when they are allocated to them. The data suggest that as students become more senior, they move from working 'with' HCAs to being used 'as' HCAs. Under these conditions students become essential non-supernumerary workers, rather than legitimate peripheral learners. By adopting a non-supernumerary position students are no longer peripheral to the function of the ward and their learning status can become readily eroded.

The idea that students within the CLE will be protected as learners fails to take into account the way power operates in this setting. In this practical context learning does not have an inherent priority over caring, which as my data illustrate, can make students vulnerable to exploitation. Their vulnerability to exploitation is predicated on students' need to pass their placements, meaning that students readily 'trade' learning in for work. Students find it difficult to protect their learning, within the power relationships, and this can lead to them colluding with the normalisation of compromised learning experiences and poor practice as a strategy to pass their placements. Participants commonly experienced compromised learning opportunities; such learning circumstances signalled a general devaluing of learning with the CLE.

Participants' conversations suggest that positive mentoring relationships may mitigate the pressures experienced by students and inflicted by the conditions of the CLE. However, the effectiveness of mentorship is reliant upon both

individual mentors' commitment and the structural circumstances in which they are operating. Students and their mentors need to grapple with the clinical imperative to try to create and protect learning opportunities. Negative mentoring experiences may exacerbate the challenges associated with learning in this environment. Despite these challenges, students are required to demonstrate their increasing competence within the CLE, which is necessarily problematic if they have not been afforded appropriate learning opportunities.

The most concerning finding is that the participants frequently experienced mentors (and others) utilising their power inappropriately. The nexus for student vulnerability is predicated on their requirement to pass their assessments in practice. Students are unable to challenge because they fear reprisals, in the form of their Practice Assessment Document (PAD) or detrimental changes in attitude towards them, which in some instances amounted to organisational collusion. Such use of power can lead to the subjugation of students in the CLE, which at worse forces them to leave the programme altogether.

Conclusion

The experiences of students show that there are significant challenges to learning within the CLE that are poorly appreciated. Nurse educators need to better understand the relationships within the CLE and the ways in which these are subject to power dynamics, which can lead to diminished learning opportunities, and the oppression and subjugation of students.

Chapter 2: The literature review

2.1 An overview

Literature reviews function to provide: an overview, synthesis and a critical review of previous research; a challenge to existing approaches, theories and findings and to identify novel research problems and contemporary research questions (Alvesson and Sandberg, 2011). There are multiple ways in which a literature review can be undertaken, but within the context of primary research, the literature review methods must align with the epistemological approach used within the study. For this reason a hermeneutic narrative approach was adopted in this literature review (appendix B), which aligns with the hermeneutics ascribed to Paul Ricoeur (1981), used to underpin the research methodology of this study. This literature review provides the information necessary for contextualising the study. It also provides theoretical and practical perspectives that augment my existing knowledge of this area from my professional experience. Analysis of prevailing narratives within the literature provides a platform for the gathering and interpretation of empirical data.

The search process

There is a strong hermeneutic tradition in nursing research, which emphasises the experience, interpretation and the construction of meaning (Charalambous *et al.*, 2008). However, this tradition can fail to reach the expectations of those operating within the more established positivist paradigm, in which systematic literature reviews dominate. Positivism assumes that there exists a truth '*out there*' in the world, which can be discovered through observation, and that a neutral and systematic approach is the best way to produce an objective knowledge. From this perspective it is assumed that a neutral and comprehensive systematic review can provide an objective answer to a relatively focused and predefined question. Systematic review often emphasise extraction, tabulation and synopsis of empirical data (Greenhalgh 2018). Such studies may be highly appropriate and add value when considering complex clinical problems, when meta-analysis may confirm whether an intervention is clinically significant. However, a systematic approach may be an unsuitable

strategy in the humanities and social sciences where the focus is on developing an awareness of experiences, interpretation and processes of understanding (Boell and Cecez-Kecmanovic 2010). These disciplines often require a synthesis of research relating to multifaceted situations and perspectives and as a consequence the reviewer may include a wide range of literature searches, and undertake complex interpretation using both judgement and creativity (Greenhalgh *et al*., 2018). Greenhalgh *et al.* (2018) argue that systematic reviews should not be synonymous with high quality, with an assumption that narrative reviews are relatively inferior: rather these are two different approaches which must be used as is appropriate given the aims of the research and the broader epistemological and methodological commitments of the study. Accordingly, the focus in this study on understanding the clinical learning experiences of student nurses and the commitment to a hermeneutic epistemology justifies the use of a narrative approach to the literature review.

Narrative reviews consider plausible truth as it emerges through the construction of a coherent narrative (Greenhalgh *et al*., 2018) and constitute a thorough narrative syntheses of published information (Green *et al*., 2006). In aligning this thesis with a hermeneutic epistemological position it is assumed that achieving a neutral epistemological perspective is not possible. This hermeneutic narrative review will authentically represent the underpinning evidence and articulate how this evidence is utilised and drawn together to inform conclusions; requirements of a narrative literature review (Green *et al*., 2006). A hermeneutic narrative review aims to create an interpretive understanding (Greenhalgh et al., 2018) and is thereby interpretive in nature (Boell and Cecez-Kecmanovic 2014).

A criticism of narrative (hermeneutic) review is that researchers may '*cherry pick*' particular evidence to bolster their arguments and perspective (Greenhalgh *et al*., 2018). However, contra to the assumptions of positivism, the hermeneutic perspective assumes there is no objective truth and consequently it is the role of the researcher to reflectively and critically select the best evidence judiciously

and purposefully to address the issue under consideration (Greenhalgh *et al.,* 2018). From this perspective the common claims made by systematic reviews of being unbiased and replicable may be considered naïve and unrealistic (Hjorland, 2011). All literature reviews, whether systematic or narrative (hermeneutic), proceed from a set of concerns which may prejudice any review process. What is important is that the hermeneutic approach is explicit about its interests and values, and that these are critically reflected upon, and claims to neutrality and/or universality are thereby avoided. The hermeneutic narrative literature review does not claim to be an objective and technically correct search (in terms of a systematic review) however it identifies relevant academic sources, results and critically appraises them to further understanding (Boell and Cecez-Kecmanovic, 2011).

Boell and Cecez-Kecmanovic's (2014) hermeneutic framework for undertaking narrative literature reviews was broadly utilised to guide this literature review (appendix C). This framework describes two main hermeneutic circles: *the search and acquisition circle* and the wider *analysis and interpretation circle;* both are mutually intertwined. A literature review (predicated on the hermeneutic circle) constitutes: literature searching; mapping; critical review and argument formulation (Boell and Cecez-Kecmanovic 2014). The hermeneutic approach thereby emphasizes continuous engagement with a body of literature during which a depth of understanding is developed. This process is usually open ended and circular in nature. It is thereby iterative; understanding a paper is not an isolated event, it is interpreted within the context of other related papers. There is movement between the parts and the whole in the process of understanding, described by the hermeneutic circle (Boell and Cecez-Kecmanovic 2010). A hermeneutic narrative approach therefore enables a deeper understanding of both the body of literature and individual texts, incorporating the researchers' own experience and knowledge as an '*insider*' to the context.

Following a hermeneutic, narrative approach, it is important to acknowledge that I entered this literature review process with considerable knowledge, gained principally through my earlier Doctoral studies and professional nursing career. I developed the knowledge gained through undertaking my IFS and I built upon broad themes of interest gained through reading key authors (for example, Levett-Jones and Lathlean) whom I knew to be important to this study. In hermeneutic terms this is known as the entry to the hermeneutic circle (Boell and Cecez-Kecmanovic 2010). During the *search and acquisition stage* I developed understanding by undertaking multiple, iterative literature searches to build a narrative around the broad themes of the research question.

During this stage I searched and acquired papers of potential relevance and organised the papers (within Mendeley reference management software). While the procedures differ from the more typical positivist methodology associated with systematic review, they are not unsystematic in their approach (in the sense of being ad hoc) (Greenhalgh *et al*., 2018). This hermeneutic narrative literature review is based on multiple searches, within relevant databases (appendix B). Additionally, snowballing techniques were utilised. The component words within the research question, taken in combination with my existing knowledge of the research area and associated literature guided the initial search areas. The formulation of key word searches (for example: mentorship, placements, belongingness), phrases (for example: learning in practice), and the combination of these were used to formulate powerful search strategies. These searches incorporated key searching techniques: synonyms; Boolean search operators; truncation and broad inclusion and exclusion parameters (appendix B). Appropriate search timelines were decided (appendix B).

I utilised Mendeley to enable me to effectively manage and organise the vast quantity of papers. Electronic note taking techniques were used (within Mendeley) to enable key points to be highlighted for future consideration. Through critical reading of the papers, I was able to deepen my understanding. I utilised the Critical Appraisal Skills Programme (CASP) tools to assist this

critiquing process, which served to augment my own critical research judgement. This tool enabled me to systematically appraise both qualitative and quantitative published material (CASP, 2020). Because of the volume of material I purposefully chose an appraisal tool which is robust but relatively easy to apply; the tools have 10 key questions against which to appraise the literature.

Through critically reading the texts, new lines of interest were identified, search strategies were refined, new searches were undertaken and the hermeneutic literature searching circle continued (Boell and Cecez-Kecmanovic, 2014). The following broad areas were developed as areas of critical interest during the *search and acquisition* stage: a review of contemporary nurse education (including the regulatory framework); a consideration of learning within the CLE; supervision and learning arrangements (including mentorship); placements; belongingness within the CLE context; learning opportunities; access to learning opportunities and concepts of competence. These areas are included within this literature review. I gained a sense of the concerns of the study from my professional experience, earlier studies and reading of the literature in this initial search phase. I utilised this knowledge to guide the 'edges' of my search. Lines of enquiry, for example, relating to professionalism, identity formation and socialisation were purposefully not followed because they were not deemed strictly relevant to the research question.

During the next stage (*analysis and interpretation circle)* (Boell and Cecez-Kecmanovic, 2014) key theoretical frameworks were introduced to enable analysis and interpretation to occur. The theoretical frameworks of Lave and Wenger (1991) and Lukes (1974) were specifically selected (in the *search and acquisition stage)* to introduce lenses through which to understand, analyse and interpret the literature initially addressed during the *search and acquisition* stage. I chose Lave and Wenger (1991) due to my knowledge of the applicability of this framework gained during my IFS. Lukes (1991) was added as a consequence of discussions with my supervisors and followed initial coding, which flagged the need to understand power relationships in the CLE. The

theoretical frameworks of Lave and Wenger (1991) and Lukes (1974) provided a lens though which to understand the literature, framing the literature within concepts of situated learning and power to address the research question.

Utilising the hermeneutic process means there is no final understanding of what constitutes 'relevant literature' because there is always scope for further interpretation of texts through the hermeneutic circle (Ricouer, 1981). Therefore a pragmatic decision needs to be made when to stop searching, usually at the point when additional publications are only making a marginal contribution to further understanding (Boell and Cecez-Kecmanovic, 2010). I did reach a point in October 2018 when I felt confident I had sufficient literature to address the research area and I had reached saturation. Additional literature searching was becoming superfluous because significant ideas and results had already been considered and references cited within publications were familiar. That said I did review the policy literature prior to submission to ensure it remained contemporary.

This literature review will begin by considering the learning arrangements for student nurses in practice (as they stood at the time of the data collection in 2017), incorporating: a review of contemporary nurse education (including the regulatory framework); learning in the CLE; mentorship and placements. I will explore how the chosen theoretical frameworks (of Lave and Wenger, 1991 and Lukes, 1974) inform my understanding of how student nurses experience learning within the CLE. Finally I will consider the 'gap' in the extant literature, which forms the justification for undertaking this study.

2.2: A review of contemporary nurse education

To qualify as a Registered Nurse (RN) in the United Kingdom (UK) students must complete (as a minimum) a Degree level pre-registration nursing programme at an Approved Education Institution (AEI). Approval to run nursing programmes is given by the Nursing and Midwifery Council (NMC), at the time of this study, under the NMC (2010) *Standards for Pre Registration Nursing*

Education. The NMC (2010) Standards have been superseded by new Standards (NMC, 2018a): *Realising professionalism: Standards for education and training*. The institution, where this study was conducted, will utilise these new Standards from September 2020. At the time of the study, the participants were studying under the NMC (2010) Standards and therefore reference to the new Standards will not be made until the discussion chapter.

The Nursing and Midwifery Order (2001) established the NMC, and sets out its primary purpose of protecting the public, detailing its functions and activities. The NMC, as the nursing regulator, set Standards of education, training, performance and conduct, with the aim that nurses will deliver good quality patient focused care, throughout their careers (NMC 2019). In addition, they prescribe, in the Code (NMC, 2018b), professional standards of practice required of all nurses. Prior to registration, students are designated as pre-registration student nurses; referred to as 'students' in this study.

Within the nursing profession, the clinical practice setting is commonly referred to in the UK as the Clinical Learning Environment (CLE) and students experience 'placements' within this setting. To comply with the NMC regulations, students are required to spend approximately fifty percent (equivalent to 2300 hours) of their programme in clinical practice, in assigned placements, and the remaining theory time is spent studying nursing related subjects (NMC, 2010). The programme spans three stages, which are typically synonymous with years; students must pass the required clinical and academic components before progressing into the next stage and before finally being recommended for registration (NMC, 2010). There are varying qualification routes, including: traditional BSc; Post Graduate Diploma and Masters. The participants in this study were BSc (Hons) (non-apprentice) students.

2.3: Learning in the Clinical Learning Environment

Nursing is a practice based profession and the time spent in clinical practice affords students the opportunity to practise and learn in the '*real world'* (Murphy

et al., 2012, p170). From a student's perspective, '*clinical practice becomes the curriculum'*, whilst they are in placements (Egan & Jaye, 2009, p121). Clinical practice is a critical component, within pre-registration curricula, because it provides students with the opportunities to develop the required competencies in the application of skills, knowledge and attitudes (Chan, 2001). Arguably the CLE is the most significant resource in the development of competence in nursing (Kelly, 2007; Murray and Williamson, 2009; Henderson *et al.*, 2012). Clinical practice occupies a considerable component of the programme. The experiences, which occur in this context, are considered powerful in modelling students' attitudes towards practice and in influencing their learning and professional development (Henderson, *et al.,* 2012). This emphasis on practice means that the quality of the learning in nurse education, rests considerably on the quality of the learning experiences gained in this environment (Henderson *et al*., 2006; Shivers *et al*., 2017).

Notwithstanding significant enhancements in nurse education over the last 20 years, UK literature indicates that students frequently characterise their clinical placements as being punctuated by pervasively negative experiences *(Randle et al.,* 2007; Thomas *et al.*, 2012; *Ion et al., 2016;* Wilson, 2016). These negative experiences can potentially have a detrimental impact on students' ability to learn in practice, with far reaching effects on the development of their clinical competency, occupational identify and on their propensity to leave the programme altogether (Newton *et al.*, 2009). It might be considered that these negative experiences can, in part, be attributed to the inconsistent and substandard support mechanisms which exist in practice, notably mentorship.

2.4: Mentorship

Professional responsibilities, bestowed through The Nursing and Midwifery Order (2001) require Registered Nurses to assure the competence of its workforce, in order to protect the safety of the public using their services. Until Universities validate under the NMC (2018a) Standards, the mentor remains centrally placed as the nominated supervisor and clinical gatekeeper within this

process (NMC, 2008; RCN, 2015). The requirements for mentors of pre-registration nurses is stipulated by the NMC, within its *Standards to Support Learning and Assessment in Practice* (NMC, 2008). The NMC (2008, p56) define a mentor as a nurse who 'facilitates learning, and supervises and assesses students in a practice setting'.

In order to operate as a mentor in the UK, a nurse must have been registered for a minimum of one year, have successfully completed a NMC approved mentorship programme and must have met, and continue to meet, required mentorship Standards (NMC, 2008). During the final placement, mentees are required to be mentored by, what are referred to as, 'sign-off' mentors. Sign-off mentors are required to fulfil eligibility criteria, in addition to undertaking three assessments which are supervised by an experienced existing sign-off mentor (NMC, 2008). All mentors must attend biannual updates to ensure that their practise remains contemporary (NMC, 2008). Mentorship duties are undertaken in addition to the other nursing roles and responsibilities, and there is no financial reward or remission for being a mentor. Becoming a mentor is entirely voluntary, however it has long been regarded as a means of career development. Nurses often state this as their motivation for undertaking the mentorship role, rather than a genuine interest in developing students (Robinson *et al*., 2012).

The NMC (2008) mandates that designated mentors are responsible for teaching and assessing students within the CLE. Mentors determine if their students have reached the required levels of competency during each clinical placement. Ultimately mentors determine if their mentees are ready (from a clinical perspective) to register with the NMC, as a qualified nurse at the end of the programme. Competency is assessed by the mentor and documented within a PAD. When students are unable to work with their designated mentor, they should be allocated (by their mentor) to learn alongside another qualified nursing colleague (NMC, 2008). In some settings, students are assigned co-mentors (sometimes called associate mentors), in addition to their primary

mentors, although this is not a requirement (NMC, 2008). The co-mentor may be a qualified mentor or a qualified nurse gaining mentorship experience. Students must work at least 40% of their clinical time with a designated qualified mentor(s) (NMC, 2008).

The mentor/mentee relationship in UK nursing is a formal relationship (NMC, 2008) and quite different from the more common understanding of the term 'mentor', which frequently depicts an informal relation between a junior and senior colleague, with the senior colleague acting more like a trusted friend (Fulton, 2015). The nursing mentorship relationship, in the UK, usually only lasts as long as the duration of the placements, typically between four to twelve weeks. Whereas commonly (outside of nursing) a mentoring relationship can last for many years, even spanning an entire career. The key qualities required to fulfil the role of a mentor include: an absolute commitment to student nurse education; the ability to facilitate learning and give timely constructive feedback; personal characteristics and demonstrated behaviours, including professional confidence and the ability to reflect on practice; positive regard toward students; demonstrable knowledge of the pre-registration curriculum and appreciation of varying styles of learning (Robinson *et al*., 2012).

Mentorship is situated within a complex set of roles and relationships, set between AEIs and the service providers. Working within the Standards set by the NMC (2008; NMC, 2010), Universities and healthcare providers are required to work together, within an integrated relationship, to ensure that suitable learning opportunities in practice are provided (Robinson *et al*., 2012). Facilitating mentorship involves an array of resources and activities, which vary in their configuration between different service providers and AEIs (Robinson *et al*., 2012). Typically, in practice areas, mentorship activity is supported by senior nurse leads for education, whose remit includes overseeing mentorship provision and (what are commonly called) the Learning Environmental Leads (LELs). LELs support and guide mentors, especially when they are dealing with difficult mentorship scenarios, for example, failing students. They are also

instrumental in identifying consistent and educationally appropriate learning opportunities and placing students within their services. The LEL remit is primarily educational; they do not have clinical responsibilities. Within AEIs, mentorship activity is typically supported by: a principal lecturer for practice; a mentorship programme leader; placement allocation officers and lecturers who link into practice (Robinson *et al*., 2012).

2.5 The central position of the mentor within the CLE

The literature indicates that mentors are central to enabling student nurses' learning within the CLE (Gray & Smith 2000; Saarikoski and Leino-kilpi, 2002; Pellatt, 2006; Jokelainen, *et a*l., 2011; Foster, *et al*., 2015). The results of a recent RCN mentorship project (RCN, 2015), involving key stakeholders, reiterated the importance of good mentorship for supporting clinical education, especially for the transference of knowledge from theory into practice and for promoting a learning culture within clinical settings.

Notwithstanding the critical role of mentorship within nurse education and the mandatory mentorship Standards in the UK (NMC, 2008), concerns continue to be raised in relation to the standard and effectiveness of mentoring within practice (RCN, 2015). These concerns are documented in: the Willis Commission (Willis, 2012), the National Nursing Research Unit (Robinson *et al.,* 2012) and the Shape of Caring Review (Willis, 2015). Concerns about mentorship may in part be due to continued uncertainty surrounding the nomenclature of 'mentorship'; the nature, expectations and application associated with the role are poorly articulated and understood (Carnwell *et al*., 2007). Concerns also exist regarding the resourcing of this critical role.

At the time of this study, there was a recognised shortage of qualified nurses within healthcare settings in general, but particularly within the National Health Service (NHS). It is always difficult to quantify nursing shortages and figures generated by different sources, i.e. Health Education England (HEE) and the Royal College of Nursing (RCN) often vary. The NMC data indicated that there

were 689,738 nurses and midwives on the register in September 2017, representing a reduction of 1,678 nurses (0.2%) since September 2016 (RCN, 2017b). The NMC statistics demonstrate that more nurses were leaving than joining the register (RCN, 2017b). This was driven by a multitude of inter-related issues, affecting both recruitment and retention within the profession (RCN, 2017b).

Although there is no defined measure of overall vacancy data, HEE, responding to the House of Commons, Health Committee (2017-2018) stated that there were 36, 000 nursing vacancies within the NHS in England, which equates to a vacancy rate of 11% (based on NHS Improvement analysis of Trust data). The RCN reported to the Committee that the figure was 40, 000. HEE indicated that 33, 000 posts were being filled by either bank or agency staff, leaving an overall vacancy rate of 3,000 (1%). Although bank and agency staff support the delivery of health care, these staff groups do not usually mentor students. The Committee noted overall that the workforce is certainly not keeping up with population growth and that, in too many areas, the nursing workforce is overstretched.

Due to the complexity of both healthcare and local education provision, it is difficult to reliably gauge whether mentorship provision is adequate. A joint project between Chelsea and Westminster Hospital NHS Foundation Trust and the National Nursing Research Unit of King's College, London (Robinson *et al*., 2012) indicated that AEIs and Trusts (in the main) were, at that time, fulfilling their requirements for enabling sufficient mentorship numbers. Although it was reported that there were sufficient mentors in 2012 (Robinson *et al*., 2012), recent increases in nursing vacancy rates, compounded by the increased complexity of healthcare delivery, may impinge on mentor provision. The operationalisation of mentorship is vulnerable to contextual influences, specifically political, economic and professional factors, affecting healthcare and higher education (Robinson *et al*., 2012). At service level, the process of

mentorship is particularly susceptible to the challenges of mentoring within busy clinical environments (Veeramah, 2012).

Mentorship is an intrinsically multifaceted role; mentors are charged with balancing innumerable and frequently conflicting responsibilities, within characteristically pressured CLEs. Mentors may be required to manage conflicting ideologies between their responsibilities for delivering good quality care, alongside their mentorship role (Webb & Shakespeare, 2008; O'Driscoll *et al*., 2010). The challenges associated with balancing high workload pressures, in combination with the educational responsibilities associated with mentorship (and the perhaps inevitable deleterious impact on the latter), has been documented across a range of different clinical settings (Hurley and Snowden, 2008; Myall *et al.,* 2008; Marks-Maran, 2013).

High workload pressures may lead to mentors being unavailable to students. An important aspect of the mentorship role is to safeguard the student as a learner, rather than a worker (NMC, 2008). Workload pressures, in combination with mentor unavailability, may lead to students operating outside of the student remit, in 'worker' rather than 'learner' roles. In such scenarios, the student's supernumerary learner status in the CLE may be readily compromised. In circumstances when students are not being supervised by their mentor, the literature suggests that this responsibility regularly falls on HCAs (Kessler *et al*., 2010; O'Driscoll *et al.*, 2010).

When students are working with HCAs, they focus primarily on task delivery rather than on learning. HCAs do not have a legitimate responsibility for teaching within the CLE; this is the remit of qualified nurse mentors (NMC, 2008). However because HCAs form approximately one third of the hospital caring workforce (Cavendish, 2013) and deliver approximately 60 per cent of bedside care (Willis Commission 2012) students are likely to be allocated to 'work' alongside these employees. This allocation is likely to lead to a diminution of students' learning experience primarily because healthcare support workers

are non-registrants. Also, despite the current policy focusing on the training of this group of workers, support, training and assessment has been shown to be inconsistent and requiring improvement (Sarre *et al.*, 2018).

2.6: Contextualisation of 'placements'

The CLE, particularly within the NHS, is a pressured environment in which to learn and teach in (Needleman, 2013; Royal College of Nursing, 2013; Appleby *et al*., 2014). Qualified nurses are expected to deliver high quality patient care whilst meeting the demands associated with caring for increasingly high acuity patients (Needleman, 2013). There has been a long period of rising public demand for high quality healthcare, at the same time as the implementation of sustained cost saving measures. This has resulted in many health and social care practitioners needing to work under considerable and sustained pressure (Cribb and Gewirtz, 2015), in an unrelenting target driven culture (Department of Health and Social Care 2018-2019). Staff commonly work with inadequate qualified nurse staffing levels and an inappropriate skill mix (RCN 2017b) against a backdrop of organisational failings (Francis, 2013). At the time of this study, the NHS was working to bed occupancy capacity; for the second quarter in 2016, the average occupancy rate for beds open overnight was 87.5% (NHS England, 2016). Within this pressured environment, trained nurses are expected to work and mentor and their students are expected to learn. Of course CLEs are disparate in nature and there will inevitably be variation between the placements, with some environments being inherently more pressured than others.

Within their placements student nurses are designated a supernumerary status, meaning that they should be treated as additional to the workforce establishment (NMC, 2010). Initially, students require direct supervision from their mentor but, as they become increasingly competent, the level of supervision should decrease to enable students to grow into confident clinicians. The NMC recommend that the level of required supervision will depend upon

the nature of the activity being undertaken and evidence of student competence (NMC, 2008).

Students experience a variety of placements within different CLEs, with the aim of developing knowledgeable, compassionate, competent and caring nurses by the end of the programme (NMC, 2010). They are exposed to diverse clinical settings, encompassing different clinical specialities, team compositions, located within varying settings, for example hospitals and the community (NMC, 2010). Placements typically range from four to twelve weeks in length. Students are therefore required to navigate through relatively short placements in significantly differing environments. For students to achieve determined levels of competency, placements need to be varied and high quality (Freer and Penman, 2016); each CLE is audited to ensure that it is a suitable learning environment (NMC, 2010).

Within different placements students are likely to experience considerable variation in what is expected of them, reflecting the opportunities which arise from learning in environments with differing patient/client needs and service configurations. For example, within a ‘care of the elderly’ ward, students will predominantly deliver fundamental care to elderly clients, including personal care, and gain specialist elderly care skills (Lea *et al.*, 2014). Whereas in an intensive care environment, students will be expected to demonstrate more technically orientated knowledge and skills (Williams and Palmer, 2014). Placements are broadly organised, across the three years, with increasing patient acuity, although this arrangement is not always possible. Within these fundamentally differing environments, students will work alongside a variety of professionals, with a wide range of occupational roles. Students are expected to understand how these different clinicians function, in caring for patients across the lifespan (NMC, 2010).

Although varied placements can arguably be beneficial for student learning, students report insufficient time to prepare for placements, which can be

problematic (Killam and Heerschap, 2013). Students need time to prepare for their placements to enable them to feel informed (Sun *et al*., 2016). Preparation usually involves students reading around the clinical specialities of the ward and revising, for example, the associated pathophysiology and pharmacology. This type of preparation facilitates students in managing their anxieties, particularly for their first placement (Sun *et al*., 2016). The patterning of placements may preclude students from having sufficient time to prepare; students frequently move from one placement to another without space in-between. In addition, placement allocation details may be released late to students, potentially encroaching on their preparation time. Such delay is frequently attributed to the challenge that AEIs encounter in finding sufficient and suitable placements (Murray and Williamson, 2009).

In the UK there is a pervasive shortfall in student nurse placement capacity, finding sufficient and suitable placements is a challenge in nurse education (Murray and Williamson, 2009). In June 2019 the Council of Deans of Health welcomed the publication of Interim NHS People Plan, which makes a number of commitments, including a rapid growth of student placements by September 2019 (The Council of Deans of Health 2019). This commitment demonstrates that placement shortfall remains a challenge beyond the timing of this study. Placement shortfall is not unique to the UK (Smith *et al*., 2010; Barnett *et al*., 2012); the cause is multifactorial. At the time of this study, HEE commissioning was still in place and the annual nursing commissions, in England, increased by 2,732 (15%) from 18,009 in 2014 to 20,741 in 2016 (HEE, 2016). This increase translates into 6,000 more student nurses due to qualify by 2020 (HEE, 2016), requiring more student placements. In their plight to meet this increase in required placement numbers, different Universities frequently approach the same hospitals to provide increasing placement numbers, at times causing students to be displaced. This competitive situation is unhelpful because the overall student placement capacity remains unaltered (Barnett *et al*., 2012).

The increase in required placements has coincided with a contraction in available placements for pre-registration students across both the primary and secondary care sector, due to healthcare policy changes (The Health and Social Care Act, 2012). The Health and Social Care Act, 2012 arguably brought about the most extensive reforms in the NHS since its inception in 1948, affecting most parts of the service in some way. There has consequently been extensive changes and reconfiguration, and in many cases reduction in service provision, particularly in primary care. In the clinical location, where this study is set, significant changes in service provision have occurred, including the merging of services, which has had a deleterious impact on our placement capacity.

The lack of available placements can be exacerbated by the AEIs academic calendar because it reduces student availability during specific time points, i.e. holidays, which can cause fluctuations in placement demand (Murray and Williamson, 2009). Furthermore, the clinical audit process, which informs local student capacity, is often inaccurate, predicated on historical figures, rather than being an accurate representation of student capacity (Hutchings, *et al*., 2005). This inaccuracy can potentially lead to underutilisation of clinical placements and consequently mentors.

Placement provision and the number of students who can be supported in clinical practice, are under constant pressure from a sustained reduction in the numbers of qualified nurses, and from nursing teams being broken up and reconstituted, with different profiles (Robinson *et al*., 2012). The push to increase placement capacity, against a backdrop of increased competition between Universities for placements, changes in service provision, a potential underuse of placements and clinical staff (notably mentors) and shortages in clinical staff, may lead to a situation where CLEs are saturated with students. Such pressure may force some CLEs to be utilised, which are unsuitable for student learning (Harrison-White and Owens, 2018).

The University takes responsibility for finding and negotiating suitable placements for students, often based on historical relationships with local health care providers. These negotiations include identifying student numbers, the seniority of the learners (in terms of year of programme) and the allocated placements - identifying both the length and speciality of the placement. Students are placed principally in NHS community and hospital settings. Some placements occur in the private, voluntary and independent (PVI) sectors; with placement shortages, AEIs are increasingly turning to non-NHS sectors to meet the shortfall (Sherratt *et al*., 2013).

2.7: Introducing the theoretical frameworks

Understanding the complex dynamics in the CLE (and inherent power relations) is difficult. Both learning and operations of power are opaque and difficult to observe directly within the clinical context. I therefore needed tools to frame my enquiry, to support interpretations of data and the emerging understanding. The theory provides a scaffolding for conceptualising the key emerging concerns: i.e. learning in practical contexts and understanding power dynamics. Lave and Wenger (1991) is useful for the former, but this framework does not offer a theory of power. Therefore Lukes (1974) (supported by Nye, 2009) was introduced to provide support for developing this understanding further. I used the theory critically, insofar as it fits my aims for the project and helps me to develop a deeper understanding of narratives (and gaps) in the literature and the emerging data. The theoretical frameworks enabled me to conceptualise broader concerns and questions, e.g. issues of belonging, legitimacy and incivility, which otherwise may have been absent from the study, thus deepening the analysis.

2.8: Utilising situated learning theory

Lave and Wenger's (1991) situated learning theory, and more specifically what they coined, '*legitimate peripheral participation*', offers a useful theoretical lens to better understand how students learn in the CLE and to appreciate the

challenges associated with learning within this community of practice. Their theory provides a considered practice learning model and a familiar learning structure which is highly relevant to placement learning within nurse education (Morley 2016). This model is useful for understanding how the exigencies associated with the CLE may compromise students' position as learners, pushing them towards worker rather than learner roles. Workforce pressures may impede student's access to their mentors, reducing opportunities for mentors to engender a sense of belonging and to facilitate meaningful learning opportunities. Lave and Wenger's (1991) model helps to explain how under such circumstances students readily become marginalised within the community of practice and their status as *legitimate peripheral participants* compromised. It is difficult for mentors to assess competence, when students occupy a marginalised position. By utilising Lave and Wenger's model the consequences of such compromises are highlighted.

2.8.1: Situated Learning theory

Lave and Wenger's (1991) seminal text entitled, '*Situated Learning. Legitimate peripheral participation'* was inspired by Lave and Wenger's increasing dissatisfaction with traditional learning theory, which they felt did not account for how people learn new skills and knowledge, without engagement in formal education or training activities (Fuller *et al*., 2005). Situated learning theory provides a theoretical framework for understanding learning in environments outside of typical classrooms and formal educational settings, for example within a CLE setting.

Lave and Wenger (1991) propose 'situated learning' as a theory of learning occurring within a community of practice. Situated learning theory provides a fundamental alternative to conventional cognitivist theories of learning (Lave and Wenger, 1991). It offers a critique of two key assumptions embedded in cognitivist learning theories. Firstly, that 'learning' encompasses the acquirement of objective knowledge and secondly, that optimal learning is achieved through training/educational sessions that are quite separate from the

environments in which that learning will be applied (Handley *et al*., 2007). Lave and Wenger (1991) suggest that learning should not be perceived in terms of the transference of highly abstract knowledge, but as entrenched in contextualised, social and physical environments; the CLE is a good example of such an environment.

Within situation learning theory, the emphasis is shifted from purely concentrating on the characteristics of an individual learner, to understanding that learning is embedded in a complex social world (Lave and Wenger, 1991); the characteristics of the learner are only one consideration. The CLE is a good example of a complex social world because it encompasses a multifaceted institution, housing a multitude of different professional groups, with a remit to care for an array of people. Within this environment the characteristics of the learner are only one dimension. Greater consideration needs to be given to the impact of other social factors, which can enhance or diminish learning opportunities. The premise then of situated learning theory is that attention should be focused directly upon learning as an ubiquitous, embodied set of activities, encompassing the acquisition, preservation, and transformation of knowledge, through complex social interactions. The relationships that students have with their mentors, within the CLE, is a good example of such social interactions; interactions can serve to enhance or diminish opportunities for learning within this environment.

The major contribution made by Lave and Wenger (1991) is that they utilise the notion of practice to construe a reformulation of learning (Arnseth, 2008). Lave and Wenger use the term 'practice' as synonymous with the work environment.

Lave and Wenger (1991, p35) assert that:

> '*learning is not merely situated in practice – as if it were some independently reifiable process that just happened to be located somewhere; learning is an integral part of generative social practice in the lived-in world.'*

Thus they perceive that learning is constituted in the real world, the world that it is experienced in, within the context of social practice (Arnseth, 2008). Lave and Wenger's (1991) contribution added to a mounting interest in theorising the processes and meaning of learning, within social activity (Scribner and Cole, 1973; Lave, 1988; Brown *et al*.,1989; Jordan, 1989). Within Lave and Wenger's (1991) theory, practice is afforded primacy in shaping, influencing and constituting knowledge and knowing. The CLE (and the social practices therein) are a world/reality in which students enter, and so understanding students' learning (and the broader challenges) means understanding their activities and experiences in this world. This focus on practice means adopting an epistemology which positions practice in a primary role and learning as a fundamental aspect of practice (Arnseth, 2008). This position amplifies the importance of learning occurring within the CLE and the requirement for educationalists to understand impediments to this process.

Lave and Wenger (1991, p27) describe a theory of *legitimate peripheral participation* to explain the learners' move from the periphery of a community of practice to the centre; once placed centrally, learners achieve full worker status and identity (Fuller *et al*., 2005). The learners' journey is dependent on the social context, which their learning is immersed within. Learning is not viewed narrowly, in cognitive terms, but rather it is appreciated that progress is based upon the quality of their social interactions within particular settings, and the opportunities afforded to apply their expanding practical skills and knowledge (Fuller *et al*., 2005*)*. Their research and explanation of apprenticeship learning was the stimulus of their work, but their aim was more ambitious in providing a comprehensive theory of learning, immersed in social practice (Fuller *et al.*, 2005).

2.8.2: 'Communities of Practice'

The notion of communities of practice is one of the most significant ideas developed in the social sciences in recent years (Blackmore, 2010) and it is applicable to health settings (Eraut *et al*., 2000; Sayer, 2014) and in the

consideration of learning during nurse training (Thrysoe *et al*., 2010; Morley, 2016; Molesworth, 2017). It is argued that the process of learning to become a nurse, and the development of professional capital, is situated as occurring within communities of practice (Gobbi, 2010).

