Preparing for and entering nursing:
the occupational socialization of a cohort of students.


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A thesis submitted in accordance with the regulations of the University of Surrey and in fulfilment of the requirements for the degree of Master of Philosophy.
Abstract.

The focus of this longitudinal case study is on the occupational socialization of a cohort of students preparing to become general nurses, and following qualification. The perceptions of the cohort about nursing and the role of the nurse are identified at the beginning and over time, as the cohort progresses and develops through the training period and as qualified nurses. The perceptions of a number of key people in this socialization process are also sought.

The research approach is qualitative - interpretive, and the main method of data collection is the semi-structured interview, supported by open questionnaires, retrospective biographies, repertory grids and written evaluations of specific experiences.

Three areas were identified by the respondents as important to them during their first interviews; social/leisure activities; being in the school; working in the clinical areas.

Topics raised in these areas were discussed during subsequent interviews.

Data analysis reveals that the perceptions of the cohort about nursing did not appear to change. The role of the nurse however was perceived initially to be concerned with administration and management and later becoming more involved with direct patient care. These perceptions were not apparently influenced by the respondent's gender, age or previous educational attainments. Nursing was learned in the clinical areas and basic knowledge and principles of care in the school.

Influences on the socialization of the cohort are identified and discussed and reveal the importance of the peer group, the ward team and the personal tutors on the learning and socialization processes.

The concluding discussion raises some issues for consideration and suggests some areas for further study.
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Chapter One.

Setting The Scene.

-----today was yesterday's future and
today is tomorrow's past.
Collins 1981.

Introduction.

Florence Nightingale described nursing as both an art and a science, and it can be argued that her ideas provided the foundation of a knowledge base called theory unique to nursing (Miller 1989 p.47). Nursing education underpins nursing practice, and the enhancement of both is in part dependent upon research extending and developing this body of knowledge peculiar to the profession.

There has been a steadily increasing amount of research into nursing and nursing education over the years in the United Kingdom, stemming particularly from the 1970's, for example, the role and style of ward sisters, Pembrey (1980), Ogier (1982), wastage during and after training Birch (1975) Mackay (1989), other aspects of the nursing training curriculum Bendall (1975), Alexander (1982), Gott (1984) and Fretwell (1985). All these studies are concerned with various aspects of the learning environments and the way students are prepared for the role of the nurse. Specific studies into the socialization into the occupation of nursing include Wyatt (1978), Heyman Shaw and Harding (1983,1984), Melia (1987) and Wilson and Startup (1991). This current research study is unique as far as the researcher is aware, because it is a longitudinal case study in which the perceptions of a group of students into nursing and the role of the nurse, are explored at the beginning of the course, examines whether age, gender and academic background influence these perceptions, and if there are changes during the three year period and once the students are qualified nurses. The perceptions of the personal tutors to the students, a senior tutor, tutor, allocation officer and ward sisters are also sought.

In any study of a group of students entering a profession, it is important to place it within the national and local scene, which is the focus of this chapter.
1. The National Scene.

(i) The Statutory Bodies for Nursing Midwifery and Health Visiting.

One main recommendation of the Committee on Nursing (Briggs Report 1972) that there should be a single body responsible for professional standards and discipline, came to fruition in the Act of Parliament "Nurses Midwives and Health Visitors Act 1979" which established the statutory bodies responsible for pre and post registration training - the four National Boards for England, Scotland, Wales and Northern Ireland and the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC). The statutory regulations encompassed the European Community directives for general care in 1977.

The four Boards and Central Council replaced the previous nine Bodies and marked a "significant change in the evolution of the Nursing Midwifery and Health Visiting professions" (UKCC report 1983/84). This significant change meant for the first time education could be a continuing process under one unified control as envisaged by Briggs (1972), and the Act gave the new Bodies powers to improve the standards of education and training and professional conduct for nurses midwives and health visitors.

The UKCC and Boards' prime concern is to protect the vulnerable public, and to this end the UKCC formulates rules (to be approved by the health ministers) regarding:-

i) admission to training.

ii) kind and standard of training to be undertaken for registration, and of ongoing education and training for those already registered.

The UKCC also maintains the professional register, and together with the Boards has a professional conduct function.

The four Boards work closely with the UKCC and have statutory responsibilities to provide, or arrange for others to provide at institutions approved by the Board:-

a) courses leading to registration, or for the recording of additional qualifications on
the register, and courses of training for those already registered,

b) such examinations as are needed to satisfy requirements for registration or to obtain additional qualifications.

Educational Officers provide links between these statutory bodies and schools of nursing. These schools translate the statutory requirements into approved curricula. The situation for the majority of students of nursing is complex, in that they occupy a peculiar role, that of student and worker. As workers the students are subject to the same rights as other employees with regard to employment legislation, having contracts and being subject to disciplinary procedures. At the same time, the students are called students and have to satisfy the statutory requirements of the appropriate National Board and UKCC.

There appears to be a change in political thinking, as evidenced by the government's acceptance of the principles of Project 2000 "A New Preparation For Practice" (UKCC 1986). In future schemes the students will receive grants, have supernumerary status for 80% of a three year scheme and gain diplomas in higher education as well as professional qualifications. This current thinking is perhaps influenced by the current wastage rates in conventional programmes and the predicted fall in entrants to nursing. Figures released by the Department of Health in 1989 showed that 200 fewer students entered nursing in 1988 than in 1987, continuing a trend started in the early 1980s (Department of Health NHS Workforce in England 1989).

(ii) Recruitment and entry into schools of nursing.

All candidates have to apply initially to the Nurses Central Clearing House, indicating three schools of choice in priority order. Schools of nursing have their own selection criteria embracing the interview and health clearance, and sometimes academic requirements higher than the minimum acceptable to the UKCC-5 GCSE/ "O" levels, or equivalent, or DC test (a specific test designed by Dennis Childs et al, University of Leeds) or Access to Higher Education Courses under Rule 16 (1) (D) of Statutory Instrument 1987 No.46. The UKCC also publishes a list of comparable and acceptable educational qualifications for overseas candidates.
Until 1948-50, in most nursing schools, the majority of entrants into general nursing were eighteen year old white women (UKCC Project Paper 8 Feb.1987). Since that time there has been an increase in the numbers of entrants from overseas, but a Commission of Racial Equality (CRE) survey published in 1987 showed that black and ethnic minority trainees were still under-represented in nurse training schools. In three Inner London nursing schools only 15 out of 1365 trainees were from ethnic minority groups. (King's Fund Equal Opportunities Task Force 1990). This task force position paper confirms the views of Hicks (1987), that many of the candidates from overseas were "pressurised" into taking enrolled nurse training - a two year practically based scheme - even though the qualification was unrecognised in many of the home countries. Hicks (1987) states that in 1982, learners from overseas were still channelled into certain specialties, for example into care of the mentally ill, and mentally handicapped. She quotes the General Nursing Council for England and Wales figures for that year, that out of a total of 5105 overseas learners, 1653 (32%) were in those two afore mentioned specialised trainings.

Traditionally, proportionally more men were admitted to the register from mental training (RMN) than from general training (RGN) in England, although there is currently an increase in the numbers of men entering general training, as can be seen from figures obtained from the UKCC annual report 1985/86, and UKCC letters Ref.PH/KC/403,PH/KB/390.1992.

<table>
<thead>
<tr>
<th>Part</th>
<th>Year</th>
<th>Female</th>
<th>Male</th>
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<tr>
<td>RGN</td>
<td>1985/86</td>
<td>11801 - 94%</td>
<td>766 - 6%</td>
<td>12567</td>
</tr>
<tr>
<td>RGN</td>
<td>1990/91</td>
<td>12688 - 91.5%</td>
<td>1178 - 8.5%</td>
<td>13866</td>
</tr>
<tr>
<td>RMN</td>
<td>1985/86</td>
<td>1377 - 63%</td>
<td>807 - 37%</td>
<td>2184</td>
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<tr>
<td>RMN</td>
<td>1990/91</td>
<td>1714 - 65.5%</td>
<td>901 - 34.5%</td>
<td>2615</td>
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The effects of the "demographic time bomb" with the predicted fall in the number of eighteen year old white women reaching the lowest point in 1995 is already being felt in the nursing schools (UKCC Project Paper 8 Feb.1987 p.7). This has meant that instead of a restricted entry into nursing courses, with some schools setting the academic entry requirements above the level required by the statutory body, (Hicks 1982), there is now competition for recruits, not only between nursing schools, but also between nursing and other professions- commerce/business eg. medicine and
banking. Many schools of nursing are now accepting candidates who have obtained only the UKCC minimum entry requirements, at a time when schools are linking with institutions of higher education over Project 2000 schemes.

The Department of Health is publicising nursing by means of advertising campaigns in the national press and television, and recruitment packages are being designed to attract mature men and women of differing ethnic backgrounds into nursing. In a small survey carried out in England in December 1988 in two secondary schools from different social settings, in different areas of a town with male and female pupils, it was found not one had selected nursing as a career. The first choice was banking and accountancy for 16 out of 70 respondents. 38 had friends or relatives who were nurses, but few had had conversations with them about nursing. The few who had apparently acquired a dismal picture-pay too low, overworked, lots of pressure and responsibilities, although great parties were to be enjoyed! The respondents seemed to have a clear understanding of the need for study during training, and of the need for academic ability as an entry qualification. Interestingly, all but five of the pupils considered nursing to be a career for both men and women (Hall 1989).

The UKCC recognised the need to widen the academic entry gate into nursing (UKCC Circular Ps/88/06). Two early experimental Access to Nursing schemes were approved for a limited intake number. These two London based schemes enabled students who successfully completed the course to enter the 146 week scheme for general nursing in specific schools of which the School being studied is one. Both these schemes were evaluated by the UKCC, which then enabled some Access to Higher Education schemes to be approved as an acceptable academic entry qualification.

(iii) Living in a group.

Traditionally, the majority of entrants to nursing lived in residential accommodation provided by the Health Authority responsible for that school. Since 1947, The General Nursing Council for England and Wales, then the statutory body, required all schools to provide a minimum of eight weeks as a preliminary training course for students preparing to become general nurses. Many schools provided this experience in a large house, often away from the hospital and main school. The students lived in this house, and were taught the essential skills of caring for patients. This group, or
set, ideally remained together throughout the training programme, coming together for formal study sessions. The students developed friendships with others in this set, although retaining family contacts, and other friends who might act as reference groups to enable standards of behaviour to be maintained or monitored.

MacGuire (1968) suggests that this "Set" was regarded by some senior nursing staff as a focal point, giving the students basic emotional stability while being moved from ward to ward. She (1968 p.278) writes

Because of this physical isolation the student nurses are left to draw on the resources of the group for their entertainment, intellectual stimulation and morale. A strong sense of community develops. Bonds of friendship between pairs and cliques are built up. Shared patterns of behaviour, attitudes towards study and practical work and towards nursing as a whole are a product of the close interaction between the membership of the set during this period.