Lave and Wenger (1991, p98) represent communities of practice as:

> *'…..a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice'. A community of practice is an intrinsic condition for the existence of knowledge. …..Thus, participation in the cultural practice in which any knowledge exists is an epistemological principle of learning. The social structure of this practice, its power relations, and its conditions for legitimacy define possibilities for learning (i.e. for legitimate peripheral participation).'*

It is important to note that Lave and Wenger (1991) are discussing their conception of learning predominantly in relation to apprentices, who learn their craft over many years, within communities of practice. Student nurses experience 'placements' across a range of different practice areas, arguably in different communities of practice, for relatively short periods of time. It could therefore be questioned if it is appropriate to apply Lave and Wenger's (1991) notion of a 'community of practice' to a nursing programme; this discrepancy is not acknowledged widely in the nursing literature. I argue that Lave and Wenger's (1991) conception of learning is highly relevant to nursing because it offers a platform to explore students' position, as peripheral learners, and the power relationships that they need to navigate to successfully complete their programme.

In relation to student nurses, the notion of a Clinical Learning Environment is synonymous with a 'community of practice'. Students learn within specified placements (communities of practice), typically a ward environment. Lave and Wenger (1991, p98) also refer to '*tangential and overlapping communities of*

practice', which from a student's perspective could include their University and potentially other clinical environments, where they experience placements. Such communities of practice form part of a wider hospital environment, immersed within an organisation, i.e. NHS. Within each community of practice, specialised knowledge typically exists, which reflects the clinical speciality, for example emergency medicine. Students are expected to learn within these disparate environments. Learning is dependent on the learning support structures and mechanisms, including mentorship arrangements, and the opportunities afforded to students to learn, as legitimate peripheral (supernumerary) participants. Such positioning may be influenced by the subtle interplay of power relations within the CLE. Narrowing the scope of the community of practice to the level of individual CLEs may be perceived as too narrow. I argue that students' learning is mostly influenced and understood by students in relation to local learning arrangements, of which mentorship is the most significant. Of course, such arrangements are directed by organisations, i.e. individual Trusts and Universities and more widely by the NHS/ HEE and influenced by the professional body (NMC) and political drivers.

Narrowing the scope of the community of practice to the individual CLE level, aligns with Lave and Wenger's (1991) theory. Although Lave and Wenger (1991) acknowledge the influence of wider networks on communities of practice, Wenger (Farnsworth *et al.,* 2016) argues that they consider their theory to focus on the negotiation of competence around specific and local domains of practice. If I had utilised a different theoretical lens, for example by drawing on the work of Bourdieu (1980) or Engeström (2001), undoubtedly the scope of the community of practice would need to be different. I am primarily focusing on understanding the students' journey from being a peripheral to a full participant in localised communities of practice, whilst acknowledging the surrounding support structure, i.e. from the University.

It is important to consider what a CLE 'community of practice' might encompass. The composition of CLEs is difficult to accurately articulate because of course

they are varied; inevitably there is some commonality. In discussing the notion of 'community', it is essential not to assume homogeneity, which implies consensus and coherence in its practices; communities of practice are not immune to fractures, schisms and unstable alignments (Contu and Willmott, 2003). The notion of community of practice does not refer to a specific group of people, but rather the social processes involved in '*negotiating competence in a domain over time'* (Farnsworth, *et al.,* 2016, p5). *S*tudents will commonly need to negotiate their learning (within social processes) with a defined group of clinical personnel, including: their mentor(s); other trained nurses; the ward/ community manager; HCAs, the wider multi-disciplinary team (MDT); LELs and the patients. Students are transient in their placements, they are therefore required to negotiate their learning in multiple CLEs during their training*,* which may be problematic for some learners, a point I will return to later.

Learning theory places the way in which learners negotiate meaning at the heart of human learning, as opposed to conceptualising learning as merely the acquisition of knowledge and skills (Farnsworth *et al*., 2016). Referring to a community of practice is therefore not to imply the existence of a specific group or social system, within an organisation, but rather to highlight that every practice is predicated on the social processes through which it is maintained and perpetuated and that learning occurs through the specific engagement in that practice (Gherardi, *et al*., 1998). Lave and Wenger (1991) claim that membership and social relations, within a community of practice, underpin learning and practice and it is through the varying social relations that learning can be understood (Hodkinson and Hodkinson 2004). Thus highlighting the importance, within this research, of understanding the significant social relationships that students have within the CLE and the consequent impact that those relationships have upon learning. The most significant of which is with the mentor (Smedley and Morey, 2009; Robinson *et al*., 2012; Jokelainen *et al*., 2013; RCN, 2015). It is a sense of belonging (mediated primarily through the mentor) which enables learning to occur within the CLE. The importance for students of feeling belongingness within the CLE, to enable learning, is reported

in the nursing literature (Levett-Jones *et al*., 2009) as well as the deleterious consequences of its absence (Levett-Jones and Lathlean, 2009b).

2.8.3: The practise of nursing

In considering 'communities of practice', attention also needs to focus on understanding what the 'practise of nursing' actually entails; what 'practises' do students actually need to learn? What are the students trying to become? There are numerous definitions of 'nursing', for example, the International Council of Nurses (ICN, 2002); RCN (2014) and The World Health Organisation (WHO) (2018). However, the practise of nursing remains ill defined; nursing is experienced by most people at some point in their lifetime and yet it is inherently difficult to describe and it remains poorly understood (RCN, 2014). Perhaps this difficulty arises because not all nursing is performed by qualified nurses; other people who 'nurse' may include relatives and other unqualified carers. The RCN (2014) suggest that although their contributions are essential and valuable it does not constitute professional nursing. The RCN (2014) go on to argue that it is imperative that there is a clear distinction between professional nursing and nursing duties that can be undertaken by other people (including relatives and non-nurses, i.e. HCAs).

The RCN (2014) suggest that professional nursing encompasses the following key features: clinical judgement; knowledge; professional accountability; a structured relationship with the patients, which incorporates professional regulation and a code of ethics within a statutory framework. There is debate in the literature in relation to what the professional attributes of a good nurse should be. Begley (2010) suggests they might include: autonomy, advocacy, accountability and assertiveness. Whilst in placements, student nurses are required to demonstrate that they are assimilating the required attributes and capabilities of a professional nurse. This progression is captured evidentially though the completion of practice assessments in each placement, as required by the NMC (2010). Following Lave and Wenger's (1991) learning theory, it is through *legitimate peripheral participation* that learners can engage in the social

practices associated with nursing, enabling them to learn and assimilate the required knowledge, skills and attributes.

2.8.4: Legitimate peripheral participation

Lave and Wenger (1991, p 29) argue that learning perceived as situated learning has as its critical defining feature a process that they call '*legitimate peripheral participation'*. From this position, learners are afforded time and space to legitimately occupy a fringe position, while they learn the practice associated with that particular community. They are afforded opportunities to learn through participating in activities, which are peripheral to main functions of the workplace. Legitimate peripheral participation is essential and marks the beginning of becoming a full member of the workplace and encultured into the profession (Lave and Wenger, 1991). Within this position, learners are able to participate within a community of expert practitioners, as they gain '*mastery of knowledge and skill'*; the newcomers move towards becoming full participants within the sociocultural practices of that community (Lave and Wenger, 1991, p29).

It is important to identify the conditions required for student nurses to occupy a position of legitimate *peripheral participation* within the CLE. The most important condition is the affordance of supernumerary status, required by the NMC (NMC, 2010). Supernumerary designation legitimately allows students to learn alongside their mentors, thus protecting them as a learner, rather than a worker. As a supernumerary learner, students can also participate in learning opportunities with other qualified nurses, and members of the wider MDT, as they occur. Students need to be given opportunities to undertake key aspects of nursing, under supervision (commensurate with their level of training) (Jokelainen *et al*., 2011), and to learn they need to feel that they belong within the environment (Levett-Jones and Lathlean, 2009a). Initially students should participate in simple activities, for example caring for one or two patients, in the first and second years, before progressing to managerial activities towards the

end of the programme. All activities should be supervised by their mentor or another delegated Registered Nurse (NMC, 2008).

2.8.5: Mentor accessibility

Lave and Wenger (1991, p101) are vociferous in arguing that:

> *'To become a full member of a community of practice requires access to a wide range of ongoing activity, old-timers, and other members of the community; and to information, resources and opportunities for participation.'*

It is through access to mentors and participation within the CLE, that student learning can occur. Without such access knowledge may remain inaccessible to learners or be assembled in such a way that it is rendered useless within the workplace; knowledge is unlikely to be gained through discovery alone (Billett, 2001). Within nursing the mentor is centrally placed to support student learning in practice (NMC, 2008; Jokelainen *et al.*, 2011; Robinson *et al*., 2012; Stayt and Merriman 2013; Sundler *et al.*, 2014; RCN, 2015).

The nursing literature suggests that students often struggle to gain access to their mentors (Murray & Williamson, 2009; Stayt and Merriman, 2013; Sundler *et al*., 2014) . There are a number of potential consequences for students if they fail to secure the required level of access, including a potential impact on their socialisation into the nursing profession. The process of socialisation occurs principally during nurse training, marking the time when students gain required attitudes, behaviours, professional values, and the culture of the profession which they are aspiring to join (Ousey, 2009). It is through sharing knowledge, information and experiences, with the wider professional group, that members have the opportunity to develop professionally and personally (Lave and Wenger 1991). Students require exposure to social interactions within the community (i.e. with qualified staff and more specifically the assigned mentor) as *legitimate peripheral participants.*

If students' access to their mentor is compromised, there is a risk that they become marginalised from their professional group and fail to gain full exposure to the community of practice; this position is disempowering (Molesworth, 2017). A person's position is legitimised, as peripheral, based on the fact that they are a newcomer and their claims to competence are widely accepted, within the community, to be provisional (Farnsworth *et al.,* 2016). However if those claims to competence are consistently rejected, the newcomer, i.e. the student, will feel marginalised within the community (Farnsworth *et al,* 2016).

2.8.6: Questioning student nurses' position as '*legitimate peripheral participants*'

Students' designation as supernumerary within the CLE (NMC, 2010) should serve to legitimise their position as peripheral participants, a position from which they can learn. In reality, the position of students as supernumerary learners is frequently eroded due to workload pressures. Research analysing the workload, staffing, and patient dependency in over one thousand, three hundred specialist and general wards, suggests that students contribute considerably to hands on care, casting considerable doubt over their designation as supernumerary learners (Hurst, 2011). Escalating staff shortages and the exigencies associated with service provision are likely to increasingly lead students into becoming used as an essential part of the workforce, despite the rhetoric which surrounds their supernumerary status and the primacy of their learning (O'Connor, 2007).

An erosion of students' supernumerary status undermines their status as '*legitimate*' learners within the CLE, but it may also jeopardise their position as '*peripheral*' learners. Lave and Wenger (1991, p 37) argue that peripherality is '*a way of gaining access to sources for understanding through growing involvement'*. For student nurses this peripheral position should encompass understanding the practice of nursing through involvement with qualified nurses, principally their mentors. Ideally learners should not move too quickly towards a central position within a CLE, because that could be at the expense of gaining

valuable learning opportunities (Fuller *et al.*, 2005). Peripherality affords learners opportunities to engage in expansive learning opportunities; they have the opportunity to freely and flexibly engage in learning activities alongside experienced workers (Fuller *et al*., 2005).

The nursing literature suggests that students are frequently not engaging in learning opportunities alongside experienced nurses, i.e. with their mentors, but rather they are being instructed by HCAs (O'Driscoll *et al*, 2010). When mentors are inaccessible to students, they frequently default to 'working' with HCAs; the literature suggests that HCAs are required to 'teach' students, particularly what O'Driscoll et al., (2010, p215) refer to as 'bedside care skills'. HCAs may be competent to complete specific clinical tasks, however they are not qualified to teach students. HCAs undertake an important role within the CLE but they are not qualified nurses.

Students often see HCAs delivering beside care, whilst their mentors are typically involved in more technical aspects of care, for example drug rounds and ward organisation; students may therefore naturally value the latter, rather than the former (Allan and Smith, 2009; O'Driscoll *et al*., 2010). Allan and Smith, (2009) argue that this situation is problematic because the nurses that they interviewed felt that students should be learning how to deliver bedside care, as they had themselves learnt as students. However, because the qualified staff (in particular mentors) did not have time to deliver bedside care, students did not witness them undertaking such duties, thus causing a tension and a general devaluing of such care. Allan and Smith's (2009, p12) data demonstrate that mentors mostly focus on the tasks that only qualified staff can do, while students give 'unqualified' care, predominantly supervised by HCAs. This division of labour may lead students to categorising nursing duties into high and low status work (Allan and Smith, 2009).

In Allan and Smith's (2009) study, the students tried to resist undertaking bedside care because they believed it interfered with their learning of more

technical skills. This forms a potential source of disconnect between mentors and students because many trained staff inherently value caring duties; this value base may not be transferred to students (Allan and Smith, 2009). If students refuse to undertake bedside care, they risk alienating themselves from their mentors and they risk being perceived as lacking the required practical skills (Allan and Smith, 2009).

With many aspects of nursing care undoubtedly becoming more medicalised there is a risk that, if students do not work closely enough with their mentors, they may be unable to develop a full understanding of 'nursing professional habitus', including an appreciation of professional purpose, in addition to the development of skills competency (O'Connor, 2007, p752). Nursing holds the notion of 'caring' at the centre of its justification for calling itself a profession, the expansion into more technical roles may necessarily become problematic for the profession (O'Connor, 2007).

If students are predominantly supervised by HCAs, there is an inherent risk that they will be exploited as a worker, because the HCA role is principally task oriented, rather than learner focused. Allan *et al*. (2011) demonstrate that because students are expected to work as part of the NHS labour force, and to be deemed a competent practitioner at the point of qualification, their designation as a supernumerary learner in the CLE is rarely viewed a legitimate. It has been recognised for many years that the NHS is more of a workforce-orientated machine, rather than oriented towards learning (Melia 1987).

Learners within a community of practice may experience engagement in long periods of repetitive and routine work, which is no longer a source of learning but instead meets the requirements of the institution (Eraut 2002). The nursing literature demonstrates that students may be expected to contribute to the workload, within the CLE, with little consideration for their learning needs; a scenario which arises particularly when there are staff shortages (Myall *et al*., 2008; Molesworth, 2017). This may be the invidious situation that many student

nurses find themselves in, when they have reduced access to their mentor, and they are working alongside HCAs. From this position, students may experience marginalisation, within the community of practice, because they are prevented from participating in nursing practises (Molesworth, 2017).

Peripherally and marginality both include a mixture of non-participation and participation and the difference between them can be subtle (Wenger, 1998). Peripherality requires some degree of nonparticipation, because this enables the learner to access the community of practice. Whereas in marginality the nonparticipation is restricted and disabling, from a learning perspective (Wenger 1998). When students are working alongside HCAs, they are at risk of being marginalised because their access to their mentor is diminished and they are undertaking routine tasks, orientated to work rather than learning. Those learners allowed access to non-routine activities are more likely to have enhanced developmental opportunities, especially when accompanied by support and guidance, than those learners whose work is curtailed to only routine tasks (Billett, 2001). Mentors have a central role in enabling access to the learning activities occurring within communities of practice (Molesworth, 2017). The type of participation afforded to students is therefore significant, i.e. being enabled to participate as a peripheral learner, rather than participating as an essential worker.

Lave and Wenger (1991, p14) highlight that learners should participate *'…..in the actual practice of an expert but only to a limited degree and with limited responsibility for the ultimate product as a whole*'. Mentors need to carefully craft their mentee's learning experiences to ensure they are commensurate with their level of training (NMC, 2008). Learning the specific and changing elements of work is most likely influenced by how students are allowed and elect to participate in work related activities and interactions (Billett, 2006). It is important that students initially experience short and simple tasks to enable understanding; tasks which tend to be positioned towards the edges of the practice of the community. Through engagement in specific goal-directed

actions in practice, learners come to learn or to know new knowledge, which enhances and strengthens what they have already learnt (Billett, 1998)**.** Consideration of student learning goes beyond the mentor and the learner but also encompasses the possibility of targeted learning opportunities, afforded by other nurses and the wider MDT. Of course this type of engagement may be readily compromised within a busy CLE, potentially offering limited opportunity for learning targeted competences (Anderson *et al*. 2015)**.**

2.8.7: Belonging

A fundamental assumption contained within the community of practice literature is that participation necessitates a sense of belonging (or an aspiration to belong) within the community, shared understanding and a 'progression' along a trajectory from peripheral towards full participation (Handley *et al*., 2006). In order to learn, within a community of practice, the participants need to experience a sense of belonging (Hodkinson and Hodkinson, 2004). Ways of belonging is *'not only a crucial condition for learning but a constitutive element of its content'* (Lave and Wenger (1991, p35). The nursing literature is aligned with this sentiment. An absence of a sense of belonging has a negative and often long-lasting impact on student nurses' approach to learning and on their likelihood of becoming involved in experiential learning opportunities in practice (Levett-Jones and Lathlean, 2008). There is a tension between being a *legitimate peripheral participant* and feeling a sense of belonging within the CLE, with an assumption that those occupying peripheral positions may feel a diminished sense of belonging. However Lave and Wenger (1991) approach this tension by asserting that *legitimate peripheral participants* must be welcomed, with the community engendering a sense of belonging through the trajectory from peripheral to full participation.

Students are in the invidious position of needing to belong and thereby 'fit' into multiple learning environments, typically experiencing short placements, some only lasting for four weeks. Even with preparation, the literature indicates that it takes between two to four weeks for students to acclimatise to each new ward,

in terms of understanding the terminology, routines, associated medical language, practices and values (Levett-Jones, *et al*., 2008). Shorter placements of four - six weeks may therefore be particularly problematic for some students. The length of clinical placements can therefore affect students' sense of belongingness (Levett-Jones *et al*., 2008). Levett-Jones *et al*., (2009) concluded, from their study, that the qualified nurses whom the students work alongside, namely their mentors, have the most significant impact on their sense of belongingness and consequent propensity to be able to learn effectively in the CLE; a conclusion previously drawn in the literature (Nolan, 1998). Diminished access to mentors may impact negatively on students' perception of belonging within the CLE, potentially deleteriously affecting their competency development.

2.8.8: Considerations of competence

In considering how students demonstrate their competence within the CLE, the first challenge is to overcome the confusion in relation to what the term 'competency' actually means. Reviews of this term conclude that there is no single accepted definition and unhelpfully the terms 'competencies' and 'competency' are used interchangeably (Watson *et al*., 2002: Lauder *et al.*, 2008). The most informed discussions of competence occur when people clarify why they are using this word, which particular practice problem or policy they are considering and what (if any) theoretical assumptions they are making (Eraut, 1998).

The NMC (2010) assert that the function of nursing competencies is to: maintain standards; protect the public; protect the staff; maintain safe care; optimise practice and achieve the best outcomes for patients. Although it is difficult to argue against these important functions, competency based curricula attract considerable criticism (Ashworth and Morrison, 1991; Manley and Garbett, 2000; Watson *et al*., 2002; Dolan, 2003; Mcmullan *et al.,* 2003; Winch, 2010). Many nurse educationalists view competence based curricula as behaviouristic,

isolated and reductionalist; reduced to measures which can be accumulated and tallied (Gallagher *et al*., 2012).

Despite such criticisms the notion of 'competence' continues to have significant influence and traction in pre-registration nurse education (Blazun *et al.* 2015; Burke *et al*., 2016) and considerable effort is invested in attempting to assess the competency of student nurses in practice (Cowan *et al.*, 2007; Butler *et al*., 2011). There have been various iterations of the NMC Standards, the most recent published in 2018 (NMC, 2018a); they all attempt to grapple with the assessment of competency and knowledge. Within the NMC (2010) Standards a framework is laid out, setting down competences (captured within the PAD), that student nurses must achieve at defined points within their programme, and before qualification. Achieving competence may be perceived, by both mentors and students, as a constitutive of the development of belonging within the CLE, rather than a marker of competency per say. Appraisal of how effectively a student has settled into a CLE may influence appraisal of competency, specifically when students have utility (in terms of their ability and willingness to undertake work rather than embark on learning activities) within the CLE.

Some curricula are designed to incorporate the grading of practice into the calculation of Degree classification. In this way achievement in practice is seen as equivalent to theoretical achievement (Fisher *et al*., 2017). The participants in this study were graded in practice, meaning that their mentors had direct influence over their Degree classification. Whilst capturing achievement in practice is a laudable intention, there are many criticisms of this system, not least that grading in practice may not accurately determine performance, levels of competence and ultimately preparedness for registration (Donaldson and Gray, 2012).

In the final placement mentors (who have undertaken enhanced mentorship training) are required to 'sign off' their students' practice competence, indicating to the University that the student is fully prepared for registration (NMC, 2008).

This is the most significant point of assessment for student nurses because it marks the juncture between being a student nurse and registrant. Failure at this stage means that the student exits the University with accrued academic credits, but without registration as a nurse. Students in this position will have devoted three years to their nurse education, often accompanied by considerable emotional and financial investment.

A student requirement to achieve and demonstrate increasing levels of competence (NMC, 2010) may be compromised by short placements. Students need significant time within a CLE to be able to expand their knowledgebase and to be able to provide competent care to families and their patients (Benner, 1984). This issue is typically less of a problem in the final 'sign off' placement, because it is required to last at least twelve weeks (NMC, 2010). Even if students have the opportunity to gain competence, they still need to be able to demonstrate their competence to their mentors. The literature indicates that some mentors do not always feel they have the necessary preparation, support or protected time to undertake such assessments (Myall *et al*., 2008; Veeramah, 2012; Bennett and Mcgowan, 2014). When mentors do not have sufficient time to work alongside their mentees the learners often work more closely with HCAs (O'Driscoll *et al*., 2010), who are not qualified to assess competency.

Demonstrating competence within the CLE may be problematic for some student nurses, in part due to the associated difficulties in defining and measuring competency. In addition, some students face difficulties in securing sufficient time with their mentors, to be able to adequately demonstrate competence. Conversely some mentors feel ill prepared to undertake this important assessment role. Undermining determinants of competency and achievement may lead to a hollowed out sense of the value attached to the nursing qualification. This scenario does not align with Lave and Wenger's (1991) notion of competency; they perceive competence as an absolute and accurate indicator of skill acquisition and an ultimate marker of membership identity within a specific community of practice.

2.8.9: Summary – situation learning theory

Situated learning theory, and the notion of peripheral participation, is useful for understanding the position of students in the CLE. This theoretical lens highlights that student nurses' position, as *legitimate peripheral participants*, may be precarious. It brings into focus considerations of relationships and the importance of belongingness, whilst remaining sensitive to the context beyond the community of practice. In considering how communities of practice function, questions relating to power and vulnerability in these communities remain partly unanswered.

2.9: Exploring power relationships within the CLE and consequent impact

Lave and Wenger (1991, p 42) acknowledge that their theory does not fully address issues relating to power. A full understanding of the nuances of power in operation within the CLE is required to understand the literature and interpret my data. To that end, I have drawn on the work of Lukes (1974) and Nye (2009) whilst integrating the work of Lave and Wenger (1991) and the wider literature, into this final section of the literature review. I begin by discussing how Lukes's (1974, p21) 'third dimensional view' may be used to understand the inherent pressures associated with learning and teaching within the CLE, whilst being exposed to the power exerted by the 'clinical imperative'. I go on to explore other nuances of power occurring within the CLE, highlighting the source of mentors' powerbase and the influence of hierarchy and personal mentor/mentee attributes. Finally, considerations of student coercion will be explored.

It may be near impossible to learn in practice and thereby be identified as a *legitimate peripheral participant*, within that community of practice, when power relations serve to obstruct or deny access to the 'experts'; conversely power relationships can facilitate access to learning opportunities (Contu and Willmott, 2003). Control over resources for learning and potential alienation from participation are integral to the sculpting of legitimacy and peripherality of participation (Lave and Wenger, 1991). Within the NHS, like in many employment contexts, power is highly stratified, through the multifaceted

division of labour, and it is affected by organisational, cultural and wider political factors. It is within this environment that student nurses are expected to learn and their mentors teach.

Legitimate peripheral participation is centrally placed in Lave and Wenger's (1991) understanding of the conceptualisation of learning, and 'power' is essential to their analysis of how communities operate (Contu and Willmott, 2003). Lave and Wenger (1991, p98), state that:

> '*The social structure of this (community of) practice, its power relations, and its conditions for legitimacy define possibilities for learning*.'

Thus power relations operate to enable and restrict access to a position of (initial) peripherality and potentially eventual mastery; it does not exert an external or unrelated pressure. Situated learning theory thereby provides a useful platform from which to understand the position of student nurses within the CLE, and broadly the power relations within that particular community of practice. However, Lave and Wenger (1991, p 42) acknowledge that unequal power relationships require further analysis and development within their theory. Lave and Wenger's (1991) theory certainly does not provide the tools to fully explain the implicit power exerted by the clinical imperative and the influence this has on students' learning.

Acknowledging this limitation, and appreciating that understanding power is instrumental for my data analysis, I decided to add an additional (power, rather than learning focused) theoretical lens in order to explore further the nuances of power operating within this environment. For this purpose I chose to primarily utilise the work of Steven Lukes (1974), a British political and social theorist, in '*Power – A Radical View*', supported by the work of Joseph Nye, an American political scientist. The work of Nye (Nye, 2009) provides a general backdrop of how to think about power. Lukes (1974) provides a more specific set of tools for understanding complex notions of power, describing power as '*three*

dimensional' (Lukes, 1974, p10), illuminating the distinctive features within each dimension.

Lukes has not been widely used as a theoretical framework in the nursing literature; there are many other theories of power, which I could have selected. The choice of Lukes (1974) was suggested by my supervisor. In line with the hermeneutic process of developing understanding, we had iterative conversations relating to the pervasive nature of power within the CLE and we discussed theories of power including the authors Foucault and Lukes. I chose Lukes (1974) because it fitted my broader inquiry best and complemented Lave and Wenger's (1991) theory. Lukes (1974) theory was added later to my literature review than Lave and Wenger, but still within the *search and acquisition* stage of the hermeneutic (literature review) circle (appendix C).

Lukes (1974) is a political theorist whose work is used to understand practice; the tenets of his theory can therefore be extrapolated and applied within this thesis. Lukes (1974) is not a highly complex post-structural sociological theory with a great degree of abstraction, like Foucault. Lukes (1974) therefore allowed me to engage in questions of power, hierarchy and epistemology without taking me too far away from the real focus, which is to understand the experiences of the students learning within the CLE. This theory enabled me to unpack and make sense of the pervasive power dynamics operating within the CLE: it proved useful for developing my understanding.

2.9.1: Using Lukes's 'third dimensional view' to understand the 'clinical imperative'

It seems there is an implicit assumption within nursing (and the literature) that patient care should to be prioritised over students' learning within the CLE. After applying Lukes's ideas to my experiences of students' learning in practice, I began to review this assumption and coined it '*the clinical imperative'* within this thesis. The '*clinical imperative'* has an organising effect on behaviour, roles, positions and relationships within the CLE. This imperative requires that

students negotiate their learning needs, predominantly with their mentors, in an environment where such needs are naturally placed as a secondary consideration. This negotiation may be challenging for both students and their mentors, as they attempt to adapt the clinical space into a space where learning can occur, alongside clinical care. It is the duality of mentors' sphere of responsibility (in terms of clinical care and mentoring), which makes them especially susceptible to the power exerted by the clinical imperative. Students are also at the mercy of the clinical imperative because clinical pressures can readily require them to abandon learning activities, to engage in work tasks.

The work of Lukes (1974), supported by Nye (2009) compliments Lave and Wenger (1991) and lends itself to understanding this unchallenged assumption, implicit within the CLE. Lukes (1974) sets out his idea of how power operates, calling it a three-dimensional view. Lukes's (1974) primary argument is that we need to consider power in broad terms, but specifically address the elements of power, which are most difficult to observe. Lukes (1974) considers three different dimensions, or ways of considering power but the third dimension is the most effective mechanism for accurately interpreting and understanding the power relations, surrounding this notion of the clinical imperative. The other two dimensions are valuable and I will refer to them within my arguments.

Lukes (1974) third dimensional view claims that for power to operate effectively, there needs to be a general acceptance of the status quo, predicated on a tolerance of the underpinning ideology. The clinical imperative operates as a powerful force within the CLE. It is assumed and accepted that the needs of patients should take priority over the learning needs of students. Sometimes these needs can be met together, for example, by a mentor demonstrating elements of nursing care to a student. However, if patient requirements and learning needs conflict, it is the patient's requirements which are usually prioritised. This power dynamic in healthcare is accepted because people have a genuine and unquestioning belief in the system and perhaps do not question potential ramifications. People are unable or unwilling to conceptualise

alternatives, preventing them from raising questions or grievances. Lukes (1974, p24) argues this is because people:

> *'Accept their role in the existing order of things, either because they can see or imagine no alternate to it, or because they see it as natural and unchangeable or because they value it as divinely ordained and beneficial.'*

Lukes's three-dimensional view of power is ideologically rooted, and analogous to what Nye (2009) refers to as soft power. In comparison to hard power, soft power has the capacity to persuade others into a course of action. The major elements of soft power incorporate values (when consistently practised and attractive), culture (when it is pleasing to other people), and policies (when viewed as legitimate and inclusive) (Nye, 2009). Lukes's (1974) three-dimensional view of power and Nye's (2009) notion of soft power are useful for considering the powerful critical ideological assumption held within CLEs, that patient care takes natural precedence over student learning needs. It is useful for explaining how the clinical imperative can exert power within the CLE.

The 'clinical imperative' may initially seem like an uncontroversial and innocuous position; the NHS functions to care for people and, therefore, care must take precedence over the subsidiary learning needs of students. Health care provision is primarily focused on care delivery, with teaching and learning being viewed as a secondary activity, i.e., when time permits (Henderson and Eaton, 2013). However this unchallenged position means that students (and to some extent their mentors) need to negotiate a powerful inherent tension between care delivery and learning needs. Students' lack of agency means that they may be unable to challenge this ideology and defend their position as *legitimate peripheral participants* within the CLE, because there is a pervasive belief that care needs must take precedence.

2.9.2: Implications of the 'clinical imperative'

The position of students within the CLE is challenging because, regardless of the pressures associated with clinical care, students are required by the NMC (2010) to gain access to an array of learning opportunities and to ultimately demonstrate that they are competent to register as a nurse. Such learning opportunities predominantly occur through caring holistically for patients, alongside their designated mentors (NMC, 2008). These opportunities may include learning about patients' diagnosis, treatment and affiliated care but fundamentally students are required to harness the knowledge, skills and behaviours of their mentors, to ultimately make them safe practitioners (NMC, 2008).

Mentors are essential in identifying appropriate learning opportunities for students, and embracing learners into the CLE team (Henderson and Eaton, 2013), by ensuring that they occupy the position of a *legitimate peripheral participant* (Lave and Wenger, 1991). Although other colleagues will inevitably be involved in supporting student learning within the CLE, it is the mentor who holds this primary responsibility (NMC, 2008). The clinical imperative may compromise learning within the CLE, with deleterious consequences for student learning, skill acquisition and development and, ultimately, overall achievement on the programme. This situation may have far reaching ramifications for the profession, including an adverse impact on the general expertise within the nursing workforce and patient safety.

Power is inevitably related to the roles and positions of both mentors and students within the CLE, operating under the unwritten rule of the clinical imperative. Given the weight of the clinical imperative, mentors may struggle to position students as *legitimate peripheral participants* within the community of practice. Similarly students may struggle to occupy this position within the CLE, particularly if their mentor is unsupportive of their learning needs. To fully appreciate the position of mentors and students, a number of other important considerations need to be explored, which highlight nuances of power occurring

within the CLE, including an exploration of: the source of mentors' powerbase; the impact of hierarchy; the influence of the personal attributes of students and mentors and issues relating to coercion.

2.9.3: Lukes's 'one dimensional view'

It is important to consider the mentor/ mentee relationship, particulary examining the source of the mentor's power. The power dynamic which underlies the mentor/mentee relationship can be understood in terms of what Lukes (1974, p11) refers to as 'one dimensional'. The one dimensional view of power, is often called pluralist and is linked to the work of Dahl (1957), who asserts that the seat of power can be elicited by determining dominance in decision making, particularly evident when there is observable conflict (Lukes, 1974). Dahl (1957, p10), describes power:

> *'as something like this: A has power over B to the extent that he can get B to do something that B would not otherwise do.'*

From a student perspect this is signficant because the mentor may, for example, instruct them to priorise work over learning in the CLE, meaning that the student no longer occupies the place of a *legitimate periperhal participant*. This type of decision making power is likely to be overt rather than covert (Lukes, 1974) and is synonymous with what Nye (2009, p160) refers to as, 'hard power'. Hard power involves the use of individuals exerting power over others, usually through means of coercion (Nye, 2009). In the mentor/mentee relationship the mentor holds overt (hard) power over their mentee.

Mentor power is seated within the legitimate foundation of being registered with the NMC as both a mentor and a nurse; registration which confers mentors with the entitlement to facilitate learning and assessment activities of student nurses, within the CLE (NMC, 2008). Conversely, mentors also have the right to use their power to direct students away from learning and towards work related activities, because of their professional mandate to meet patients' needs (NMC Code, 2018b). This requirement is enshrined within the Code (NMC Code, 2018b, p7), requiring that all nurses '*make sure that people's physical, social*

and psychological needs are assessed and responded to'. Mentors' professional requirement, to care for patients, may readily conflict with the fulfilment of their mentorship role, particularly in the busier environments. The intentional use of power, by mentors, is nested in the wider cultural structure of the CLE and the institutional expectations of both the healthcare setting and affiliated University, endorsed by the NMC Code (NMC Code, 2018b).

Undoubtedly the strength of the mentors' *'one dimensional'* power is inextricably linked to considerations of hierarchy. Nursing is inherently hierarchical and mentors are expected to teach and students learn, within a highly stratified power dynamic. There is typically a multitude of colleagues locally involved in this power dynamic including: mentors, other qualified nurses, the ward manager, other members of the MDT, HCAs, LELs, peers and University staff. There are clear grade boundaries between nurses and the non-registered workforce; all NHS staff (with the exception of doctors, dentists and most senior managers) are assimilated into bands 1- 9 (NHS Staff Council 2019). Mentors typically occupy bands 5 or 6, whilst HCAs are usually in bands 2-4, depending on their competency level. Arguably throughout their programme, students occupy the lowest position in this hierarchy (Lee *et al,* 2018), beneath the non-registered workforce (i.e. HCAs). This positioning may make it difficult for students to negotiate learning opportunities.

Mentors are themselves subject to the impact of the CLE hierarchy, the effects of which may either hinder or support them in managing their mentorship role (Veeramah, 2012). Utilising Lukes '*one dimensional view'* highlights how mentors' position in the hierarchy influences their dominance in decision making, in relation to the clinical educational provision. Band 5 mentors are more junior, within the hierarchy, and therefore arguably less able to protect their mentee's learning opportunities within the workplace. They will have less influence in how local educational arrangements are managed, compared with more senior nurses. However, band 5 nurses typically deliver direct patient care and therefore may be more readily available to support students' learning, which

often occurs at the bedside. Band 6 mentors have a more senior and thereby influential role. However, they will have extended managerial responsibilities, potentially taking them away from mentoring activities. Therefore, although more junior mentors are less able to advocate for students' learning needs, structural considerations may to an extent ameliorate this comparative lack of power.

Historically the ward manager has had a significant influence in creating a conducive learning culture within the CLE (Ogier, 1982; Saarikoski and Leino-kilpi, 2002; Warne *et al.*, 2010), thereby supporting mentors in navigating these inherent tensions within their role. They were so influential because they had (from Lukes one dimensional view) dominance in decision making, in relation to the local clinical education arrangements. However, ward managers experience competing management, clinical and educational demands (Midgley, 2006). Where traditionally ward managers led and influenced learning at ward level, now increasingly this responsibility has been devolved to mentors, a role they need to balance with other key responsibilities, including direct patient care (O'Driscoll *et al*., 2010). Given this lack of senior support, with knowledge of the pressures associated with simultaneously delivering patient care, it is perhaps unsurprising that mentors find it challenging to fulfil their role (Veeramah, 2012; McIntosh *et al*., 2014).

Notwithstanding the important arguments so far, to some extent mentors may choose how effectively they utilise their power to influence student learning. This point acknowledges that people who have control over resources can utilise their power to create or remove boundaries and barriers to facilitate or inhibit participation (Lave and Wenger, 1991). Mentors can thereby (to some extent) use their power positively to facilitate student learning and progression, maintaining students successfully on the programme until qualification (Robinson *et al.,* 2012). The antithesis to this position is that learning is compromised for some students because they feel disconnected and unsupported by their mentors within the CLE (Levett-Jones *et al*., 2009). Such

students become preoccupied with building interpersonal relationships, principally with their mentor, rather than focussing on learning (Levett-Jones *et al.*, 2009). Students who do not fit in become vulnerable to bullying behaviour (Bowllan, 2015;.Thomas *et al.,*2015) and are more likely to conform to poor practices in their attempt to fit into the environment (Levett-Jones and Lathlean, 2009b).

In relation to Lukes (1974) one dimensional view, it is essential to consider the varying power base of individual students. Students require facilitation because they do not have sufficient power to negotiate learning opportunities unaided. However, it is overly simplistic to portray student nurses as a homogenous group, in relation to their position at the bottom of the CLE hierarchy. Inevitably individuals' agency and intentionality shape their engagement in the work place and mediate what is learnt through engagement (Billett, 2004). Individuals are not passive participants in practices and learning (Hodkinson and Bloomer, 2002). The individual's agency determines how they construe learning opportunities and judge what they should participate in (Billett, 2004).

Senior students may be better able to protect their position as *legitimate peripheral participants* and thereby gain access to the required learning opportunities, compared with junior students. Other students may be able to deploy negotiation skills to access learning opportunities (Elcock *et al.* 2007). More assertive students may be able to negotiate their learning more effectively in the CLE, conversely others may feel less able to protect their status as students (as opposed to workers) within this environment (O'Driscoll *et al.* 2010). Resilient students, who perceive a depletion of available learning opportunities, may be able to develop strategies to seek out new opportunities (O'Mara *et al.*, 2014). Beyond personal resilience, issues relating to age (Shivers *et al.*,2017), gender (Sedgwick and Kellett, 2015) and ethnicity (Salamonson and Andrew, 2006) may also impact on student learning and achievement, demonstrating that students should not be viewed as one homogenous group. Additionally, students with previous healthcare experience

may have different experiences within the CLE. This group of students may be vulnerable to exploitation, because they can be readily asked to complete tasks (usually undertaken by HCAs) at the expense of more expansive learning opportunities (Hasson *et al.*, 2013). Conversely positive discrimination may also occur, when students with previous experience, are encouraged to participate in more advanced care, based on a perception that they have mastered the basics (Hasson *et al*., 2013).

2.9.4: Lukes's 'two dimensional view'

Lukes (1974) two-dimentional (non-decision making) argument illuminate further elements of power dynamics occuring within the CLE. Lukes (1974) argues that the exercise of power is often subtle and nuanced, operating beyond pluralistic mechanisms. This second dimension acknowledges Dahl's (1957) observable power theory, but additionally asserts that power is also exercised when issues are specifically arranged to avoid the need for discussion. Behaviours associated with coercion, influence, authority, force and manipulation occur, when actor 'B' refrains from voicing their opinion, relating to a point of direct personal interest, because they anticipate an unpleasant repsonse from actor 'A'. Nye (2009, p160) refers to this type of power as 'hard' power. By ensuring that potential points of conflict are avoided, observable conflict is not evident, however power over another is still exercised (Lukes, 1974). Fundamentally, students may refrain from voicing their opinion or protecting their position as a *legitimate peripheral participant*, because they fear an unpleasant response from their mentor, which may include fear of placement failure or other deleterious consequences.

The assessment creates a potential nexus of student vulnerability, solidifing the students' position within the CLE hierarchy and perhaps explaining certain student behaviours within it. Students may fail to protect their position as learners partly due to their lack of agency but also through fear (Levett-Jones and Lathlean, 2009a). Relating to Lukes (1974), two (non-decision making) dimensional view, students may be manipulated through the power asserted by,

for example, the assessment; students attempt to fit into their environment as a strategy to pass their placement. In an unpublished report Champion *et al., (1998*) describe the way that student nurses adapt to the institution's values and team norms and adopt their behaviours, as they move through different placements, in the hope of becoming accepted. Champion *et al., (1998)* liken this behaviour to a chameleon, fitting into the environment. Inevitably, this position does not encourage students to adopt an inquisitive approach to learning or practice, facilitate students in exploring evidence based practice or encourage confidence in engaging with patients. Behaviours which support learning about clinical practice, whilst simultaneously encouraging a questioning approach are important because they help eliminate a ritualistic approach to caring for patients, which may compromise the quality of care (Henderson *et al.*, 2005).

In an attempt to fit in, students may willingly take on the roles and duties assigned to Healthcare Assistants (Harrison-White and Owens, 2018). Although this strategy may enable students to fit into the team, it can compromise their position as learners. Melia (1987) was amongst the first to note that students attempt to gain entry and to be accepted by teams by undertaking the duties and embracing the roles of the nurses with whom they work with. By undertaking tasks, students are attempting to enhance their utility within the CLE, from which position they may be better positioned to bargain for learning opportunities. Undertaking clinical tasks is linked with the clinical imperative. By contributing to clinical tasks, students are putting the needs of patients and clinical aims of the nurse before their own learning needs. Undertaking clinical tasks is obviously a central nursing role, which student nurses are necessarily involved, with the aim of enhancing their learning and skill acquisition (Chan, 2004; Perli and Brugnolli, 2009; Smedley and Morey, 2009; Henderson *et a*l., 2012). However, the clinical experiences gained, through placements, need to contribute meaningfully to student learning, by embedding learning within task completion. In other words, learning needs to be carefully constructed and is unlikely to occur through undertaking repetitive tasks.

The nursing literature indicates that a desire to fit in can lead some students to conform to prevailing poor nursing practices and cultures within the CLE (Champion *et al*.,1998; Nolan, 1998; Sedgwick and Yonge, 2008; Levett-Jones and Lathlean, 2009b). Relating to Lukes's (1974) two-dimensional view, students conform because they anticipate an unpleasant response from their mentor. Such conformity can encompass a range of affiliative behaviours, for example: acquiescence; adaption of behaviour; engaging in negative behaviours endorsed by the group and automatic agreement with others (Baumeister and Leary, 1995). This position is necessarily problematic for student nurses because they are required to raise concerns in the same way as qualified nurses (NMC, 2018c). Students cite the potential consequences for them if they raise concerns, these include: apprehension about the potential impact on their clinical grades; the prospect of conflict with colleagues and an uncertainty relating to the seriousness of the concern (Ion *et al.,* 2015).

To optimise learning and reduce such acquiescent behaviours students need to feel a sense of belonging. In terms of the power relationships, a perception of belonging may engender feelings of security and diminish the perceived threat from hard forms of mentor power. The processes, experiences and relationships within a community of practice form students' sense of belonging, which influences the nature and extent of subsequent learning (Fuller *et al.*, 2005). Lave and Wenger (1991, p35) assert that belonging is 'a crucial condition for learning'. Taking into consideration the work of Lukes and Nye, belonging might encompass an open and honest acceptance of hierarchy and vulnerability, accompanied by mentor reassurance that vulnerability will not be unduly exploited. Thereby creating a form of legitimacy around peripheral participation, resulting from membership of a community of practice that reduces any vulnerably associated with the tension caused by the clinical imperative in CLE. In other words, the mentor is able to recognise tension in CLE, caused by the clinical imperative, and explains to their mentee that they will attempt to navigate through the pressures together to preserve meaningful learning opportunities. On the other hand, failure to recognise the tension created by the clinical

imperative, means that legitimacy and peripheral status, along with a sense of belonging, may be readily eroded for students.

Failing to create a culture of belonging and legitimate peripheral status is problematic (given the tensions in CLE). However, there are cases where bullying/toxic mentorship makes this situation worse. The nursing literature suggests that far from engendering a sense of belonging, some students face incidents of bullying (in a nursing context bullying is also called incivility and horizontal/ vertical violence) within the CLE (Webb and Shakespeare, 2008; Hathorn and Tillman, 2009; Rees *et al.*, 2015; Thomas, *et al.*, 2015; Birks *et al.,* 2017; Jack *et al.*, 2018). These acts of hostility demonstrate an abuse of power and position within the CLE. Such behaviour links with Lukes's (1974) two-dimensional view of power in that mentors sometimes exercise subtle but potentially forceful and manipulative behaviour, which at its extreme may amount to bullying. The extent of incivility can be serious; some students need to navigate what Darling (1985) coined 'toxic mentors'. This term refers to instances where mentors fail to establish positive relationships with their students. This problem can be extended to include an insidious culture of bullying within the NHS (Wilson, 2016).

2.9.5: Summary – power

Power relations are an inevitable part of the CLE and are not necessarily deleterious to student learning; the impact of power relations on student learning depends upon how power is used within the community of practice and whether students are positioned as *legitimate peripheral participants* (Lave and Wenger, 1991). The way in which work is organised and controlled will inevitably affect learning within the workplace (Fuller and Unwin, 2003). In theory, mentors are positioned to be able to facilitate students (as legitimate peripheral participants) to gain access to learning opportunities through participation. Such access will afford students opportunities to gain meaningful learning experiences, appropriate to their stage of training.

Through the theoretical perspectives presented it is evident that mentorship effectiveness is inevitably influenced by the critical notion of the clinical imperative, which operates as a powerful force within the CLE, placing learning as a secondary consideration. In addition, a number of other important factors may enhance or diminish students' opportunities to learn in practice including: local education arrangements; local structural circumstances; mentors' position with the hierarchy; students' agency and utility and the mentor's individual willingness to undertake the role.

Ideally students should experience a sense of belonging within the CLE, which fosters ideal learning conditions. However, far from experiencing belongingness, some students are exposed to incidences of incivility. It is important to acknowledge that the process of assessment forms a potential nexus for student vulnerability, within the CLE, potentially leading students towards a number of acquiescent behaviours, thereby diminishing the quality of their learning experience.

2.10: Literature review conclusion

The knowledge gained through this literature review forms a platform from which to explore the research question: *How do student nurses experience learning within the CLE?* Lave and Wenger's (1991) theory synthesised with theories of power from Lukes (1974), provides a perspective that draws attention to poorly understood issues of how learning takes place in clinical settings, and how power relationships affect this learning, which would otherwise have not been visible. These theories fit with my prior experience and knowledge, helping to deepen this understanding and to guide the analysis of the empirical data. Much of the extant nursing literature has a relatively narrow remit, for example focussing on issues relating to mentorship and belongingness within the CLE. While these are important topics, there is a need to deepen the understanding of the subtle interplay occurring between experiences and within relationships occurring in the CLE, to fully appreciate students' experiences of learning in this environment. Although I have started to understand the precarious nature of

learning in the practice environment, I want to explore in more detail, through empirical research, some of the conclusions drawn within this literature review.

Chapter 3: Methodology

Within this methodology chapter I will describe how I utilised hermeneutic phenomenology, and specifically the work of Ricoeur (1981), to gain an in-depth understanding of the lived experiences of learning within the CLE, from the perspective of the participants. I will begin this chapter by defending my choice of methodology, before explaining the study: question; research design; sampling procedure; recruitment strategy; data collection and ethical considerations. Finally I will consider the critical issue of research rigor, specifically in relation to reflexivity, procedure and analysis.

3.1: A qualitative approach

I intentionally chose a qualitative methodological approach for the purposes of this study because this aligns with my area of exploration, that being, an examination of how student nurses experience learning within the CLE. Yilmaz (2013, p312), drawing on the research literature (Miles and Huberman, 2002; Patton, 2002; Creswell, 2007; Denzin and Lincoln, 2011), defines qualitative research as:

> *'an emergent, inductive, interpretive and naturalistic approach to the study of people, cases, phenomena, social situations and processes in their natural settings in order to reveal in descriptive terms the meanings that people attach to their experiences of the world.'*

To achieve an in-depth understanding of the learning experiences of student nurses in the CLE, I needed to utilise a qualitative rather than a quantitative methodological approach; a quantitative, statistical approach, would have yielded little insight into the issues under consideration. While qualitative researchers are interested in understanding the inherent qualities of entities and on meanings and procedures, which are non-experimental in nature, quantitative researchers are concerned with the measurement and analysis of specific causal relationships, between known variables (Denzin and Lincoln, 2011). My primary interest focuses on understanding the educational

experiences of student nurses in practice. I am interested in understanding the construction of these students as subjects in the CLE, and their broad experiences in that context, relating to their clinical education and learning. As such I am not assuming that the experiences that students have in the CLE are neutral and objective and can be understood through positivist research methodology. Student's experiences of learning in the CLE are socially constructed; experiences which are created and reproduced through practice, through discourse and policy. A quantitative methodology that is premised on positivistic epistemology and therefore assumes the experiences of student nurses to be fixed, neutral and stable would be inappropriate for this research.

3.2: Epistemological and methodological framing of the study

As Crotty (1998) argues, researchers must operate consistently with their epistemological positioning. It is important to recognise the requirement for constructing research processes, which align adequately with the purpose of the research intent, rather than striving to blindly observe traditional approaches, simply for reasons of tradition particularly for healthcare education research (Clark *et al.,* 2018). Given these important points, in light of the research aim to investigate the educational experiences of student nurses in the CLE, a qualitative methodology based on hermeneutic phenomenology was deemed appropriate.

Hermeneutic phenomenology, encompassing the processes of interpreting and describing human experience in order to understand the fundamental nature of that experience, is appropriately positioned as a suitable methodology for research within the human sciences (Tan *et al.*, 2009). Hermeneutics have been utilised widely since the 1970s as a qualitative research method in nursing science to investigate an extensive range of issues, through understanding the lived experiences of participants (Charalambous *et al.,* 2008). Hermeneutic phenomenology evolved through the contributions of a number of philosophers, notably: Husserl; Dilthey; Heidegger and Gadamer (Tan *et al.,* 2009). The methodological and philosophical views of hermeneutics offered a new course

of study, not only within philosophy but across many different disciplines, including nursing (Finch, 2004).

Ricoeur, following on from Gadamer, indicated that we should no longer define hermeneutics (the theory of interpretation) as merely uncovering the psychological intent of another person, sealed beneath text (Charalambous *et al.,* 2008). Rather, according to Ricoeur (1981, p185), the process of interpretation '*releases something like an event, an event of discourse, an event in the present time'.* The process enables the interpreter to achieve a new perspective on the world (Charalambous *et al.,* 2008). Tan *et al*., (2009) suggest that although Heidegger's hermeneutic phenomenology provides an appropriate philosophical underpinning for social science research, that aspires to understand the meaning of individual's lived experience, it does not offer clarity with regard to the actual research process. Ricoeur (1981) developed Heidegger's and Gadamer's ideas, in the domains of method and interpretation in a way which addresses this shortfall.

Ricoeur's philosophy is particularly useful for understanding text (Ghasemi *et al.*, 2011). He concentrates on textual interpretation as the primary focus of hermeneutics and established a theory of interpretation (Ghasemi *et al.,* 2011). Most qualitative research involves collecting narratives about a specific phenomenon of interest; a hermeneutic approach is utilised to understand and interpret these narratives (Wiklund *et al.,* 2002). The key concepts, which underpin the analytical processes developed by Ricoeur (Ricoeur, 1981) include: distanciation; appropriation; explanation and interpretation; these concepts will be expanded upon later in this chapter.

3.3: Justification of hermeneutic phenomenology

I chose Ricoeur's interpretive theory for several key reasons. Firstly, Ricoeur's theory avoids the predilection of the Cartesian subject/object split, thereby making it possible for the researcher to explicate intersubjective knowledge (Ricoeur, 1974). In doing so, Ricoeur's theory of interpretation recognises the

critical interrelationship between epistemology (the interpretation) and ontology (the interpreter/object) (Ricoeur, 1974). I purposefully chose this methodological approach because it enabled me to interpret the spoken word, utilising my own 33 year knowledge and experience as a student nurse, nurse and a nurse educator to develop a new and deeper understanding, based on a conjunction of the two understandings. Ricoeur (1974) asserts that textual interpretation is captured inside a circle formed by the unification of interpretation and the interpreter. I perceived that this unification would yield considerable depth of understanding of the phenomenon under consideration.

Secondly, Ricoeur (1976) asserts that interpretation is the axis between language and the lived experience. This point is relevant to my research because the data collection method culminated in written text, which required my subsequent interpretation of the lived experience of the participants. It was through the text that I was able to understand the lived experience of the participants. The data thereby acted as a text; a medium which allowed me to understand and interpret the learning experiences of the students and to reflect on how they experience this learning environment. A positivist approach would not afford this type and depth of insight. Aligned to Ricoeur (1976), I utilised the data with in an interpretative way, to yield a deeper understanding.

Thirdly, Ricoeur's hermeneutic approach incorporates considerations of the beliefs, values and culture in the context, specific to the participants and the researcher, which he believes are essential elements to consider during the data collection and analysis phases. In considering the experience of learning to be a nurse in practice, it is arguably important to consider such experience, within the context of contemporary prevailing beliefs, values and cultures. I utilised a wide body of both historical and contemporary literature to understand these contexts. The relevant contemporary literature and some historical literature is presented in the literature review. However, not all the historical literature could be included due to the word limit; examples of key historical literature are presented within appendix B. Of course, cultural considerations

may influence and principally alter interpretation of the text to create conflicting interpretations (Ricoeur 1976). Ricoeur (1976) accepts that conflict of interpretation may lead to the possibility of very different and even opposing understandings; this being a fundamental element of interpretation.

Finally, Ricoeur rejects the notion of bracketing, enabling the researcher to assume a more active role within the process of interpretation, again recognising the knowledge that the researcher brings to the procedure. In rejecting bracketing, I reached a deeper understanding of the data because I was able to draw on my professional/ academic experience and understanding gained through the literature. The combination of these fundamental elements contribute to making this methodological approach an appropriate choice, fitting both the requirements of my research and aligning to my personal research orientation.

I could have utilised other qualitative approaches, for example ethnography or grounded theory (Denzin and Lincoln, 2011). I judged an ethnographic study inappropriate principally because such studies require the researcher to be present observing or interacting (Denzin and Lincoln, 2013). I was concerned that my presence as a researcher may affect the nature of what is being studied. I anticipated that I would likely influence the interactions and therefore the results may not be a true reflection of the students' experiences of learning in practice. On a practical level I was concerned that research ethical approval may be rejected, for this type of study, due to this reservation.

Another approach I could have utilised is grounded theory. Grounded theory requires that the researcher comes to the study without a wealth of knowledge of the study area; knowledge grows organically from the data (Corbin and Strauss, 2008). Due to my considerable related experience, I also judged this methodology inappropriate. The research process would not be inductive, comparative and iterative; requirements of grounded theory (Wertz *et al.*, 2011). In addition, I felt that my experience as a nurse educator was a resource that I

wanted to draw upon, albeit critically and reflexively, according to the hermeneutic method.

Recognising and respecting the fact that student nurses are immersed within the CLE and have experienced, first-hand, the reality of learning within this environment, means that they are well placed to answer this research question knowledgeably and with insight and therefore credibility. As an epistemological starting point, it is essential to consider the value of the knowledge under consideration and for whom it is being pursued (Crotty, 1998). Essentially this study is predicated on a fundamental assumption that the complex questions, relating to the experience of learning within clinical healthcare settings, are relevant to those embroiled in learning within it, i.e. student nurses. In researching this area I was mindful and respectful of their experience, indeed my respect for their insight directed my research methodology. The nature of the knowledge under consideration (student learning in practice) forms a fundamental part of student nurses' remit and function within practice; they are placed within practice to learn nursing. Therefore, through understanding their experiences, a legitimate insight into this area of inquiry can be ascertained, which will serve to inform both educators and policy makers.

By utilising the hermeneutics ascribed to Paul Ricoeur, I have been able to merge my prior knowledge of this subject area with the insights gained through talking with the participants, to achieve a new and more comprehensive understanding. My prior knowledge of the subject area is based on having worked in the NHS for eighteen years and Higher Education for fifteen years. During my employment within the NHS I worked in a variety of roles, starting as a student nurse and progressing to the level of Senior Sister. At Senior Sister level I was employed in a full time clinical post and later as a clinical educator. During all my clinical roles I acted as a mentor to student nurses. Within Higher Education I have been employed at Senior Lecturer level, as a Head of Academic Department and more recently as an Associate Head of a School of

Nursing/ Associate Professor. Arguably this wealth of experience enabled me to engage with the data at the level demanded by hermeneutics.

Therefore, when I interpreted the data, I was not approaching this activity from a neutral, isolated position, but rather, I merged the students' narrative, with my own experience and knowledge, to bring a new and fresh interpretation (a new truth). Methodologically, the hermeneutics of Ricoeur's (1981) does not espouse that there is only one possible interpretation of the data. Drawing on the work of Quine (1951), when we talk about truth, in this way, we are not meaning correspondence but rather we are establishing how claims 'fit' together coherently, i.e. joining the claims of the participants, with the knowledge and experience of the interpreter (supported by the extant wider literature) to reach new levels of understanding.

3.4: The hermeneutics of Paul Ricoeur

I will briefly describe the hermeneutics of Paul Ricoeur before returning, in detail, to the application of his theory to my research, specifically within the data analysis section. Central to Ricoeur's (1981) theory is his interpretation of text and specifically his notion of distanciation (Tan *et al*., 2009). Ricoeur (1981, p145) argues that '*text is discourse fixed in writing'*; he discusses the nature of the relationship between speech (occurring for example during an interview) and text (occurring following transcription). Ricoeur (1981) concludes that there is an inevitable separation of the text from the oral situation, i.e. the interview. This separation causes a natural change in the relationship between the original language and the immediate and subjective concerns of both the interviewer/ interviewee, compared with the later interpretation of the reader. Ricoeur (1981) highlights that discourse is altered by passing from the spoken into the written word. Geanellos (2000) explains that the process of distanciation moves the text away from understanding that its meaning can only be understood from the perspective of the author; it is not a methodological technique, but rather a natural part of written text.

Ricoeur (1981) also argues that the written text can be read and interpreted by a wide audience, who are distant from the original oral context, with inherent social and psychological nuances. What remains is merely an imprint of the original spoken word, and therefore there is a natural distance, even if the person interpreting the text was present during this original oral situation (Tan *et al.,* 2009). However, Ricoeur (1981) is resolute in his argument that the process of distanciation does not obscure the essential elements of the discourse. He asserts that distanciation requires the interpreter's inner world to meet with the unique world held within the text to enable a new understanding to be developed, held within the consciousness of the interpreter. This positioning resonates closely with Heidegger's (1967) notion of the hermeneutic circle.

Alongside distanciation, Ricoeur (1981) placed centrally the concept of appropriation. Ricoeur (1981, p158) states that:

> "*By 'appropriation' I understand this: that the interpretation of text culminates in the self-interpretation of a subject [the interpreter] who thenceforth understands himself better, understands himself differently, or simply begins to understand himself."*

This means that the person interpreting the text emerges as a new self, by merging prior personal knowledge and understanding with the new possibilities gleaned through immersion with the text.

The concepts of distanciation and appropriation shape the paradigm of text interpretation (Tan*er et al.*, 2009). Ricoeur (1981, p113) used the term "hermeneutic arc" to describe how the researcher moves backwards and forwards through the text during the interpretation process; interpretation occurs at an initial naïve level of explanation and understanding, through to a complex level of in-depth understanding. Ricoeur did not dismiss Heidegger's (1967) concept of the hermeneutic circle, on the contrary, he claimed,

> "*Ultimately the correlation between explanation and understanding [which incorporates the process of appropriation], between*

understanding and explanation, is the hermeneutic circle.'' (Ricoeur, 1981, p. 221).

3.5: The research question

The research question was remodelled numerous times; previous iterations included:

An exploration of power dynamics occurring within the Clinical Learning Environment and the consequent impact on student nurses' learning

And

An examination of the challenges facing student nurses in the CLE.

It was decided that neither of these titles would enable me to fully understand the subtle interplay occurring between experiences and within relationships in the CLE. To achieve this, I realised a more open question was required, which is why I decided upon:

How do student nurses experience learning in the CLE?

In formulating the research question, I remained aware of the importance of not making the question too restrictive (Denzin and Lincoln, 2011), enabling me to explore the research area with flexibility and latitude.

3.6: Research design

I chose to utilise one-to-one interviews and focus groups for my research design; both utilised a semi-structured format. This combination of one-to-one interviews and focus groups was judged to be the most effective research method for gaining insight into the students' experiences of learning within the CLE. I chose to begin by undertaking semi-structured interviews to enable me to develop a rapport with participants, and gain an initial deep and personal understanding of their experiences, tailoring questions to suit the emerging discussion. The focus groups were then subsequently used as opportunities to draw out what previous participants had said, and to establish confirmation

through dynamic group conversation; the focus groups therefore enabled further exploration of emerging themes. I had completed most of the semi-structured interviews before the focus groups, which meant I had a good understanding of the student's experiences of learning to draw on within the focus groups.

Stage 1: Semi structured Interviews

In qualitative research interviewing is the most common method of data collection (Doody and Noonan, 2013) and a semi-structured format is the most commonly used qualitative interview technique (Hollway and Jefferson, 1997; DiCicco-Bloom and Crabtree, 2006). Semi-structured interviews engender reciprocity between the participant and researcher (Galletta, 2012), enabling the researcher to create flexible follow-up questions, responding to the participant's responses (Rubin and Rubin, 2005; Polit and Beck, 2017). Semi-structured interviews facilitate an environment where in-depth personal experiences can be shared (Kallio *et al*., 2016). Despite these advantages, semi-structured interviews are recognised as being labour intensive, time consuming and require interviewer experience (Newcomer, 2015).

I utilised the inter-related phases for the development of semi-structured interviews, described by Kallio *et al.*, (2016), which encompass: (1) ascertaining the preconditions for utilising semi-structured interviews; (2) utilising previous knowledge; (3) devising the preliminary semi-structured interview questions; (4) piloting the interview questions (5) presenting the finalised semi-structured interview questions. Semi-structured one-to-one interviews were deemed an appropriate method of data collection because this technique enables both the participant and researcher to focus on meaningful and pertinent issues, allowing a diverse range of perceptions to be explored (Pollard *et al*., 2007; Cridland *et al*., 2015). As the researcher, I required a certain level of prior knowledge to enable me to formulate informed and insightful research questions; I have a wealth of relevant knowledge and experience to draw upon to support me throughout this research activity.

I formulated the draft interview questions, which aimed to direct the conversation during the interview (Cridland *et al.,* 2015) and give participants space to provide a comprehensive account of their experiences (Smith *et al.,* 2009). I was mindful that interview questions affect both the implementation of the interview and the quality of the data yielded (Rabionet, 2011); they needed to enable new concepts to emerge during the interview, aligned to the research question (Dearnley, 2005). The questions generated aimed to accomplish the richest possible data-set (Turner, 2010). They were carefully worded (Barriball and While, 1994), avoided leading questions (Bryman and Cassell, 2006) and they were open ended, sensitive and clear in style (Doody and Noonan, 2013).

I switched four and five of Kallio *et al's.*, (2016) phases, presenting the semi-structured interview questions to my supervisors, before progressing to the piloting phase. I made this decision because I preferred to address any shortcomings in the questions before the pilot phase, thereby maximising the potential of this phase. One of my supervisors required me to make some minor alterations to my questions, specifically he suggested that I should add one question at the beginning to open up the discussion; this question was: '*tell me about your experience of being a student nurse and learning in practice*'. Finally I piloted the interview questions; the aim of the pilot phase was to confirm the coverage of the questions and determine that they yielded relevant content (Kallio *et al.*, 2016).

Initially I planned to recruit three participants into the pilot phase, but the first interview progressed so well that I decided to discontinue the pilot and progress to the main study. The only alteration I made was to curtail the length of the interviews; the pilot interview lasted for 1 hour 5 minutes. On listening to the recording and reading the transcript, I realised that I could utilise the drafted questions (appendix D), but I needed to focus future interviews; during the pilot I allowed the participant to become unfocused. However, the quality of the data obtained in the pilot interview was so good that I decided to include it within the main dataset.

Stage 2: Focus Groups

Focus groups are a common choice of data collection method, both in qualitative research and as the qualitative component within a mixed methodology (Carey, 2016). The social-psychological element of group dynamics is particularly important because the energy and synergy created, arising from the interactions and discussions of the group members, often encourages participation (Carey, 2016). Participants frequently question each other to seek clarification, justify and elaborate specific points and prompt the group to refine generated concepts (Brondani *et al.*, 2008). Through this social process, predicated on the exchange of experiences, ideas and opinions, participants are able to construct a new shared reality (Brondani *et al.*, 2008). However, the strength of group participation may also be a source of weakness, due to potential censoring and conformity, which may occur within a focus group setting (Carey and Asbury, 2012). Getrich *et al.*, (2015) argue that researchers often fail to take into account some of the complexities associated with focus groups; such complexities will be discussed within the context of the data collection. Carey (2016) argues that homogenous membership and good facilitation skills can mitigate these factors.

After discussion with my supervisor, I decided to use a vignette to prompt conversation, rather than utilise the questions I had prepared for the one-one interviews. I made this decision because I anticipated it would provide a prompt and focal point for group discussion should this be needed, and would encourage participants to talk about practice in a focused way. Vignettes are a sociological research design tool, developed to provide a sketch of a fictional (or fictionalised) scenario (Bloor and Wood, 2006). Through preliminary coding of interview data I was able to generate a vignette (appendix E) that typified the participants' experiences. In particular, I drew together a collection of anxieties and concerns that emerged repeatedly in the one-to-one interviews. The vignette therefore reflected concerns that I was hearing from participants and was used as a platform to explore views within the focus groups.

The one-to-one interviews and focus groups were transcribed by an external transcription company. I received a £5000 research grant from my University, which I used partly to pay for the transcription costs.

3.7: Sampling

I decided to aim for a sample size of between 10 - 15 participants for the one-to-one interviews and 3 - 5 focus groups, with 6 – 12 participants. Researchers need to set an initial sample size, during the planning phase, and then appraise the sample size continuously during the research process, to ascertain whether it is sufficient to meet the needs of analysis and publication (Malterud *et al.,* 2016). Morse (2003) argues that estimating the number of participants needed to reach data saturation should take into consideration the following key factors: the scope of the study; the quality of the data; the nature of the topic; the quantity of useful information gained from each participant; the qualitative method and study design and the use of shadow data. Morse (2003) suggests that the number of participants should be overestimated, during the planning phase, to allow a contingency. It was through such careful consideration that I decided upon the proposed sample sizes; the required number of participants was reviewed during the data collection phase. The notion of saturation, within qualitative research, has become the quality marker against which to determine the sample size (Guest, 2006). O'Reilly and Parker (2012) argue that arbitrarily adopting data saturation as a generic indicator of quality is inappropriate. Rather, the quality of the data needs to be considered.

The University, where the participants were studying, focusses on delivering professional Degrees. The participants were all studying on a BSc (Hons) Nursing (Adult) programme, within a medium sized School of Nursing. To enable sufficient depth of discussion, I realised that I needed to include only second and third year student nurses within the study sample. First year students spend six months in the University before they go out into practice. Since the interviews were planned to occur predominantly within the University block, the first years would not have experienced any clinical placements. First

years were therefore excluded from the study. The second years, having recently finished their first year clinical placements, would be able to share their experiences of the first year and were therefore included. I also planned to include students at the beginning of their third year, i.e. they would have completed their second year placements, and students at the end of their third year, just prior to qualification. The sample would therefore enable me to research the experience of learning within the CLE, from the perspective of students from all three years of their training. Second and third year student nurses would have experienced a number of diverse placements across London. I did not advertise the research to second and third year students who were in their practice block, because I felt it would be disruptive and logistically difficult for students to participate who were immersed in shift patterns. However, if second and third year students in practice wanted to participate, they were not excluded.

This type of sampling is called purposeful sampling. Purposeful sampling is one of the distinguishing features of qualitative inquiry (Patton, 2002) and its aim is to target appropriate people, to yield the most informed and representative data. Within selective sampling, the participant is intentionally selected to meet the needs of the particular study (Silverman, 2013). The self-selecting students were likely to be amongst the most motivated students, interested in both sharing their experiences and gaining insight into research processes. This bias towards recruiting more motivated (and perhaps able) students is permitted because, arguably, they may yield the richest data.

I decided that the sample should only include those students studying adult nursing; additionally, I could have included students studying child and mental health nursing. As the then Head of Academic Department for Child Nursing I realised that there would be inevitable power and conflict of interest issues, which would preclude me ethically from including the child students. I anticipated that the mental health students would have very different experiences of learning in practice, due to the nature of the client group and

service provision. I therefore chose to purposefully sample only students studying adult nursing. For the focus groups, participants belonged to the same seminars groups, thus ensuring that they both knew each other and were representing the same year of study.

3.8: Recruitment Strategy

After the relevant ethical approval, I utilised a multipronged recruitment strategy, starting at the beginning of February 2017. I developed a poster, advertising my research, which was displayed within the University areas, where nursing was taught. The poster included my contact details, enabling students to speak with me directly. I asked the Student Union to make the students aware of my study in their meetings and conversations with second and third year students. We have a 'Nursing Society' within my University, and they also advertised my study. From the poster, I immediately received interest from four students: two at the end of their programme of study (one became recruited in the pilot study) and one at the mid-point of year 2 and one at the mid-point of year 3. These four students went on to become participants.

At the beginning of the semester, all students receive a lecture session (per year group) welcoming them back into their University block of study. I utilised this opportunity to speak with the students to advertise my study, whilst explicitly stating that participation was entirely voluntary. I ensured that I had participant information sheets available and I took contact details for those who were interested. Through this strategy, five students said that they were interested in being involved; on following up three became participants. The strategy of the poster, advertising and talking with all potential participants, ensured that the students were aware that the study was taking place, which proved useful.

In appreciating that students' time is precious, I was keen to ensure that they gained personally from the research process. I informed them that the one-to-one interviews and focus groups would take approximately 40 minutes, and would occur within the University. I also informed them that that I would leave

20 minutes, after the interviews/ focus groups, when they could use the time to debrief and/or discuss my research methodology or methodologies in general. I anticipated that methodology information would be useful for their research modules, in particular for writing up their dissertation. This strategy was successful and seemed to act as a 'hook' to draw students towards my study. I purposefully decided not to offer monetary incentives, anticipating that I may attract students who were more interested in financial gain than contributing meaningfully to my research.

After the initial show of interest by the students, interest stopped. I had anticipated that this may occur, I therefore enlisted the support of seminar leaders. The seminar leaders know their students and therefore I predicted that they would have built up a rapport, enabling them to discuss my research and hopefully garner interest. At the beginning of the semester, I reviewed the second and third year adult student timetables. There were approximately 180 adult students per year at this time. I calculated that there were eight groups, per year, to approach and I identified their respective seminar leaders. I chose the research seminar leaders, who would be in a position to draw a synergy between my research and the subject area they were studying.

I approached each seminar leader and I carefully explained my study. I gave them the participant information sheets, a contact information sheet and an envelope. The contact information sheets identified potential dates and times when students could participate in both one-to-one interviews and focus groups, in addition to my contact details. I asked the seminar leaders to stress to their groups that participation was entirely voluntary and they could withdraw their intent at any time. I specifically requested that the seminar leaders should hand the contact information sheet and envelope to their students. The seminar leaders then handed the sealed envelopes (containing the populated contact information sheets) back to me. I made direct contact with those interested students at a later date, meaning that the seminar leaders were unaware of the

names on the sheet. The seminar leaders were supportive of my research and this approach proved to be a successful strategy.

I set aside time to phone each interested student and I used this time to give additional information about the study; by this time the students had already received the participant information sheets. Five students declined to be involved in the study at this point. For the students who wanted to participate, I confirmed the date and time that they would meet with me and I explained the interview/ focus group process. Following this conversation I sent them electronically a further copy of the participant information sheet and a consent form. I realised that I had more participants than required, totalling twenty-two for the one-to-one interviews and seven focus groups. I decided not to cancel any at this stage; I was keen to have a contingency plan in case of student cancellations or 'no shows'. I contacted each student five days before their scheduled meeting, to confirm the arrangements, including details of the room booking. Interestingly none of the students participated in both the one-to-one interviews and the focus groups. Some of the students explained that they felt drawn towards one type of data collection method, whilst others felt that they could only spare one hour.

As detailed in the consent process, I collected key information about each participant including: their age; gender; year of training and details of previous clinical experience prior to commencing the programme. I put this information into a spreadsheet, but immediately anonymised this information to comply with data protection requirements (appendix F and G). This key information demonstrates that the participants were diverse and representative of the wider student population group. I did not capture the exact clinical placements that the participants had experienced (as planned), because I felt that collating this level of detail was unnecessary. The participants would have experienced numerous clinical placements, both within the acute and community sector during their programme.

3.9: Data Collection

Semi-Structured Interviews

Between 10.02.2017 – 24.03.2017 I completed a total of fifteen one-to-one interviews. Whilst I was data collecting I was on study leave to give me the time and space to complete this activity. Seven students needed to cancel their one-to-one interviews, due to conflicting study pressures and I cancelled two focus groups because I felt that I had reached a stage of data saturation. For the two cancelled focus groups, I offered to still talk with students about research methodology, but they declined my offer. In total, for the one-to-one interviews, I recruited the following participant groups: four at the beginning of year 2, one at the midpoint of year 2; seven at the beginning of year 3; one at the midpoint of year 3 and two at the end of year 3 (appendix F).