While students still enter a general scheme as a group at a particular time during the year, the practice of the introductory period of between 6-12 weeks being spent in an isolated house has largely disappeared, but many students choose to be resident in residences which may house students at different levels of experience, as well as students from other professional schemes and trained staff and others from many different occupational groups. Wilson and Startup (1991) in their study of nurse socialization in three Welsh nurse education centres found that at the commencement of training the majority of students expected both emotional and practical support from their group membership, and by the end of the year two thirds had obtained it.

Increasingly, as mature men and women enter nursing, some with families and other dependants, others in their second or third career choice, living at home or sharing with a partner or friends becomes an attractive option to being resident, since this may be viewed as restrictive with conflicts between communal living and personal freedom. For some, freedom to have friends into their rooms, to cook whatever and whenever they wish, without worrying about the smell or the noise are the reasons for becoming non resident, despite the increased costs in terms of travel and money.
(iv) Culture and reality shock.

Kramer (1974 p.4) differentiates between "culture" and "reality" shock. Culture shock being

---a state of anxiety precipitated by the loss of familiar signs and symbols of social intercourse when one is suddenly immersed into a cultural system markedly different from his home or familiar culture.

She defines reality shock as

---a term used to describe the phenomenon and the specific shocklike reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared and then suddenly find they are not.

Kramer (1974 pp.vii-viii)

Students preparing to become nurses may experience both these reactions at the same, or at different, times.

Potential recruits to nursing may have different and increased social expectations about their own lives, and differing expectations of nursing from those traditionally held. This may be because of new assumptions about flexibility of working practices, about women's employment following marriage and childbirth, and perceptions of greater class mobility (Davies and Rosser 1986). Students may have their own expectations of nursing, and what nurses do. These expectations are influenced by past experiences, family background—for example a father or mother who is a nurse or doctor. These expectations are sometimes also affected by the portrayal of nursing and nurses by the mass media, and by the glossy advertising in the press and on television. Sometimes the set system, previously mentioned, produces conflict, the values held being challenged by the current group's beliefs and attitudes, which may or may not be similar to those held by the teachers of nursing and other nursing staff. Some students coming from a strictly conformist social/ethnic background might be
expected to find group pressures disturbing. Alternatively some might revel in the
freedom of being away from home, adopting a different lifestyle-going out to parties,
visiting public houses, taking up smoking- which in some instances may induce
feelings of guilt if different from the usual practice.

The shock of experiencing the actual sickness scene and the clinical environment may
affect all students, particularly those whose previous experience or study has been in a
different field, and if the reality presented by the school is different from that in the
wards. Coping with ill people and relating to their relatives can cause high levels of
anxiety. Birch (1983) records that students and pupils who were not adequately
prepared for their role in relation to the patients' emotional needs, experienced high
anxiety levels. Fretwell (1985) in an action research study, confirms the findings of
Birch (1983), that learners experienced stress when dealing with bereaved relatives,
nursing patients in great pain, changing wards and being shown up in front of patients
and staff. Menzies' (1960) classic study shows that the nurse occupied herself with
tasks and procedures to reduce anxiety. In these days, whilst written care plans are
crucial for detailing and sharing information, it is nevertheless possible for nurses and
students to become so concerned about the preparation of the plans, that their time in
real communication, in contact with and caring for the patient, is reduced.

Mixed signals and cues may be perceived by the student- what is stated in the formal
curriculum, and what is expected in the real work situation. The student may deal
with this in different ways. Benson (1973) suggests that some may fail to recognize
that a dysfunction exists, others find or develop a series of ploys to deal with the
choices that confront them. It is the importance of this hidden agenda, the hidden
curriculum, defined by Meighan (1986 p.66) as:

All the other things that are learned
during schooling in addition to the
official curriculum.

which determines to a great degree how the various participants, in particular the
students, play the game and adapt to circumstances to achieve their goal of becoming
qualified nurses.

Studies in other countries with a different heritage and culture include Melia (1987), a
study of the occupational socialization of students in two Scottish Colleges of
Nursing, which demonstrates that two versions of nursing were presented, one the
"professional" long term version from the college, the other a more immediate
"workload" approach. The students' perceptions were ones of competing factions within nursing, and their response was to

Negotiate their way through training by learning when and how to reproduce whichever version of nursing is required.

Melia (1987 p.162)

It can be argued that this "negotiation" is similar to the strategies employed by the students to enable them to be successful in Olesen and Whittaker's (1968) study of American student nurses, and to the adoption of behaviour which seemed to work for the medical students in the study by Becker et al (1961).

In conventional 146 week schemes of general courses, the students of nursing, employees of the Health Authority, spend approximately 60% of time giving direct patient care under the supervision of qualified nurses. The rest of the time, apart from annual leave, is spent in a school of nursing which does not exist in isolation, but forms part of the total health service provision within the Health Authority, interacting with the hospitals and community it serves. This may change in the future, with all schools changing to Project 2000 schemes and becoming faculties of nursing within a higher education institution.

The service to patients and clients is given largely by an untrained labour force - auxiliaries, care assistants and nursing students. The English National Board for Nursing Midwifery and Health Visiting regulations specify

a minimum of one appropriately qualified first level nurse must be available, in a ward or department, to supervise students on each shift. The degree of supervision will vary according to the experience of the student and the complexity of the patients' care requirements.

ENB (1990 p.15)

This use of nursing students can give rise to high anxiety levels and high wastage among the student population. The estimated national wastage during conventional training programmes is 30-35%, and 10% of qualified staff leave on qualifying (UKCC Project Paper 8.Feb.1987). Evidence to the Briggs Committee (1972)
frequently included the fact that

the needs of the labour force take
precedence over training needs, and that
after a few weeks of introductory work
trainees are frequently dispatched to
wards which seem to them to have been
chosen at random.

Report of the Committee on Nursing
(1972 para.207)

More recently, the Student Association Officer, RCN, in a letter to the nursing press referring to Project 2000, stresses that supernumerary means students giving care in clinical situations under direct supervision, "without having the burden of being just a pair of hands" (Dolan 1989 p.13). This perceived use of students as part of the labour force is found in countries other than England. Reid (1985 p.73) in her research into the educational environments provided in hospital wards for student nurses in Northern Ireland, reports that a high percentage of learners felt they had been "pairs of hands".

Over the past fifty years there have been a series of reports, commissions, proposing reforms advocating the separation of nursing education from the service elements. Horder (1943) proposed a link up with the national education system, the Wood Committee (Min. of Health 1947) that students have full student status. Platt (1964) recommended student status and financial independence for the first two years, Judge (1985) recommended total transfer into the mainstream of higher education. The consultative document of the English National Board in 1985 proposed supernumerary status for the first two years. As previously mentioned, government adopted the principles of P2000, which advocates supernumerary status for the three year education period, with 1000 hours of rostered service contribution during this time. This will be the pattern of pre registration nursing education for the future.

There will be a need for adequate numbers of supervisory and teaching staff to ensure all students, including those in conventional schemes, are protected and that patient care is not adversely affected. Teachers will need to spend more time than is current in the clinical situation with students to help them to synthesize the knowledge gained from the study of different disciplines into high quality nursing practice. The students will also be helped to reflect on their practices, to identify and generate knowledge from experiences, and to help them as practitioners to think "on the job" (Schon 1983). Such measures should reduce or eliminate the gap between two versions of
Students currently spend a high proportion of time in the clinical situation, and it can be postulated this is where a great deal of learning occurs. Alexander (1982) describing an educational experiment - a method of teaching nursing intended to help student nurses integrate theory and practice - in five Colleges of Nursing preparing students in Scotland for registration as general nurses, found that 77% of the respondents in the pre experiment stage felt they learned more in the wards than in the College. The dichotomy between what is learned in the school and what is practised in the wards has been well documented. Apart from Melia (1987), Bendall (1975) found that the ideal of patient centred care taught in the school was not carried out in the wards, where the care given was task centred. A later study indicated that nursing practised in the wards differed from the nursing practice taught in the school (Gott 1984). Olesen and Whittaker (1968) in an earlier American study found the students experienced the same phenomenon.

Since the early 1970's, with the development of British nursing research, and the conceptualization of a framework for practice, an holistic view of nursing is increasingly being adopted (Pembrey 1985). This view was incorporated into a statement of Educational Policy by the General Nursing Council for England and Wales - the then statutory body for nursing-

the concept of the nursing process
provides a unifying thread for the study
of patient care and a helpful framework
for nursing practice.

GNC (77/19/A p.4.)

This was further elaborated in 1983, and confirmed by the ENB, together with the statement

the wards and departments chosen for
training must offer a good climate for
learning in which Ward Sisters and
Charge Nurses are examiners and
assessors

GNC (83/13/A p.4)

(v) The roles of qualified nurses as teachers and mentors.

The role of the qualified nurse and the relationship between the nurse and the student
has been clarified and developed over the years. The ENB in its regulations and guidelines for the approval of institutions requires that in areas used for practical placements for students of nursing

---appropriately qualified first level nurses and midwives to be available to students to act as supervisors assessors and if possible mentors. The same person can undertake different roles. It is important that the students know which role the person is occupying at any given time.

ENB (1990 p.15)

The definition of a mentor is given in the glossary of the above document

An appropriately qualified and experienced first level nurse/midwife/health visitor who, by example and facilitation guides, assists and supports the student in learning new skills, adopting new behaviours and acquiring new attitudes.

ENB (1990 p.152)

In two separate evaluations of six ENB pilot schemes, it was found that the effectiveness of mentorship varies considerably, with little consistency or clarity about which activities were included in the role (Collins 1989,NFER 1990) Armitage and Burnard (1991) argue that the roles of mentor and preceptor are different, the preceptor role being more concerned with enhancing clinical competence through direct role modelling, with the mentor role being concerned with "looking after" the student nurse.

The key role of the ward sister in the learning environment has been well studied. Fretwell (1980) in her investigations into the ward learning environment concludes that the ward sister is the key person in providing an effective environment. The key features are good communication, teamwork, negotiation and the availability of trained nurses during and after the work is completed, with the sister being patient orientated, democratic and fulfilling an active teaching role.

Ogier (1982) in her study "An Ideal Sister" found that the ward sisters who seemed to
have an open approachable style had patterns of verbal interactions with nurse learners which they perceived to be propitious to them. These ward sisters tended to be in charge of medical wards. Wilson and Startup (1991) report the reverse. In their study, the surgical allocation was most liked by the students, with the sisters and staff nurses deemed to be approachable, and learner orientated. The surgical ward sisters were seen to teach, and work with the students, with the environment conducive to the promotion of satisfactory role modelling.

Jacka and Lewin (1987) in a study of three schools in England, confirm the importance of the ward sister in a clinical training programme, and the value of maturity in all its aspects. They also discovered a lack of effective monitoring of the individual student's practical learning in the wards, suggesting the sister is an intermittent overseer of a given student's development, and only then for a short period lasting eight to ten weeks. However dedicated to education the sister may be, she is also committed to other tasks.

(vi) The preparation of the nurse teacher.