The one-to-one interviews took place in a private office, in the University, recognising the need for a private and quiet environment. I did follow the pattern of the interview questions but I used them flexibly (depending on the participant's answers) rather than as a script. It is essential that the researcher feels free to vary the wording and order of the questions, depending on the direction the interview takes, and to pose additional questions where necessary (Corbetta, 2003). I felt that the interviews flowed and each participant had much to say. Irrespective of their year of training, most of the participants were extremely insightful and they demonstrated that they had deep understanding, and were clearly able to articulate their experiences of learning in clinical practice. After the interviews were completed, a number of the participants used the 20 minute allocated time to speak with me further in '*off the record' conversations*'; this was an opportunity for the participants to debrief. I respected the fact that these conversations were confidential and they were therefore not included within my dataset. However, this knowledge enriched my understanding, undoubtedly guided future areas of inquiry and facilitated the process of data analysis. Many of the students used the time to discuss research methodology.

Focus groups

The focus groups were held in a private room, at the University, between 23.03.2017 – 07.04.2017. I completed five focus groups. Three second year and two third year focus groups occurred. The focus groups varied in size: focus group 1, n = 3, focus group 2, n = 6, focus group 3, n=12, focus group 4, n = 6, focus group 5, n = 4 (appendix G). I found it difficult to achieve a consistent number in each focus group because when the students signed up, within their seminar groups, there was natural variation in the size. The literature suggests there should be between 6 – 12 participants in each focus group (Krueger and Casey, 2000; Johnson and Christensen, 2004; *Onwuegbuzie et al*., 2009). The rationale for this size range is that the group should include sufficient participants to yield diverse information, but not so many that the participants feel uncomfortable in sharing their beliefs, opinions and experiences (Krueger, 1994). Mostly my focus groups fell within this range; it was useful for me to have a smaller first focus group because the small group gave me the opportunity to test out the vignette. Certainly the first group still yielded rich data, although I appreciate that the variety of data may have been curtailed.

Getrich *et al.,* (2015) highlight that, as qualitative researchers, we must discuss the reality of facilitating focus groups and share our experiences, even when the process does not go to plan. I felt that the focus groups ran smoothly without any specific issues to report. I asked the participants not to talk over each other, during the focus groups, because I anticipated that if this occurred, it would have a detrimental effect on the quality of the recording. I paid careful attention to the dynamics within each focus group. Carey and Smith, (1994) reiterate that researchers, utilising focus groups, need to pay attention to the impact of group dynamics, or their data interpretations may be misleading.

The strategy of utilising homogenous focus groups (groups who knew each other well and who were from the same year group) seemed effective. Focus groups are a suitable data collection choice when the researcher needs to gather information from a homogenous group (Pabst *et al.,* 2010). However

homogeneity means that the participants have a similar background (i.e. within the context of this study, they share the same programme, year group and seminar group) rather than similar views and attitudes. If the participants had similar views, the discussion would be rendered ineffective (Curtis and Redmond, 2007). I did however note that during the focus groups, the participants had many points of agreement. However, I felt that their agreement did not merely represent group conformity because the participants frequently gave detailed examples to represent their personal experiences. I did remain vigilant to any waves of consensus occurring during the focus groups (Belzile and Öberg, 2012); when I suspected such interactions were occurring, I clarified the positioning either with individuals or with the group as a whole.

I noticed that all participants chose to speak within each focus group, although naturally some participants contributed more than others. One of the documented problems with focus groups is that some members may dominate the group (Reed and Payton, 1997). Although many of the participants demonstrated their passion in relaying their experiences, none of them seemed to dominate. However, I accept that the group members knew each other well and therefore previously formed power relations, and their subsequent impact, may have remained undetected (Reed and Payton, 1997).

The inclusion of the vignette proved useful because it served as a platform to begin the conversation. The participants were given time to read the short vignette before the focus group commenced. In each focus group discussion, the students used the vignette as a platform to discuss their own experiences of learning in the CLE, as instructed, rather than to discuss the detail of the scenario itself. Presumably their readiness to discuss their own experiences occurred because the vignette resonated so closely to their personal clinical experiences. The discussion, which occurred in FG1, exemplifies the participants' readiness to move straight into discussing their own experiences:

> *"It's quite sad really, yes because on placement you do find things like that, you know? I can relate to her being worried about her book being*

signed off because, at the end of the day, I always feel like, yes, we are there, we are meant to be student nurses. We are meant to be helping and gaining a lot of experiences but we also have to get our book signed. That's what is going to carry forward and if you can't get it signed you are failing your placement and you're worried about that."(FG1, p1).

For each focus group, I needed to stop the conversation after 40 minutes; I felt that the conversations could have easily continued, however by this stage the participants had had the opportunity to engage in deep conversations, supplying rich data. All students took the opportunity to discuss methodology, rather than engage in '*off the record'* conversations as some of the participants had in the one-to-one interviews, presumably due to the personal nature of such discussions.

3.10: Data saturation

O'Reilly and Parker (2012) argue that the notion of data saturation is ubiquitous, being embedded unquestionably within research without methodological consideration. Researchers often fail to give sufficient detail relating to how they determine data saturation (Bowen, 2008). I did get to a point, towards the end of the data collection process, where I felt that I had reached data saturation. I was certainly hearing similar accounts and no new information was emerging. Following the fifth focus group I considered that data saturation had been reached. I felt that it would be unethical to continue the data collection process, utilising the participant's time but potentially failing to use the data provided (Francis *et al.*, 2010). I felt that I had gathered enough data to sufficiently describe the phenomena under consideration (Fossey *et al.*, 2002).

3.11: Ethics

Ethical approaches were adhered to throughout the study. I complied with the ethical guidelines for educational research (British Educational Research

Association (BERA) (2014). I gained ethical approval from both King's College, London (where I am undertaking my professional Doctorate) and from the University where I work and where the participants were studying. I was granted ethical approval at King's College, London, through the 'minimal ethical risk' process. Additionally, I gained approval from the appropriate gatekeeper where the students were studying, the then Head of School.

To meet the requirements within the ethics application process (for both Universities) I prepared separate consent forms for the one-to-one interviews and focus groups (appendix H) and a participant information sheet (appendix I). Prior to commencing each one-to-one interview and focus group, I confirmed that the participants understood the purpose of the study (detailed within the participant information sheet) and I ensured that consent forms had been signed and dated. I reiterated that the interviews were being recorded and I explained how data anonymity would be protected. I gave all participants the opportunity for clarification; none of the participants required further clarification.

There were four specific ethical areas that I felt I needed to consider in relation to this study. They included: the need to determine how the power imbalance between the participants and me should be managed; how confidentiality within the focus groups could be protected; how I proposed to respond to the potential scenario of participants sharing information that I felt a responsibility act upon, and thereby breach confidentiality and how I should mitigate against the potential distress caused by the participants in sharing sensitive 'stories'.

Within the discussion of the ethical dimensions of the research it is essential to consider issues of power, specifically relating to the relationship between researcher and participant. There is a recognition that power differentials exist in qualitative inquiry and that, in themselves, they exert an influence within the study, but the important point is that they are recognised and accommodated (Karnieli-Miller *et al.,* 2008). Despite the different traditions, inevitably there remains a power asymmetry between researcher and participant, mainly

because the researcher has control over the research design and process (Vähäsantanen and Saarinen, 2013). However, the researcher does not have exclusive power within the relationship, because the participant can choose to withhold information or divert conversations and they may also challenge the researcher (Kvale, 2006; Kvale and Brinkmann, 2009). Ricoeur's (1981) interpretation of hermeneutic phenomenology necessitates the researcher's '*world*' meets with the world of the participant, enabling a new understanding to be created. This notion of '*meeting*' is inherently respectful of the participant's unique contribution to the research process and may, to some extent, reduce the inherent power imbalance between researcher and participant. Of course, the extent of power imbalance may be influenced by the researcher's personality, ethic, gender, social background, world view, in addition to the research methodology (Karnieli-Miller *et al.*, 2008).

There was perhaps an inevitable power imbalance between me as the researcher (and at the time, Head of Academic Department (Child Nursing) at the University) and the participants (students at the university). I did employ a number of strategies in an attempt to mitigate against this power imbalance. I purposefully designed the study to ensure that the participants recruited were students studying the field of adult nursing, thereby not in the same field of nursing as me. They would, therefore, not need to interact with me as their Head of Academic Department. I ensured that I had no previous or current connections with the participants, particularly in the context of managing disciplinary or Fitness to Practise proceedings. I reiterated to the students that, during the research study, I was working in the capacity of a '*researcher*' and not Head of Academic Department. The participants were informed both verbally and in writing that their participation was entirely voluntary. The participant information sheet explicitly states that there is an option, for those participating in the one-to-one interviews, to withdraw from the study up to six weeks after data collection. It was stated that withdrawal could occur, without reason, or risk of disadvantage. As already described, I was careful to ensure that my recruitment strategy was not coercive, predicated on a power imbalance.

The use of semi-structured one-to-one interviews and a vignette within the focus group was designed to enable the participants to have increased control within the interview, particularly in determining what and how much they wished to reveal to the researcher (Vähäsantanen and Saarinen, 2013). In some of the one-to-one interviews, I also used a strategy of self-disclosure, in terms of acknowledging that I had experienced similar situations as a student nurse; this strategy may be effective in mitigating against power inequalities (Rapley, 2007). Despite these attempts, inevitably the participants understood that I was a Faculty member and a Head of Academic Department, however they seemed to share openly with me their experiences of learning in clinical practice. I did not perceive that the power imbalance had a deleterious effect on the quality of the communication between the participants and me.

In striving to maintain anonymity and confidentiality, I adhered to the guidance set out by BERA (BERA, 2014). Accordingly, participants were informed that data would be anonymised by using pseudonyms for individuals and organisations. The participants were reassured that information gained through the research process will be regarded as confidential and data, transcripts and tape recordings will be secured safely until the end of the research process, when they will be destroyed. Arguably, confidentiality may be compromised through focus group discussions, if the participants chose to discuss information shared outside of the group. Participants were informed of this risk, within the participant information sheet, and they were required to sign a consent form explicitly requesting that they maintain the confidentiality of the focus group discussions.

I anticipated that the participants may discuss scenarios, which would require me to professionally respond outside of the interviews/ focus groups and thereby breach confidentiality. BERA (2018) highlight that dual roles, i.e. my role as a Head of Academic Department and researcher may introduce an explicit tension in relation to the maintenance of confidentiality, and as such the research design must address this potential. In anticipating this risk I included

in the participant information sheet and the consent forms, a statement indicating that if information was shared, which I deemed placed patients at direct risk, I may be required (as an NMC Registrant) to tell a third party. I did not actually need to breach confidentially, as a result of information disclosed by participants. The scenarios discussed, which posed substantial risk to patients, had already been appropriately appraised and managed prior to the interviews and focus groups.

I was concerned that the participants may find the experience of sharing their stories traumatic. The qualitative literature indicates that participant's vulnerability may be increased while they share their stories, because they are re-living traumatic events (Johnson and Macleod Clarke, 2003; Dickson-Swift *et al*., 2007). In anticipation of this issue, I allowed time for debriefing after the interview or focus group. Where required we spent this debriefing time discussing some of the issues raised. None of the participants indicated that they wanted to discuss the issues further but they articulated that they were pleased to be given a 'voice' and relieved that their experiences would be shared anonymously, through publication and conferences. Many of the participants wanted to understand how I was planning to disseminate the research, to change and improve some of the more problematic areas. This positioning is reported in a number of international studies, demonstrating that although participants report emotional distress during interviews, most enjoyed the opportunity to share their experiences (Turnball, *et al.*, 1988; Wong, 1988; Kavanaugh and Ayres, 1998; Frank, 2000).

3.12: Issues of rigor when using Ricoeur's theory of interpretation

It is imperative for qualitative researchers to employ methods which are rigorous, if they want their results to be perceived as credible and making a genuine and significant contribution to knowledge (Tan *et al.*, 2009). Crotty (1998) suggests that unless there is overt clarity and accountability of research method, it is difficult to ascertain the degree of rigor, which is required in an era which remains dominated by a positive paradigm. Morse *et al.*, (2002) argue

that the process of qualitative research is iterative and, as such, the researcher is required to move back and forth through the research stages to ensure continued congruence between the question formulation, underpinning literature, participant recruitment, data collection and analysis. Such validation enables the researcher to know when to modify the research strategy to ensure rigor (Morse *et al.,* 2002). Tan *et al.,* (2009) specifically argue that for researchers using Ricoeur's (1981) theory, rigor is tested principally through considering how the interpretative stages are managed, although considerations of reflexivity and procedural precision are also critical. In using Ricoeur's (1981) theory it is important to align the determinants of rigor, thereby referring to measures of indicators of reflexivity, interpretive robustness and procedural precision (Tan *et al.,* 2009), rather than referring to more traditional qualitative measures of rigor, including considerations of validity, reliability and generalisability (Morse, 2015). I will begin by discussing issues of reflexivity and procedural rigor before considering the critical area of interpretative rigor.

3.13: Reflexivity

Reflexivity is the process through which the researcher reflects critically on oneself (Bradbury-Jones, 2007). Reflexivity is increasingly recognized as essential to the process of generating knowledge through qualitative research (Koch and Harrington, 1998; Horsburgh, 2003; Blaxter *et al.*, 2006; Gerstl-Pepin and Patrizion, 2009). Central to the notion of reflexivity is the need for researchers to constantly critically locate and relocate themselves within their research, and to remain in close dialogue with the research practice, the participants and the associated methodologies (Bott, 2010). Qualitative researchers need to understand the role and impact of the self within the creation of knowledge; this requires that they carefully appraise the impact of their own personal experiences, beliefs and inherent biases and how these factors impact on their research (Berger, 2015). The maintenance of reflexivity is critical throughout the whole research cycle, from the formulation of the research question, through to drawing conclusions (Guillemin and Gillam, 2004; Bradbury-Jones, 2007).

I approached this study as an 'insider' (Kacen and Chaitin, 2006). I had been a student nurse myself (albeit thirty years ago) and I had practised in clinical practice as a Registered Nurse, mentored student nurses and supported them as an academic. Being part of the context bestows both advantages and disadvantages. Being an 'insider' means that the researcher '*knows*' the research context and therefore usually has knowledge of the language, symbols, rites that perhaps an "external" researcher might not possess (or, at least, not to the same level) (Kacen and Chaitin, 2006, p212). However, prior understanding and knowledge can be disadvantageous because it may cause researcher bias, potentially preventing new insights from being discovered (Kacen and Chaitin, 2006). An insider positioning carries the risk of blurring boundaries, with the researcher imposing their own beliefs, values and perceptions within the research process (Drake, 2010). The key question becomes how to utilize one's own experience as a researcher, to promote a deeper understanding of the phenomenon under consideration (Berger, 2015).

In using Ricoeur's hermeneutic theory of interpretation as a method of analysing my research text, it was essential for me to understand reflexivity within this context. I needed to ensure that there was synergy between my understanding of reflexivity and the choice of methodological approach. Ricoeur, (1974) states that interpretation is caught inside the circle formed by the conjunction of interpretation and the interpreted being. Distanciation allows researchers to approach the text, without preoccupation for discovering authorial intent (Geanellos, 2000). The researcher needs to interact with the data, whilst maintaining distance, by acknowledging and dealing with pre-understandings during the process of interpretation (Wiklund *et al.*, 2002). Intrinsic to our pre-understanding is the inherent struggle to approach the text with an open mind because pre-understandings may lead to unconscious bias; it is important to take account of the potential barriers they create and approach the text with an open mind (Wiklund *et al.,* 2002).

For hermeneutic researchers understanding of self (reflexivity) allows the text to be approached in a way that enables a unique combination of knowledge and understanding (between the researcher and participant) that potentiates the expansion of horizons. This does not mean that researchers are given permission to project themselves onto the text; the process of appropriation is not a reflection of researcher possession but rather an act of disposition of ego (Ricoeur, 1981). Understanding our prejudices or preunderstandings and the extent to which these and those of others influence our research remains an ongoing challenge (Spence, 2017).

I utilised a number of reflexive strategies to try to mitigate against adversely affecting the quality of my data collection and interpretation. Most importantly, before I started this study, I reflected upon the experiences that I was bringing to this research and how such experiences could be utilised positively. I remained vigilant to incidences where I could inappropriately and inadvertently influence the research process; this vigilance spanned the entire research process, but was particularly important during the data collection and analysis phases. Recognising this I deliberately utilised open questioning and summarizing techniques and I interviewed many participants to gain a broad impression of experiences. During data collection and analysis I was shocked by many of the traumatic stories that the participants shared, demonstrating a departure from my pre-understanding of this research area. I felt a deep sense of responsibility to faithfully represent the findings.

During the analysis phase I presented my data to my supervisors and an experienced nurse academic; to protect her anonymity I will use the pseudonym '*Helen*'. Helen worked within the NHS and HEI sectors and completed a Doctorate in Education. I chose Helen because I felt she would intuitively understand the subject area and academic requirements. In remaining faithful to Ricoeur's (1981) theory, it would have been inappropriate for Helen to read and interpret the text, because this process relied on merging my prior personal knowledge, with the text, to understand new possibilities. The insertion of a

third person into this process would therefore not align to Ricoeur's (1981) theory. Instead I utilised Helen's experience to specifically critique my theming. This opportunity to present to Helen was incredibly useful because it made me justify, and where appropriate, adjust my analysis; in some areas there was misalignment between the categories, sub-themes and themes, which I subsequently adjusted.

In keeping with Ricoeur's theory of interpretation, the purpose of peer review was not to try to exactly replicate my findings, but rather to affirm (validate) that my '*interpretation must not only be probable, but more probable than another interpretation*' (Ricoeur, 1976, p 79). Ricoeur (1976) does not advocate using peer review *per say*, he suggests that the interpreter needs to reflect upon whether their initial (naïve) interpretation of the text is credible or merely the result of the interpeter's pre-understandings. I utilised the process of peer review to support the process of validation. Ricoeur (1976) explains that the concept of validation is not the same as verification; verification is an inappropriate tool through which to judge the veracity of hermeneutic knowledge. The process of validation aims to underpin the credibility of the interpretation, not to exclude the possibility of all other interpretations (Wiklund *et al.,* 2002). Objectification of the text gives researchers permission to move beyond the belief that only one possible understanding is correct or meaningful (Geanellos, 2000). Consequently textual plurality (that preunderstandings may lead researchers to interpret the same text accurately but differently) and multiplicity (that texts have multiple meanings) is respected (Geanellos, 2000). In this way all we aim to do is tell a coherent story.

3.14: Procedural rigor

In terms of procedural rigor my entire research process is open to scrutiny, from the question formulation, through to analysis. I have carefully detailed such processes within this theses and I have retained the supporting information, including: the interview questions (appendix D); the vignette (appendix E); the anonymised transcripts and evidence of the iterative development of the

interpretation of the data and theming. I am confident that a rigorous procedural research methodology has been attained throughout the research process. Following Ricoeur's (1981) methodological approach, in utilising the three levels of analysis, a clear identifiable process has been documented, which could be repeated by others. However other researchers repeating this process will most certainly not arrive at exactly the same results (Tan *et al.,* 2009). This does not mean that the results are unreliable but recognises that textual interpretation is captured inside a circle formed by the unification of interpretation and interpreter.

I am confident that my findings are representative of the participants' experiences because the inferences made within this study are drawn directly from students, who are well placed to articulate those experiences. In addition, I have taken time to carefully understand and interpret the data, whilst remaining reflexive. Within this thesis I have explicitly detailed how I analysed the data and, within the 'findings' chapter, I have expressed logically the participants' experiences of learning in practice. I have provided over 90 direct quotes to enable the reader to gauge if my inferences are indeed well founded and aligned sensibly to themes. I harnessed specific strategies for attaining rigor, which include having prolonged exposure to the student population, through 15 interviews and 5 focus groups. This exposure yielded rich descriptions from the participants.

I am confident that if the study were repeated, with the same methodology and in the same geographical location, broadly similar results would be gained. This confidence is based on the participants sharing similar experiences (despite being placed in different CLEs), with a convergence of the discussion across the one-to-one interviews and focus groups (Lambert and Loiselle, 2008). In addition, many of the participants' experiences are echoed within the nursing literature. That said, the findings of this study only claim to represent the experiences of the participants, who completed their placements within a

particular geographical location, which operated within the nuances of local power dynamics, at a specific time.

3.15: Data analysis – ensuring interpretive rigor

I utilized Tan *et al's.*, (2009) application of Ricoeur's (1981) theory of interpretation to guide the steps of my analysis. I found this guide particularly useful because it outlines clearly the actual process of analysis. Ricoeur's (1981) theory requires three levels of analysis: level 1 - Explanation; level 2 - Naïve understanding and level 3 - In-depth understanding. I treated the data from the focus groups and one-to-one interviews as one data set. I could not have made this decision if the focus group participants had centred their discussions around the vignette, rather than on their own personal experiences of learning in practice. I am confident that the focus group discussions represent actual personal experience.

I decided to analyse the data from the one-to-one interviews and focus groups as one data set because there was a striking continuity in what participants reported, and a convergence of the experiences that the participants shared. This convergence is perhaps unsurprising because the vignette was a constellation of the experiences the students had reported in the one-one interviews. Amalgamating the datasets masks the fact that different research instruments were used in the collection of this data, and reduces the possibility of examining the dynamic interactions of focus group participants. However, treating the interview and focus groups as separate data sets would have risked fragmenting the emerging continuity within the data by introducing an analytical divide that seemed unnecessary and may consequently have prevented me from reaching the same depth of understanding. While the students' stories would have converged at some point within the analysis, separation of the interview and focus group data would have meant this convergence occurred later in the process in a way that may have limited the development of the emerging analysis.

The method used for analysing focus group research vary based on the methodological approach used. Focus group theorists disagree about whether it is individual, group, or group interaction which are the most appropriate unit of analysis (Duggleby, 2005). Some theorists specifically argue that the individual or the group should be the focus of the analysis instead of the unit of analysis (Kidd & Marshall, 2000). Carey (2016) argues that as long as the purpose, process and product are logical, the outcome is likely to be defensible and useful. I treated the focus group dataset as multiple individual participants, rather than the focus group itself forming the unit of analysis, because I wanted to hone in on the individual voices to understand different perspectives. In analysing the focus group data I was interested in understanding the views of individuals within the group to draw out and amplify the voices of student nurses. This also allowed me to merge the interview and focus group data into one data set that provided opportunities for a more unified and comprehensive analysis. In this way, I was careful to ensure that within the analysis of the focus group data individual (and at times conflicting) voices were represented, rather than treating the data as representing one voice (Kitzinger, 1994).

I was cognisant of the fact that focus group discussions can demonstrate an evolving consensus, following a period of discussion (Reed and Payton, 1997; Kidd *et al*., 2000). I specifically reviewed the focus group text to elicit if this had occurred and my impression is that the participants' opinions were formed prior to meeting; this is a topic that they were passionate about and clearly came to the focus group with personal knowledge and experiences, which they were keen to share. As such, it is my understanding that the participants' discussion did not develop as a consequence of evolving consensus, although there were many points of consensus. I am confident that such consensus represents convergence of their experiences.

I chose to undertake the process of coding manually, rather than using available software, for two principal reasons. Firstly, my previous experience of using software made me feel distant from the data. Secondly, although the software

serves as a useful tool for organising the data, the actual task of analysis still needs to be undertaken manually. The process of manual coding for this study proved to be an arduous and time-consuming activity, but incredibly valuable.

Analysis

Level 1 analysis: Explanation

I started the process of explanation by reading both the one-to-one interview and focus group transcripts and listening to the audiotapes. At this stage I did not attempt to achieve anything other than regaining familiarity with the text. Seven months elapsed between data collection and analysis but reading the text and listening to the audiotapes, although time consuming, enabled me to feel reconnected with and excited by the data. I then re-read the text again; at this stage the text took the place of the 'live' discourse (distanciation)(Ricoeur, 1981). The transcripts were then analysed, utilising coding: each transcript was coded, utilising 'free nodes' (emergent ideas) and in-vivo coding. This involved coding words, phrases or sentences or groups of sentences that said anything in relation to learning in practice (appendix J). At this stage words were literally taken at face value, with no attempt to interpret or join similar words. Some examples of these words were: "*the student," "being used," "thrown in the corner," "not feeling like a real person," "the book is used as a weapon," "heard stories," "being roared at," "backlash," "pair of hands," "abandon," "the book is everything," "latching on," "feeling lost."*

This first naïve interpretation has characteristics of being a qualified guess but when Ricoeur discusses 'guess', he does not use to term to indicate an arbitrary conjecture but rather he uses this term to denote understanding (Ricoeur, 1981). The '*guess*' needs to be deliberated to decide whether the naïve interpretation is indeed credible or a mere reflection of the interpreter's pre-understanding (Wiklund *et al.,* 2002). Before progressing to level 2, I re-read the transcripts to ensure that I had not missed any critical details and to check that the initial coding decisions were indeed credible. At this stage I realised that I had a substantial volume of data to manage. I decided to place these initial codes in a

grid, one per transcript. I copied the relevant words, phrases and sentences into a grid (without any ordering at this stage), anticipating that this strategy may help me to organise my thoughts coherently.

Level 2 analysis: Naïve understanding

I then proceeded to examine the free nodes, which had been coded during the level 1 analysis, and I came to understand which ones may be referring to the same or similar ideas. I then started to consider the subthemes and themes. As an example, I initially identified the category called 'being used' under the subtheme of 'feeling intimidated/ oppressed' and within the theme of 'the impact of a power imbalance'. I continued this process, initially identifying four key themes: *the impact of a power imbalance*; *learning by working; access to learning opportunities* and *fitting in* (appendix K). At this stage I felt as if I was beginning to incorporate my world of related experiences, with the world portrayed through the text, to gain a new perspective and understanding (appropriation)(Ricoeur, 1981).

On a practical level, to manage the data, I created an overarching grid, which captured the initial categories, subthemes and themes. This initial iteration was 32 pages long. I purposefully incorporated both the free nodes and the wider related quote from the participants, detailing the location within the text. This technique helped me to manage the data, specifically when I refined the categories, subthemes and themes later in the process. At this stage I presented the first draft of my coding to my supervisors and they were confident that this initial interpretation was following the correct trajectory, although clearly requiring further work. They commented on the richness of the data and the powerful stories that the participants conveyed.

Level 3 analysis: in-depth understanding

Following the meeting with my supervisors, I embarked on the next level of analysis. To understand the text, I moved backwards and forwards through parts

of the text, whilst still visualising the entirety. Ricoeur, (1981, p113) used the term, 'hermeneutic arc' to describe this process. The process of reaching an understanding of the text incorporated the process of appropriation (Ricoeur, 1981). As I progressed through this process, I realised that my initial theming did not achieve consistent alignment between the categories, subthemes and themes; it felt as is the elements were not slotting together sufficiently. It was at this stage that I presented my theming to Helen, the experienced nurse academic, previously introduced. This was a really useful process and she confirmed that I needed to review the theming. Helen identified a number of areas where the categories, sub-themes and themes seemed misaligned.

After this deep discussion, I reconsidered the theming in its entirety and after long periods of reflection and adjustment, I settled on three themes: 'educational realities associated with the CLE'; 'the influences of mentorship' and 'power and powerlessness' (appendix L). Once I had invested this time, all elements seemed to slot into place and I felt confident with the theming. Following my initial example, the category 'being used' became termed, '*leaving the learning to do the obs*' and was slotted under the sub-theme of, 'factors affecting the quality of the learning experience' and assigned to the theme *of 'educational realities associated with the CLE'*. Naturally within the theming there are areas of overlap (and perhaps contention). For example, the mentor/mentee relationship is fundamental to the quality of students' experience of learning within the CLE. This relationship is based around institutional roles and responsibilities, so is inherently characterised by a power imbalance. Despite the overlapping nature of power, it was important to bring out the nature of the power dynamics in more depth in light of participants comments and the risks, challenges and oppression they described.

Although the various iterations of the theming took considerable time, I felt that this investment was critical to reaching a valid interpretation. Most importantly, I felt that I had effectively utilised the rich data, shared by the participants. Through the intense process of appropriation I perceived that I had merged my

prior personal experiences and knowledge of learning in practice, with the new knowledge gained through immersion in the data. Indeed I felt that I had reached a new level of understanding, which I will share within the findings chapter. In generating the themes, inevitably I could not include all of the data; I included that data which enabled me to best address the research question.

Chapter 4: The findings: an interpretation of the data

4.1: Introduction

At its most general, my interpretation of the data indicates that the CLE is often a pressurised environment for student nurses to learn within. Students need to navigate their learning in an environment where care is naturally prioritised above learning needs. This 'clinical imperative' can readily lead to student exploitation within the CLE. The student/mentor relationship is seen to significantly influence the quality of learning within the CLE. Some mentors are able to 'manage' the clinical imperative to create relationships and opportunities conducive to learning. However, students are typically afforded limited time to work alongside their mentors. Instead they are commonly 'taught' by HCA's, particularly in the busier clinical environments. Initially many students are directed, by their mentors, to work 'with' HCAs, but this direction readily translates into work 'as' a HCA. This reduces the quality of the learning experience and, ultimately, compromises the student's preparedness to practise as a Registrant. Although many mentor-mentee relationships can be described as positive, some students experience pervasively oppressive mentoring behaviours, which can lead to subjugation. The student practice assessments and their fear of poor treatment together constitute a nexus for vulnerability, because opportunities for potential repercussion are present, should students raise concerns.

The presentation of these findings is centred on three key themes, which emerged from the data. These are: i); Educational realities associated with the CLE ii); the influence of mentorship iii) Power and Powerlessness. I have presented the data within themes, subthemes and categories and each element is labelled for clarity (appendix L). Each theme has two subthemes; NVIVO comments have been utilised as labels for the categories.

4.2: Theme 1: Educational realities associated with the CLE

It is evident that there are a number of *educational realities associated with the CLE* emerging from the data, which directly affect the quality of the learning

experiences within the CLE and students' ability to utilise their own agency effectively. The relationship which students have with their mentor is critically important, however the pressure exerted by the clinical imperative, being taught by an unqualified workforce and witnessing poor practice are also important considerations; each of these considerations are seen to impact on the quality of the learning experience.

Despite experiencing challenges in learning within the CLE, some participants reported developing strategies to enhance their own agency, using such strategies to construct effective learning opportunities. The participants explained how they attempted to: 'pilot' their own learning; defend their learner status and 'fit in' with the team to establish themselves as learners and ultimately to pass their placement. Those with prior clinical experience and more senior students seemed to find these strategies more straightforward. The participants recognised that, despite invoking such student strategies, they remained dependent on mentors for some learning activities.

Subtheme: Factors affecting the quality of the learning experience

Category: '*being lucky'*

The participants characterised the relationship with their mentors as having the most significant impact on the quality of their learning experience. The quality of the relationships varied, influencing and shaping positive or negative learning experiences. The participants in Focus Group 5 concluded *"you see a bit of both"* (referring to optimal and suboptimal mentorship experiences) (FG5), denoting normalisation of inconsistency in the standard of mentorship. The participants frequently used the term "*being lucky"* when in receipt of effective mentorship. Lawrence typified the participants' fears when he spoke of "*trouble ahead"*. Such "*trouble"* will be explored later when the oppressive behaviour of some mentors is interpreted within the theme of *power and powerlessness*:

> *"I feel, if you'd just put me straight into a team, that would've been a lot more difficult, but the fact that we did have someone to guide us ….. So yes, the mentors were very, very important, I do feel. I was, just, also*

lucky that I had two nice mentors. I'm expecting some trouble ahead because I think it's the norm, but in general my experiences, so far, with my mentors have both been positive." (Lawrence).

Mary explained that it is imperative that mentors guide learning and offer feedback, predicated on a good mentor/ mentee relationship:

"I feel as if they guide you in the right direction, and they also listen to your needs, and what you want to achieve in that placement. So, it's really important for me, because I like to have that ability to be able to be comfortable with my mentor, and ask, "Am I in the right direction?" ….. So, I just need a bit more guidance at times with my practical, to make sure that I'm in the right direction." (Mary).

Effective mentor-mentee relationships can engender feelings of support and care, creating learning opportunities. Conversely disengaged mentors can create isolation and disengagement, limiting learning opportunities:

"If it's when I'm working with my mentor who doesn't want to work with me, I feel very uncomfortable. I just feel in the way, like I'm not learning anything. I'd just rather be at home. When I'm working with my co-mentor I just love it there. I feel really comfortable, really at home." (Mark).

Whilst there were many accounts of positive mentoring experiences the problematic nature of some mentor/mentee relationships was severe enough to cause participants to consider leaving the nursing programme, as explored in FG4:

"*I thought, if they're (mentors) all going to be like that, I won't survive the placements, I will leave."* (FG4).

This consequence is striking, particularly given the relatively short duration of the mentor/mentee relationship and the support mechanisms available elsewhere, demonstrating the significance of this relationship. Mentor/mentee relationships may become compromised due to the pressures exerted by the

clinical environment, compounded by structural reasons, i.e. band 6 nurses have managerial responsibilities, typically restricting their mentorship activities. Some mentor/mentee relationships become ineffective due to poor mentor engagement. These points will be explored fully under the theme of '*the influence of mentorship'*. Other mentor/mentee relationships are severely compromised through oppressive mentor behaviours (explored fully under the theme of *power and powerlessness*).

Category: '*Leaving the learning to do the obs'*

The participants widely articulated that they understood that care needs take precedence over learning; accepting unquestionably the notion of the 'clinical imperative':

> *"It's busy, it's really busy on some wards and sometimes that impacts on your teaching. You understand that they're busy."* (Philippa).

The quality of the mentor/mentee relationship is influenced by the pervasive pressures exerted by the exigencies associated with busy clinical environments; environments which function primarily to care for sick patients and their families. Mentors commonly have limited time available for learning activities as a result of prioritising care. However, this places students in a predicament because they are expected to learn within an environment of high patient need, which is necessarily seen as predominant, and in a system which is under resourced. Learning needs, necessarily, therefore occupy limited status and, as a result, the quality of the learning experience for students is diminished. One of the participants in FG3 explained this point:

> *"I told the nurse in charge that if there were any transplants, I would like to go to see them. On that very morning, I asked him, "Do you remember I told you?" He said, "Yes, there is a lot of work on the ward; why are you going to see a kidney transplant, when there is work on the ward?" which means I have the HCA's job to do. That is what it means."* (FG4).

One of the participants in FG2 explained that she was required to prioritise work over learning; failure to follow such instruction could lead to punishment. (Such threats will be explored more fully under the theme of *power and powerlessness*):

> *"….. If I was being shown drugs and going through all the medications, I'd say, "I have to go now because I have to do the obs." So I had to leave the learning to do the obs because no one else would do it and I'd get in trouble if they weren't done."* (FG2).

The data demonstrate instances where care needs supersede learning needs. Broadly speaking it is accepted that the primary function of the CLE is to meet to clinical requirements of patients, rather than the learning needs of student nurses. Placing student learning within this environment will therefore predetermine a level of conflict. This conflict leads to compromises and sacrifices of the students' learning interests. Because students are less powerful or more vulnerable, they are likely to experience compromise, for example in their supernumerary status. The data suggest that students are often required to forego supernumerary learning by operating as HCA's. Under such circumstances students are not learning 'nursing' through *legitimate peripheral participation* (Lave and Wenger, 1991). While students are utilised as a critical part of the workforce they are not necessarily learning to become competent Registered Nurses. Students' non-supernumerary role within the workforce is highlighted by Mark:

> *"I found that, in my cardiology ward, I rang in sick one morning, at 5 o'clock in the morning. The nurse in charge on the phone said "Well, you're leaving it a bit late". I said, "Yes, but I'm supernumerary, it doesn't matter if I call in sick". She said, "Oh well, I'll just have to speak to the Bed Manager". That just made me feel horrible because even though you're a student, they're relying on you to come in to fill in the HCA's spot, basically."* (Mark).

First year students, with no prior experience as HCA's, may have difficulty in undertaking HCA roles, particularly if they have no prior healthcare experience or if they are in the busy clinical environments:

> *"I was able to handle it because I was in a nursing home and I was, I was okay. But say if you were someone just starting out, without healthcare experience, in week one."* (FG2).

In contrast there were also challenges for those who did have previous experience. Philippa felt it is difficult for those who were previously HCAs, because there is a propensity for them to fall back into this role when exposed to the pressure exerted by busy ward environments. In being used as workers, with little regard for their learner status, students inevitably miss valuable learning opportunities:

> *"I did fall back into that role. Also, I know it shouldn't really be done, but when they're short staffed, you do tend to fall into an HCA role. Especially because things like drug rounds with a student take hours. There's nobody to help that patient out to the toilet, there's nobody to go and wash that…..So, when you're short staffed you fall into that role that you're so used to."* (Philippa).

The consequence of falling back to HCA work is that students then opt out of the student role. Heather appreciated that HCA tasks are repetitive; by undertaking such work students are not learning the required nursing skills:

> *"Then sometimes I'll get stuck doing obs for the healthcare assistants because everybody's busy….. Don't get me wrong, I don't mind because everything's practice and it's helping but sometimes it's just like, I'm here to learn the nursing side, not other healthcare things that I've been doing for ages."* (Heather).

Alice expressed the tension between learning and caring, belonging and being peripheral:

> *"It's like, where do I stand? Do I have to look after the ward? Or do I have to look after myself? At the end of the day, I'm qualifying in 'x' amount of weeks and I need to get this experience."* (Alice).

The participants, in FG5, explained that when they tried to protect and pursue learning opportunities they were made to feel as if they were abandoning work:

> *"I worked in a few wards where if you say, "Can I go see this procedure or can I attend this MDT with the nurse?" they will look at you like you're kind of running away from work or something."* (FG5).

Deborah explained that, despite compromises in their learning experiences, students are still expected to accumulate nursing knowledge commensurate with their level of training. It is evident that mentors can, to some extent, mitigate such pressures and protect student learning. However, the extent of the pressures experienced by the mentor will undoubtedly influence the degree to which such protection can be achieved:

> *"Sometimes I do sit and wonder how, at the end of the three years, you are going to come out as a qualified nurse, if you're being used as a HCA a lot and people don't want to teach you. That is what I do wonder a lot – if you've been unlucky with mentors, then you get to your third year and they expect you to know all this stuff when you really don't know a lot. Do you understand what I mean?"* (Deborah).

Category: '*Thrown on the back burner'*

Many participants explained how their mentors relied heavily on HCAs to 'teach' the basics of care and instruct students, particularly during the early placements and when there were time constraints. However, being 'taught' by non-nurses was perceived to directly affect the quality of the student learning experience. Mentors were frequently engaged in clinical practice, typically drug rounds or managerial duties. Instead of inviting the participants to learn alongside them, they were tasked, by their mentors, to either 'learn' from (for junior students) or 'work' as HCAs (as previously discussed). There are various explanations for

this delegation. There seems to be a belief that first years can learn "the basics" from HCAs: *"Because we were in the first year, they said we needed to know the basics"* (FG4). "Basic" care typically involves elements of personal care and clinical observations. Registered Nurses perform "basic" nursing care less often, especially in busier ward environments because they are fulfilling other duties; such care is frequently undertaken by HCA's. However, students are required to learn these essential skills, which are assessed through their PAD document. Mentors may therefore think it is reasonable to delegate this element of 'learning' to HCAs to demonstrate. Although HCAs can demonstrate basic nursing care, they are unqualified to impart the underpinning evidence-based knowledge, decision making skills and professional attributes required of Registrants. Thus the quality of student learning experience may be compromised. This point is highlighted by the language used by Philippa; she describes, 'following', rather than 'learning' these required critical skills:

> *"In your first year on some wards you do follow the HCAs, especially for maybe the first three weeks of placement, kind of getting used to the areas."* (Philippa).

When the participants were allocated to 'work' with HCAs, the emphasis was on 'working' rather than 'learning', although the participants acknowledged that they did learn some basic elements of care along the way. When Fidelma was asked, "who or what has hindered your ability to learn in practice?" she replied:

> *"Oh, well, actually I'm not surprised, but it's the HCA. They're asking me to work with them as a healthcare assistant, not for me to learn."* (Fidelma).

The learning needs of first years are frequently undervalued, particularly within busier ward environments. Undervaluing first year learning is problematic because, as outlined within FG1, this foundational learning becomes readily compromised and confidence is not engendered:

> *"….. Sometimes I think people treat first-years as, "They're first-years, they can go with the HCA", whereas this is your foundation to nursing and it's a really important year. You may not think it's really important*

but you're doing all the basic stuff that you need to have perfected. I think if mentors aren't going to have time for students, because they're first years, that's quite bad. I didn't have that experience but I can understand that sometimes they might throw you on a back-burner because, "Oh, first year." That's what I mean, it's your foundation. Especially if you're new to healthcare and you have no experience." (FG2*).*

From the beginning of the programme, students witness 'basic' nursing care being performed by HCAs, whilst other often 'managerial' duties are undertaken by the Registrants. This may explain why students may undervalue the importance of delivering a high standard of 'basic' nursing care to patients. Some elements of 'basic' care can be critical to patient safety, for example being able to interpret patient observations and respond appropriately to deterioration. HCAs are not qualified to teach this level of detail. By allocating first years to work with HCAs, they have limited access to learn under the instruction and supervision of their mentors. The participants explained that they had limited access to their mentors during the second and beginning of the third year too, this sentiment was typified by Laura's comment:

"I hardly learned anything about it (nursing) up until that last placement, because nurses would just not involve me." (Laura).

The participants explained that they often needed to "bother" their mentor to engage them in their learning, implying that the mentorship role is burdensome. Students need opportunities to engage with their mentors, throughout their nursing programme, in order to learn. From the discussions it was evident that such opportunities were inconsistent and ranged from close engagement to restricted and compromised mentor/ mentee relationships:

"Some wards they just don't have the staff or the time to sit down and say, "This is this, this is that." It's kind of just like, "Be free and get on with it. If you have any burning questions come back." ……. Whereas on other wards, I found that they are really like, "Right, come with me,

follow me. Let me show you," as opposed to, "Go away. Bother me if you need something." (Philippa).

Once students have been taught the 'basics' they are likely to be used as a HCA – an additional resource within the workforce. It is commonly not until the final 12 week placement that third year students are afforded opportunities to learn alongside their mentor, during their sign-off placement. This means that some students are potentially not working closely enough with their mentors to learn from them, through mechanisms of instruction, supervision, feedback or role modelling. This denotes a compromised learning experience and means that students are potentially qualifying without receiving the underpinning clinical preparation; they may not be safe and prepared to practise.

Category: '*Turn around, I don't want you to see this*'

The participants unequivocally reported that they commonly witnessed poor practice within the CLE, which adversely affected the quality of their learning experience. There is an assumption that students are placed in the CLE to learn how to competently care for patients and their families, applying the theory learnt within the University setting. Instead many participants reported incidences of poor practice which, at its worse, amounted to abuse.

The participants spoke widely about witnessing poor moving and handling techniques, a subject which is taught in the University prior to the first placement, and every year thereafter. Moving and handling is not merely a theory (thereby more readily dismissed); it is a psychomotor skill, underpinned by knowledge. Because students receive formulaic, mandatory moving and handling instruction, they clearly felt qualified to comment on this area of clinical practice:

"In some of the hospitals that we were in we've never seen sliding sheets being used. Obviously, it is a big thing, but there could be worse things done, but in my entire 10 weeks on the ward, that I was on, I

never saw one sliding sheet used…..They don't even have any in their cupboard, and it's a surgical ward, so people are just out of operations and they don't have sliding sheets." (FG2).

The qualified staff are required to receive the same instruction, as part of mandatory updates, and equipment should be available in every clinical setting in the UK. It can only be assumed, therefore, that such poor practices are attributed to the pressure exerted by the stressful clinical environments, compounded by inappropriate staff resources or an unwillingness by staff to adhere to protocols. In breaching the required standards, patient safety and students' learning is compromised.

Some of the recounted incidences demonstrated blatant abuse. This student did report this incident and it was managed appropriately:

"He just had everything wrong with him: Down's syndrome, ADHD, Asperger's. He was really challenging. He was quite sweet, but he'd hit and he'd kick and he'd spit and he'd pull your hair. He grabbed my hair and then the carer came over and she just sort of said, "Stop that." Then she pulled a bit of his hair. Then he sort of jumped back and sat on the floor. I just thought, "Okay, that is not good." Then she said, "If he does that again, just pull his hair and then let go." I just thought, "Oh." Then I was thinking, "Oh my God, what am I going to do about this?" But, you see, she was quite caring at the same time, but I thought, "Oh my God, that is not allowed." (Deborah).

In some incidences the participants reported that the trained staff attempted to blatantly shield their poor practices from the students; such shielding was clearly ineffective. This behaviour is demonstrating a lack of respect from mentors towards student learning (as well as patient safety):

"When sometimes they're doing something like after taking bloods and putting the needle somewhere and they're like, "Turn around, I don't want you to see this. You are a student." I'm like, "Well, you're meant to do it right in the first place if you know I'm a student here." Yes,

> *because even though you are there observing they're like, "Turn around. You're a student, you're not meant to be seeing this. You're meant to be doing it in the right way." I'm like, really?"* (FG1).

In such cases, students commonly reported a sense of powerlessness to challenge such practices, in part due to their position within the hierarchy and partly due to the risk of repercussions. Such repercussions will be discussed under the theme of *power and powerlessness*. Witnessing but not challenging poor practice may be a source of moral distress for students.

Subtheme: Student strategies

Category: *'Piloting' learning*

Some participants highlighted the importance of being pro-active, taking control and directing their own learning; Philippa (who was a HCA for 5 years) described this as 'piloting' her own education:

> *"I think I'm lucky, because I have the experience and I can say to them, "Can I please go to the library and look at that then?" Or, I kind of took myself away and did some self-education. If I saw that my mentor was busy, perhaps I would go to another nurse. I kind of piloted my own education on some of the wards which, again, is completely understandable. I made sure that I came away from the placements with something. I wasn't just going to bumble around for the days. I was definitely going to take control of my education."* (Philippa).

Philippa recognised that her prior experience as a HCA enhanced her position in the CLE hierarchy and subsequent 'agency' (and consequent ability) to negotiate and *"pilot"* her learning. However, by inference, less experienced students may not possess this level of agency, which may compromise their learning experience. One participant in FG5 explained that those students who do not take control will typically "*just be left behind"* (FG5). Philippa explained that senior students are able to control their learning opportunities more

effectively because they are more familiar with how the environment operates. Prior experience, therefore, influences their ability to *"pilot":*

> *"I think if I went back as a second year, or even as a third year I could gain a lot more from it now, knowing my way around the system….. I think that I could have gone back and made a bit more of a difference in my learning, but it's first year, so you can't really do much."* (Philippa).

One of the participants, in FG1, acknowledged that there are limits to how much students can *"pilot"* their own learning because, to learn nursing skills, they need to spend time with their mentors; they clearly struggled to gain the required access. Restrictive access to mentors can lead readily to students feeling *"lost"* within the CLE:

> *"I know which area I have to focus ….. I just plan myself and I use computers when I get stuck and I always need my mentor while I do my drugs round. I cannot do this without supervision. For things like even to do the dressing and other sort of nursing care where your mentor has to be there, I had to struggle actually. Yes, I had to wait, I felt lost. I can't really plan the day."* (FG1).

One of the participants highlighted that even though they could arrange to work with other nurses and members of the MDT, they needed to ensure that their mentor was in sight and thereby fully aware of the activities they were engaged in, for the purposes of completing their PAD. So even students with agency cannot escape power relationships, rather they calculate how to operate most effectively within these relationships. In piloting their learning students are also constructing ways in which the mentor's observation might offer an approval, reflected positively in their assessments. Students reported that this need to be in "*sight"* of the mentor can clearly limit the learning activities that they can engage in:

> *"You want to not get out of sight from your mentor because at the end of the day they are going to sign and you don't want a situation whereby in the end it's like, "I didn't see you do this. I wasn't aware when you did*

this." You know? You want to be working with other people but you want to keep your mentor in sight as well, so they can see you doing stuff." (FG1).

Category: '*I need to learn this'*

Some participants described how they were able to defend their position as a learner within the CLE by utilising assertive behaviour and negotiation skills. However the data suggest that these were infrequent occurrences.

"I would explain, like, "I will come back and I will do this, this and this, but I need to learn something from this experience," because if they said, "But you can do this next week, you're here next week," but next week there's no guarantee, maybe you might not have time. You might not have the same person who's working with you who will let you go, so you have to get the opportunity there and then rather than waiting for it for the next week. You have to kind of negotiate and be a bit more assertive in saying, "I need to learn this." (FG5).

One of the participants, in FG1, described how they drew on their learner status to guard against exploitation. However such behaviour is risky because it goes against the hierarchy and power structures. Not all participants had the confidence to behave in this way:

"I realised as well when you are a student and doing a lot of HCA work, the HCAs also pick up that you're going to do this for them and they don't end up doing it. What you do is when you're sitting on a computer, you're doing your work, the bell goes off and you can see there's a HCA there, you need to stand your ground. You need to sit, don't go anywhere. If they say, "Could you do…?" You say, "No, I'm doing some studying". …..I realised that they pick up on that, "The student will go and help the patient with personal care, so we don't have to go." (FG1).

Many of the participants remained cognisant of the potential consequences of student confrontation in the CLE, even if the confrontation was predicated on the need to protect their learning opportunities. When asked what the consequences of confrontation could be, Davina replied:

> *"I think I would be, not in trouble, but in a position where people would not help me. They would hold a grudge. They could just neglect me, or they could find a way to get rid of me."* (through failing the placement). (Davina).

Davina was very aware there may be consequences to her actions, demonstrating the operation of power within the CLE. The participants perceive this power dynamic as natural but in other adult learning contexts (i.e. the University), this would deemed inappropriate. This is an example of coercive power, and is aligned to what Lukes (1974) refers to as a two-dimensional construct of power. This statement demonstrates how vulnerable students are within the CLE; defending their learner status could lead to *"neglect"* or they could "*get rid"* of the student, i.e. fail their placement. Students are balancing the need to protect their right to learning opportunities, set against potential reprisal; such consequences will be revisited within the theme of *power and powerlessness*.

Category: 'Fitting in'

Participants felt that their approaches to piloting learning and defending their learner status needed to be carefully balanced with the need to 'fit' into the team. The participants in FG5 explained that they willingly undertook HCA duties in order to build relationships within the team, but they acknowledged that these activities conflicted with engaging in learning activities. Students need to navigate a significant tension between wanting to learn whilst being vulnerable to more senior people, who predominantly require students to place work above learning needs:

> *"Yes. It's good that you build up a relationship with the staff in that way when you're doing these things (referring to undertaking HCA duties)*

but then your learning outcomes, you need to consider those as well." (FG5).

Student vulnerability is predicated on the understanding that they need to *'fit in'* because they are reliant on their mentors to: welcome them into the team; afford them learning opportunities and ultimately (and perhaps most importantly from the students' perspective) grade their PAD and award a pass/ fail classification. Jane realised that if she did not participate as a worker (at the team's behest) there could be deleterious consequences, affecting her future learning opportunities and potentially isolating her from the team. This is a really powerful threat considering students are in the CLE to learn:

> *"If you don't want to participate and you don't want to work as a team then they have a problem with you …… Then you are going to have a lot of problems. They don't want to associate with you anymore and they don't want to teach you anymore….."* (Jane).

Most students are aware of the precariousness of their situation, needing to carefully balance their need to learn, against the pressures which force them into 'worker' rather than 'learner' roles. In their attempt to successfully navigate the inherent tensions within the CLE, many students attempt to '*fit in'* but this strategy often compromises their learning.

4.3: Theme 2: The influence of mentorship

This theme focuses on the *influence of mentorship* and the elements of mentorship that the students highlighted as having positive and negative features. It has already been established that the participants recognised the relationship with their mentors as having the most significant impact on the quality of their learning experience. The participants expressed that effective mentoring can go some way to ameliorate the pressures and challenges associated with learning in the CLE. Such features: enable students to fit in and learn; engender participation and provide a high standard of feedback and

grading. However, the negative features can serve to interrupt and even obstruct learning within this environment, even in less pressured settings. Negative features include: abandonment; inappropriate mentor expectations; obstruction (rather than protection) of learning opportunities and a poor standard of feedback and grading of practice.

Subtheme: Positive mentoring features

Category*: 'learning as much as I can'*

Many participants echoed Philippa's sentiment in appreciating mentors who enabled them to quickly fit in and engender a sense of belonging within the CLE. Once students feel they belong, they are in a position to learn. In enabling students to fit into the team, their propensity to undertake 'work' rather than 'learner' related activities may be diminished and incidences of lost learning thereby reduced:

> *"All of the staff, but my mentors in particular, they were just so excited to teach me. I didn't ever feel like a student there. I always felt like a member of the team. A lot of the time you go in, and especially on your first couple of weeks, you feel like an outsider. That never happened. I think that's really positive, because I didn't have to feel my way around. I could get straight into it, and get straight down to being on the floor, learning as much as I can."* (Philippa).

Within FG1, the participants described mentors who demonstrated high levels of commitment to their students' learning needs; due to lack of time they regularly came in on days off, stayed late or worked through breaks to complete the PAD:

> *"Two of my mentors really, they came when they were not on duty and they came on purpose, just to see me."* (Tracey).

It seems that to be an effective mentor in the busier CLE requires a high level of commitment:

"The mentor that has been assigned to me, she's amazing. She is so interested in being my mentor, every little thing she will explain it to me in so much detail and, you know….. We took time out, went to a quiet room, did learning objectives….. Because I think when the mentors are really interested in your learning and really want to teach you, you will have time with them…..They will make the time, honestly, they will really make the time." (FG1).

Davina clearly articulated that effective mentors are able to protect and structure learning opportunities. Protection involves guarding the students' supernumerary status against exploitation. Seen in this way effective mentors are able to exert some control over the clinical imperative in order to create opportunities and relationships conducive to students' learning:

"For me it's very important. If you have a good mentor and a good relationship with your mentor, she can actually fight your corner as well….. Like any workplace, there's always people who want to abuse your position. They know you are a student, they know you're there and that you're going to try and please everyone, because you want to be helpful. You don't want to be in trouble, of course. You try to please everyone. A lot of people abuse that, and send you to do things that they probably would not ask if you worked with them, rather than being a student. If you have a good mentor, the mentor can prevent this abuse, basically." (Davina).

Alice appreciated when the mentors structured learning, rather than leaving students to "*pilot*" their own learning opportunities. This is the standard expected from mentors by the NMC (2008), but such standards can be readily eroded within busy CLE environments:

"That mentor called everybody for me, "I want you go to and see this person, do this, go to this hospice, do this." And she was very good as well, she was making appointments for me here and there. I could get

to see all different aspects of the community and that was really nice." (Alice).

Lawrence explained how effective mentors encourage and engender self-direction within the students, giving them permission to learn. Engendering self-direction is important because it is imperative that students learn to function autonomously, preparing them for the skills required as a Registrant.

> *"After a few weeks, I didn't feel I necessarily needed to ask permission….. I think my mentor wanted me to be as proactive and see as much as possible."* (Lawrence).

Category: '*Getting a chance to actually do it*'

Many participants explained that they preferred their mentors to be band 5, particularly during their first and second year, because they were more available to them. Band 5 mentors generally deliver direct patient care rather than undertake ward management activities. By working alongside band 5 mentors the participants had greater opportunity to participate in nursing care with Registrants. This demonstrates how workforce structures can impact the efficacy of mentorship arrangements. Most participants had two mentors (one mentor and one co-mentor) but not all of them had a band 5 mentor, creating inconsistencies in their learning experience. Mark explored the advantages of having a band 5 mentor:

> *"I don't know. It's just because every co-mentor I've had is usually Band 5, so they have the time to work with you. They're with patients. Whereas your Band 6 is in charge, they're running around the wards, or running to bed-meetings. So with Band 5, they have more patient contact, so you're getting more patient contact. They're showing you more things, changing dressings, putting in catheters, putting in NG tubes, and you get a chance to actually do it."* (Mark).

Through participating in care with their mentors students have the opportunity to engage with nursing role models, as Laura explained:

> *"….. She was just a role model, so you could just notice the way she did things, and in that aspect it was like, well, doing everything properly, according to how it is, you know, the guidelines or whatever. But also being assertive, at the same time, communicating properly. And getting things done. I mean, she was quite remarkable because you would think, Ah, how does she keep up, maintain the level of focus and energy and enthusiasm.*" (Laura).

By working so closely with their mentors students are afforded opportunities to engage fully in supernumerary learning activities, as *legitimate peripheral participants*. Under such circumstances students are learning to nurse rather than being utilised as part of the workforce, i.e. by undertaking repetitive HCA related duties.

Category: *'Our book is everything'*

Many participants spoke passionately about the benefit of receiving high quality mentor feedback and grading. The importance of this aspect of mentorship to students is perhaps unsurprising given that students are required to pass each placement and their placement grades contribute directly to their Degree classification. One participant captured this sentiment by stating, "*Our book (the PAD) is everything" (FG1, p13).* It is essential that students receive interim feedback to enable them to improve, where required. Failure to provide such feedback can lead to students unnecessarily failing their placements. Students do value timely, high quality, detailed feedback as Heather explained:

> *"So my mentor as well, on the feedback sheets, she'd sit down and explain to me why I got scores and in the midpoint she'd say what I could do better and then at the end she'd be like, "You did what I said and it's really improved."* (Heather).

The positive features of mentorship can go some way to ameliorate the pressures associated with learning in the CLE through: enabling students to 'fit in' and as a consequence learn; engendering participation and providing high quality feedback and grading. High levels of personal mentor commitment can enhance the effectiveness of this role but structural considerations and clinical pressures can readily undermine such commitment.

Sub-theme: Negative mentoring features

Category: '*A deer in headlights'*

The participants articulated that they frequently felt abandoned by their mentors within the CLE. Abandonment was attributed either to individual mentor's disinterest, structural challenges or to the inherent pressures exerted by the clinical imperative. Students do not have the required agency within the CLE to challenge and address issues of abandonment. Where the mentorship role was poorly executed, the PAD formed a nexus of vulnerability and anxiety. Most importantly, under such circumstances, the participants recognised that they were not learning how to nurse.

Many participants recognised that "*some mentors don't really want to teach. They have their mentorship (course) and they have to mentor….."* (Deborah). They recognised that undertaking the mentorship role is sometimes professionally rather than personally driven. This factor may explain why some mentors readily abandon students within the CLE, leading Deborah to conclude: "*So she sort of ditched me in a way."* (Deborah). It is thereby possible to experience mentor abandonment, even when the CLE is not exerting pressure on the learning arrangements. Thus demonstrating the influence of individual mentor's investment in the relationship, as outlined by in FG2:

> *"When I was on my last placement the hospital was amazing. The learning that the students got was absolutely phenomenal, it was a brilliant hospital, but my mentors were non-existent….. So at the end to get my book signed off I said, "How are they meant to sign my book when they were never with me? I don't want to be getting ones and*

twos because you weren't with me….." It was a bad experience in a brilliant hospital. It was the mentor that let it down." (FG2).

When students are abandoned and feel *"lost"* (Deborah), they readily default to focussing on the completion of their 'book', rather than maximising their learning experience: *"I just wanted someone to do my book." (Deborah).* One of the participants, in Focus Group 5, explained how vulnerable they felt when their mentor was absent. Mentor absence forces students to forge new relationships with other colleagues who are more appreciative of their needs; such colleagues are often HCAs rather than trained nurses:

"*You feel like you're a deer in headlights, you just don't know what's going on, so you just go with the flow, either latch on to a Healthcare Assistant or latch on to someone who seems to be more engaging or showing you attention or acknowledging the fact that you're a student and you're here to learn."* (FG5).

Structural arrangements can influence the quality of mentorship; band 6 mentors are less available to their students because they have conflicting management duties. The data appear to indicate that others fail to adopt students who are abandoned by their mentors, for whatever reason. When mentors were absent, the participants were typically required to work with or as HCAs, rather than learning 'nursing'. Mentor absenteeism provided a further reason why participants reverted to working as HCA's. The participants reported that periods of abandonment adversely affected the quality of the mentor/mentee relationship and students felt uncared for and unsupported. This participant attributed abandonment to lack of care towards them, compounded by the impact of structural circumstances and inherent clinical pressures:

"To be fair, I had a horrible time on my fourth placement. My mentor didn't care about me, she was a ward sister and I never got any time with her. Then my co-mentor, she was always on annual leave. Anytime I went to a mentor I was like, "Have you got anything to show me

today?" she would be like, "Just go with one of the HCAs." Don't get me wrong, I appreciate all the HCA showed me because in my first two weeks they showed me an awful lot…..but I wasn't there to learn how to do that for the 10 weeks, so it was just a horrible, horrible place to be. I cried at least twice a week. She (the mentor) was the ward sister and they didn't have a ward manager at the time….. So she never ever had time for me." (FG2).

Tracey articulated the sense of lost learning, which abandonment causes, and the futility of undertaking basic tasks, which have already been mastered:

"Oh dear, I wish I could have done something with them (the mentors), because they know so much about how to manage the ward, prioritising, doing all the paperwork, which I think it's good'….. I already performed them (HCA roles) for so long as a Healthcare Assistant, I make beds, I wash patients, which I love. I stay with patients, I feed them…..I think when I'm not with them (trained nurses), *I do Healthcare Assistant jobs, which I don't mind."* (Tracey).

Students who do not work closely with their mentors find it challenging to fully understand the holistic practice of nursing. The term of taking *"me into her space"* is interesting because it denotes the *"space""* of qualified nursing practice, rather than HCA work. It is evident that students readily recognised that this *"space"* was distinguishable from other activities:

"…..If, however, if she had involved, if she had shown me what I was meant to be doing, if she had taken me into her space or whatever, but I didn't in that particular ward….. but she probably was doing stuff that I wasn't aware of, and so….. So the other mentors, apart from the last one, they would give me jobs to do, which I was quite happy to do because I still felt that I'm learning no matter what I'm doing, but they would kind of give me certain jobs to do, but they wouldn't show me the – I never got an insight into the whole, broad picture until I worked with this mentor on the last placement." (Laura).

Category: '*Well go familiarise yourself*'

It is important that mentors have realistic expectations of their students. They must be able to support, teach, delegate and appraise development appropriate to the stage of their programme. The participants expressed that many mentors had inappropriate expectations, requiring students to quickly assimilate into new 'work' environments, without appraisal of prior knowledge and experience and with an apparent disregard for orientation or learning needs. Such disregard illustrates the requirement for students to operate as workers within the CLE, with little consideration for their learning needs as peripheral participants in this environment. The discussions in FG2 illustrate this disregard:

> *"When I went there I wasn't inducted. On my first day in they showed me around for less than one hour…..I wasn't shown the safety exits….. There were certain things that weren't shown to me. Then they just said, "Right, now, there you go, go straight in there" and I'm thinking, "I don't know what I'm even supposed to do."* (FG2).

At times mentor expectations and consequent instructions were inappropriate. Within the discussion in FG4, the pressure that the nurse was working under readily translated into inappropriate demands being made of the student; she simply did not have time to teach the required skill. Students cannot undertake an echocardiogram (ECG) accurately, without demonstration and initial supervision. The advice to "*familiarise yourself"* is inappropriate and will lead to poor performance of this task, with a potential risk to patient safety:

> *"…..well, it wasn't my mentor; it was just that I was allocated to a nurse…..She had some patients who had a critical temperature, and there was a lot going on. She needed to do an ECG for a patient, but she didn't manage to do it on time, and I wasn't familiar with the machine. It was a 12-lead ECG machine. She asked me to go and do the ECG. I said, "I'm not familiar." "Well, go," she said. "Familiarise yourself."* (FG4).

Category: '*That's not in your learning outcome'*

Many participants explained that they had experienced incidences where their mentors deliberately obstructed learning opportunities, an assertion of 'hard' power (Nye, 2009). It is not possible to understand this behaviour without asking the mentors; it can only be assumed to be driven either by clinical pressures and/or a misunderstanding of students' learning needs. As one participant in FG3 explained, at times students are questioned by their mentors when they seek out learning opportunities:

> *"And some of the mentors don't like you being with other nurses. Even if I've asked, "Since we've finished all the personal care….. I see you're busy is it - would it be okay to go with another nurse?" And a lot of them would say, "Well, why would you…?" It's a question, why?"* (FG3).

The scenario outlined by Mark (below) seems unreasonable; watching a laryngectomy is an excellent learning opportunity. Proactive students may have entirely reasonable learning requests rejected by their mentors, presumably because they want students to remain in the CLE, available to 'work':

> *"I found my mentor on the ENT ward - I wanted to go and watch a laryngectomy, and she said, "That's not in your learning outcome". I was thinking, even though it's not in my learning outcome, I could still go. I could learn a bit about surgery, so if a patient comes in I can give them some insight into what surgery's about."* (Mark).

Laura explained that she felt caught between two different types of mentorship, with some mentors actively obstructing learning opportunities, whilst others insisted that students were responsible for seeking opportunities and protecting their own learning:

> *"…..this was one thing that my mentor in the last placement kept saying to me: "You have to seek out your own learning opportunities". And I was a bit offended, because it was like, I've been trying to seek out my own learning opportunities for the entire time, and I've been knocked down on everything."* (Laura).

Category: '*I'll just sign it at the end*'

Students should receive contemporaneous feedback from their mentors, which is formally documented (at three specified time points) within their PAD, accompanied by grading. The PAD, or as the participants commonly called it, "*the book"* was discussed in each interview and within every focus group, demonstrating its critical importance to students. The PAD serves as a site of acute vulnerability for students, but some mentors, as Philippa described, seem unaware of its significance and the inherent associated risks:

> *"Your book is always in your mind. I always keep mine where I can see it, because I'm not risking it. For a mentor, some of them are a bit like, "Oh why do I have to sign this?" "Oh fine, yes, fine, give me the book. I'll take it home." You're like, "Oh no. Not letting it out of my sight." Others are really excited to sign you off. They see it as a progression for you."* (Philippa).

As Deborah expressed, for less academically able students, scoring highly in practice is especially important. The PAD is a mechanism for increasing Degree classification but it is also a portal through which achievements and contributions in practice can be celebrated:

> *"For me, it's not that I struggle academically, but I find the academic part harder, whereas, for the practice, I'm a quick learner in that way. So I try to get as high in that book as possible."* (Deborah).

Heather explained that the process of undertaking the three required interviews during each placement was rarely followed, which was stressful for the participants and compromised valuable feedback opportunities. As a result a weaker student would be unable to take remedial action at an early juncture:

> *"Well I worry, it plays on me and then I feel bad if, for example, the midpoint interview isn't done when it's meant to. Then I think if we get behind, I'm not going to have a chance to improve."* (Heather).

As highlighted by Fidelma, sometimes this feedback is only available at the end of the placement:

> *"From my previous experience, they only managed to go through my practice assessment book nearly at the very end. You just have to repeat yourself and remind them again….."* (Fidelma).

In some scenarios students suggested that the mentors lacked time but on other occasions they described an apathy towards engaging with the PAD. Students described a lack of agency to be able to effectively challenge such apathy:

> *"I had two experiences from my previous placements where they did it at the very end. For me, they're not giving me quality time…..Some of them are probably too busy, and some of them just don't want to do it….."* (Fidelma).

A delay in completing the PAD is less problematic if students are receiving contemporaneous feedback from their mentor, with discussions captured within the PAD at a later stage. However the data suggest that such contemporaneous feedback is commonly compromised because students do not work closely or frequently enough with their mentors. The PAD is then utilised as the primary portal for student feedback when mentors review performance through the interviews. If the mentor does not work with the student, the extent to which the feedback can be provided authentically is questionable. The relationship may become too weak to support meaningful feedback and evaluation of student performance. Many participants experienced delay in their feedback and grading and they also questioned its veracity.

Some participants experienced a decrease in their grading but were unable to elicit an explanation or meaningful feedback; the mentor may not be able to comment because they had not worked closely enough with their mentee. The nature of the mentor-mentee relationship precluded the option to challenge:

> *"Yes, this was on the surgical, for example with the midpoint and things, I would ask the same questions like, "What do you think I could do? Could you explain these comments?" and things and it was just like, "Are you not happy with my scores?" and I was like, "Yes of course I am, I just want to know what I could do better," and then I never really*

got an answer. So I was just like, "Okay". Then at the end it turned out that my last one I got worse scores than I did through the rest of them, they'd actually gone down from 5s and stuff - down and I was just like, "Okay," and then I never got an answer to why." (Heather).

Many of the participants explained that the grading seemed to be very subjective, with little regard for its importance for the students; this sentiment was typified by Philippa's comment:

"I do feel like some mentors are very subjective. It's, "Oh, fill in the book and I'll just sign it at the end". You think, "No, you're responsible for this." (Philippa).

Some mentors simply did not understand the grading system, believing wrongly that students cannot achieve the highest grades:

"Yes, the book is a big problem because they're like, "You're so good but I can't give you, you'll never be a five because you're training so we can't give you five." (FG5).

It is unjust and potentially demotivating for students to receive feedback and grades which are unreflective of their clinical achievements. Inaccurate grading undermines the veracity of the whole 'marking' process within the CLE, potentially leading students to devalue the process. The participants questioned the mentors' overall ability to accurately complete the PAD. Each mentor receives detailed instruction in relation to completing this document; this instruction is given during original mentorship training and during yearly mentor updates. The PAD has existed, broadly in its current form, since 2012. The lack of mentor engagement in this important document demonstrates a general disregard for students. This disregard was noted widely by the participants. As Mark explained, the PAD can be seen as a burdensome exercise, *"nurses just want to fill the book out and get rid of it."* (Mark). *S*ome mentors are not concerned with accuracy. This is problematic because, arguably, positive feedback and grading in the PAD is the most significant reward (beyond direct patient feedback) that students receive. Inaccurate grading could be

demotivating for those students who make considerable effort in practice. Conversely, less able students may progress inappropriately.

4.4: Theme 3: Power and Powerlessness

Of particular concern are the pervasive, negative learning experiences reported by many participants. Such experiences are beyond what could be classified as normal power dynamics and serve to highlight the polarization of power and powerlessness. Set within distinctly oppressive hierarchies there are instances of hostility, reprisals and collusion. Many participants expressed that they felt suppressed and defeated as a result of their treatment by mentors, and others, within the CLE. They realised the futility of challenge and became resigned to a compromised learning experience. Some participants contemplated leaving their programme as a direct consequence of their experiences.

Subtheme: Oppressive experiences

Category: *'Starting from the bottom'*

Nursing is in itself a highly stratified profession; the influence of the hierarchy can be oppressive and serve to interrupt learning experiences. The participants demonstrated an acute awareness of the nursing hierarchy within the CLE and students' subordinate position within it, typified by Alice's comment:

> *"Hierarchy is such a big issue in the ward. Like, this is my position and you're here" (pointing to the floor).* (Alice).

First years seemed to be placed at the bottom of the hierarchy, with a common belief that they need to undertake menial tasks within the CLE before earning the right to learn. This point was exemplified in FG3:

> *"I think when you're in your first year, it's the most difficult year, I've found. In my first placement, I was working with my mentor and ….. The nurse in charge came up to my mentor and said, "Why are you teaching her some management roles? She should be starting from the bottom, cleaning the floors."* (FG3).

The participants expressed that this hierarchical position is reinforced through a number of mechanisms: all years commonly received instruction from HCAs; first years (particularly) were often excluded from participating in direct care with qualified nurses; and students had a diminished 'voice' when raising concerns (either about care or their own learning arrangements). It is from this diminished hierarchical position that students need to negotiate their learning needs, which is particularly problematic in the more pressured clinical areas, when the mentor/mentee relationship is most likely to be compromised.

As already considered, first year students are often directed to learn and then engage in basic care, instructed by HCAs, rather than qualified nurses. HCAs 'right' to instruct student nurses, reinforces their subordinate status within the CLE. Whilst students are 'working' alongside HCAs, they are excluded from engaging in elements of care with their mentors. Perhaps their exclusion is, in part, driven by an intention for them to learn 'the basics', but may also be due to issues relating to clinical utility, compounded by the pressure exerted by the clinical imperative. First year students have less utility because of their lack of experience and skill acumen. Apart from demonstrating incivility towards this student, the behaviour seems to be driven by the first year student's lack of utility:

> *"I had a senior staff nurse shut a curtain in my face when I told her I was a first-year. We were doing the rounds, he got to the last patient and that patient needed something to be done…..It was me, a second year and a third year, the second and third year were in there and he was like, "Are you coming in?" "Yes" and then he was like, "What year are you?" I was a first year and he closed the curtain in my face. He was so disinterested in me as well."* (FG2).

Students' occupancy of the lowest strata within the hierarchy means they are vulnerable to exploitation, due to their lack of agency; a situation which is magnified in areas of high patient acuity. When immersed in an environment with sick patients, it is necessarily difficult to negotiate learning needs,

particularly from a compromised hierarchical position. Under such circumstances students reported their learning needs were typically disregarded and they were readily exploited. However, in FG2, it was evident that such exploitation was not always due to clinical pressures but seemed to be an expression of hard (Nye, 2009), one-dimensional power (Lukes, 1974). Although this participant had access to patients, and thereby arguably potential learning opportunities, this scenario still demonstrates exploitation:

> *"I think the HCAs use it a lot as well. I know when I was on the 12 week placement….. I was on a ward where there were three big bays and if I was working I was considered a HCA. So I would have a whole bay to myself from 7:15 in the morning until night-time…...I had to ask if I could have help….. "Oh, okay, give me a minute." The HCAs would be up at the nurses' station drinking tea."* (FG2).