Prior to 1987, different courses were established to enable a suitably qualified nurse to become either a clinical teacher or a nurse tutor, the clinical teacher, as evidenced by the name, supposedly spending the majority of the time in the practical areas working with students. Nurse tutors had a longer preparation intended to enable them to teach both in the classroom and clinical settings. The report of the Nurse Tutor Working Party (DHSS 1970) had previously recommended that tutors should have the opportunity of teaching their specialised subjects. The move towards one basic preparation for nurse teachers was initially recommended by the GNC in two documents entitled "Teachers of Nursing", one published in 1975, the other in 1976. The recommendation was based on research which established that there was a lack of teaching in the practical areas, and clinical teachers were filling gaps in the classroom due to shortages of tutors. This finding and recommendation was accepted by the extant statutory bodies and subsequently endorsed by the current. These documents emphasised the need for more nurse teachers to teach in the clinical areas as well as in the school building, and this was reiterated in the Educational Policy Document (1977).

Alexander (1982) in her Scottish study, found that 80% of 112 student respondents
stated they did not receive supervision from tutors in the wards, and 91% had never received a ward tutorial from them. A study of the nurse tutor role in Northern England found that the students in the sample perceived a role as a clinical specialist for the nurse tutor, whereas the tutors as a group did not (Shehan 1981). His findings also suggest that nurse tutors serve functions as role models, which, as Shehan himself points out, contradicts previous research, MacGuire (1966), Dodd (1973) and Lamond (1974), who found it was the students' peers or the ward sisters who were considered to be the significant others.

The tutor is also usually responsible for the support and pastoral care of a group of students throughout their training period, a constant figure to whom the students can relate in a changing environment. In an interesting finding, Shehan (1981) discovered that the nurse learners in a sample drawn from 11 schools in one region, comprising 317 learners and 93 nurse teachers, put more emphasis on the moral and pastoral role than did the nurse teachers.

The role of the tutor encompasses the planning, implementation and evaluation of the curriculum with the involvement of nursing service colleagues, as well as the teaching of students within the curriculum. In developing curricula, the tutor has to work within the statutory framework, to plan a scheme enabling students to achieve the UKCC competencies (Approval order 1983 no.873) to become a first level nurse. The involvement of clinical specialist nurses is crucial so that the nature of the educational process is understood and shared. This educational process also involves the socialization of the students - a social process which, as Jarvis (1986) suggests happens to a student, or to an intake of students, as they undergo this professional preparation.

2. Previous research - socialization into nursing in Great Britain.

Previous research mentioned has a bearing on the socialization into nursing, whereas professional socialization into nursing is the primary focus of the following studies.

Wyatt (1978) in a small scale survey found that the students felt the teachers were remote from the realities of the ward (see Alexander 1982 above), but all placed the ward first as the place where most had been learnt about being a nurse. The students in her study felt they had learned from a wide variety of individuals, including patients, auxiliaries and doctors as well as their own peer group and qualified nursing staff.
Wyatt suggests that part of the learning process of the students is to modify their behaviour to the norms of the ward.

In a longitudinal study of student and pupils in two general hospitals, Heyman, Shaw and Harding (1984 p.304) write

> the finding of decreased trainee satisfaction with their work situation must be explained in relation to the finding of our previous paper (Heyman et al.1983) of strongly increased identification with the world of medicine during training. This apparent paradox can be explained if we assume the trainee identifies with what she sees as the essence of nursing, i.e. caring for patients whilst becoming alienated from what she sees as arbitrary constraints coming from outside her core nursing role, for example "silly administrators". Such a split, if it exists, cannot enhance the trainees capacity to give care within an organizational setting.

In a more recent study, Melia (1987 p.162) deduces that

> for the students nursing resembles neither the "professional" nor the "workload" approach to nursing as canvassed respectively by the education and service segments. This puts into question the whole business of occupational socialization, because students are being socialized into neither version of nursing. Instead they learn to recognize when one form of nursing rather than the other is appropriate and "fit in" accordingly. In other words they learn how to be student nurses and not how to be nurses.

Wilson's and Startup's (1991) comparative study shows that even at the commencement of training a significant number of students perceived that the sisters/charge nurses and teaching staff would expect them to perform in different ways. There were also differences in the opportunities offered for role modelling in the
different wards.

A felt problem was that students were expected to perform those skills "the school way" if they encountered teaching staff on the ward, but were also expected by most of the trained ward staff to perform the "ward way" when working on the ward.

Wilson and Startup (1991 p. 1481)

The students believed that the sisters/charge nurses were predominately responsible for the practical components of the course, and had more power than the teaching staff, although thought to be less knowledgeable. This "power" was related to the belief that teachers were only "in charge" of students, but the ward staff were leaders of the ward team.

The above studies indicate that, as Wilson and Startup (1991) conclude, student nurses do not undergo a homogeneous and integrated socialization process during the preparation to become qualified nurses. The studies support the contention that the students are often presented with different and confusing views on nursing, and the students may adopt whichever version of nursing is acceptable at that particular time to the qualified nurse with whom they are in contact. Melia (1987) is concerned with how students learn to function as staff nurses - particularly when the staff nurses, arguably role models in the ward - are more concerned with administration, rather than the patient care for which the students are being prepared.

It is from the reading of such studies as above and other American research on occupational socialization, Merton et al (1957), Becker et al (1961), Simpson (1979), together with the comments made to this researcher by some students of nursing about their feelings of confusion, anger and sometimes doubts about their training, that the idea of exploring one group of students' perceptions about nursing and the role of the nurse in some depth and over time emerged. The location of such a study was considered, accepting the problems of investigating a cohort of students in a situation where the researcher is head of the school (debated in Chapter 3), but the awareness that the richness of such a study could be enhanced by a cohort of both men and women, with a wide age range and from different ethnic backgrounds, who enter training with differing academic attainments, was felt to outweigh the acknowledged
disadvantages. It is also realised that such a study might enhance the curricula at local level, as well as providing a unique contribution to the literature on occupational socialization.

3. The local scene.

(i) The District.

The focus of this study is a Health Authority which serves a District which is among the five considered to have the highest rates for urban deprivation among the 365 Districts in England. The four indices of deprivation are taken from the 1981 Census (Country Report) -Basic, Housing, Social and Economic. The District features on all four indices. It has a diverse ethnic population, reflected in the patient and client groups receiving health care. The resident population was 145200 in 1981, and was expected to rise to 153100 by 1991, but the relatively high mobility rate makes it difficult to predict how the population will change in the future.

The Health District consists of four hospitals together with the community services, serving the local population. The main hospital was founded in 1740, and has "a proud history and reputation jealously guarded" Collins (1967). There is a medical as well as a nursing school, and students from other paramedical disciplines also receive education and training within the District. The amenities for staff include a social club, and a swimming pool on the main site where all the staff can mix and relax when off duty.

The Health Authority and the special trustees own residences on site which are made available to students, and other members of staff. The senior officers of the Authority work closely with the School to agree and fund the numbers of students, the number and types of education and training schemes to be mounted, and the criteria to be achieved for a satisfactory learning environment.

(ii) School of Nursing.

The school has educational facilities on all four hospital sites, and the main centre was
opened by royalty in 1967. The School has a valued past, having the first preliminary training school in England opened in 1895. The School has responsibility for approximately 680 students in six different educational programmes preparing the students to achieve the UKCC competencies for a first level nurse for registration on Parts 1 and 111 of the register-RGN and RMN. The largest numbers of students are in the 146 week general scheme, with six intakes of 37 students a year.

The school is also responsible for the ongoing education of the qualified staff - nursing, midwifery and health visiting - in the District, organising programmes aimed at the clinical, managerial and educational development of staff at a professional and individual level. Specific ENB courses for trained staff are also mounted eg. renal, theatre and intensive care schemes which are nationally recognised.

The majority of teachers are nurse tutors, who, like the students are employees of the Health Authority, and are nurses who fulfilled the criteria for entry into a course in further or higher education to enable them to have their qualification recorded by the UKCC. A small number of clinical teachers are also employed.

The students of nursing are recruited from all areas of Great Britain, and until 1987, the School had no difficulty in attracting applicants into all the schemes. Since that time there have been fewer entrants into nursing training (Dept of Health 1989), with this trend particularly affecting schools in city areas. In 1988, for the first time in the School's history, one intake for the 146 general scheme had to be cancelled through lack of recruits. A full time recruitment officer is employed in the School, and she arranges open days, and visits local schools and colleges to encourage interest and motivation in joining the nursing profession. An active campaign to recruit individuals living locally was mounted, and arrangements for work placements for pupils attending local schools have proved successful in helping to demonstrate what patient care means, and dispelling some of the myths about nursing, showing for example, that the role of the nurse is actually about making decisions on the nursing care of patients, and illustrating this in reality.

A video designed to attract Asian men and women into nursing was made in the School, and produced by local community groups with the support of the Health Authority and in collaboration with the Department of Health. This video - "Nursing for All" - is translated into six dialects and is available nationally, and is used as part of the school's local recruitment campaign.

The School collaborated with a local College of Further Education in developing an Access to Nursing scheme, mentioned previously. (Appendix 1). This initially was
aimed at attracting individuals from the local Bengali and Somali population, who, for whatever reason had not been able to attain the usual educational requirements for entry into nursing. The scheme was not successful in recruiting from these two specific groups, and the target population was enlarged to include anyone living in the local communities. Approximately 70% of the total of 39 who entered the three approved intakes were successfully recruited into nursing training. The school's recruitment department stated it is more difficult to attract candidates directly from overseas into training although this does happen. The difficulties are the need for an interview with the candidate perhaps having to travel to England, a student visa, and probably the biggest problem, in obtaining a work permit on completion of training, which has to be approved by the Department of Employment and the Home Office.

Since 1987, there has been an increase in the number of men entering the general nursing schemes. Prior to this period, the norm was one to three in an intake latterly the percentage of men to women has increased to 30-40%.

Nursing service personnel and teachers participate in the selection of candidates, who are invited to bring family and/or friends, and a tour of the clinical areas, accommodation and School facilities is made prior to the interview. This part of the process is made as informal as possible and efforts are made to enable the interview to be a sharing experience. A "criteria check list" is used to eliminate as far as possible, the interviewers selecting those who conform to their (the interviewers) expectations of what may constitute a "good nurse". The interviewers' expectations of students are discussed, for example, the need for students to take a great deal of responsibility for their own learning, and the value of previous knowledge and experiences. The candidates are encouraged to relax and questions are answered as accurately as possible. It is spelled out that residency is not mandatory, but accommodation is on offer.

In this School, students were required to be resident until the mid 60s, then for the first six months, until the 1970s when students could choose to be non resident from the beginning of the course. In the 1980s, approximately 40% of the total student population lived out, the majority being second and third year students. The stated reasons for moving out are the need to get away from the work situation, and being restricted by rules and regulations.
4. Issues to be addressed.

Having decided to undertake an investigation locally into one cohort's perceptions about nursing and the role of the nurse, the questions to be asked are-

- Do these perceptions change, if so, when, why and how do they change?
- Do they vary between the men and the women?
- Does previous educational attainment and age have any relevance?

Research that focuses on a limited number of aspects of socialization studied at a particular point in time, rather than over a period, "capture only temporary reactions to immediate situations" (Simpson 1979 p.206).

This study focuses on one cohort of students, as they experience the formal and "hidden" curriculum, and on their views and beliefs as they progress over a 3 year 10 week period. A longitudinal case study approach was therefore adopted. Data were collected by a researcher who had followed a similar (albeit not the same) process of professional preparation.

Summary.

This chapter has introduced the research, given reasons for its location and the type of study being undertaken, and placed it within the national and local professional scenes. The next chapter explores the concepts of nursing, learning, and socialization into the role of the nurse, and ends with the framework of the research study.
Chapter Two.

Becoming a Nurse.

Yet a nurse must be something more than a lift or a broom.
Florence Nightingale 1898 p.98.

Introduction.

Student nurses are expected to become competent practitioners of nursing, and to perform the role of the qualified nurse following a three year ten weeks preparation period. During this time, the students learn the appropriate knowledge, skills, values and attitudes which form the essentials of professional nursing.

1. What is nursing?

There continues to be much debate on the definition of nursing. Henderson (1978) argues that as long as organisations at all levels define nursing and nurses in different ways, and as long as nursing personnel are prepared for their work differently and given different rewards and roles in health services the concept of nursing will continue to be debated.

Many candidates at selection interviews for entry into a preparatory programme to become nurses, identify nursing as giving care, and this is the main reason they wish to become nurses.

Henderson (1978 p.117) writes that most people including nurses would agree that, of all health providers, nurses render the most intimate personal service, and that this service is the most constant factor in health programmes since the nurse is the only category of worker available on a 24-hour, 7-days a week basis. ------ if there is a universal concept of nursing it embodies the characteristics of a service that is
intimate, constant and comforting.

Clark (1991) in a letter to the British Medical Journal suggests that there are two main perspectives on nursing, the first that it is a collection of tasks or procedures requiring a degree of manual and technical dexterity and little knowledge, the second that nursing is a kind of interpersonal interaction with the goal of enabling people to maximise their potential for health, to promote comfort, healing and recovery. She argues the distinguishing factor between this perspective and the first "is its intellectual component: the use of clinical judgement based on knowledge" (Clark 1991 p.376).

Vaughan (1992 p.162) writes of her own experiences as a nurse, and suggests that the so-called basic nursing tasks which are deemed to be simple---are fundamental to nursing.

She considers that many of these tasks and acts e.g. washing, toileting, belong to the private domain of nursing, and are not openly discussed unlike operations or medical treatments.

However nursing is defined, the title of nurse is protected by statute, and to become registered, students have to achieve prescribed UKCC competencies (UKCC.Nurses, Midwives and Health Visitors Rules Approval Order 1983 No 873,18(1)). These competencies require the students to demonstrate knowledge of the scientific basis on which their practical skills are built. In applying this knowledge, the students learn to adapt their skills to suit the particular individual or individuals and the specific circumstances in which the care is given. The practice of nursing takes place in many different situations - the ward, home, factory, school, health centre for example - and is affected by the developments in medicine, science, the patterns of health care and its provision, as well as national and international trends, for example the Nurses Midwives and Health Visitors Act 1979, which followed the Committee on Nursing (Briggs Report) recommendations in 1972; the European Nursing Directives 1977.

Students use cognitive processes to assess the needs of a patient or group of patients, to plan and deliver the care according to their needs and circumstances, and to monitor and evaluate the care given. This requires clinical judgement, and the students learn this under the supervision of qualified nurses, who use professional judgment and skills gained from past experiences and an informed knowledge base.
Carper (1978) suggests there are four domains of knowledge in nursing, which are used in every nursing act; the scientific, aesthetic, moral and personal knowledge of self. As students learn about nursing and the role of the nurse, they also learn about themselves as individuals as well as students of nursing, and how others perceive them in these roles.

The knowledge, skills, standards and values inherent in nursing are learnt by the students in different ways and in different contexts - from the formal curriculum in the classroom and clinical placements - and the covert curriculum, social interactions between peers, student and nurse, teacher, patient, auxiliary, doctor, and others. The students may receive overt and covert, and sometimes conflicting cues and messages from these important socializing agents met during the course of the training period preparing them to become nurses.

The role of the nurse is learned to a great degree, by a process of socialization. Cox (1983 p.120) postulates that whether or not nursing is a profession, it fulfils a number of generally recognized criteria for professional status, and the preparation of students to become qualified nurses is frequently considered to be a process of professional socialization.

Bradshaw (1986 p.51) proposes

Learning in basic nursing courses occurs by teaching, training, conditioning and indoctrination but little of this conforms to criteria by which professional education is recognised. Indeed the most potent source of learning is by socialisation. Learning occurs as students interact with other significant people in their working environment with whom they have to co-operate in order to learn the rules and survive.

Socialization is therefore a learning - but not necessarily an educational - process. Jarvis (1986 p.468) suggests that socialization is a social process that happens to an individual or group of students as they undergo the process of professional preparation, irrespective of what type of education is practised. Informal situations provide opportunities for individuals to get close to others to observe their behaviours, and to imitate and practise them.
2. Socialization.

Socialization is a continual process from birth to death, and is part of the culture, being essential to the survival of the beliefs and values of that culture. It is through a series of complex interpersonal relationships that individuals learn the roles and the behaviours expected of them in these roles - and what they also expect and demand of themselves. The behaviour which conforms to the expectations of others may be rewarded, for example through acceptance into an admired group; behaviour which is deemed incorrect may be punished, for example denial of group membership. An individual must be able to predict how others will react to him to guide his own performance successfully (Brim 1966).

Berger and Luckmann (1967) distinguish between primary socialization, the process an individual undergoes during childhood, and secondary socialization - being any other subsequent process including socialization into an occupation. Jarvis (1983 p.88) suggests that socialization into an occupation forms a major part of this secondary socialization, but another sociologist believes that the whole process of role development and behaviour in an occupation is a separate process, which he calls tertiary socialization (Musgrave 1967). In these processes the objective world of reality becomes internalised and meaningful to the individual. Values, ideals and attitudes are internalised by interaction at a personal level and built on those acquired earlier in an individual's experiences. This may give rise to conflict, if there is incongruity between the values and ideals. Resolution of this conflict depends on many factors, for example the motivation of the individual to succeed in the role and the perceived rewards, amount and type of group pressure, particularly from peers and family.

It was noted in Chapter One, that more men are entering general nursing, but some may have to convince their families and friends, and sometimes professional colleagues, that nursing and nursing acts may be performed by men, and are not solely the province of women.

Jarvis (1983) indicates that while many of the experiences a new recruit into a profession learns are as a result of socialization, he views this as a distinct process from professional education although occurring concurrently and sometimes it is difficult to distinguish as a separate entity. This may be illustrated by the following example. In learning about death, the care of the dying patient and the bereaved, the students of nursing may learn how to comfort the bereaved by observing how the
trained nurses in the ward deal with the situation - observing and copying their actions, a form of occupational socialization. The students may learn, for example, that it is acceptable to share emotions with the bereaved, but this will depend on the attitudes and behaviours of the trained nurses. One may feel it is unprofessional to weep with the relatives of a dead patient, whilst others may encourage the students to share the grief. As the students become more experienced, and learn from these experiences, they may decide for themselves the most appropriate behaviour. This they may exhibit, or conform to the trained nurses' expectations with whom they are working, if these conflict with their own beliefs.

By discussion and reading on this subject, the students may gain further professional knowledge and understanding, from research and from planned professional educational experiences - planned seminars and lectures, debates with the tutor and the peer group - in which the feelings and views of others can be expressed and explored. This, it is argued is where occupational socialization and professional education offer two approaches to a particular situation.

In the above example, the students may learn from all the experiences. The qualified nurses are dealing with people in situations which are meaningful to the students, the nurses are relating directly with people and may be seen as credible role models. The way the nurses behave, as ones in authority, can influence the students, and this learning process is akin to professional socialization. In the other situations, it can be argued the processes are educational, education being viewed as

\[
\text{any planned series of incidents having a humanistic basis directed towards the participant(s)' learning and understanding.}
\]

Jarvis (1983 p.5) (researcher's emphasis)

Brim (1966) writes that the number of people directly involved in the socialization process has a great influence on the individual because of the frequency of contact, as well as their perceived importance to the individual and their control over rewards and punishments. In nursing practice, the ward sister/charge nurse is in charge of the ward, a person of power and authority (Wilson and Startup 1991). The staff nurses are sometimes perceived as having more influence on the students' learning than the ward sisters, and are the specific role models because they are seen as supportive and have interpersonal skills, while the sister is the person who administers and plans the ward work (Ogier and Barnett 1986). The qualified nurses give praise or blame if the behaviour of the students matches, or does not conform to their particular
expectations, or the norms of the ward. These sisters and staff nurses in wards where students of nursing are placed, are "formally charged" with the training of these students (Wheeler 1966 pp.54-55). These socializing agents also form an important part of the student's role set, defined by Merton (1957 p.369) as

that complement of role relationships
which persons have by virtue of
occupying a particular social status

Difficulties may arise if these qualified staff do not see themselves as contributing to the students' learning experiences, treating them as "pairs of hands" rather than as individuals needing to be supervised and taught skills inherent in nursing practices. This disruption of principles fostered by the school of nursing can cause conflict for the students, who may learn when and how to produce whichever version of nursing is required (Melia 1987, Wilson and Startup 1991).

People socialized together communicate with each other more frequently, and can establish quite a social force. By enabling students to remain in a particular set throughout a three year period (see Chapter one), friendships are formed enabling a sharing of feelings and experiences, for example anger, frustration, and concerns in a safe, secure environment. The set may be targetted as a totality in the socializing process by others. Sets may be given numbers, and it is not uncommon for a set to be known as "stimulating" or alternatively as a "disruptive" group. This stereotyping can take place in reverse, with a particular sister or tutor being viewed by the set as "difficult" or "friendly" even before many of the set have had direct contact.

On entering a scheme of training, an individual changes both social and occupational status, and this change may be marked by various symbols and rites. For example, many schools isolated the set in a large building away from the learning environments, and this was known as the PTS (Preliminary Training School). It is interesting to note that the term PTS is still used by many current students who have never undergone such an experience. The group may be identified as a specific set (see above), and individuals may wear uniform and be called nurse by others. As the students make these status changes from the school to the wards, then rotating into different wards, they have to develop workable definitions of the environments very quickly to help guide their actions. How the students adjust depends to a large degree on the social climates in the wards established by the sisters (Wheeler 1966).

The wearing of a uniform confirms a degree of professional status and a sense of
belonging on the students; but it may also, in others, raise expectations of professional behaviour and standards of ability which the students have not achieved. Pride in identification as a nurse can therefore also give rise to feelings of anxiety, a lack of confidence. It can be argued uniforms give a degree of protection - sanctions the students' right to perform nursing skills - but they may create social distances between students and the patients, who may expect the students to conform to their expectations, the stereotyped image of nurses who are knowledgeable, trustworthy, honest, clean. The students may also wear different uniforms from each other according to their year of training, and from the trained staff, reinforcing the social and professional distance between them, but which may also act as motivation to the students, symbols to be achieved.

3. American research into occupational socialization.

Simpson (1979) proposes that the two fundamentally different views of socialization into a profession as evidenced in two classic studies "The Student Physician" Merton et al (1957), and "Boys in White" Becker et al (1961) need not compete, both are essential aspects of socialization.