The data appears to imply that HCA's acquire greater legitimacy within the hierarchy as a result their role in 'teaching' students. This acts to further erode learning opportunities and results in further exploitation. In such scenarios, as Alice explained, students are in a predicament because they still need to negotiate their position as a learner within this environment, in order to meet the requirements of the programme. However, such negotiations may prove problematic for some students. In prioritising learning, they may be accused of being 'poor' students; such accusations function as a way of silencing students and potentially suppressing their learner identities:

> *"You're not really seen as a staff member. So then you're like, "I wanted to make it about my learning." But at the same time, when I do, I get this big backlash and, "Oh, you're a rubbish student because you speak back and you do this."* (Alice).

Tracey added to this interpretation by suggesting that perhaps students' general position in the hierarchy is compounded by their transient status in the CLE. Tracey's use of the word "invader" is interesting, suggesting that students are not seen as belonging:

> *"…..at the end of the day it's like going to a place, only for a month or a month and a half or two months maximum. They don't see you like permanent staff …..I felt that in some places, but it's normal, I see it as a normal thing because we are only going for a period of time. We are invaders in a way…..We go to learn, and it seems to me that some people don't see that."* (Tracey).

Due to their position within the hierarchy, many participants perceived they had a diminished voice, not only in relation to their own learning, but also in safeguarding the standard of practice within the environment. This places students in an invidious position because they are required to report poor practice. After reporting poor practice and being largely ignored one of the participants concluded, "*I tend to keep my mouth shut now, so I don't say anything."* (*FG3).*

In FG1, the participants' discussion demonstrated how experience is readily valued over knowledge, thereby justifying the dismissal of the student voice and further legitimising their weak position within the CLE hierarchy:

> *"I don't think they are ready to hear any sort of comment from the student. They think, "They are a student, how could you just tell me?" That's the mind-set in most of the staff in the ward. They think we are doing with the theory and that's what sometimes makes them mad. They think, "You're coming with the theory." They think we know everything while they've been on the field and doing this for a long time. "Why would she tell me? She's sat in the classroom and this, so why would she tell me she knows best?"* (FG1).

Category: '*The student'*

In many of the discussions, the participants described oppressive experiences. They reported this was typified by being constantly referred to as 'the student', most often in exploitative situations. Such incivility proved demotivating and

ultimately oppressive for the students because they felt neither cared for nor respected within the CLE. As described by Philippa, such demotivation led them readily into undertaking 'worker' activities rather than engaging in learning:

> *"One of my wards I was just "a student". No one knew my name; no one knew anything about me, or even what year I was in. It was just, "Get the student to do it. Get the student to do it." Again, because I stand up for myself, I was just like, "That's not okay. Stop doing it." It's frustrating because you kind of go in there ready to learn, and by 10am you're just battered down and just, fine, I'll just get on with doing this and doing that."* (Philippa).

In this scenario, outlined by Deborah, the mentors knew the student's name but still chose to refer to her as *"the student";* this seems particularly derogatory. Deborah felt compelled to answer the bell, presumably because of the inherent hierarchical power imbalance within the mentor-mentee relationship. The mentor was clearly abusing the student by using her as a HCA worker, rather than protecting her as a supernumerary learner in practice:

> *"They know your name, but they still refer to you as, "The student." "The student can do that. The student can go and answer the bell." I know obviously you have to answer it, but sometimes they did like to use you as a HCA, because they felt that they were above doing HCA work, when really nurses still have to do that as well."* (Deborah).

The participants, in FG3, explained that part of being *'the student'* incorporated feeling ignored and intentionally abandoned in the workplace, with learning needs disregarded. Some of the participants perceived this behaviour to be deliberate and not attributed to high workload pressures. Such hostility and disrespect compromises learning opportunities:

> *"….. you can feel the pressure from everyone, you're being ignored even though they have a good time, because they are sometimes - they're not short of staff, but you might still be ignored, just because, "Oh, I'm going to have to teach you something….. " But they kind of*

interact with others and sometimes you're asking, "Oh, I have a question, how should I fill this paper? I'm not sure I haven't done this referral or something." And then, "Just follow through, just read it and it's self-explanatory." "Okay, but I struggled and that's why I asked you. Could you tell me how to…?" But she's - they're kind of trying to get away with the things - from the things you want help with." (FG3).

The participants spoke widely about feeling fearful, isolated and intimidated in the CLE. Philippa described a disconnect between an idealistic anticipation of mentors as caring role models, and the reality she encountered:

"I've seen mentors make their students cry. I've seen all sorts and you think, my God, you're supposed to be who I'm looking up to. You're just horrible sometimes." (Philippa).

In this scenario, Alice (a third year student) described feeling *"terrified"* trying to learn under the threat of *"you can't be a nurse"*. This mentor showed a disregard for Alice's learning need through her behaviour. Alice had passed all of her placements until this point, with outstanding grades:

"I struggle with memory because of my dyslexia….. She was just like, "Yes. But you can't be a nurse and you can't do this". Then she'd make me memorise things and I'd be under pressure again. I'd feel really terrified if I couldn't remember them and I was saying to her, "I find this really hard". …..I kept telling her, "I find this really hard." She wasn't sympathetic or anything. She was very hard and like, "Why can't you do this?" (Alice).

As a consequence of her mentor's behaviour, Alice required counselling and she considered leaving the programme; the impact of the mentor's behaviour is evident in this statement:

"I went to counselling because of how bad it was. I said, "I feel really depressed. I don't know what I want to do anymore. It's making me feel like I just don't know what I'm doing with my life. Should I carry it on (with nursing)?" (Alice).

Alice questioned why she should continue on the programme, given these experiences. Her desire to nurse made her persevere. She realised that to maximise learning in practice students require nurturing. The hierarchy within the CLE seems to suppress the option of nurture, which is troubling for the profession and counterintuitive given that nurses are supposed to be caring.

> *"As the student, they don't see your point of view at all….. need to think, if someone isn't getting paid to be here, they have to come on the bus, travel an hour and half, that's what I did every day…..Then on top of that, if you're getting ridiculed every day, you feel like, "Why am I putting myself through all this?" But you want to be a nurse, you want to look after people to the best of your ability, you all want the same goal. Someone just needs to nurture you through the process. That's how you get a better result at the end….."*(Alice).

Alice recognised that her mentor's behaviour towards her had a negative impact on her ability to learn within the CLE, demonstrating the detrimental impact of inappropriate use of power.

> *"I became quite fearful of her because of the way she was with me. It made my learning not very good. Because when you feel like you're being watched all the time, you're not achieving. Or, you go home and you feel like, "Why? What have I done wrong?" And then you cry. Then you're like, "Oh, I don't want to fail." It's all pressure and it's not a very nice experience going in. It's horrible."* (Alice).

Many participants described feeling "*lucky*" if they avoided acts of hostility in practice, suggesting that this behaviour is not unusual:

> *"I was lucky not to have a mentor that really made my life hard or difficult."* (Jane).

Category: *'Weapons'*

It seemed that the majority of participants anticipated that their PAD could be used as '*a weapon'*, a way of threatening failure. This was a common thread of

conversation and sentiment throughout all interviews and focus groups. It is, therefore, a significant finding. Sometimes the threat seemed to be used as way of demonstrating power and prowess but mostly it was used, by mentors, to 'dissuade' students from making allegations relating to poor standards of mentorship or practice. This is a good example of what Lukes (1974) referred to as two-dimensional power, when behaviours associated with authority, coercion and manipulation are evident. Mentors are vulnerable if students report poor practice, therefore students are potentially able to act within the power dynamic in this way. While aware of this potential, mentors can pre-empt such a challenge through the threat of failure, using the PAD as a '*weapon*'; this scenario is captured by Mark:

> *"Well I've heard of other students saying that they've spoken against their mentor, and their mentor has actually failed them…..It's always in the back of your mind, especially in the grading."* (Mark).

Philippa demonstrates the tension students' experience of negotiating power relationships, set against the normative dimension of doing what is right. The participants were aware that challenge may result in reprisal (in the form of their grades being diminished):

> *"…..you feel a level of pressure, because these mentors at the end of the day are responsible for your grade. They are responsible for writing the stuff in your book that's going to get you a good grade. You think if you piss them off, then that's going to impact on your grades. It's a fine line between doing what's right and looking after yourself; and challenging it to a stage where your mentor gets spoken to by the Ward Manager. Then their practice gets questioned, and you think, "Oh no. She's going to hate me for this. She's going to take it out on my mark."* (Philippa).

It was evident, through the discussions of FG1, that in some of the more welcoming CLEs, the participants felt able to challenge because they perceived that their confrontation would not be translated into negative grading. In other

environments the participants tactically remained silent about their concern in order to avoid confrontation and the potential deleterious consequences for their grading. The threat of failure is pervasive, which can have a negative impact on both learning conditions and potentially patient safety:

> *"In my nursing home placement, the carers were just lifting people. You look at that and you're like, "No, that's not right. You're not meant to be lifting vulnerable people that way." Sometimes you feel like, "Do I say something or do I not?" It could be taken out of context most of the time. That's my worry when I see those practices going on as well it depends on the environment. Some environments are welcoming, they involve you in as a student and you feel like you can say something but some places you just feel - it all comes back to this book. Some mentors have been using that as a weapon. Yes….. so you're kind of worried. "Do I say something? Is that going to go against me in the end?" Most of the time you end up not saying anything at all."* (FG1).

In FG2, a participant explained that one of the elements of grading assesses their level of participation within the team. Students understand that if they refuse to participate in poor practice they may be downgraded for their inaction in this category. This was a stark reality portrayed by some participants and goes beyond the more ambient and perhaps unintentional power dynamic (e.g. the non-negotiable idea that "caring supersedes learning"). In this scenario there is obviously a more intentional and interpersonal power dynamic in play, which students are experiencing and are relatively powerless to defend:

> *"They have the power of signing our books so they have that power to control us. Obviously, you've got to think, "Do I be nice and shut up?" it's one of those things. You're always constantly afraid that they're going to fail you. So if you say to them, "No, I'm not going to do that," they can give you a one on your participation just because you refused to do bad practice. They'd be like, "You should've done that because someone higher than you told you to do it."* (FG2).

When asked, where the bar was for reporting poor practice, this response was typical:

> *"For me personally, if it something like physically hitting somebody then those ones are like, I feel like I cannot be quiet about that."* (FG1).

The participants understood that their position on the programme was tenuous because it could easily be withdrawn by two failed placements. Alice described how her mentor threatened to fail her in her final placement, with only three shifts left to complete. This statement clearly demonstrates the students' level of vulnerability within the mentor-mentee relationship:

> *"But as a student, you don't have that Degree. You don't have anything. If you leave that's the end of that. Everything is at stake. It was my life. I had nowhere to go if I left. It was so stressful because I had a cat, I had a house. How do I afford this if I quit? What would I do? Where would I go? I'm away from home…..I didn't really have the support that I'm used to around me and that impacted on me feeling more trapped. I just felt like, "I have to do this but she doesn't like me."* (Alice).

Many participants described the consequences of challenge, which included having a deleterious impact on their grading, but it also included other reprisals. Such reprisals included: negative attitudes towards students; a reduction in learning opportunities; disinterest from the mentor and a challenging workload allocation. As Lawrence explained, students are, "*scared of a backlash of criticism."* (Lawrence). It was evident that the participants did not trust or understand the extent or effectiveness of support from the University, who are also part of the construction of power dynamics operating within the CLE:

> *"It's difficult to raise concern as a student, even if you see the bad practice there because in the end, they take it as a negative - a lot of negativity comes afterwards and that might affect a student's learning and especially our book which is very important. Then we don't know how strongly we are supported (from the University) if we bring some sort of concern. We are not very aware of that, I am not aware. What*

will be the backup for us if I bring something as a concern? Am I going to stay in the ward? Am I going to be changed? Is it going to be kept confidential?" (FG1).

The participants were conscious that after making an allegation against the team, they may need to remain within the CLE and deal with any reprisals from their mentors and potentially the wider nursing team:

(Following raising concerns) *"They could easily take it out on your grade. Or, they could just make your shifts hell, by just giving you the littlest or the shittiest work to do. Sorry. They can make your life hell on your placements."* (Philippa).

Category: '*In the doghouse*'

Many participants discussed their experiences of team collusion, set against student nurses. They explained that should students raise concerns (of any kind) in practice, it was common for the nursing team to collude against them. Such collusion usually took the form of a change in attitude towards the students, which could ultimately influence grading or their work workload allocation; this scenario typifies their discussions:

"This girl that I was working with on my first placement and first year. She was making an effort to work as part of the team. I think she complained about her mentor because she had done something wrong. I think she told the ward manager, because they were quite friendly and…..Yes. And the ward manager went and told the mentor that she did this. I think it was something related to moving the patient or something. And the mentor had a go at her afterwards saying, "Why didn't you come to me? Why did you go to the manager to complain about me?" And then the atmosphere really changed. And it's like a little gang, they sort of ganged up against her. Then she was always crying in the toilets. She was really upset." (FG3).

Jane described how she witnessed another student legitimately refuse to participate in the preparation and administration of intravenous drugs; students are precluded from involvement in this activity by the University and local Trusts. She witnessed the consequent negative behaviour of the nurses towards this student, which amounted to rejection, reiterating the risk of challenge. If students do administer intravenous drugs and this action is reported to the University, they are usually suspended and referred to a Fitness to Practise panel; this panel has the power to withdraw students from their programme of study. In such instances students are placed in an untenable predicament:

> *"I can't do that (participate in intravenous drug administration) because the Uni tell us not to do this. I am not going to do this. I am not going to do that." At the end her mentor was very upset and she said, "Okay, you can go back to Uni. I don't want to teach you anymore". The other nurses they didn't want to teach her anymore."* (Jane).

Davina explained that students commonly do not defend their learner position or raise concerns about practice because they do not trust the response, which may culminate in team collusion against them. The term, *"outsider"* is interesting and resonates with the term, *"invader"* used earlier, when describing students' position within the CLE hierarchy. Both terms suggest an attitude which regards students as not belonging in the team, implying they are imposters in this environment:

> *"It's more about being scared. You have a situation where you think, she will go and say things, inventing stuff. You don't know what relationships they have between all of them. You are an outsider. If something happens, I believe they will stick by each other, and you're the one going to be in the doghouse. I think that's why we put up with those sort of things."* (Davina).

One participant, in FG5, described a scenario where a student needed to be re-allocated to another ward, as a direct consequence of raising concerns. In this incident the student needed to be put back by one cohort, with personal and

financial implications. Students understand the ramifications of raising concerns, either through their own experiences or through the experiences of others. In this example the collusion within the team manifested as incivility:

> *"….. and then working will be harder in the team because then everyone talks to everyone and then they think you're the one who's the problem…..Yes, and then they'll isolate you because of that….. I've seen it with someone else. The whole staff, how they handle the student differently than the others because that student challenges…..Yes, because we told …..and it made it a really big, awkward situation for them, and they had to move and do the whole placement."* (FG5).

Such behaviour can be very isolating for students as this participant in FG3 explained:

> *"I think that sometimes you don't really know the person to talk to, apart from the university, because if you talk to the manager, they're friends with the manager, it's going to come back to you. If you speak to another nurse, it's still going to come back to you. So probably, sometimes, you don't really know if you have a concern, who you can go to talk to in person."* (FG3).

Davina explained how mentors behave differently when the link lecturers are in the CLE. In some circumstances, the LLs can be an important ally for students, transiently changing the power dynamics during their link visit. Although some participants appreciated that they could confide in the University staff, they often chose not to. They presumably appreciated that they would need to remain within the CLE, once the link visit has finished, with potential adverse consequences:

> *"It's like you're part of their team. It's like suddenly they treat you better. Suddenly they don't send you to do all the horrible jobs. They try to explain something to you. They say, "Oh, do you want to ask me something?" Or, "If you go on the internet, you can look for this." They try to help you more than if they were not there …..You can speak to*

the link lecturer. You can call the university and say something about it. But the reality is that we don't do it. We don't want to be in trouble, and we don't say anything." (Davina).

Rachel described a scenario, which appeared indicative of organisational collusion. The scenario occurred when she was in a community placement, working with a band 5 nurse; her mentor was unavailable. After visiting a client, the participant completed the required documentation, which the nurse checked for accuracy and signed. However, the nurse proceeded to also sign as the student. Rachel challenged this practice but the nurse continued to sign on behalf of her for the rest of the day. In her mentor's absence, Rachel therefore reported her concerns directly to the University. These concerns were subsequently escalated through the Trust. Rachel was concerned whether she would be believed and of the potential consequences of raising concerns:

"I was worried about this because I was like, do they still like me? I'm not gossiping…..This nurse has made a mistake…..I didn't think she'd believe me, because it was just something that you say and people just think, are you joking? That's ridiculous ….. So I didn't think she'd believe me ….. I was really worried because they would fail me for being dishonest. I was telling the truth but they'd think I was lying." (Rachel).

Rachel subsequently faced a number of intimidating meetings within the Trust in which she felt they dismantled her claims, isolated her and colluded against her. The actual issue of the forgery was not addressed:

"The Team Leader said, "We could have kept it between ourselves. You've messed this up for everybody." …..They all shouted….. I cried….. It's not fair. No-one is here for me. Because they weren't. My mentor wasn't there, she was upset because it made her look bad that it shouldn't have happened. Then the Team Leader, because this nurse was forging documentation, and the Placement Lead was like, "You went above everybody. Why are you causing these problems?" I'm a

strong person but it was just so unfair, so I was crying. Then they were saying…..They didn't stop. More things were coming at me. I said, "I want to go home….." "You can't run away from the problem." I was like, "I am not the problem." Anyway, I think what made it worse was then they wouldn't let me go home. They were like, "You need to just toughen up." (Rachel).

In terms of reprisal, Rachel (who usually received 100% for her grading in practice) was downgraded because she was late for one of the investigative meetings. Rachel was late because she was locked out of the meeting room building. Rachel's isolation and the risk associated with raising concerns is evident:

"I got 40 out of 50 overall, but it was just a bit unfair…..Looking at whose fault is it and actually where does the issue lie? It should never be the student who voices….. Even colleagues that have mentioned concerns, they say, "It's a culture of just blame the student." Students don't speak up. I think the sense of loneliness was a big one because you do feel alone in it. Uni is there but your world in on placement. Your grades are on placement. You're being marked on placement." (Rachel).

This scenario demonstrates organisational collusion against a student who raised legitimate concerns. Ultimately the student faced reprisal through downgrading. The influence of the University within this power dynamic is nullified because grading occurs within practice, with little opportunity for University influence or scrutiny.

Sub-theme: Subjugation of students

Category: '*Because nobody cares, or nobody listens'*

Many participants recognised that they had justification to challenge both their own treatment as students and elements of witnessed poor practice. Students did not seem to directly challenge poor learning experiences (due to the

associated risk of reprisal). Some did initially report poor practice, but if they encountered deleterious consequences they desisted and complied with the practice.

> *"At the start of my placement I refused to move a patient using the bed sheets. I basically just got roared at for that so I just started doing what they told me to save myself from being upset all the time."* (FG2).

Many participants stated they refrained from challenging, explaining that they had heard 'stories' relating to adverse consequences. Hearsay from other students proved an effective portal to transfer 'stories' and instil anxiety and fear within the student groups. One of the participants in FG1 described how helpless students feel within the CLE, with an apparent lack of agency. Comparing the clinical circumstances to the occurrences at Mid Staffordshire Hospital, highlights the gravity of their concerns:

> *"It's like similar to - is it the Francis report, where there's poor practice, but everyone is too scared to say something."* (FG3).

Some participants intentionally pretended to hold less knowledge because they were afraid to raise concerns. Such fear leads to feelings of helplessness:

> *"Because I need to be non-knowledgeable, stupid, every day you're going in just because you're afraid to say something like in this case and scenario. It doesn't work when you notice that there's something wrong and you can't do anything about it."* (FG3).

The participants articulated they often reached the conclusion that challenge is futile. Students do not have the required agency to influence care and they are too vulnerable within the CLE. After raising concerns about the way a patient was treated, Alice concluded:

> *"Nobody did anything but I did report it. After that I felt like, "Is there any point in me reporting things? Because nobody cares, or nobody listens." I think unless it's an extreme thing, no one would listen to me because*

as a student you're not seen as level, or you don't know what you're talking about because you don't have a lot of experience." (Alice).

Category: '*I'll just get on with it*'

Although the participants seemed reluctant to challenge compromised learning arrangements within the CLE, they still made considerable attempts to engage in learning activities, even in the more difficult environments. Such attempts were made through demonstrating that they were worthy of such investment, usually by undertaking work activities. However, if such attempts were thwarted, they resigned themselves to the situation and waited for their placement to finish before focussing on their learning again, thus losing considerable clinical learning time. A participant in FG5 described how they had been used repeatedly as a HCA:

"Well, you do disengage, don't you? I had a similar situation in the first year, and then you have days, then you say no, I'll try my best, try to convince them that we are worth taking the time and tell us how we should be doing. Then some days you're just like, Okay, so I'll just get on with it, I just want it to end and have another placement, and just move on." (FG5).

Category: '*I wanted to quit*'

The poor clinical experiences of some participants made them question whether they should remain in the profession long-term. Mark's comment is typical of this sentiment:

"It puts you off nursing. It literally puts me off nursing. I don't think I'll even - I'll probably work a year as a nurse ….. because I see patient care dropping - the quality of care dropping. There's just not enough staff. People aren't doing their jobs properly. The NHS is a sinking ship." (Mark).

Alice was discussing the impact of her mentor. It is significant that mentors can have such a detrimental effect on students, even towards the end of their

training, when they are generally more confident: "*It's was just so stressful. It was horrible. I wanted to quit."* (Alice).

4.5: Summary

The participants portrayed the CLE as a pressurised environment to learn within. They needed to navigate learning opportunities in an environment where care takes natural precedence over considerations of learning needs. This 'clinical imperative' readily leads to students being exploited within this environment. The participants articulated that the student/mentor relationship significantly influenced the quality of their learning experiences within the CLE. However, they recognised that mentors were often unavailable due to conflicting clinical pressures. Unavailability forces mentors to allocate (particularly junior) students to 'work' with HCAs, under the premise that they are 'learning the basics'. The participants recognised that they were commonly exploited as 'workers' when they are allocated to HCAs. Many participants experienced a shift from work 'with' a HCA to work 'as' a HCA. Under these conditions, they readily become essential, non-supernumerary workers, rather than legitimate peripheral learners. The participants recognised that they were not learning how to 'nurse' under their instruction. Some participants felt able to 'pilot' their own learning, but recognised that there were limitations to this strategy.

To an extent positive mentoring relationships mitigated some of the pressures experienced by the participants, imposed by the conditions of the CLE. However the effectiveness of mentorship was dependent upon both mentor commitment and the structural circumstances in which they were operating. Negative mentoring experiences served to exacerbate the challenges associated with learning in this environment. Despite their relationship with their mentor, the participants were still required to demonstrate their increasing competence within the CLE, which was necessarily problematic for those who experienced restricted appropriate learning opportunities.

The data reveal that students frequently experienced mentors (and others) utilising their power inappropriately; the nexus for student vulnerability is predicated on their requirement to pass their assessments in practice. The participants were often unable to challenge because they feared reprisals, in the form of their PAD or deleterious changes in attitude towards them, which may amount to collusion and incivility. In some instances the abuse of power led to subjugation of the students, which at worst made them consider leaving the profession altogether.

Chapter 5: Discussion

In light of the data analysis this discussion will focus on further consideration of two key themes: '*legitimate peripheral participation'* and '*power and the clinical imperative in the CLE*'. Analysis in this chapter will combine reflection on the findings, with key insights from the literature review, and the theoretical frameworks of Lave and Wenger (1991), Lukes (1974) and Nye (2009) in order to reach a deeper understanding. Through this discussion full consideration will be given to the core research question of the thesis: *how do students experience learning within the CLE?*

This chapter will begin by considering the extent to which students are positioned as legitimate peripheral participants in the CLE, and the consequences of achieving or failing to achieve this positioning. The ensuing impact on competency development will be explored. The work of Lave and Wenger will be specifically drawn upon to discuss the data in more detail; the concepts of *legitimacy, peripherality* and *participation* will be deconstructed and applied to inform this discussion. Lave and Wenger's (1991) situated learning theory is important to this discussion for two principal reasons. Firstly, it provides a critical understanding of the importance of positioning student nurses as *legitimate, peripheral participants*. Secondly, it allows one to appraise, drawing on the data, the extent to which this positioning is achieved in practice, and illustrates the consequences of perceived achievement or compromise for students' experiences of learning.

This analysis highlights the challenges of positioning students in a CLE as *legitimate, peripheral participants*. The data suggest that pervasive clinical pressures readily move students away from this positioning towards being utilised as an essential member of the workforce. This situation may be compounded by mentors who, set against clinical pressures, need to manage their dual clinical and educational responsibilities.

This discussion will be further expanded by examining how the work of Lukes (1974) and Nye (2009) can be used to understand the power dynamics, described by the participants as operating within the CLE, and the potential consequences these dynamics have on students' experiences. In particular, Lukes and Nye's ideas will be used to better understand how and why students may either be protected as learners or exploited as workers within this environment. Finally, these theoretical lenses will be used to consider students responses to compromises in their learning experiences, examining the reasons why students may be relatively powerless to raise concerns.

5.1 Legitimate peripheral participation

5.1.2 Legitimacy

Conferring legitimacy in the community of practice is more important than providing teaching because if legitimacy is absent students cannot learn effectively (Lave and Wenger, 1991). The participants experienced inconsistency in their positioning as '*legitimate'* learners within the CLE. This meant that some students felt they were afforded appropriate time and space to legitimately occupy a fringe position within the CLE, without wider clinical considerations, while they 'learnt' the profession. However many participants reported not being perceived (or positioned) as legitimate learners within this environment and thereby their learning was compromised. Threats to the status of legitimacy meant that some learners '*fail to learn until considerable time has passed'* (Lave and Wenger, p76). The participants routinely noted that they experienced significant feelings of lost learning opportunities. The causes of these experiences will be explored in the following paragraphs.

A threatened legitimate status meant students were frequently required to undertake essential clinical duties, with little consideration for their learning needs. In some environments students who were not prepared to work were seen to have an illegitimate right to claim learner status. Seen in this way they needed to work to earn the right to study: '*if you don't want to participate and you don't want to work …they don't want to teach you anymore'*. Such threats

to legitimacy are most likely due to the inherent and pervasive clinical pressures present in this environment (Needleman, 2013; Royal College of Nursing, 2013; Appleby *et al*., 2014; RCN, 2019). The participants reported that in such circumstances their mentors were often forced to ignore students' claims as legitimate learners and they were required to work.

As Lave and Wenger (1991) highlight, the manner in which legitimate access to learning is secured for learners is dependent upon the way in which labour is divided within the community of practice. This point helps to explain some of the inherent difficulties experienced in securing students in stable 'legitimate' learner positions, because there is ambiguity in the division (and classification) of 'labour' within the CLE. Participants reported ambiguity in who delivers aspects of care and how students are supervised. For example the students understood that they could learn whilst completing what they perceived as basic nursing care; care which can be undertaken by nurses but (in contemporary healthcare) is typically ascribed to the role of a HCA (O'Driscoll *et al.*, 2010; Cavendish, 2013). Whilst this may be true, if these opportunities are poorly supervised (by Registrants) or scaffolded (in terms of being appropriate for the stage of their programme), they readily transfer from being a learning opportunity into a work experience. As highlighted by Lave and Wenger (1991, p 76) within the workplace learners can easily be transformed into 'cheap source of unskilled labour'.

Students' status as *legitimate* learners within the CLE may be undermined because of the indistinct terminology used, by both students and their mentors, to describe students' function within this environment. For example, the participants consistently referred to '*working with my mentor'* rather than '*learning with my mentor'*. This blurring of language is significant because the framing of students' function as workers may legitimise their exploitation, exemplified by this statement: *there is a lot of work on the ward; why are you going to see a kidney transplant?*' Such blurring means that students may be readily utilised as part of the workforce; this responsibility for work reduces their

legitimate access to available learning opportunities, under the supervision of their mentors.

Mentors were perceived by the participants to be critical in protecting and structuring their learning space, thereby confirming students as *legitimate* learners. Effective mentoring that confers legitimacy on the peripheral status of students enabled the participants to quickly assimilate into the CLE and maximise available learning opportunities from the beginning of their placement. Some mentors were characterised by participants as effective, even in the busier environments – they were able to establish and maintain the legitimacy of students' peripheral status. However due to the duality of their role, this usually involved an investment of considerable time, energy and resources. Given that mentors are the key gatekeepers of a legitimate learning status, and they have conflicting educational and clinical duties (Webb & Shakespeare, 2008; O'Driscoll *et al*., 2010), it is challenging to protect this status in pressurised circumstances. It may not be reasonable or personally sustainable to expect mentors to '*come in when they are not on duty'* to fulfil their mentorship duties. This may account for the participants' impression of being 'lucky' when receiving effective mentoring. This terminology served to highlight students' anxieties in relation to the potential inconsistency of their experiences and their vulnerability within this relationship.

The extent to which legitimacy within the community of practice is achieved is dependent upon perceptions of belongingness (Lave and Wenger, 1991). Belongingness is therefore not only a critical condition for learning but an essential element of its content. Legitimate peripheral participants must be welcomed, within the community, engendering a sense of belonging through the trajectory from peripheral to full participation (Lave and Wenger, 1991). An absence of a sense of belonging affects the likelihood of students optimising learning opportunities in practice (Hodkinson and Hodkinson, 2004; Levett-Jones and Lathlean, 2008). Belonging to a community of practice bestows the right to question practices; a fundamental condition of learning (Lave and

Wenger, 1991). To optimise learning students need to be able to legitimately question practices. It was evident that, in some instances, the participants feared questioning elements of practice, particularly poor practice.

The participants reported perceiving that their mentors were critical in engendering feelings of belongingness within the CLE. They noted that when feelings of belonging were experienced they could immediately engage in learning opportunities, rather than invoking strategies which they perceived would enable them to fit-in within this environment. Such strategies included a propensity to engage in work rather than learning activities and to conform to prevailing poor practice. In some of the more challenging environments participants reported using these strategies to avoid perceived risk. According to the data, risk could surface as a negative change in attitude towards the students and through downgrading in their PADs, should they fail to conform to demands made by the nursing team. These strategies are deleterious to learning (and patient safety) and highlight the imperative for students to experience belongingness in this environment.

Students' transiency may lead a busy workforce to question why they should invest in legitimising learning for students who are merely passing though the environment. The notion and consequences of transiency in nursing were noted by Melia (1987), over 20 years ago. Although shorter placements of typically 6-8 weeks enable students to gain a breath of nursing experiences, the data suggest this arrangement may affect the quality of that experience and contribute to compromises in learning. The students noted that they were seen as transient in this environment; their transiency seemed to be corrosive to their sense of belongingness and thereby legitimacy within the CLE. Feelings of transiency were reinforced by the use of certain language. One of the strongest examples was when the students reported being referred to as 'the student' instead of by name, sometimes for the duration of the placement. The students' used the terms 'invader' and 'outsider', which denotes their own feelings of transiency. As highlighted by Lave and Wenger (1991, p35) ways of belonging

is *'not only a crucial condition for learning but a constitutive element of its content'.* Thus, explaining the impact on learning of the diminished sense of belonging commonly reported by the participants. Student nurses are supposed to be learning how to belong in the clinical environment, but this will inevitably be challenging in CLEs which confer feelings of illegitimacy.

5.1.3 Peripherality

According to Lave and Wenger, (1991) for optimal learning to occur students must participate in a peripheral way. This requires students to have broad access to a spectrum of mature practice, with limited overall responsibility within the community of practice. From such a peripheral position, learners are able to view the whole enterprise and gauge learning opportunities, which are guided by the experts. Learners should incrementally move to a place of decreasing peripherality as their competence increases. Such movement requires that learning is scaffolded through the congruent arrangement of learning opportunities, with increasing complexity of skill and responsibility (Lave and Wenger, 1991). Although the data shows incidences where the participants experienced such arrangements, many accounts suggest their learning was ad hoc and opportunities were dependent on the intensity of clinical pressures and the investment of individual mentors.

Students' position in the CLE should be accepted as peripheral because their competence is provisional; only those who are competent are required to occupy a critical, central position within the community of practice (Lave and Wenger, 1991). Student nurses' peripherality is influenced by their supernumerary status (NMC, 2010; NMC, 2018a). This status should afford them opportunities to learn, irrespective of prevailing clinical pressures. It was evident from the data that the participants commonly occupied an essential (non-supernumerary) workforce position within the CLE, highlighted by this comment: '*they are relying on you to come in to fill in the HCA's spot'*. Under such circumstances students are not allocated a *legitimate peripheral* function within the CLE and are thereby marginalised from learning opportunities. It is

essential that students are able to engage in such learning opportunities under supervision (commensurate with their level of training) (Jokelainen *et al*., 2011) to enable them to gain '*mastery of knowledge and skill'* (Lave and Wenger, 1991, p29).

It is helpful to draw on the work of Lave and Wenger's (1991) to highlight the difference between being positioned peripherally and marginally. Both peripherality and marginality include a mixture of non-participation and participation (Wenger,1998). Peripherality requires a degree of nonparticipation, because this enables the learner to freely access the community of practice in an empowering way. However in marginality the nonparticipation is experienced as restricted, disabling and disempowering. Students' learning is restricted when they are required to undertake routine, repetitive tasks, which they have already mastered (Billett, 2001). The participants recognised that they often experienced marginality by being required to undertake repetitive HCA tasks, without reference to their learning needs. Students dis-identify with learning under such circumstances (Farnsworth, et al., 2016). Although by undertaking HCA tasks, students are participating in the CLE, they are marginalised from what matters: gaining valuable, carefully scaffolded learning experiences under expert supervision. The concept of 'peripherality' can therefore be seen as an oxymoronic concept. For student nurses, peripherality means being allowed to be both at the centre of what is happening in the CLE, whilst not having to take part as a worker. Students must be positioned as *legitimate peripheral* learners in this setting, under the supervision of their mentors.

It was evident in the data that compromised peripheral positioning was problematic for the participants with previous HCA experience where they found themselves repeating previously mastered tasks. However, without adequate mentor supervision there is no assurance that the skills were undertaken to a high standard, with the application of underpinning evidence based practice as required by the NMC (2008). Those participants without previous HCA experience were often expected to undertake tasks with limited Registrant

instruction and supervision, which leads us to question the quality of both the learning experiences and care delivery.

The participants who experienced a restricted peripheral position reported that they struggled to gain a holistic understanding of nursing and experienced considerable compromises to their learning. Indeed, some of the participants noted how they *'never got an insight into the whole, broad picture…'* This is significant because students may fail to fully understand *nursing,* including the role, required knowledge and behaviours. However, at the point of qualification nurses are expected to quickly assimilate into the role of a competent registrant, with the associated levels of responsibility and accountably, with strict adherence to the precepts documented in the Code (NMC 2018b).

5.1.4 Participation

Overall the relationship with and the availability of mentors in general is identified as critical to the quality of the participants' learning in protecting their position as *legitimate peripheral participants*. Lave and Wenger (1991) explore the types of social engagement required to provide a context suitable for learning to occur in the practice setting. They conclude that the mode of learner engagement with an expert is critical; learners must engage with an expert but only with limited responsibility. Lave and Wenger highlight learning is critically compromised (as reported by the participants) when opportunities for engagement with an expert are reduced. The participants recognised such compromises in their learning by reporting that they only understood 'nursing' if their mentors took them into their 'space'. Being taken into a mentor's 'space' requires mentor availability. It is essential that mentors are available to enable sharing of the craft of nursing (Henderson and Eaton, 2013). The participants readily recognised that situational factors often prevented them from accessing this 'space' and they were in effect abandoned.

The NMC (2008) Standards require only 40% (direct or indirect) mentor supervision. The participants commonly reported lower levels of supervision due

to sickness or inadequate mentoring arrangements. In addition, periods of supervised practice were commonly interrupted by the pressures exerted by the clinical environment. In line with the literature (Myall *et al.*, 2008; Robinson *et al.*, 2012), feeling of abandonment were exacerbated when mentors were unavailable to them due to disinterest in this aspect of their role. The participants' reported that learning was often not accounted for when mentors were unavailable; under such circumstances the students felt '*ditched*' and their learning suffered.

Abandonment affected the participants' relationships with their mentors in that they were distanced from them; they were thereby unable to *participate* in learning activities (in a *legitimate, peripheral* manner) alongside their mentors, which resulted in compromised learning experiences. Under these circumstances the participants were commonly required to '*work with'* HCAs (under the guise that they were being taught) or '*work as'* HCAs. When students are taught by HCAs it is important to question the quality of their instruction; HCAs do not hold the required Registrant qualification to meet the clinical educational needs of student nurses (NMC, 2008). Abandonment was particularly significant for junior students because they required more bedside instruction and they had less experience to draw upon to navigate such challenging scenarios. However, senior students recognised that their learning was similarly compromised, presenting as a concern for skill acquisition, specifically their preparedness to register as a qualified nurse. This is a realistic concern given that skill acquisition is required to meet the competency demands of new roles (Arrowsmith et al., 2015).