Merton et al (1957) found the relationship between the medical student culture and the medical faculty was complementary, rather than conflict ridden. The students were like colleagues being groomed to full professional status.

-----it is the function of the medical
school to transmit this subculture to
successful generations of neophytes.

Merton et al (1957 p.71)

Becker et al (1961) emphasise the subordinate status of the medical students, with a marked social barrier between the students and the medical school. The students in Becker et al's study reacted to educational experiences, shaping their own behaviour and forming a distinct subculture.

Simpson (1979 p.10) argues that a main difference between these two approaches to professional socialization

hinges on the question of social control
of behaviour, its locus and its effects on
the orientations and behaviour of the student and the certified professional.

Merton et al (1957) suggest the medical students learnt norms and values of the practitioner role and the medical profession, during their educational and training period - the professional school being

both a part and an agency of the profession, charged with inducting students into it in a way that ensures its continuous structure and function.

Merton et al (1957 p.10)

Alternatively, the model presented by Becker et al (1961) views social control as a matter of power - the students being students in separate groups, not part of the medical fraternity, with the learning of attitudes and behaviour appropriate to a qualified practitioner occurring after, not before, the individual becomes qualified (Simpson 1979 p.11).

Simpson's own study into the professional socialization of students into nursing specifies the multidimensional nature of occupational socialization, suggesting it involves

learning skills and knowledge of the occupation, developing orientations to the occupational roles and a place in the occupation, and relating the person to the occupation. Each dimension consists of distinct processes, and these were developed by different conditions.

Simpson (1979 p.225)

This study investigated students at least one year after graduation and found

---that orientations persisted across the status transition from student to practitioner, but personal relatedness to nursing declined. This difference in persistence indicates again the multidimensionality of socialization, and the need to distinguish its dimensions in
analysis.

Simpson (1979 p.229)

Oleson and Whittaker (1968) in their work on student nurses, discuss the concept of "studentship", (a similar concept to the students'culture described by Becker et al 1961), - strategies for success and survival developed by the students - and propose the students created their own guidelines for safety and protection against what they viewed as the untrustworthy members of the school

studentmanship also provided some insulation for the student self, since it incorporated the student norms on how much of that self to expose in meeting the institution's demands for expression of awareness. -------norms of student culture constituted an added set of difficulties that sharpened awareness, for presentations of self frequently had to be made to two audiences, faculty and peers whose rewards and punishments were on the one hand official success or failure, and on the other the esteem or derogation of classmates.

Oelson and Whittaker (1968 pp.292-293)

Issues highlighted in Chapter One and the above studies, such as the perceptions of students about the relationship of the clinical situation to the school; friendships within the set; whether their training prepares students to perform the functions of qualified nurses; and if attitudes to nursing and the role of the nurse change once the students become staff nurses, are addressed in this current research, and in later chapters.

Wheeler (1966 pp.53-54) proposes that socialization processes are not just confined to closely knit networks, for example, the student set, and suggests that much can be learned by a close look at the structures and situations within which the process of socialization occurs. The next section of this chapter focusses on the students in the current study, and the school and formal curriculum to which they are exposed.

4. Framework for the present study.
4.1. The curriculum.

The curriculum is devised on a modified modular basis in accordance with the stated philosophy of the School, but within the parameters set to provide a continuous flow of students to the clinical areas. A module consists of a preparatory formal study period followed by a planned clinical experience and a consolidation study session. This sequence is not always followed in the scheme, due to changes in the current clinical situation. (Appendix 2.)

(i) Introductory period.

The main aim of the seven week introductory period is to introduce the students to nursing and nursing skills and the first ward placement - the care and welfare of acutely ill adults. Visits to the wards with the tutors are undertaken during this time to enable the students to become familiar with the setting, and for essential care to be given under supervision e.g. bathing the patient in bed. Subjects contributing to nursing, such as physiology and anatomy, communication, as well as theoretical concepts of nursing are taught during this period.

(ii) Study sessions

The titles of the nineteen study sessions are given in Appendix 3. Appropriate visits are arranged and experts brought in to speak with the students, for example a pharmacologist, a partially sighted person. Study days when the students leave the clinical areas, are arranged during certain placements, e.g. the care and welfare of the mentally ill, the elderly. The maternity care experience in the third year is a self contained unit of learning. Community experience, a minimum of 60 hours, is integrated into specific sessions during which the students accompany health visitors, district nurses and school nurses to clinics and other community areas.

(iii) Allocation.
The planning of the clinical experiences is undertaken by a senior nurse, not an educationalist, supported by administrative staff and a computer system. This nurse liaises closely with senior tutors, tutors, and clinical nursing staff, and meets with each set of students at regular intervals to explain the allocation and listens to complaints and requests. The students are able to ask for specific off duty, which at times is agreed. Night duty commences after the first two ward experiences and conforms to the ENB 1977 syllabus requirements, of 320 minimum to 1440 hours maximum reducing to 960 hours as soon as practical.

(iv) Clinical experience.

Students are allocated to specific wards and departments and are notified approximately four weeks prior to the experience.

The wards are headed by a ward sister/charge nurse supported by a stated number of staff nurses (first level nurses), enrolled nurses (qualified following a practical based programme), and auxiliaries who receive an inservice training. Experience in the assessment, planning, giving and evaluation of care - the nursing process, part of the District's nursing philosophy - is gained by the students under the supervision of qualified staff, one of whom acts as a mentor to a student. All full time nursing staff including students, work a 37 1/2 hour week, which means in practice, the student and the staff nurse or sister may not work on the same shift unless it is planned at the time the ward allocation is devised.

The mentor role, for which the staff nurses and sisters and charge nurses are formally prepared, is seen as one of support and advice, together with the teaching and assessing of the students' progress.

The ward sisters/charge nurses are responsible for the management of the area, both in terms of patient care and the environment. They are the key people formally in the wards, who together with the staff nurses, devise a philosophy of care, which is translated into models of nursing geared to the needs of the patients. Pembrey (1980), describing the role of the ward sister in the management of care on an individualised basis, found that 82% (41 out of 50) of the sisters in a sample drawn from five general hospitals - three in England two in Scotland - did not manage the daily nursing on an individual patient basis. Those who did were among the most highly qualified academically and professionally in the total sample.
In the current situation, the qualified staff work closely with the tutors linked to the wards to specify the outcomes of the learning experiences which may be achieved by the students.

A senior nurse (nursing officer) co-ordinates and monitors a group of wards and/or departments.

(v) Tutors.

The organisational structure of the school underwent a radical change in 1985, documented by Parker (1987).

The policy is for tutors to teach both pre and post registration students and qualified staff from their areas of expertise in the school and in the clinical areas. The students are exposed to a variety of teachers and teaching methods e.g. lectures, project work, seminars. A senior tutor co-ordinates and monitors parts of the curriculum and ensures that time is offered during study sessions for the students to meet with their personal tutors.

Personal tutors are responsible for a number of students from each set, and remain with the students throughout the training period. The students and personal tutors have a degree of choice in the partnership, being able to change to a different person at any stage. The personal tutor role is seen by the tutors as one of supporter and friend, the focal point of contact and for discussions on academic and clinical progress. This tutor would also be the one to initiate the first part of the disciplinary process should the students fail to meet the set standards of academic and/or clinical competences, or if there was "excessive" sickness and/or absence.

(vi) Assessments/Examinations.

The students are assessed in specified domains of clinical competencies - practical, social, teamwork, communication, teaching and management - in the clinical placements. The stated procedure enables feedback on performance to the student by a staff nurse or ward sister/charge nurse, and the final level of achievement in each of the domains of nursing are agreed by the qualified staff and discussed with the student. Problems in performance are discussed with the student and also with the
personal or link tutor to the ward. This system of ongoing assessment (BARS- Behaviourally Anchored Rating Scales) is research based, and devised specifically for and with the school of nursing (Dunn 1984 pp.55-59). Written examinations are held in study sessions 5,7,10, with a final determinate examination in accordance with ENB regulations held nearing the end of training. Students are enabled to sit the examinations twice and are also expected to submit projects, essays, and care studies for marking and comments throughout the course. The students apply for posts as qualified nurses (staff nurses) near the end of their training period.

(vii) Student Council.

The policy of the School is to enable students to participate in the majority of groups and committees of the school, e.g. library, course monitoring. A specific group, the Council, is formed by each set of students electing a set leader and a deputy to sit on this Council. The Council has its own officers and conducts its business according to the constitution. The Council invites people to meet with the members, e.g. the Principal, catering manager, and circulates the minutes of all meetings to wards, departments and the school. The Council acts as a forum for the airing of student problems and acts on behalf of its members in meeting with authority.

5. The cohort.(Appendix.4)

The respondents in this study formed a set who entered this 146 week general training scheme in April 1987 and completed it in July 1990. The set numbered 27, from different ethnic backgrounds. One of the number joined the set after the Introductory Course, having commenced with a previous group but having a period of sickness which necessitated “dropping down” a set. 21 of the set were women and six were men, with an age range on entry of 18-36. Seven members left the set at various times during the first two years (see Chapter 8).

The 21 women and six men had previous experience in “looking after” people in some way e.g. voluntary work in hospital or homes, auxiliary work, looking after children, handicapped or elderly.

The academic entry ranged from four admitted via the first Access to Nursing course,
to two with degrees, with the remainder having achieved five or more O/GCSE levels (or equivalent).

Summary.

This chapter illustrates how students may learn to become nurses and develop as individuals as they undergo an ongoing period of formal education and socialization, then focuses on the locus of the present study.

The next chapter will begin to detail the rationale and methodology used to explore the perceptions of the cohort of students, and the "significant others" involved in the process of the socialization of the respondents into the nursing profession.
Chapter Three.

Methodology

In all qualitative research the purpose of enquiry is to identify the properties existing in the real world and to gain a fuller understanding of what constitutes reality for the informants in a particular real life setting. Thus the understanding that emerges from the research is the product of the interaction between the researcher and the phenomena under study.

Field and Morse 1985 p.111.

Introduction.

Treacy (1987) notes the importance of considering the messages implicit in, and the incidental learning that takes place in, the training experiences of students. The focus of this study is on the individuals' perceptions of events and people and the principal concern is

with an understanding of the way in which the individual creates, modifies and interprets the world in which he or she finds himself or herself.

Cohen and Manion (1985 p.9)

The questions posed in this ethnographic study are:

• what are the perceptions of students about nursing and the role of the nurse on entry to the course?
• do these perceptions change as the respondents are exposed to a variety of formal and informal learning experiences?
• if so, when do these occur and what influences these changes?
• are there differences in perception between the men and the women, between those who entered training with different academic attainments?
• is age relevant?
• what are the views of "significant others" - people in authority to students - about nursing and the role of the nurse? Do they concur with each other and/or with the respondents?

A longitudinal case study approach was selected because of the focus on the individuals' experiences and possible changes in perception; trends can be established; a diversity of data collection methods were employed to reduce possible researcher bias and enhance external validity. The underlying reason for the methods used in the data collection was the need to understand capture and record the individuals' own views and beliefs - their subjective reality. The interview was the main method selected supported by repertory grid, open ended questionnaires, retrospective biography, and written evaluations on specific experiences.