Some participants reported attempts to 'pilot' their own learning (typically during periods of abandonment) in an attempt to self-direct their participation. Typically, senior students or those with previous HCA experience were most able to invoke such strategies, however many recognised that there were limitations to this strategy. The students wanted to '*make it about my learning'* but when they did prioritise learning over work they commonly experienced a '*backlash*' and

were accused of being a '*rubbish student'.* These sentiments serve to highlight the tension between working and learning in the CLE. Mentors encounter considerable clinical pressure, which may lead them to both abandon students and utilise them as an essential part of the workforce, with little regard for their learning needs. Students' are in a relatively weak position to negotiate their level of participation in nursing (with their mentors) in such pressured circumstances. However, students should not be expected to negotiate learning needs, it is the role of the mentor/ supervisor to protect and construct learning opportunities within this environment (NMC, 2008; NMC 2018a).

Access to physical activities is important for students to learn the required skills, but it is also important that they are exposed to contextualised, professional conversations so that they can understand what they observe and hear (Lave and Wenger, 1991). When student nurses are 'working' remotely from their mentor and not 'learning' alongside them, they are removed from such professional conversations and therefore they are missing this critical component in their development. Such exclusion led one of the participants to conclude: '*I never got an insight into the whole, broad picture until I worked with this mentor on the last placement'*. It is therefore essential that students are enabled to learn alongside their mentors, throughout their placements, to allow incremental development and avoid compromises in learning. Leaving it until the last placement to gain '*insight into the whole'* is problematic because it relies on the ability and availability of the mentor in the last placement to pull key strands of clinical learning together. As highlighted by Lave and Wenger (1991, p76) learning arrangements *can 'prevent rather than facilitate learning'.* Student nurses spend approximately eighteen months within the clinical environment and within this time they are expected to move from a novice to a position of preparedness for qualification (NMC 2010; NMC, 2018). This diminution of their experience is therefore significant and may explain criticisms levelled at the profession in terms of a lack of preparedness at qualification (Willis Commission, 2012).

5.1.5: Witnessing and participating in poor practice

The workplace learning literature considers how learning occurs within work settings (Hodkinson and Hodkinson, 2004). However, much of this literature, including the work of Lave and Wenger (1991), assumes that the practices which students are exposed to (and participate in) are of a satisfactory standard. But, as is suggested by this research, this is not always the case. The impact on learners of witnessing or participating in poor practice is likely to be significant given that practice is the primary location for influencing, shaping and constituting knowing and knowledge (Lave and Wenger, 1991).

In this study poor practice was a pervasive element of many of the participants' experiences; the extent of poor practice was unanticipated at the outset of this study. Most participants discussed how they had either seen or knowingly participated in poor practice, an experience supported by the literature (Bellefontaine, 2009; Francis, 2013; Keogh, 2013; Green and Garland, 2015; Ion *et al.*,2015; Rees *et al*., 2015; Ion *et al*., 2016; Ion *et al*., 2017). Examples of poor practice in the data ranged from incidents of poor moving and handling techniques and poor communication to incidences of patient abuse. Managing exposure to incidences of poor practice was a significant challenge for students; this point will be explored fully later in this discussion.

The literature suggests that students sometimes struggle to recognise poor practice (Bellefontaine, 2009). However, the examples reported in this study were indisputable. The participants witnessed both Registrants and HCA involvement in such practices. This is significant because the CLE should be the place where students learn how to deliver a high standard of patient care, under the guidance and supervision of expert practitioners (NMC, 2008: NMC, 2018a). Exposure to (and being required to participate in) poor practice corrupts the quality of students' learning experiences and potentially interrupts their skill acquisition and competency development because the CLE is the most significant site for the development of competence in nursing (Kelly, 2007; Murray and Williamson, 2009; Henderson *et al.*, 2012). Compromises in

standards of care represent a real threat not only to patient safety and the reputation of the profession, but more broadly to safety cultures. Nurses are required to significantly contribute to safety cultures within the NHS (NMC 2018b); such requirements may be unrealistic for both learners and Registrants immersed in environments where poor care is abundant.

We must question what students are learning in an environment in which poor care is ubiquitous and consequently how they are being prepared to meet current and future healthcare needs. If such fundamental learning is not achieved during this critical period of pre-qualifying learning, further instruction will be required post qualifying.

5.1.6 Competence

Competence development was a real challenge and concern expressed by the participants within the CLE. Despite experiencing compromises in their learning experiences within the CLE, the participants recognised that they were still required to demonstrate their knowledge and professional attributes, commensurate with their stage of training. Lave and Wenger's (1991) theory provides a useful lens for considering 'competence'. They highlight that students need to express their competency within their community of practice in such a way that they are recognised as a member (Farnsworth *et al.*,2016).

Increasing competency marks the transition from peripheral to full membership within the CLE. Students are required to increasingly demonstrate those attributes that qualified nurses recognise as constituting competence (NMC, 2010; NMC 2018a). This is necessarily problematic for those students who have not had adequate clinical learning opportunities to acquire the required knowledge, skills, values and ethical comportment. Many of the participants identified concerns about their competency development throughout their training. First year participants worried that they had failed to master basic care delivery, principally because they were commonly taught and supervised by HCAs. Many participants felt that this shortfall in competency development

undermined their continuing development and potentially compromised the quality of patient care. As their training progressed, the participants became increasingly concerned about their preparedness for qualification: '*they expect you to know all this stuff when you really don't know a lot'*. These reported experiences may in part explain why students feel ill prepared to fulfil their role at the point of qualification; the period of transition therefore remains a challenging time for many graduate nurses (McKenna and Green, 2004; Newton and McKenna, 2007; Kelly and Ahern, 2009; Pellico *et al*., 2009).

It is of professional concern if student nurses' clinical competency development is interrupted due to comprised learning conditions within the CLE. Some nursing students consider that they have been well prepared and are competent at the point of qualification (Björkström et al., 2008; Holland et al., 2010; Deasy et al., 2011; Kajander-Unkuri et al., 2013; Woods et al., 2015). However, in line with some of the participants' accounts, there is evidence of a lack of competence at the point of qualification (Järvinen et al.,2018). Nursing students may feel insecure about working as a Registrant, lacking professional confidence (Ross and Clifford, 2002 Carlson et al., 2005; Cooper et al., 2005; Andrews, 2013).

5.2 The clinical imperative

The clinical imperative is the second key theme of this discussion. Lave and Wenger's (1991) learning theory provides an important theoretical lens to understand student nurses' experiences of learning within the CLE and specifically the extent to which they are positioned as *legitimate peripheral learners*. This understanding will be extended by using the work of Lukes (1974) and Nye (2009) to specifically appreciate the power relationships operating within this environment.

Applying Lukes' (1974) third dimension is useful for analysing the dataset because it affords the opportunity to understand the difficulties for students tasked with learning in a space shared with sick patients and professionals

responsible for both patient care and students' clinical education. This tension within the CLE may be accentuated when clinical and educational demands clash, requiring mentors to prioritise one or other of these duties (O'Driscoll and Smith, 2010). Lukes (1974) third dimensional view asserts that for power to operate most effectively, there needs to be a general acceptance of the present circumstances, predicated on a tolerance of the underpinning ideology. Applied to the CLE, the interpretation of the data indicates a general acceptance that the needs of learners are perceived as a secondary consideration, compared to clinical needs; coined the 'clinical imperative' in this thesis.

The clinical imperative asserts a power which is analogous to what Nye (2009) refers to as 'soft power', incorporating the elements of values, culture and policies. Applied to the CLE soft power is exerted when staff (including mentors and students) are co-opted to prioritise care delivery over learning activities because there is a deeply entrenched belief (supported through professional policy) that this is the right course of action. Soft power is non coercive in nature; the status is naturally accepted rather than forced, leading one participant to explain, '*it's really busy on some wards and sometimes that impacts on your teaching. You understand that they are busy'*. This statement highlights that there is an assumed and unnoticed power structure at work within the CLE, which seems natural and therefore may remain unchallenged by students, mentors and the profession as a whole.

Nurses are encultured specifically through University instruction and clinical experiences to prioritise patient's needs. However the data demonstrate that such prioritisation commonly compromises the learning opportunities and experiences in this environment and readily displaces students from their positioning as *legitimate peripheral participants*, as highlighted by this comment: *I had to leave the learning (alongside the mentor) to do the obs ……I'd get into trouble if they weren't done'.* Seen in this way the clinical imperative serves to divert student learning in favour of operational functions. Set against a busy clinical environment, students are required to engage in activities which are

directed by clinical need, rather than their needs as learners. Such direction is readily accepted: '*I do Healthcare Assistant jobs, which I don't mind'.* The 'clinical imperative' operates as a fundamental ideological imperative because it is incontrovertible in the context of the CLE. Mentors and students need to navigate learning opportunities within this fixed position.

Lukes (1974, p55) argues that groups or institutions '*could combine or organise to act differently*'. If the CLEs were better resourced (from a staffing perspective) students would not need to form a critical part of the workforce and therefore their learning would be less vulnerable to inherent clinical pressures. Students could then learn alongside their mentors, directed towards learning opportunities (as *legitimate peripheral participants*). Additionally, the nursing profession should not expect mentors to hold such critical dual roles, particularly given the pervasive clinical pressures experienced in the NHS. Ideally those responsible for clinical instruction should not have dual clinical/educational responsibilities.

5.2.1 Power and risk

The data demonstrate that acceptance of the clinical imperative readily led to the exploitation of students, unless mentors were able to challenge the power exerted by this arrangement to effectively protect students' as *legitimate peripheral participants*. By exploitation I mean the data demonstrate that students were readily used as an essential part of the workforce, without consideration for their learning needs or the requirement for supernumerary status set by the NMC (2008, 2018a).

The exploitation of students manifested through the expectation of them to undertake HCA work, thereby moving students away from their status as *legitimate, peripheral participants*. Lukes (1974) '*one dimensional view'* is helpful in furthering this understanding because it highlights the root of such powerbase. Lukes (1974) argues that a one dimensional view of power exists when a person (in this context the mentor) has power over another person (the

mentee) to the extent that he/she can get that person to do something against their interests (i.e. undertake HCA duties). The data reveal that it was not only the mentor that yielded this power. The participants also experienced direct instruction from HCAs to undertake 'work' rather than 'learning' activities, reiterating the students' placement within the hierarchical structure.

The mentor's powerbase is predicated on their right to instruct students bestowed by the NMC (2008). While the students' response to such instruction seemed to be governed by their notion of risk. Such risk was commonly associated with anxieties about the potential negative impact on their assessment or their general treatment in this environment should they not acquiesce. The participants recognised students' propensity *'to try to please everyone',* by undertaking (for example) HCA duties, to ingratiate themselves; they invoked this behaviour as a strategy to avoid risk. However, set against the pervasive clinical pressures, the participants reported that this strategy translated into an expectation (by the mentors) that students should be readily available as essential workers. Effective mentors were sometimes able to manage these tensions and '*fight your corner'* to protect the students' learning even in the busier environments, however given the demands of the clinical environment and the duality of their role, this was not always be possible.

It is important to consider why mentors may need to direct students towards work, rather than learning activities 'to *fill in the HCA spot'*. Whilst mentors may understand the critical importance of exposing students to appropriate learning experiences (Myall *et al.*, 2008; McIntosh *et al.,* 2014), as *legitimate peripheral participants*, pervasive clinical pressures may force even 'good mentors' into placing students in work roles. Given such pressures, the participants were sympathetic towards mentors' instructions to work rather than engage in learning opportunities. Lukes (1974) argues power is consequential: it does not need justification because it is inherent within communities, but it does require legitimacy. Within the context of the CLE, legitimacy is based on the requirement of registered nurses to meet patient's clinical needs and protect their safety

(NMC, 2018b). When patient care needs and students' learning needs clash, the *legitimate* needs of patients' take natural precedence over students' *legitimate* claims as *peripheral participant* learners: demonstrating the strength of the clinical imperative in action. Seen in this way, power is not the means to an end, but rather the required condition facilitating a group of people to think and act to achieve set goals inter alia the delivery of patient care. There is thereby a sense of 'naturalness' and 'rightfulness' behind the power dynamic associated with the clinical imperative, perhaps indicating that the participants had internalised the notion of the clinical imperative.

Mentors may be legitimately directing students towards 'work' rather than facilitating and protecting their learning opportunities. However, this action may have a detrimental effect on the quality of their mentees' learning experiences, especially if the 'work' allocation is not aligned to their learning needs. The participants spoke widely about their experience of being given inappropriate instructions by mentors. Such instruction had various manifestations. For example, some students were forced to undertake tasks for which they felt poorly prepared and supervised; they were expected to self-direct: *'familiarise yourself'*. These students often felt compelled to complete tasks, regardless of the risk to patient safety, and the evident compromise to their learning experience. Other examples involved students who had worked (or continue to work) as HCAs. These students were regularly required to undertake various functions of the HCA role; expectations which are inappropriate. However the participants felt powerless to challenge and so they concluded, '*I'll just get on with it'* until the next placement, which may or may not be any better. For those with previous HCA experience, being required to move between the two roles (of student and HCA) inevitably caused tension for the learner and may compromise their experience (Draper, 2018). When students resisted undertaking requests to 'work' in favour of 'learning' some of them articulated that they were made to feel that they were '*kind of running away from work'.* This highlights the tension between working and learning in this environment. Other students felt that they may be 'in *trouble'* should they desist.

5.2.2 Understanding students' responses to compromised learning experiences

The participants frequently articulated that they felt unable to raise concerns either about their learning arrangements or experiences of poor practice because they felt fearful. Understanding the silencing of students in the CLE is important. It is imperative that the learning experience is understood holistically, otherwise there is a risk that the learning experiences are portrayed as merely compromised, without understanding the cause and extent of students' vulnerability. The work of Lukes (1974) second dimension is especially useful in understanding their vulnerability. The second dimension asserts that power is exercised when a person or group (in this case mentors) either consciously or unconsciously create or reinforce barriers to conflict. The barrier (to raising concerns and thereby entering conflict), for the participants, was the perceived risk to either their assessment or their general treatment within the CLE.

The most omnipresent risk was to their 'book'; the PAD. The participants spoke about their 'book' in each interview and focus group. They were anxious that they would either be failed or receive poor grading if they spoke out; some participants cited examples when they experienced such repercussions. Instead of being used correctly as a tool to appraise and document student progression, the PAD therefore served as '*a weapon'.* It can thereby be a source of vulnerability in itself and a means through which to effectively silence and control students within the CLE. This point is especially significant because it demonstrates how students are routinely experiencing the CLE as a site of vulnerability, rather a place which fosters and optimises learning conditions. The extent of this portal of vulnerability is not drawn out in the extant nursing literature.

Beyond experiencing assessment repercussions, the participants were also concerned that there could be a general change in attitude towards them should they raise concerns; some students reported experiencing (or witnessing) such changes after they raised legitimate concerns. In addition to changes in attitude

some participants experienced what could be classified as hostile behaviour, typified by being intentionally allocated difficult tasks or encountering instances of team collusion. This use of hard power (Nye, 2009) diminishes the quality of learning experiences and serves again to silence students. There were instances where the participants intentionally downplayed their knowledge to preclude the requirement to challenge poor practice. Some students initially challenged but if they were *'roared at'* they learnt to supress their concerns and either comply with poor practice or distance themselves from it, demonstrating their lack of agency. In some instances the students were expected to participate in practices which the University specifically prohibited. The participants reported that when students refuse to engage in such prohibited practices, there are potential repercussions, either within their assessment or mentors may be reluctant to teach such students. These repercussions are set against the risk of being investigated under the Fitness to Practise procedure should the student be reported to the University for participating in such practices.

Students are thereby encountering significant ethical tensions in their training which are under reported in the literature and poorly understood. Students should not be expected to rationally decide their response to concerns, balancing (in the case of poor practice) perceived risk to patients, set against personal risk, should they raise concerns. This positioning is precarious and does not represent the espoused values of the profession. The vulnerability of students could be addressed by adjusting the power dynamics at play between the mentors/ supervisors and students. To some extent this may be achieved by uncoupling the supervision and assessment arrangements under the new NMC (2018a) Standards. However, these Standards are unlikely to go far enough in addressing this deep routed problem because of the direct reporting line from the practice supervisor to the practice assessor (appendix M).

The silencing of students is problematic, both because it can compromise patient safety and also it fails to install confidence and curiosity within student

nurses. Silencing is problematic for a profession which claims to place critical thinking and astute clinical decision making skills as essential components of nursing practice (McCartney, 2017). Silencing students also prevents them from contributing to the monitoring of care standards within the CLE (Duffy et al., 2012; Francis, 2015). Students do potentially offer a unique and fresh perspective within the CLE because they have received recent instruction and they are potentially less invested in the ethos and culture due to their transiency (Engel et al., 2017). However, this view does not take into consideration students' inexperience, vulnerability and the incivility they may encounter. For these reasons, students should not be placed as the gatekeepers of nursing standards within the CLE, this should be the remit of Registrants.

It is important to question why some mentors (and other healthcare workers) behave in an uncivil manner towards students. Such behaviour seems perverse given that nursing is referred to as a 'caring profession' (ICN 2002; WHO 2018). Mentors are senior to students and therefore there is a direct power imbalance, meaning students are vulnerable to the actions of mentors' behaviour. Students may perceive there to be few safeguards to monitor or respond to inappropriate mentoring behaviours. Mentors themselves are often working under immense pressure (Myall *et al.,* 2008; Andrews *et al.*, 2010; Bennett and McGowan, 2014), juggling their dual clinical and mentoring role; such pressure may lead mentors into acting uncivilly. Poor organisational cultures, including those which are overly hierarchical and who have employees who feel disempowered (set against high workloads) may contribute to incivility (Quine, 2001; Burnes and Pope, 2007; Sauer, 2012). Incivility can be a learned behaviour, with mentors and preceptors bullying students; a cycle which is then replicated through the generations (Randle, 2003). For the profession to develop, these shortcomings need to be addressed.

Regardless of the cause, as a result of these pervasive and powerful dynamics, some participants considered leaving the programme to be most rational option. Data obtained by the Health Foundation and RCN (Jones-Berry, 2018),

demonstrate that high numbers of students ‘choose’ to leave their nursing programme: of 16,544 UK student nurses who commenced a three-year Degree due to complete in 2017, 4,027 suspended their studies or withdrew from their studies early. This calculates as an attrition rate of 24% in the UK, similar to statistics produced in 2006 (Jones-Berry, 2018).

To some extent compromised clinical experiences could be ameliorated through adequate University support mechanisms. However, the data suggest that the students were commonly unaware of the potential robustness of the University support processes, which in this context principally involved the Link role. The quality of relationships between students and academic staff will undoubtedly influence students propensity to talk to academic staff, particularly in relation to incidences of poor practice (Bellefontaine, 2009; Green and Garland, 2015; Ion *et al*., 2015). Some participants anticipated that should they raise concerns the Link Lecturer may support them, whilst they were physically in the practice environment, however after they left students would encounter reprisals alone.

This commentary highlights the potential isolation of students in the CLE, which is often only broken by the interception of the Link Lecturers. The reported temporary improvement in the treatment of students when the Link Lecturer was in ward area, demonstrates an adjustment to the power dynamic during such periods. However, the Link role does not consistently support students within the practice environment and therefore may not effectively mitigate against compromised learning experiences and perceived risk. Until the influence of the clinical imperative and assessment are recognised, along with the pressures that staff themselves are under, power dynamics in the CLE will remain a significant challenge for students.

5.3 Summary

The theories of Lave and Wenger (1991), Lukes (1974) and Nye (2009) have enabled the findings to be understood and discussed in more detail. In considering the data pertaining to student nurses’ experiences of learning within

the CLE, the analysis has focused on the challenges of establishing students' legitimate peripheral participation in the CLE, within the complex power dynamics operating in this context. The latter discussions augment the former, as Lave and Wenger (1991) do not have a strong conception of power in their account of situated learning.

The student/mentor relationship has a fundamental impact on students' experiences of learning in this environment. However, the data show that this role often does not operate effectively to protect students' as *legitimate, peripheral learners*. Participants' comments reveal that it is often the duality of mentors' clinical/educational responsibilities, set against pervasive clinical pressures, which primarily undermines the effectiveness of this role. Such compromises are significant because they can readily lead to students being utilised in worker roles and diminish their opportunities to participate in meaningful learning activities alongside their mentors. Further compromises to learning occur when students are exposed to poor practices, which were described as pervasive in this study. It is worrying that students are exposed and (in some circumstances knowingly) participate in poor practice. Equally concerning is that students may feel unable to raise concerns (either about poor practice or their learning arrangements) due to perceived risk; in this way students may be effectively silenced within the CLE.

Chapter 7: Conclusion

This research sought to develop a contemporary understanding of student nurses' experiences of learning within the clinical learning environment. I have understood and interpreted students' stories by utilising a qualitative interpretative approach to analyse the data. This research generated rich data, investigating the learning experiences of forty-six student nurses, effectively giving them a voice. According to the hermeneutic tradition, I integrated my own experiences and understanding (supported by the extant literature and theoretical frameworks) with the stories of the students, to build a new understanding and perspective on the world of student nurse learning within the CLE. Gaining such insight is personally important for me as a nurse educator and professionally significant. My analysis of the data may be of interest to the NMC as well as those who support students in both University and practice settings, with the aim of making substantial improvements to practice learning. Students may also find the research valuable, enabling them to better understand their position as learners within the CLE. This research is timely since the data may be used to inform the operationalisation of the new NMC (2018a) Standards. This research may also have relevance to other disciplines which incorporate a practicum as part of professionalisaton. Set against the findings of this thesis, the key and subsidiary research questions will now be considered.

How do student nurses experience learning within the CLE?

The findings of this study identify a number of issues of concern relating to student nurses' experiences of learning within the CLE. Three areas are of particular significance to this research; the difficulties associated with negotiating effective relationships (particularly with mentors); the management of vulnerabilities and, finally, securing learning opportunities within the CLE (especially in those characterised as oppressive). The data show that oppression may be exerted and experienced variously, including through the dynamics and relationships bound up in the clinical imperative.

The extent to which the widespread and inherent ideological assumption that care takes precedence over learning, has a powerful effect on students' learning experiences within the CLE. Students are expected to learn (and their mentors teach) in an environment where learning needs are placed secondary to the care requirements of patients. Set against the pervasive pressure exerted by the clinical imperative, students and mentors are often relatively powerless to advocate for learning needs. Both mentors and students seem to readily accept that learning is not the primary function of the CLE.

Analysis of the data reveals that the clinical imperative can influence mentors' engagement with learning and teaching activities, and in some cases can lead to them 'abandoning' their mentorship responsibilities. When mentors become unavailable, students are more likely to be directed towards work activities. This research demonstrates the challenges associated with learning and caring in the same physical 'space'. The implications of the widely held view that care delivery must surpass student learning requirements are largely neglected in the nursing literature.

The power exerted by the clinical imperative may be compounded by students' inability to advocate for their own learning needs because they fear a number of potential reprisals. The students' assessment 'book', the PAD, forms a powerful nexus of vulnerability for most students; students are scared of being failed or downgraded for voicing concerns about their learning experiences. Their vulnerability means that students are often willing to sacrifice learning in in favour of work, to achieve the status of belonging, thereby avoiding perceived risk. When a sense of belonging is engendered, principally through effective mentoring, students are more likely to disregard such risks and focus on readily engaging with available learning activities. Such learning opportunities should enable students to learn how to deliver a satisfactory standard of nursing care.

The data analysis suggests that students frequently witness poor practice within the CLE, ranging from poor moving and handling techniques to incidences of

patient abuse. The frequency with which the participants reported seeing poor practice is concerning and more widespread than anticipated in the extant literature. It is evident that due to the inherent power dynamics within the CLE, some students participate in poor practice. Students should be positioned in the CLE in a way that enables them to learn how to provide safe, evidence based care, to enable them to become capable and competent nurses. Many of the participants described feeling too fearful to speak up, their voice was effectively nullified, leading them to collude with the normalisation of inadequate learning experiences and poor practice, in order to minimise risks and 'survive' in their placements. This situation is highly problematic for students who are required to report poor practice (NMC 2018c).

I will now address the first subsidiary question:

> ***To what extent are student nurses able to engage in practice based learning within the CLE?***

The primary focus of practice based nurse learning, within the CLE, is to enable students to learn how to nurse, applying knowledge gained within the University setting, thereby moving students from a being a peripheral participant towards full membership, i.e. a Registered Nurse. This research suggests that the exigencies associated with the busier clinical environments readily lead to students being exploited in this environment as workers, which impedes their learning opportunities. More junior students are likely to be required, by their mentors, to 'work with' HCAs to learn the 'basics'. When instructed by HCAs, the data reveal that some students worry that they are not receiving good quality teaching and feedback; since HCAs are not qualified to teach students, this anxiety is justified. In the busier CLEs, many participants articulated that they were required to 'work as' HCAs, often under the instruction of HCAs. There is a subtle transference of 'working with' to 'working as'; perhaps this transference forms a demarcation between learning and exploitation.

This research has identified that students undertaking non-supernumerary/HCA roles are, as a consequence, denied occupancy of the 'space' inhabited by their

mentors. Necessarily this prevents students adopting a role as legitimate peripheral participants through the denial of access. Under such conditions, students are certainly not learning as *legitimate peripheral participants*. It is evident that some students spend very little time with their mentors, which has obvious ramifications for both the development of individual students and for the level of skill acumen within the profession as a whole. Despite these shortcomings, students still need to demonstrate increasing competence, commensurate with their level of training. The data analysis (supported by the nursing literature) indicates that students may be poorly prepared for registration at the end of their programme, perhaps in part due to the lack of opportunity to consistently learn with their mentors as *legitimate peripheral participants*.

I will now address the remaining subsidiary question of:

> ***How do relationships within the CLE affect student nurses learning experiences?***

This research suggests that students' relationships with their mentors have the most significant impact on the quality of their learning within the CLE. Positive mentoring features can, to some extent, ameliorate the pressure exerted by the clinical imperative. Good mentorship practices enable students to quickly fit in within the CLE, engendering participation in nursing, whilst providing a satisfactory standard of feedback and grading. Conversely a poor standard of mentorship may lead to student abandonment within the CLE and serve to block learning opportunities, whilst commonly directing students towards worker rather than learner roles. Poor mentorship practices may include inappropriate expectations, accompanied by poor standards of feedback and inaccurate grading. Some mentors are reluctant to fulfil this important role, and students describe themselves as "*lucky*" when in receipt of good mentorship. This demonstrates the inconsistent nature of this critical role.

This study contributes to an understanding that positive mentoring relationships may mitigate the pressures, experienced by students, inflicted by the conditions of the CLE. However, the effectiveness of mentorship is influenced by individual

mentors' commitment, the structural circumstances and the clinical pressures in which they are operating. Mentorship commitment alone may not be sufficient to counterbalance these pressures. Band 6 mentors may experience particular difficulties in the fulfilling of their mentorship role. Band 5 mentors seem better placed to undertake mentoring, because they work predominantly at the bedside, the location of much clinical education.

The participants reported frequently experiencing mentors (and others) utilising their power to coerce; student vulnerability is predicated principally on their requirement to pass their assessments in practice. Students feel unable to challenge mentors when they fear reprisals, within their PAD or deleterious changes in attitude towards them, which at worst was demonstrated through organisational collusion. In some cases, such experiences can lead to students feeling suppressed in the CLE, which may have serious mental health repercussions and ultimately lead to attrition. This finding reflects poorly on the state of nurse education and explains why students are so vulnerable to such behaviour.

This thesis demonstrates that students experience significant challenges to learning within the CLE, and that research to date has provided insufficient understanding of some of these challenges. Policy makers and nurse educators need to appreciate more fully the outcomes of this study i.e. that student learning is negatively affected by the combined influences of both clinical pressures and power dynamics. Such experiences can lead to diminished learning opportunities, the suppression of students and may contribute to attrition. Where such conditions occur students are poorly prepared for their role as qualified nurses. Greater understanding of how student nurses experience learning within the CLE can inform those responsible for nurse education how to improve and optimise learning in this challenging environment.

7.1: Implications for practice, education, research and policy

The theories of Lave and Wenger and Lukes have been valuable in developing an understanding of how student nurses experience clinical education. The two theories fit together to incorporate and expose concerns relating to the power dynamics in existence in the CLE. In light of this analysis, the appropriateness of the CLE as an effective learning environment must be re-evaluated. As the data illustrates, the pervasive power exerted by the clinical imperative means that CLEs' primary function is orientated towards care provision rather than learning. This means there can, under certain conditions, be a 'natural' diminution of the importance of learning in this environment. It is therefore important for leaders, with responsibility and influence in nurse education policy, to acknowledge this pressure, where it occurs, and design education systems which account for the powerful effects of the clinical imperative in practice. For the new Standards (NMC, 2018a) (appendix M) to impact positively on the quality of clinical teaching and learning, the local education provision needs to be carefully designed and operationalised, with named supervisors (linked with practice and academic assessors). However, under the new Standards, whilst supervisors continue to hold dual clinical/educational responsibilities they are still unlikely to effectively fulfil their education role, particularly within busy CLEs.

This research suggests that both clinical education standards and student experience in the CLE could be improved through the introduction of new clinical educational roles (specifically for pre-qualifying students) that effectively uncouple clinical/educational responsibilities. Such investment provides a way of reacting to the compromises in the effectiveness of the learning experiences documented here. If, in line with these suggestions, students receive a higher quality and more consistent clinical education, standards of practice are likely to improve. Clinical educators are also likely to feel less pressured and as a consequence students may be treated better in this environment, with fewer accounts of incivility.

This study has identified that many students operating within the workforce are not functioning as legitimate peripheral participants. There are, as a result, implications for how students should be expected to operate within the CLE in order to maximise learning. It is evident that students are frequently not operating as supernumerary members of the team. It is not enough to only question mentor/ supervisor roles. Students too must not be utilised as part of the essential workforce; they must be consistently placed as *legitimate peripheral participants* in this environment.

To remove both students and clinical educators from essential clinical responsibilities would take a considerable policy shift to ensure adequate investment in staffing resources. However, this investment could ensure that nurses are better prepared for practice at the point of registration, raising the standard of practice and thereby reducing the incidences of poor practice widely reported in this research. Such preparation may reduce some of the requirement for investment in post qualifying education. Better preparation may also reduce the disillusionment experienced within the student population. This is important because the extant literature indicates that student disillusionment can readily transfer into the qualified nursing workforce, potentially leading to attrition and a worsening staffing crisis.

The community of educators must understand the challenges posed by the clinical imperative and the importance of campaigning for mechanisms to better protect students' learning experiences in the CLE. Under the existing arrangements, nurse educators (including supervisors, assessors and academics) need to be supported (though education programmes) to understand the need to promote and protect students (where possible) as legitimate peripheral participants. Such education programmes should also highlight the presence, causes and potential impact of students' vulnerability within the CLE. Nurse educators must understand that students are likely to comply with poor practice, fail to raise concerns (either about their learning arrangements or poor practice) and readily undertake worker roles because

they fear repercussions. Education programmes should highlight that the PAD and fears about potential repercussions form a nexus of vulnerability for students.

Practice partners and AEIs need to continue to work together at strategic level to provide optimal learning arrangements. The link lecturing/practice visitor role needs to be further developed to effectively support students and educators within the CLE. Universities and practice partners need to be able to give assurance to students that it is safe for them to report any shortfalls in learning arrangements and develop distinct and responsive reporting mechanisms. Students themselves need to be better informed of the standard of education they should receive within the CLE and they need to understand (and be reassured by) the available support mechanisms and reporting processes. Preparation for practice sessions need to be strengthened to effectively convey this important information. Practice partners and AEIs need to consider if students should have longer placement patterns to engender belongingness, thereby optimising learning conditions.

This research has highlighted the precarious nature of learning within the CLE as a student nurse. The research question is orientated towards student nurses' experiences of learning in this environment. In future research it would be insightful to triangulate these findings through examination of supervisors' experiences of supporting learners; this consideration was simply beyond the scope of this study. Understanding could also be deepened by the inclusion of more clinical settings, representing additional specialities/ fields, with a wider geographical spread. Further research in this area, with both students and supervisors, once the new NMC (2018a) Standards are embedded, would indicate if experiences of learning within the CLE had improved. The challenge then for future research is to take up the themes of this research and apply them in other contexts (including settings, with students and supervisors, under the new NMC Standards).

7.2: Strengths and limitations

This research generated a rich data set that provides insights into the learning experiences of forty-six student nurses at one University, who were learning across multiple clinical sites in London. I have utilised a combination of theoretical perspectives to generate valuable insights, enabling students' experiences of learning within this environment to be understood. In addition, the subtle interplay at work within certain relationships in the CLE and the subsequent impact on students' experiences of learning in this environment has been illuminated. Based on the knowledge gained through the literature review, the empirical analysis and my own understanding of the profession, concerns about the impact of clinical pressures on learning, incivility and poor practice are likely to be common to other CLEs. This confidence is based on the knowledge gained through the literature review, the research analysis and my own understanding of the profession.

Understanding students' experiences of learning in practice is personally important for me as a nurse educator and professionally significant. This research may be of interest to the NMC as well as those who support students in both University and practice settings, with the aim of making substantial improvements to practice learning. Students may also find the research valuable, enabling them to better understand their position as learners within the CLE. This research is timely since the data may be used to inform the operationalisation of the new NMC (2018a) Standards.

This study is significant within a nursing context, however the analysis of the data may be relevant to other professions for whom practice learning for students/juniors is used as part of professional preparation. For example, there is currently a retention crisis in education (Department for Education 2019) and learning to be a teacher in school settings may be similar to nurses' experiences in the CLE. Understanding experiences of learning within professional groups is becoming increasingly important as recent governments place emphasis on the

value of work based learning (commonly through apprenticeships) and employability on completion of Degree programmes.

As previously discussed, one of the key limitations of this research is its orientation towards student nurses' experiences of learning within the CLE, without considering mentors' experiences. I would like to address this limitation through future research to enable a triangulation of experiences. More research is also needed to investigate other CLEs and other contexts to establish whether the concerns raised in this research apply elsewhere. In addressing the research question, the representation of the findings and ensuing discussion required tailoring. For example, I have more data relating to poor practice, which became superfluous, but remains significant. I plan to utilise these data in future publications. I plan to publish my research findings with distinct papers aimed towards: students; educators and policy makers. In addition to considerations relating to poor practice, these articles will encompass the following broad topics: balancing clinical work and educational responsibilities; recognising and reducing the impact of student vulnerability and the impact of current clinical education provision on the quality of clinical education.

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Appendices

Appendix A

Key findings from the Institutional Focused Study (IFS)

Nurse lecturers commonly support student nurses within both the University and the CLE, through an activity called ‘link lecturing’. My Institution Focused Study (IFS), completed as part of my Doctoral studies in 2016, considered nurse link lecturers’ perceptions of the challenges facing student nurses in clinical learning environments. This research has been instrumental in enabling me to formulate this RBT study, because it afforded me a critical insight into the reality of learning in practice (as a student nurse), from the complementary perspective of Link Lecturers (LLs). This RBT was intentionally formulated to build on the knowledge gained through the IFS, by considering student nurses experiences of learning in the CLE, aiming to gain a more holistic understanding of this subject.

The University in which the IFS research was undertaken dedicates 20% of nurse lecturer’s teaching time to the link lecturing role, in line with recommendations (at the time) from the NMC (2008). The NMC (2008) expects LLs to fulfil a number of functions, including: supporting students and mentors in practice; updating mentors; appraising the suitability of the CLE for student learners and as a method of maintaining clinical competence for the lecturers. LLs do not participate in the grading of students in the clinical setting; this is the responsibility of the mentor (NMC, 2008). Therefore, perhaps understandably, anecdotally students seem to speak more openly with their link lecturer about their practice experience than their mentors. Since LLs spend so much time in practice, with students, they are well placed to discuss the challenges facing student nurses in the CLEs.

The IFS data analysis suggests that students’ relationships with their mentors fundamentally affects the quality of their learning experience within the CLE. The LLs reported that students frequently find themselves in polarised positions, of either ‘fitting in’ with mentors and the pressures associated with the CLE (and thereby potentially gaining access to available clinical learning opportunities), or

‘falling out’ and merely learning how to ‘get through’ their placement (Harrison-White and Owens, 2018). The LLs identified that mentors significantly influence this positioning. Of importance to this IFS study was the recognition that conditions within the CLE have significant implications for learning and teaching.

The LLs articulation of the challenges student nurses may encounter within CLEs expose important themes including: the difficulties associated with nurses’ occupancy of mentorship roles; power relationships and the impact of those relationships on the quality of students’ learning experiences within the CLE. These findings have helped to shape the focus of this RBT.