Statistical information - pass rate on examinations, sickness/absence, wastage - was collected, not to make comparisons with other groups but to place the cohort within the context of the school and to provide an holistic view. While the emphasis in this study is firmly in the qualitative approach the premise is that there are strengths in using quantitative measures to augment the qualitative data e.g. it is meaningful to note if 19 out of 21 women had similar perceptions. Akinsanya (1988 p.22) considers that if numerical analysis is used with qualitative data the problem of subjectivity and inadequate attention to the need for validity and reliability are minimised.

The researcher's working life has been spent in nursing and nursing education - therefore directly involved in the process of socialization into nursing. The issues raised in the literature, highlighted in Chapters One and Two are those experienced by the researcher. In this study, which took place within the context in which the respondents worked, the researcher attempted not to intervene or to manipulate variables. The aim is to describe phenomena and induce meaning from the data.

Anyone who has done research involving humans is well aware that one cannot abandon one's own humanness in the interest of "objective" inquiry; it is both impossible and ethically undesirable to do so.

Guba and Lincoln (1982 p.240)
This is therefore a qualitative - interpretive approach consistent with the naturalistic model or paradigm tradition. Guba and Lincoln (1982 p.235) argue this is a tradition which offers a contextual relevance and richness unmatched by any other paradigm and displays a sensitivity to process (not control and experimentation), and is grounded in the theory which arises from the data.

Research previously mentioned into occupational socialization in nursing in Great Britain all arguably falls within this qualitative-interpretive model with emphasis on the participants' views of the world, and by the analysis of their responses to generate theory from the data, or to suggest possible trends in the socialization of students into nursing.

1. The longitudinal case study approach.

Polit and Hungler (1989 p.156) maintain that

case studies provide the researcher with
the opportunity of having an intimate
knowledge of the subject's condition,
thoughts feelings, actions (past and
present) intentions, and environment.

This approach enables the respondents to explore fully the reasoning behind the study and to become used to the notion that it was their own world which is of interest, and gradually to relax when in an interview encounter with the researcher.

One main disadvantage of this approach is that sample mortality can and did occur. The remaining respondents were obviously not as representative a sample as the original number, but this is the "real" world. Environments, people and their views, do not remain static but change over time. A nursing curriculum, for example, should be dynamic to reflect the changing realities of the health care settings. The nature of this longitudinal case study approach enables an illumination of the reasons why wastage did occur. A cross sectional sample might have eliminated sample mortality, but it would have been an unsatisfactory way of obtaining developmental data, with sampling complicated because different subjects would be involved at each level and might not have been comparable (Cohen and Manion 1985 pp.73-74).
Questions posed in this study were "why" and "when" and "how", and Yin (1989 p.13) suggests the case study is the preferred strategy when these questions are posed. He writes

A case study is an empirical enquiry
that: investigates a contemporary
phenomenom within its real life context;
when the boundaries between
phenomena and context are not clearly
evident; and in which multiple sources
of evidence are used.

Yin (1989 p.23)

Heyman Shaw and Harding (1984 p.33) warn that great caution must be taken not to
generalise from particular groups of students in particular hospitals to the
socialization of nurses in general but, as Cohen and Manion (1985 p.120) suggest, the
purpose of a case study is to probe deeply, and to analyse intensively with a view to
establishing generalisations about the wider population to which the cohort belongs.
Data from this study might constitute the basis of hypotheses - suggesting further
questions to be investigated.

2. The locus of the study.

The decision on where the study should take place was deliberated on by the
researcher, and the pros and cons of undertaking it in the researcher's own institution
debated with peers. The problem of finding the time to travel - to be determined by
the individual needs of the cohort and their specific curriculum - was weighed against
the respondents meeting the researcher in another role, as Head of the School. In both
instances, the position and status of the researcher would be known. The researcher
was constantly aware of and alert throughout the study to the possibilities of bias,
because of her role and perceived position of power and authority within the nursing
hierarchy, and of the danger that the respondents might give responses they felt the
researcher wanted to hear particularly about her own institution. It can also be argued
that students in another school might have held the researcher in greater awe as an
esteemed figure in nursing education, but in her own school she might be viewed
simply as the head. Therefore this might have increased the risk of bias, whereas
conducting the study in familiar surroundings over time, might enable the respondents
to know and accept the Principal in differing roles.

The researcher was slightly heartened to read that it is an erroneous assumption that forms of research exist which are immune to prejudice, experimental bias or human error (Parlett and Hamilton 1977). They suggest that any research study requires skilled human judgements and is therefore vulnerable. This researcher kept the possibility of bias to the fore-front during the study particularly during the interview sessions (see below), but believes that knowledge of the respondents and of the specific context in which the study took place, plus the fact that at a later date changes might be made at local level outweighed the acknowledged disadvantages.

In adopting the case study approach, this researcher is conscious of the criticism levelled by Atkinson and Delamont (1985 p.29), who write

\[
\text{it is therefore quite meaningless for authors of the case study persuasion to write as if the world were populated by "cases" whose status and existence were independent of methodological and theoretical concerns.}
\]

It might be true that the world is populated by little semi-independent organisational groupings, but the intent in this chapter is to demonstrate that the methodology used is well thought through and appropriate to this study. The rigorous application of the methods used will be illuminated in the following chapter.

3. Triangulation.

The use of triangulation means that not only was the risk of researcher bias lessened, but the richness and complexity of human behaviour was explored more fully within the context of this study (Cohen and Manion1986 p.254).

\[
\text{Triangulation, or the use of multiple methods is a plan of action that will raise sociologists above the personalistic bias that stem from single methodologies.}
\]

\[
\text{Denzin (1978 p.294)}
\]

Exclusive use of one method could have distorted the researcher's picture of the
reality presented, multi method use enabled a much more holistic presentation.

(i) The interview.

The main method of data collection in this study was the interview with the researcher participating in a face to face dialogue with individuals, getting close to them, and endeavouring to view the world from the respondents' perspective (Schatzman and Strauss 1973 p.69).

McHaffie (1988) proposes that interviewing is the ideal method for exploring an individual's attitudes values and knowledge. This was the appropriate method to be used in this study which explored the respondents' own views and perceptions of their experiences. Fox (1982 p.213) warns that questioning always involves an artificial situation in that people are asked for a verbal response rather than actions, and even if the verbal response is a statement about an action - it involves either what they will do or have done - and in this sense it is artificial.

A totally structured instrument, whether it is a questionnaire or interview, in which respondents would be asked to answer set questions in the same order, with closed ended questions or fixed alternative answers was debated, but considered to be restrictive and formal. Closed questions are more difficult to construct than open ended, but easier to administer and analyse. One main objection to their use is the possibility of the researcher overlooking some potentially important or vital response (Polit and Hungler 1989 p.195). It was recognised that such a method would have enabled comparability of the responses between individuals, but this was not the aim of this study.

One other method of data collection was considered, the questionnaire. This would have enabled data to be collected at specific points in time over the three year period. The positive aspects considered were that anonymity might have been more complete, questionnaires are less costly in time, and researcher bias might be minimised, because the responses would be to a written question rather than an interviewer. The response rate however, tends to be lower in this form of research than in face to face interviews, and it might be possible for the group to collude over responses. The length of time needed for the data to accumulate would be the same for both methods. The interview belongs to a more humanistic approach with the interviewees getting to know the researcher over time. The interviewee, or the interviewer can be asked for
clarification, and certain points clarified or elaborated. The questions in a questionnaire may be liable to misinterpretation by the respondent, and the answers by the researcher. Compared with written questionnaires, verbal dialogue has the advantages of flexibility and increased depth, and the interviewer can encourage reasons to be given for statements which can also be followed up. A danger is that the situational context and the interviewer's personal views and feelings might colour interpretations. The data derived are the product of an interactive exercise, and selected parts of the analyses may be used to illustrate the interviewer's perceptions rather than the interviewee's meaning. (Pope and Denicolo 1986 pp.154-155)

The researcher acknowledges the possibility that the respondents may have felt pressurised to participate in an ongoing dialogue with the interviewer being the Head of the School. It was, however, hoped that the considerable experience of the researcher in interviewing men and women of similar ages to the respondents, would have enabled a rapport to be developed over time with the respondents so they felt relaxed and confident enough to express their feelings as time went on.

In the event, an open ended questionnaire was used on two occasions in this study, at the very beginning and end of the training period and the same questions about the respondents' perceptions about nursing and the role of the nurse were asked each time. This method was used to enable the respondents to have time to reflect on their knowledge and past experiences, and to write their responses without being influenced or prompted by the researcher's questions.

(ii) Personal biography.

Denzin (1970 p.220) suggests that life history materials may include any document or record that might throw light on the subjective behaviour of an individual or group, and Polit and Hungler (1989 p.193) maintain that much information can be gained by asking people to report on their own experiences. One method used in this study was to ask the respondents to reflect individually on their lives, and to identify critical incidents which had led them to commence preparation to become nurses and which had affected their perceptions of nursing and nursing education during their first year. Reflection on past experiences and motives may open up new avenues and perspectives to be explored, and together with interviews, would enable the researcher to gain a greater understanding of the respondents' views of their experiences.
(iii) Repertory grid.

Repertory grid technique allows the interviewer to get a mental map of how the interviewee views the world, and to write the world with the minimum of observer bias.

Stewart Stewart and Fonda (1981 p.5)

The use in this study of repertory grid was to elicit from the respondents their own personal constructs of the people they believed helped them learn about nursing. Personal construct theory stems from the work of George Kelly in 1955, who postulated that there is no objective truth, and events are only meaningful in relation to the ways they are construed by the individual. Cohen and Manion (1985 p.315) suggest that personal constructs are the dimensions that men and women use to conceptualise aspects of their day to day world.

Repertory grid techniques are methods used to assess the relationships between constructs and all forms have two characteristics in common, constructs and elements - the stimulus objects that the person evaluates in terms of the constructs he employs (Cohen and Manion 1985 p.316).

In this study, the elements (stimulus objects) were the people with whom the respondents would have come into contact during their training. These elements were prescribed by the researcher, but the respondents could have added to them if they so desired. As mentioned above, the constructs were the respondents own, and not supplied by the researcher.

The use of the repertory grid technique in this study was part of a wider methodology, with the aim of adding to information already gained from the respondents on a specific topic using a different technique, as a form of triangulation.

(iv) Evaluations of formal study sessions.

The respondents were asked to evaluate in writing some of the formal study sessions held in the School starting with the introductory course, this being part of the normal
procedure followed by all sets. These evaluations varied from the completion of a printed form with specific questions to be answered, to a rating scale to be ticked with 0 being the negative and 5 the positive pole.

The analysis of these evaluations enabled the researcher to obtain a clearer picture of the respondents' impressions and reactions to school, the teaching and teaching methods, and added an extra dimension to the researcher's understanding of the respondents' perceptions.

(v) Numerical information.

Goodwin and Goodwin (1984) purport that although certain research methods are usually linked to a particular paradigm the association between paradigm and method is far from exclusive. They suggest it is important not to be rigid in the use of methods to match the paradigm. They write

> At a time when methodological advances (including substantial contributions from ethnographic and other qualitative approaches) have increased the options available to researchers it seems unfortunate to artificially dichotomize quantitative and qualitative research procedures into two non-overlapping sets with cross use prohibited.


In this study the amount of sickness and absence, the wastage and examination pass rates of the respondents is determined and compared with the School average, to add a further dimension to the analysis and to obtain an holistic picture of the cohort. The number of male and/or female respondents who shared similar or different perceptions are given to enable some of the questions posed in the study to be answered meaningfully.

4. Data analysis.
Polit and Hungler (1989 p.47) indicate that the data themselves do not provide answers to the research questions. The data must be subjected to an orderly and systematic analytical process. They write (1989 pp.315-316)

The purpose of data analysis regardless of the type of data one has, is to impose some order on a large body of information so that some general conclusions can be reached and communicated in a research report.

The process used in this research study (but not for the repertory grid) is a type of content analysis. As Field and Morse (1985 p.103) indicate the types of content analysis in recent years have proliferated, for example linguists write of semantic analysis (analyzing the language), others of analyzing for themes (phenomenologists). Fox (1982 p.392) suggests a distinction between content analysis at the manifest level, what the respondent said, and at latent level where the researcher attempts to code the meaning of responses. As Carney (1972 p.11) writes,"complete objectivity is not possible". In this study, verbal and written data were scrutinised with the researcher attempting to code the meaning of responses and seeking to make inferences about what was meant or implied, with direct quotes used to amplify and illuminate the findings. The determining of the attitudes of the respondents towards nursing and the context in which their experiences took place, forms a crucial part of this study. It was not the intention to quantify all the data because the qualitative material provided a rich source of information, enabling an understanding of the world from the respondents' perceptions. It was felt important however, to identify the number of respondents who stated or implied the same or similar views, as this would be meaningful in the context of this study. One of the questions raised in the study is whether gender has any influence on the perceptions of the individual, therefore responses from the men and women were analysed separately.

5. Research design.

This study is unique - a humanistic inquiry into the progress and development of one cohort of student nurses over time. It was considered inappropriate to conduct a pilot study on a different group. It would not have been possible to pilot everything!
The initial design of the study concentrated on the perceptions of the student
respondents, with data being collected through interviews, personal biography,
questionnaires and repertory grid technique. Field and Morse (1985 p.96) suggest that
as the research progresses and the researcher gains insight into the research problem
new questions may arise to be tested. Seven months into the study following one
session of interviews with the respondents and discussions with peers, the researcher
decided the study would be enhanced by interviewing the personal tutors to the
cohort, because they were key figures in the respondents' socialization process.

Three years into the study the design was amended to include interviewing the
respondents once they had qualified as staff nurses, to discover if perceptions had
changed and in what way. One of the aims of the 3 year 10 week preparatory
programme is to prepare students to take on the different roles and responsibilities of
the qualified nurses. It was important to discover if the respondents perceived
significant differences in their roles and if they believed they had been prepared
adequately. At this point, the researcher decided to interview a selection of ward
sisters/charge nurses from the areas where the respondents would be working as staff
nurses to elicit their perceptions of the role of the staff nurse, (but not of the
respondents as individuals), their own role and the ward as a learning environment. At
this time also - seven months following the qualification of the respondents - the
views of a senior tutor, tutor, and senior nurse in allocations who knew and taught this
and other sets in the school would be sought.

The reason for including these qualified nurses in the study was because they
occupied senior positions within the hospital and school hierarchy and were therefore
in positions of power in relation to students of nursing, able to influence the context
of the learning situations. They were able to "reward" or "punish" the students' behaviour e.g. passing or referring their clinical competencies and written work. The
perceptions of these individuals are analysed, and comparisons made between the
views of the tutors, tutors and ward sisters/charge nurses, and qualified staff and the
respondents.

6. Ethical considerations.

The observance of ethical principles highlighted by the British Psychological Society
in Pope and Gilbert (1987) and the Royal College of Nursing of the United Kingdom
(1977) was felt to be paramount, two fundamental principles being that no harm should occur to any participant and the integrity of the researcher is crucial.

The Royal College of Nursing (1977 p.1) states

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The researcher has obligations to the
subjects of study, to sponsors/employers
to colleagues and to the development
and promotion of knowledge.
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In this study, the aims and methods to be used were explained to the respondents, and time and opportunities given for respondents to withdraw from participation. The details are given in the next chapter.

Summary.

This chapter has illustrated the reasons for the methods used in this study the research design and the prime ethical considerations. The next chapter elaborates the methods used in the conduct of the study.
Chapter Four.

Methods Used In This Study.

The task of defining the research variables and selecting or developing appropriate methods for collecting data are among the most challenging in the research process.

Polit and Hungler 1989, p192.

Introduction.

The previous chapter explained the rationale for the methodology used in this study. This chapter sets the scene and describes the conduct and the diversity of methods used in this four year longitudinal case study.

1. Diary of events and conduct of the study.

On the first day of the three year ten week training scheme for entry into general nursing, 20F. and 6M. students met together as a set in the School. During this day the researcher met with them to explain the purpose and objectives of the study. A tutor to the set was also present at this time and queries were answered. It was emphasized that anyone could refuse to participate and opt out of the study at any time and this would have no adverse effect on their educational progress. An important principle of ethical conduct in research is that participation should be voluntary. The confidentiality of responses was emphasised, and that information shared with the researcher would not knowingly be used in the context of their progress in the course, and their names would not be used in the writing of the study or in articles arising from the research.

The role of the Head of the School, and of the researcher in that role was fully explored. As Principal the researcher would participate in some teaching and information sharing sessions for this set as for all other groups.

It was agreed the students would need 24 hours to think about the proposed study and
their possible involvement - primarily by individual interviews - and they were then seen again by the same tutor who answered any questions. She emphasised they could talk with her freely and reiterated that they need not participate, even though the study was to be conducted by the Principal as researcher. The students' training would not be adversely affected by their decision not to participate.

On the second day the researcher met with the set once more, and everyone agreed to participate. The approximate timings of the interviews and the possibility of these occurring when the set was in school was elaborated.

As can be seen in the diary of events Appendix 5, on the second day the student cohort was handed a questionnaire with three open ended questions to be answered:

a) Why do you wish to become a nurse?

b) What do you understand by nursing?

c) What do you understand by the role of the nurse?

These questions were selected because of the need to set a baseline of views on the essence of the study being undertaken, that is, the respondents' perceptions of nursing and the role of the nurse prior to the start of the formal teaching programme.

In offering this first questionnaire, time was allocated to enable each respondent to write a response individually within the group, and the respondents were asked not to discuss their responses prior to writing them. Opportunity was taken to reiterate the principle of being able to withdraw from participation at any time. Queries on the written questions were clarified. The same open ended questionnaire, with a change in tense in question a. was given to the respondents near the end of their three year ten week scheme using the same approach to determine if knowledge and experiences had modified or changed their views. An additional question was asked to try to determine the respondents' commitment to nursing, and to compare their predictions with the reality:

d) Where do you see yourself one year after training?

The responses to these questions enabled differences in perceptions to be highlighted between:
The men and women

- the different age groups
- those entering with different educational attainments.

The same questions posed at the end of the preparatory programme would identify possible changes and differences in perceptions e.g. if the respondents experienced the "culture" and "reality" shock as defined by Kramer (1974), and discussed in Chapter One. Collated responses to these questions might demonstrate the development of personal and professional growth of the respondents as they progressed through training. This method will be used to illuminate the way the respondents coped with the hurdles encountered in the clinical, academic and social environments, and indicates whether these affected their perceptions of nursing and their roles as nurses.

The student who joined the set following the introductory course was seen individually by the researcher. The study was explained and the student asked if she would like to participate, and following time for reflection she agreed to do so. The cohort now consisted of 21F. and 6M.

Previous studies have identified that students of nursing may become dissatisfied with their work situation (Heyman et al 1984); may learn how to adapt behaviour according to the environment and expectations of qualified nurses (Melia 1987, Wilson and Startup 1991). Mackay (1989) reports on research into issues surrounding nursing recruitment and wastage in one Health Authority in Great Britain. Part of this study involved interviews during their first year of general nurse training with one cohort of ten pupils and one cohort of eleven student nurses. She (1989 p.32) discovered that

All the learners I talked to felt they had been changed by becoming a nurse.
Most comments related to what might be called "personal growth". An increase in confidence was mentioned most often by learners while becoming more understanding and better listeners was also frequently mentioned.

Mackay (1989 pp.32) discovered that half these learners interviewed had considered leaving at some stage in their first year, with pay being a source of great
dissatisfaction. In the present study, statistical data - for example set wastage - as well as data from the interviews are recorded to provide evidence of satisfaction and dissatisfaction with nursing.

2. Interviews with the cohort and qualified nursing staff.

(i) Interviews with the student respondents.

The researcher decided that as the respondents followed a three year ten week developmental scheme it would be appropriate to interview each respondent a total of nine times, three times in each year, with the interviews following a period of formal study and clinical placements. It was agreed between the cohort the tutors to the scheme and the researcher, that it would be helpful and easier for the respondents to meet with the researcher during the time they spent in the school, albeit not necessarily during the formal working day. The respondents were therefore asked to make appointments to meet with the researcher. Certain times were offered, for example on one morning between the hours of 10-2pm., or after 4-30pm. Any four respondents were asked to book their own appointments during these times. The hours of set study periods were avoided by discussion with the tutor. The respondents chose the time to attend and often dates had to be made for the time when they were working in the clinical areas, and they attended during break times or when they were off duty. On two occasions one respondent came during annual leave times, he stated this was not a problem as he was not going away and was pleased to attend.

The researcher decided to use her office for the interviews as it would always be free, and the interviews would always be held in the same venue. To use a tutor's office or classroom on or off site may have been seen by the respondents as creating an artificial situation. No telephone calls or other interruptions were permitted during the interview periods to avoid distracting both the interviewee and researcher (Field and Morse 1985 p.67). The chairs were so positioned to enable the researcher to observe body language without the respondents feeling threatened by a face to face encounter.

The method used for recording was by jotting down responses in an abbreviated way peculiar to the researcher, on paper on which the key areas to be explored had already been identified with sufficient blank space for writing. The respondent was shown the paper at the beginning of the interview and the process explained. On occasions the
researcher asked if a quote could be written down to be used to illustrate a point made - the respondent would not be identified by name. The details on the paper were amplified by the researcher as soon as possible following the interview.

The use of a tape recorder had been considered by the researcher, but rejected partly because of personal prejudice, and previous experience suggested some respondents might be inhibited or threatened by a recorder, not wishing their words to be "captured" on tape. The researcher was mindful of her position as Principal and the possibilities of causing distress to individuals by appearing to make the occasion formal. Stage fright is common in all research in which interviews are used to collect data, and in interviews during which open ended questions are asked, the use of a tape recorder may make both the interviewee and the interviewer feel more more vulnerable (Field and Morse 1985 p.68). On the other hand a tape recorder might have enabled a greater freedom, and captured the full verbal interactions of the questions and responses. Confidentiality must be ensured when listening to and storing the tapes; this aspect gave rise to concern as the researcher thought the respondents might have been concerned over this but not willing to say so.