Appendix B:

The methodological approach to literature searching

Examples of key search terms and synonyms

(Use of truncation included with a wildcard symbol (*) to retrieve all alternative word forms after its “root” form)

Key search terms	Synonyms
Student nurse	Learner
Experienc*	Involv* Participat*
Learn*	Study Education Knowledge
Teach*	Educat*
Clinical learning	Clinical Education Skills Competence Practice based Ward based
Clinical learning Environment	Practice Ward Training Hospital Workplace Work
Culture	Philosophy Ethos Values Principles
Beliefs	Principles Philosophies
Values	Ethics Morals Standards Tenets

Mentor*	Supervisor Support Assessor
Supernumerary	Learner status
Placement*	Clinical learning Healthcare areas
Placement capacity	Clinical capacity
Staffing	Staffing levels Skill mix
Belong*	Attachment
Conform*	Compliance
Orientat*	Direction Familiarisation Familiarization Adaption Adjustment Accommodation Settling in
Competence	Competency Progression Development
Assessment	Grading Grading of practice Appraisal
Standards	Criteria
Supervision	Observation
Leadership	Management
Preparation	Fitness for practice
Educator*	Educational support Link Lectures Learning Environmental Leads
Ethical reasoning	Deportment
Poor practice	Unethical practice Unethical care
Incivility	Bullying Horizontal violence

	Toxic* Vulnerab*
Moral courage	Fortitude Honesty
Moral distress	Stress Burn-out
Attrition	Drop out Leaving
Role transition	Progression Development
Healthcare assistant	Non-registrant Healthcare support worker Care assistant Nursing assistant

Additional key searches, using key terms (with truncation) and synonyms were undertaken for the following subject areas: research; learning theory; work-based learning; situated learning; power.

Examples of key search phrases

Learning in practice

Experiences of learning

Clinical learning environment

Communities of practice

Fitness for Practice

Boolean Operators (Combined Search Commands) – OR; AND; NOT; ADJ; NEAR were used to connect words/phrases and concepts.

Key databases utilised

Name of database	**Scope**
British Nursing Index	Practice, education, and research for nurses, midwives, and health providers in the UK
CINAHL	Research database covering all areas of nursing and allied health literature

OVID	Nursing, Primary Care. Health Promotion, Nursing Specialisms.
British Education Index	All aspects of educational policy and administration, evaluation and assessment, technology
PsycINFO	Literature and research findings in psychology and allied fields
PsycArticles	Full-text source for academic, research and practice literature in psychology, psychiatry, behavioural sciences, mental health, and related disciplines
Educational Research Educational Centre (ERIC)	Education research and information
Joanna Briggs Institute EBP Content Database (JBI)	Evidence-Based Practice and best clinical intervention evidence resources
AMED (Allied and Complementary Medicine)	Literature relating to professions allied to medicine
Medline	Contains journal citations and abstracts for biomedical literature

Key journals utilised and searched within

Nurse Education in Practice
Nurse Education Today
International Journal of Nursing Practice
Journal of Advanced Nursing
International Journal of Nursing Studies
Journal of Clinical Nursing
Journal of Nursing Management
Nursing Ethics
Nursing Philosophy
Journal of Nursing Education
Nurse Educator
Medical Education
Journal of Education and Work
Journal of Workplace learning
Journal of curriculum studies

Nursing Inquiry
Nurse Researcher
Qualitative Health Research
Qualitative Research
The Qualitative Report
Journal of Qualitative Methods
Qualitative Inquiry
Educational Researcher
Qualitative Research

Key books were searched within the King's College London and Bucks New University library catalogues.

Online searching was principally used to search for key research articles and reports.

Snowballing technique was used, meaning the reference lists of papers were reviewed to identify previous papers of possible relevance.

Library services utilised: King's College, London; The Royal College of Nursing (RCN) and Bucks New University (BNU). Specialist support with literature searching and Mendeley training was provided by BNU.

Broad inclusion and exclusion criteria

Inclusion	**Exclusion**
Primary research	Secondary research
Articles written in English	Articles written in languages other than English
Peer reviewed articles	Non-peer reviewed articles
Clinical learning	Theory based learning

In preference UK articles were utilised. However, when UK research was unavailable care was taken when extrapolating results from non UK care environments

Timeframes with justification

In line with the hermeneutic narrative approach, I entered the *search and acquisition stage* (Boell and Cecez-Kecmanovic 2014) with some underpinning knowledge (based on my Doctoral studies to date and professional experience), which I initially used to guide my initial search timeframes. As I read the literature I adjusted the search timeframes to meet the specific topics under consideration (based on my new knowledge and understanding in line with a hermeneutic narrative approach to literature reviews).

When setting timeframes it was important to capture historical data for context, but also include the most contemporary, high quality, relevant research available at the time of literature searching. Capturing such research needs to be carefully managed because if the timeframes are too restrictive, important literature can be omitted. I therefore needed to set different date parameters (described below) for: contextual literature; workplace learning literature; nursing literature; research literature and statistical data.

<u>Subject areas included</u>

Contextual literature

My clinical/academic career meant that I came into the literature searching process with knowledge of the key nurse education junctures over the last 30 years, for example:

- Introduction of Project 2000 (United Kingdom Central Council, 1989)
- Dearing Report (Department of Education, 1998)
- Saving Lives: Our Healthier Nation (Department of Health, 1999b)
- Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare (Department of Health, 1999)
- Fitness for Practice (United Kingdom Central Council, 1999)
- The Nursing and Midwifery Order (NMC, 2001)
- Nursing and Midwifery Council (NMC) established in April 2002

- Nursing and Midwifery Council (2008) Standards to support learning and assessment in practice.
- Nursing and Midwifery Council (2010) Standards for pre-registration nursing education.
- The Health and Social Care Act (2012)
- Nursing and Midwifery Council (2018a) Realising professionalism: Standards for education and training.
- Nursing and Midwifery Council (2018b) The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates.
- Nursing and Midwifery Council (2018c) Raising concerns. Guidance for nurses, midwives and nursing associates.

Aligned with Ricoeur (1976), I knew from the outset (based on my Doctoral studies to date) that there was historical literature that I needed to include to set into context the prevailing beliefs, values and cultures. It was difficult to determine where to set the outer search date to capture the seminal literature. However, given the research question, inclusion of key historical literature in the past 40 years seemed appropriate. This searching yielded key literature including: Ogier, M. (1982) *An ideal sister? A study of the leadership style and verbal interactions of ward sisters with nurse learners in general hospitals;* Melia (1987) *Learning and Working; the occupational socialization of nurses*; the RCN series *The Study of Nursing Care* and more specifically, Fretwell (1982) *Ward teaching and learning: sister and the learning environment* and Ford and Walsh (1994) *New Rituals for Old; Nursing through the looking glass.* This literature was critical to advance my own understanding. However, because of the word limitation, it was not all utilised in the final iteration of my thesis.

Workplace learning literature

From my IFS, I was familiar with the emergence of important workplace literature in the early 2000s, for example: Billett (2001). I searched from 1990 –

current for workplace related literature to capture this important literature, giving a buffering of 10 years to capture additional historical information. When this literature pointed to older relevant literature, these leads were followed (using snowballing techniques).

Nursing literature

Again from my IFS, I was familiar with the important body of nurse clinical education literature, published in 2000, for example by Levett-Jones *et al.,* 2007 – 2009 and Chan (2001). I therefore set my initial search timeline to 1995 to capture this information (and allow a 6 year buffer). Again, when this literature pointed to older, relevant literature, these leads were followed (using snowballing techniques). However, generally I included the most relevant, high quality and contemporary material available at the time of the search.

Research literature

For the research literature, I utilised the most contemporary literature. Where relevant (and directed by my supervisors) I also utilised historical literature, for example Quine (1951). I knew I wanted to take a hermeneutic approach (as justified in the methodology chapter) and therefore I utilised the work of Ricoeur. The inclusion of Lave and Wenger emulated from my IFS. While Lukes was included following conversations with my supervisors after an initial review of the data.

Data

For statistical data (for example nursing admission and attrition data) I utilised the most recently published material. The earliest date included is 2013.

Subject areas excluded

Wide searches associated with professionalism, identity formation and socialisation were not undertaken because these subject areas did not align with the research question and consequent line of enquiry.

Appendix C: A Hermeneutic Approach for Conducting Literature Reviews and Literature Searches.

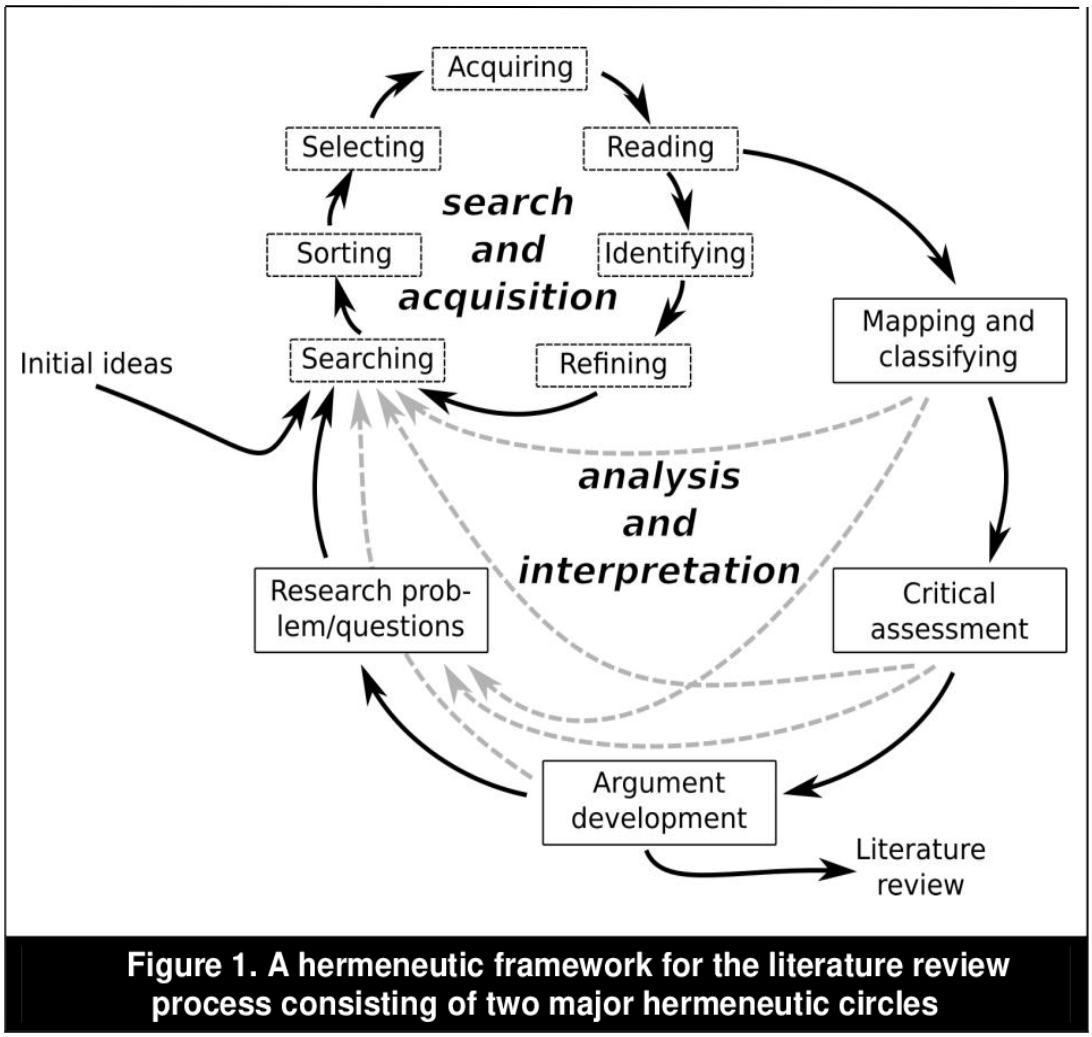


Figure 1. A hermeneutic framework for the literature review process consisting of two major hermeneutic circles

Boell, S. K., Cecez-Kecmanovic, D. (2014) A Hermeneutic Approach for Conducting Literature Reviews and Literature Searches.

Appendix D: Interview schedule

Participant information:

Age:

Gender:

Cohort:

Healthcare experience prior to commencing programme:

Interview Questions

1. Tell me about your experience of being a student nurse and learning in practice.

2. How do you feel when you are in the practice environment?

3. What is good about practice?

4. What is not so good about practice?

5. What could be improved in practice, to support and enhance your learning?

6. Outline some positive learning experiences in practice and what were the consequences of these.

7. Outline some learning experiences, which were not so positive and what were the consequences of these?

8. Who/what supported your ability to learn in practice?

9. What hindered your ability to learn in practice?

10. How prepared do you feel to be in the practice environment both now and in the previous years? And how could your preparedness be enhanced?

11. From your perspective, as a learner in practice, what else should I ask you?

Appendix E: The focus group vignette

Sam is working on a surgical ward, as a second year student nurse, and her mentor seems to be disinterested in her. Sam is in her third week of a ten week placement, but she still feels rather lost. She has latched onto other nurses, but feels as if she is mostly undertaking HCA work. Sam is worried that her learning is suffering. In the back of her mind, she is worried about getting her book completed; she questions how her mentor will complete it when she does not know her well. Sam has another worry in that she has noticed some poor practice, related to how patients are handled, but she is too scared to speak out.

- Please use this vignette as a platform to reflect on your own experience of learning within the Clinical Learning Environment

Appendix F: One-to-one interview participant information

Participant number	Pseudonym	Age	Gender	Year of training	Details of previous clinical experience
1	Alice	19 years	F	End of year 3	None
2	Mary	20 years	F	Beginning of year 3	Voluntary work in a care home for 1 month
3	Philippa	24 years	F	Beginning of year 3	HCA for 5 years in a surgical ward and Intensive Care Unit.
4	Mike	38 years	M	End of year 3	HCA for 2 years in a haematology ward.
5	Davina	41 years	F	Midpoint year 3	None.
6	Jane	42 years	F	Beginning of year 3	HCA for 7 years in a social care setting.
7	Fidelma	39 years	F	Midpoint year 2	HCA for 9 years in social care (8 years) and acute setting (1 year). Currently working as a HCA on the nursing bank.
8	Tracey	48 years	F	Beginning of year 2	HCA for 15 years.
9	Anne	22 years	F	Beginning of year 3	Voluntary work for 1 month.
10	Lawrence	39 years	M	Beginning of year 2	None – previously a hair dresser.
11	Mark	22 years	M	Beginning of year 3	Volunteer with ambulance service.
12	Laura	37 years	F	Beginning of year 3	HCA for 2 years.
13	Deborah	22 years	F	Beginning of year 2	HCA for 1.5 years in a dementia unit.
14	Heather	21 years	F	Beginning of year 2	Support worker for adults with learning disabilities for 2 years.
15	Rachel	21 years	F	Beginning of year 3	Volunteer in care home for elderly with de dementia

Appendix G: Focus group participant information

Focus group number	Age of participant	Gender	Year of training	Details of previous clinical experience
1	37 years	F	Beginning year 2	HCA for 3 years
	25 years	F		HCA for 4 years
	21 years	F		None
2	21 years	F	Beginning year 2	HCA for 3 years
	21 years	F		None
	23 years	F		None
	26 yeas			None
	21 years	F		Support worker for 4 years
	23 years	F		None
3	35 years	F	Beginning of year 3	HCA for 2 years
	29 years	F		HCA for 6 years
	21 years	F		Carer for 2 years
	35 years	F		Carer for autistic children for 1 year
	39 years	F		None
	25 years	F		HCA for 4 years
	31 years	F		HCA for 4 years
	22 years	F		HCA for 1 year
	27 years	F		Clinical Support Worker 1 year
	32 years	F		Nursing assistant (no date)
	31 years	M		HCA for 9 years
	54 years	F		None
4	29 years	F	Beginning of year 2	HCA for 9 years
	41 years	F		HCA for 16 years – nursing aid/senior carer
	37 years	F		HCA for 7 years
	42 years	M		HCA for 4 years
	47 years	F		HCA / assistant practitioner (no date)
	40 years	F		HCA for 12 years
5	22 years	F	Beginning of year 3	Cared for grandmother for 2 years
	26 years	F		None
	32 years	F		Care worker/ HCA for 5 years
	21 years	F		HCA for 2 years

Appendix H: Consent forms

CONSENT FORM FOR ONE-TO-ONE INTERVIEW PARTICIPATION
(Version 27.01.2017)
Please complete this form after you have read the Information Sheet and/or listened to an explanation
about the research.

Title of Study:
A qualitative examination of student nurses' experience of learning in clinical healthcare settings in the UK.

King's College Research Ethics Committee Ref: MR/16/17-123
XXXX University Research Ethics Committee Ref: UEP2017JanEX01

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick or initial

I confirm that I understand that by ticking/initialling each box I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes mean that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element I may be deemed ineligible for the study.

☐

Please tick or initial

1. I confirm that I have read and understood the information sheet dated [version 1, 27.01.2017] for the above study. I have had the opportunity to consider the information and asked questions which have been answered satisfactorily.

2. I understand that I will be able to withdraw my data up to six weeks after the interview.

3. I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the UK Data Protection Act 1998.

4. I understand that my information may be subject to review by responsible individuals from the College for monitoring and audit purposes.

5. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications

6. I agree to be contacted in the future by King's College London researchers who would like to invite me to participate in follow up studies to this project, or in future studies of a similar nature.

7. I agree that the research team may use my data for future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. (In such cases, as with this project, data would not be identifiable in any report).

8. I understand that the information I have submitted will be published as a report and I wish to receive a copy of it.

9. I consent to the interview being audio recorded.

10. I understand that if I raise a concern about patient care, the nurse researcher may need to share this information with an appropriate third party.

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Researcher	**Date**	**Signature**

CONSENT FORM FOR FOCUS GROUP PARTICIPATION
(Version 27.01.2017)
Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.
Title of Study:
A qualitative examination of student nurses' experience of learning in clinical healthcare settings in the UK.

King's College Research Ethics Committee Ref: MR/16/17-123
XXXX University Research Ethics Committee Ref: UEP2017JanEX01

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please tick or initial

I confirm that I understand that by ticking/initialling each box I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes mean that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element I may be deemed ineligible for the study.

1. I confirm that I have read and understood the information sheet dated [version 1, 27.01.2017] for the above study. I have had the opportunity to consider the information and asked questions which have been answered satisfactorily.

2. I understand that I will NOT be able to withdraw my data due to the nature of my participation in the focus group discussions because if my data is withdrawn it would affect the contribution of other participants.

3. I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the UK Data Protection Act 1998.

4. I understand that my information may be subject to review by responsible individuals from the College for monitoring and audit purposes.

5. I understand that in handling the data and writing up the research confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications

6. I agree to be contacted in the future by King's College London researchers who would like to invite me to participate in follow up studies to this project, or in future studies of a similar nature.

7. I agree that the research team may use my data for future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. (In such cases, as with this project, data would not be identifiable in any report).

8. I understand that the information I have submitted will be published as a report and I wish to receive a copy of it.

9. I consent to the focus group being audio recorded.

10. I agree to maintain the confidentiality of the focus group discussions

11. I understand that confidentiality cannot be guaranteed during the focus group discussions.

12. I understand that if I raise a concern about patient care, the nurse researcher may need to share this information with an appropriate third party.

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Researcher	**Date**	**Signature**

Appendix I: Participant information sheet

INFORMATION SHEET FOR PARTICIPANTS

REC Reference Number: **MR/16/17-123 (King's College London)**

REC Reference Number: **UEP2017JanEX01 (XXXX University)**

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

A qualitative examination of student nurses' experience of learning in clinical healthcare settings in the UK.

Dear student,

I would like to invite you to participate in this research project, which forms part of my Doctoral research. Since approximately half of the nursing Degree programme is set within clinical practice it is important to consider how students experience learning in this environment.

You should only participate if you want to; choosing not to take part will not disadvantage you in anyway. Before you decide whether you want to take part, it is important for you to understand why this research is being undertaken and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of this research is to understand student nurses' experiences of learning in the practice environment to inform both University and clinical colleagues. Understanding how student nurses learn in clinical settings may help us to develop strategies to optimise student learning.

Why have I been invited to take part?

I am inviting you to participate because you are currently learning in a practice setting and therefore have valuable insight which may help us to improve practice learning for future student nurses. I am specifically inviting all second and third year BSc adult student nurses to participate in this study because, by this stage of your training, you will have gained sufficient experience of learning in practice to be able to share your insights.

Do I have to take part?

Participation is entirely voluntary. You do not have to take part and a decision to not participate will not result in any disadvantage whatsoever. You should read this information sheet and if you have any questions you should ask me.

What will happen to me if I take part?

If you decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. At a time convenient for you, I will then ask you to be involved in a focus group discussion alongside other student nurses from this institution and/or a semi-structured one-to-one interview. Focus group and one-to-one

interview discussions will take place in a private room (for confidentiality reasons) in the XXXX campus. The focus group will last approximately 1 hour and will typically involve 4 - 9 other adult student nurses. The one-to-one interview will last approximately 45 minutes. If you decide to participate you do not have to participate in both activities.

The focus group discussion will be digitally tape recorded (subject to your permission) and later transcribed. Recordings of the focus group discussion will be deleted after transcription. Your anonymity will be maintained at all times following the focus group discussions. Although your anonymity cannot be maintained during the focus group discussions, each participant has signed a consent form requesting that they maintain the confidentiality of focus group discussions.

The one-one interview will also be digitally recorded (subject to your permission) and later transcribed. Recordings of the interview discussion will be deleted after transcription. Your anonymity will be maintained at all times.

You will be asked to share the following information with me:

- Your age and gender
- When you commenced your nursing Degree programme
- Which type of placements you have undertaken to date; names of hospitals and wards will not be shared.
- If you have healthcare experience prior to commencing your nursing Degree programme and the nature of that experience

Even if you have decided to take part, you are still free to cease your participation and to have research data/information relating to you withdrawn without giving any reason up to six weeks after the one-to-one interview. Due to the interactive nature of focus group discussions participants will be unable to withdraw their data.
It is planned that the focus groups and one-to-one interviews will take place at some point between January 2017 – January 2018. It is anticipated that this research will be completed and submitted, as part of my Doctorate, by September 2020.

What are the possible benefits and risks of taking part?

The information I gain from this study will enable your views and experiences of learning in clinical settings to be heard and will help further the development of the nursing profession. Upon request, I will provide you with a summary of the final research report, including a description of the main findings which will enable you to gain insight into the clinical learning experiences of your peers.

The main disadvantage to taking part in this study is that you will be donating around one- two hours of your time. There are no foreseeable risks in participating in the study, however if you disclose information that places patients at direct risk I may be required (as a Registrant) to tell a third party, for example, the Head of School for Pre-Qualifying Nursing and Vocational Healthcare.

Will my taking part be kept confidential?

Yes. All information gained will be regarded as strictly confidential and will be held securely until the research is finished. All data for analysis will be anonymised, through the use of pseudonyms for individuals and organisations. In reporting the research findings, I will not reveal the names of any participants or the organisations

where you have been placed. At all times there will be no possibility of you being linked with the data. Please note that all participants are asked to maintain the confidentiality of focus group discussion but this cannot be guaranteed.

The UK Data Protection Act 1998 will apply to all information gathered within the focus groups and interviews and such data will be held on password-locked computer files and stored in locked cabinets. No data will be accessed by anyone other than me; and anonymity of the material will be protected by using false names. No data will be able to be linked back to any individual taking part in this research.

How is the project being funded?

This study is being funded by the researcher and supported by a small research grant from XXXX University.

This study has been approved by the King's College London Research Ethics Committee and XXXX University Ethics Committee.

What will happen to the results of the study?

The results and the analysis of this research will form part of the thesis for my Doctorate and I anticipate that I will publish the results and present at conferences.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Karen Harrison-White
Head of Academic Department for Pre-Qualifying Nursing (Child)
Full address and contact details inserted – anonymised.

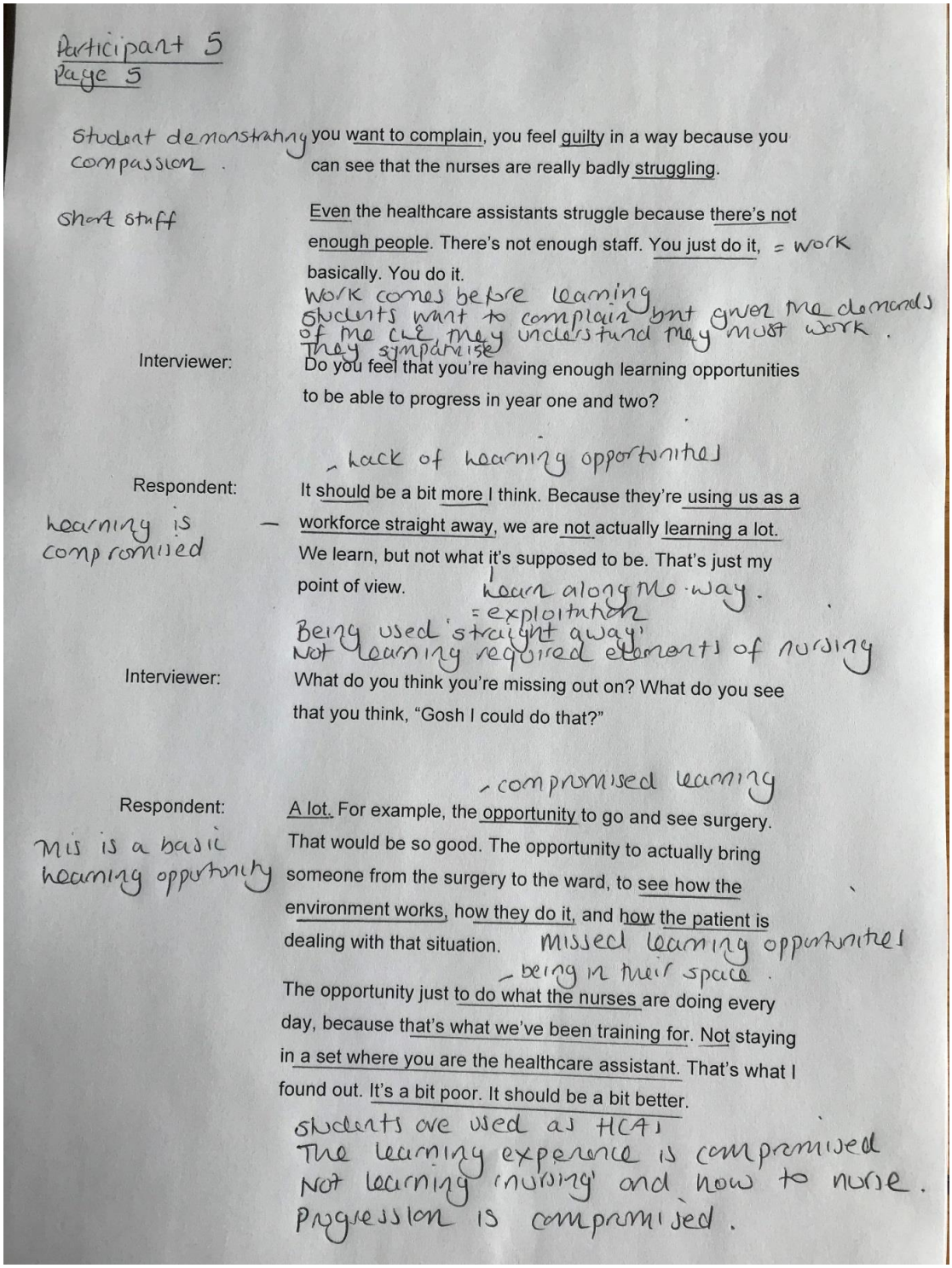
What if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London, using the details below for further advice and information:

Dr John Owens
School of Education, Communication and Society
Faculty of Social Science & Public Policy
King's College London
1/21 Waterloo Bridge Wing
Franklin-Wilkins Building
Waterloo Rd
London
SE1 9NH
United Kingdom
Tel 0207 848 3105
john.owens@kcl.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix J: Example of annotated transcript



Participant 5
Page 5

Student demonstrating compassion.

you want to complain, you feel guilty in a way because you can see that the nurses are really badly struggling.

Short staff

Even the healthcare assistants struggle because there's not enough people. There's not enough staff. You just do it, basically. You do it. = work

Work comes before learning
Students want to complain but given the demands of the HCA they understand they must work. They sympathise

Interviewer: Do you feel that you're having enough learning opportunities to be able to progress in year one and two?

- lack of learning opportunities

Respondent: It should be a bit more I think. Because they're using us as a workforce straight away, we are not actually learning a lot. We learn, but not what it's supposed to be. That's just my point of view.

learning is compromised

learn along the way.
= exploitation
Being used 'straight away'
Not learning required elements of nursing

Interviewer: What do you think you're missing out on? What do you see that you think, "Gosh I could do that?"

- compromised learning

Respondent: A lot. For example, the opportunity to go and see surgery. That would be so good. The opportunity to actually bring someone from the surgery to the ward, to see how the environment works, how they do it, and how the patient is dealing with that situation.

This is a basic learning opportunity

Missed learning opportunities
- being in their space.

The opportunity just to do what the nurses are doing every day, because that's what we've been training for. Not staying in a set where you are the healthcare assistant. That's what I found out. It's a bit poor. It should be a bit better.

Students are used as HCAs
The learning experience is compromised
Not learning 'nursing' and how to nurse.
Progression is compromised.

Appendix K: Initial analysis

Categories	Subthemes	Themes
Being used	Feeling intimidated/ oppressed/ bullied **or** empowered	**The impact of a power imbalance**
Being seen as 'the student'		
Being an outsider		
Being vulnerable to bullying behaviour		
Reprisals - punishments		
Repercussions - consequences		
Being utilised as a 'pair of hands' /Health Care Assistant (HCA) rather than as a supernumerary learner	Erosion of the student status as a 'peripheral participant' learner Learning to nurse – as a student or a worker?	**Learning by working**
Consequences of being utilised as a HCA rather than being a student		
Being protected as a student nurse rather than a worker		
Care/ work comes first and learning is secondary		
Seeing poor practice		
Learning in practice is critical		
Factors influencing learning beyond the mentor	The influence of the mentor (and the wider team) to create and protect learning opportunities (a conducive learning environment) The influence of the individual student's attributes (based on personality and previous experience in HC / of being a student)	**Access to learning opportunities and receiving accurate feedback (including grading)**
The influence of mentorship		
Mentor Feedback		
The influence of the student		
Feeling vulnerable	The influence of student attributes The influence of the attributes of the team Feeling transient	**Fitting in (with the team and mentor)** **(a strategy to pass)**
Managing the issue of poor practice as a student nurse		
Willingness to take on worker roles		
Wanting to feel part of the team		

Appendix L: Finalised analysis

Categories	Subthemes	Themes
'Being lucky'	Factors affecting the 'quality' of the learning experience	**Educational realities associated with the CLE**
'Leaving the learning to do the obs'		
'Thrown on the back burner'		
'Turn around, I don't want you to see this'		
'Piloting' learning	Student strategies	
'I need to learn this'		
'Fitting in'		
'Learning as much as I can'	Positive mentoring features	**The influence of mentorship**
'Getting a chance to actually do it'		
'Our book is everything'		
'A deer in headlights'	Negative mentoring features	
'Well go familiarise yourself'		
'That's not in your learning outcome'		
'I'll just sign it at the end'		
'Starting from the bottom'	Oppressive experiences	**Power and powerlessness**
'The student'		
'Weapons'		
In the doghouse'		
'Because nobody cares, or nobody listens'	Subjugation of students	
'I'll just get on with it'		
'I wanted to quit'		

Appendix M: A consideration of the NMC Standards (2018)

Although the participants experienced learning within the CLE under the NMC (2010) Standards, and the NMC (2008) *Standards to Support Learning and Assessment in Practice*, the publication of the new Standards (NMC, 2018a) makes it important to consider how this research may inform the future development of nurse education in CLEs and the implementation of these new Standards. A detailed analysis of the new Standards is beyond the scope of this research, but in this chapter I will provide a brief discussion of the implications that my research has for operationalising the new Standards. Some of these comments are more speculative in nature, whilst others can be made with more certainty, where anticipated change is limited. Despite the challenges associated with mentorship, when working effectively it can have a positive impact on the quality of the learning experience of students. The disbandment of mentorship (required by the new Standards) may therefore pose significant risk to the quality of student learning. The pressures exerted by the clinical imperative are unlikely to alter, therefore the diminution of the supernumerary requirement (within the Standards) may worsen students' vulnerability to exploitation. If exploitation persists, students may continue to struggle to attain the required learner knowledge, commensurate with their stage of the programme. The new Standards are unlikely to alter students' experiences of oppression within the CLE.

Supervision: future arrangements

The NMC Standards (NMC, 2018a), which will govern pre-qualifying nurse education (once AEIs revalidate) are called: *Realising professionalism: Standards for education and training*. These Standards consist of three parts: it is part 2, *The Standards for Student Supervision and Assessment*, which is particularly relevant to my thesis. Student supervision and assessment in practice will principally be supported through three different roles: practice supervisors; practice assessors and academic assessors.

Under the new Standards, student nurses can be supervised in practice by any Registered Nurse and other registered healthcare professionals. Students may feel less abandoned within the CLE because nurse supervisors are likely to be junior and thereby potentially more available for bedside teaching. However there is no requirement to identify named supervisors, which may lead to abandonment unless the local education arrangements formally link students with supervisors. Students will be assigned a more senior Registered Nurse, to act as a nominated practice assessor, either for one placement or a series of placements. The academic assessor is responsible for working in partnership with the nominated practice assessor to evaluate student progression (NMC, 2018a). Formal preparation is not required for the either the supervisor or practice assessor role; preparation will be decided locally and endorsed by the relevant AEI. Given that preparation will occur predominantly within the practice setting, rather than within the University, there is a risk that clinical demands may compete. The lack of formal preparation may lead to inconsistency and perhaps inadequacy in preparing these important roles.

In losing the mentorship role, some students may (in the absence of their supervisors) 'pilot' their own learning and attach themselves to other professional 'supervisors', i.e. doctors, physiotherapist and pharmacists. If students have significant periods of time away from their nursing supervisors, they may not have the opportunity to learn and develop within their own community or practice (Lave and Wenger 1991), thereby potentially compromising their opportunities to learn nursing. If CLEs establish named supervisors, they may be able to link students with other professionals, who can meaningfully facilitate learning within the CLE. However, the pressures exerted by the clinical imperative are likely to readily compromise such arrangements.

Further compromise may occur because the NMC (2018a, p4) *Standards for Student Supervision and Assessment* state that supporting student learning '*may include being supernumerary*', depending on the needs of the student. There is a risk that a discretionary supernumerary status could exacerbate

students' experience of exploitation in practice. Students may remain in the invidious position of needing to demonstrate 'nursing' knowledge, without gaining the required learning time with these professionals.

Changes to Assessment structures

There may be advantages in uncoupling the supervisor/assessor relationship. Students may be able to learn more effectively from the professionals who are not responsible for assessing them. However, it is unlikely that the assessor will work directly with the student. Instead assessors are likely to rely on appraisal communicated either verbally (from the supervisors) or through the PAD document. The accurate and timely transference of verbal information, from multiple professionals, working a variety of shift patterns, may be challenging. It is evident from this study that the PAD document does not consistently or necessarily accurately represent student achievement. Students are likely to remain vulnerable to the pressures exerted by this document, i.e. they may be reluctant to raise concerns, either about their own learning or incidences of poor clinical practice for fear of reprisal.

Initially it was anticipated that academic assessors would participate in a face-to-face tripartite meeting, with the relevant practice assessor and student. This arrangement might have served to enhance the veracity of the process and to some extent protect students in the more hostile CLEs. However, due to the number of students each AEI has in practice, and the geographical spread of placement areas, such arrangements will not be possible in most circumstances. However, tripartite meetings may occur if there are concerns about a student; this arrangement may serve (to some extent) to protect students, depending upon the emerging power dynamic within this relationship.

In summary, for the NMC (2018a) Standards to impact positively on the quality of support and supervision available for student nurses in practice the local education provision will need to be carefully designed and operationalised, with named supervisors. Named supervisors may be able to prevent students' sense

of abandonment and interrupt their propensity for exploitation. Supervisors may also be able to create aligned learning opportunities, linking students appropriately with other interprofessional supervisors. In working more closely with students, supervisors are arguably more likely to be able to accurately appraise development, linking with the practice assessors. However, for such enhancements to be achieved, careful consideration will need to be given to the supervisor role preparation and allocation of responsibilities. If such consideration does not occur, students' experience of learning within the CLE is unlikely to alter under the new Standards and may worsen. The new Standards are unlikely to alter students' experiences of oppression within the CLE, because they fail to take into consideration the power dynamics within this environment. In writing the new Standards (NMC 2018a) there is an assumption that the CLE is functional and fit for purpose in supporting student nurses to learn in the practice setting.