At the first interview following their introductory period spent mostly in the school and their first ward experience, the respondents were encouraged to talk freely. Field and Morse (1985 p.66) suggest this first period is the time when relationships begin to be established, a time when the respondents will be sizing up the researcher and making silent decisions about her trustworthiness etc. At this first interview the researcher made notes of all the topics covered by the respondent. From the collated responses from all the respondents, three main areas of interest to them emerged, working in the clinical areas, being in the school and social leisure pursuits. The words used to describe these areas were the respondents.

A semi-structured interview approach with these three areas identified in advance was then adopted. Themes arose from some topics initiated by a number of respondents which were then discussed with all of the cohort. This flexible approach, with the use of some open ended questions and the pace determined by the respondent, appeared to be acceptable and effective. Each interview tended to last between thirty and forty five minutes with an occasional deviation either way. The researcher was enabled to follow up statements and to elicit specifics from generalisations, e.g. a response "sister was not seen very often" followed by the question "why was that?" enabled the respondent to share the reasons for the sister's absence. At the end of each interview the respondents were always asked if there was
Heron, in Pope and Gilbert (1987) proposed a number of intervention strategies which were found to be appropriate and useful in this project, such as the skill of echoing back to the respondent the last few words spoken which can encourage further expansion. In the above situation the researcher repeating the response "off sick" encouraging the respondent to elaborate on the ward and its organisation when the sister was absent.

After each occasion when all the respondents had been interviewed the responses were scrutinised and collated. The discussion of similar topics enabled similar or contrasting beliefs, values or views to be identified and explained.

In discussions about the clinical situations the respondents' perceptions of the attitudes of key people were explored, e.g. the question "who did you work with mostly on the ward?" elicited factual responses and enabled the expression of feelings about mentors and the ward as a learning environment. These answers along with others in a similar vein led to questions on the mentorship role in the next series of interviews. In the third interview the respondents were asked to "match up" certain skills inherent in nursing - communication, relationship, practical, teamwork, social and management - with the people they believed taught them these skills. These responses will be compared to later ones as the respondents progress through their training scheme and become more senior, and experienced.

In the exploration of the respondents' views of the school during the last interviews, an open ended "share your views with me on your experiences in the School" led to a more specific "did you contact your personal tutor ? " which enabled the respondents to express views and feelings on the role of the personal tutor.

The questions on social and leisure activities were designed to explore how, where and with whom the respondents spent their leisure time together with their views on their living accommodation and environment. A question "does your professional life impinge on your social life and vice versa?" enabled the respondents to share feelings about their work and work practices.

In a sense this development of emerging themes seemed to be following the strategies proposed by Glaser and Strauss (1967) and used by Melia (1987): for example theory which is generated from and grounded in data by a process of induction, with the collection of data modified as directed by the advancing theory (Field and Morse 1985 p.109). In grounded theory the conceptual framework is generated from the data
rather than previous studies. The analytical approach is more structured with categories developed from the data constantly being compared and saturated. This is not the method used in this current study.

(ii) Interviews with the respondents - following qualification as registered general nurses.

Eight months following qualification as registered general nurses (RGN) and in the roles of staff nurses, the respondents were again interviewed, and this time a tape recorder was offered but rejected by four who preferred the system of recording in writing. The areas to be explored were written on cards which the respondents saw prior to the commencement of the interview. The researcher interjected a question or made a comment when it seemed appropriate. The researcher decided to offer a tape recorder at these times because the respondents were well known to her, they were registered nurses and might have felt secure in the use of this method. She herself had been interviewed and taped by other researchers and consequently felt more comfortable with the tool.

One respondent had left to work in a nearby hospital, but came to be interviewed refusing the researcher's offer to meet elsewhere. Another respondent had moved farther afield and filled in a written questionnaire in preference to a telephone interview. The remaining respondents were working in the same Health District where they had trained.

One question related to the staff nurse role "how would you describe the role of staff nurse?", enabled the respondents to reflect on their role and to identify positive and negative aspects. The other areas concerned leisure "do you have much time for leisure?", and school - "have you been involved in any ongoing education activities?" This last question enabled the respondents to share their views on the school and how they felt coming back to the school as qualified nurses.

(iii) Interviews - Personal Tutors.

These tutors were asked to participate in the study because they knew the respondents over a period of time in the same capacity in formal and informal situations. As in all
the interview situations it was emphasised that the tutors need not participate and that confidentiality would be respected. These tutors were key people in the respondents' professional socialization process as was discussed in Chapter Two, meeting with "their" students in a group and as individuals. These meetings usually took place in the tutor's office the request to meet either coming from the student or the tutor.

The personal tutors to the set - the ones who had pastoral and tutorial responsibilities for a certain number of the respondents - were interviewed on three occasions one in each year of the respondents' training scheme. A semi-structured interview approach was adopted with the method similar to that used with the respondents. Two years into the study one tutor left. The remaining three were interviewed again using a tape recorder, eight months following the end of the respondents' course. One of the personal tutors had left but agreed to be interviewed at her place of work. Questions were asked in the three main areas identified by the student respondents. One topic discussed on several occasions by the respondents was the personal tutor role and the question "how do you see your role as a personal tutor?" enabled the tutors to identify the areas important to them in carrying out this role, and comparisons to be made with the perceptions of the respondents.

(iv) Interviews - Ward Sisters.

Yin (1989 p.23) writes that a case study is an empirical inquiry that investigates a phenomenon within its real life context. In this study the respondents spent approximately 60% of their scheme in the clinical areas, such as the community and wards and departments managed by key people - the ward sisters and charge nurses. In the context of this study it was considered important to interview a sample of these key people who managed and therefore influenced these clinical learning environments. The names of the ward sisters/charge nurses selected from the wards and departments to which students were allocated and where the respondents worked as staff nurses were put into a hat. A random sample of seven - a third of this total - was removed by a secretary without looking, to ensure there was no bias.

The sisters (all were female) were interviewed at a time and in a room adjacent to the ward areas selected by themselves. The researcher had previously telephoned to ask for consent and to explain the research and the purpose of the interview, emphasizing it was not to talk about individuals. A tape recorder was offered because the researcher
was known to the sisters and some were familiar with the technique. One sister did not wish to be taped so the responses were written down using the same method as had been used with the student respondents. The remaining six raised no objections to being recorded. In each instance the sister was first shown a paper with the areas to be discussed identified, and queries were answered and confidentiality emphasised. The areas selected were concerned with the themes developed by the student respondents - the roles of the ward sister and staff nurses and the learning environment. One question "do you feel the students are prepared adequately?" elicited responses concerning the sisters' perceptions of the role of the school as well as the ward in the process of learning. The researcher always finished the interview by asking the sisters to feel free to ask or to share anything with her. This enabled fears and concerns to be expressed about the future for nursing and the status of nursing education.

(v) Interviews - Senior tutor and tutor.

The senior tutor was randomly selected from the six senior tutors who had responsibility for the 3 year 10 week scheme, the names going into a hat with one name drawn out. A similar procedure was followed for the tutor selection. Both selected agreed to participate and remembered the respondent set well, although it was eight months since the set had qualified. Both tutors were agreeable to the individual interview being taped and consented to being interviewed in the researcher's office. Both these tutors were asked about their perceptions of the respondents as a set, what made them remember the group, and were they different to other sets? The other areas discussed were those suggested by themes or topics arising from the student respondents' interviews, for example the personal tutor and mentor roles, and beliefs about nursing.

(vi) Interview - Senior Nurse Allocation.

The senior nurse in the allocation department is regarded by the students and ward staff as being a key person in their lives, someone who has the authority to place students in wards which they may not wish to join, and who may enable the ward to have a sufficient number of the appropriate level student nurses. The senior nurse meets with the sets regularly when they are in the school as well as being available to
meet individual students during office hours. She also meets with ward sisters/charge nurses at intervals. This senior nurse agreed to be interviewed and to the venue being the researcher's office. The interview was not taped so notes were made at the time and written up afterwards. The purpose of the interview was to seek her perceptions of the respondents as a set and, if for her, they differed significantly from other sets.

3. Personal biography - student respondents.

After one year of education and training and following several interview sessions, the researcher met with the cohort during a study week to ask for their participation in a different exercise. Following discussion all agreed to participate, and were given a page of white paper on which to draw a curved line like a snake, extending from the top to the bottom of the page. The respondents were asked to identify individually any meaningful incidents which they believed influenced their decision to become nurses and had affected them in any way during the first year of training. This exercise drew many comments and queries from the respondents, when the researcher asked for the positive and negative comments to be written on or by the bends in the snake. The respondents were asked not to confer when doing this and the papers were collected later that same day. One respondent asked for more time and submitted it later. Aspects of these snakes were discussed as appropriate at the next interviewing session.

Priestly et al (1978) comment that a completed "snake" can open up new and hitherto unrealised perspectives, helping the individual to reflect on and illuminate what may have been "invisible" patterns of behaviour and attitudes.

4. Repertory grid.

...constructs - the dimensions used by a person in conceptualising aspects of his world; and elements - the stimulus objects that the person evaluates in terms of the constructs he employs.

Cohen and Manion (1985 p.316)

The researcher asked one of the personal tutors to the cohort (the one who had been
involved in the discussions on the first day) if she would conduct this session to try to avoid possible researcher bias. The purpose and methodology was fully discussed with her, although she herself had previously undertaken a repertory grid exercise and was not unfamiliar with the method. This tutor saw the cohort as a group near the end of their training period and explained the purpose of the exercise - to identify the individuals' views on the people believed to be influential in helping them learn nursing. The titles of people (elements) were already given at the top of the page by the researcher eg. patient, sister, student, but the respondents were assured more could be added. Prior to this session the tutor worked with the respondents on a simple but similar exercise to help clarify the method of comparing and contrasting the elements to develop the constructs.

The respondents were asked to arrange the elements in groups of threes in such a way that two were similar in some way but different from the third. The ways the elements were alike or different elicited the constructs which were expressed in bipolar form (similar - dissimilar), and written on the sides of the paper (Cohen and Manion 1985 p.317). The respondents were asked to rank each element on each construct using a 1 (high) - 5 (low) scale according to how much the element resembled the similarity pole (1).

5. Data Collection and Analysis.

Field and Morse (1985 p.121) suggest that peer examination and review may be helpful to see if there is agreement on the interpretation of data and analysis. An experienced nurse educationist/researcher transcribed a number of taped interviews of the respondents when staff nurses and the ward sisters, separately from the researcher. Subsequently, two transcriptions were amended. This nurse researcher also read and commented on the content analysis, and independently analysed a number of the student respondents' interviews.

The analysis of the data is divided into the three separate years of the preparatory period to become nurses. The rationale for this approach is that the respondents progress and develop as people and students over this time, and the perceptions of their experiences might change as maturity and development occurs. Students are perceived as being in their first second or third year in terms of seniority and the data are recorded in these years. The numerical data will be used to illustrate unanimity, or
divergence of view, not to negate the qualitative thrust of this study. Statistical information e.g. wastage, is provided to place the cohort within the context of the school as previously stated.

The examples in this section are given to illustrate the method of data collection and analysis - whereas the findings are reported in later chapters.

The steps taken in the analysis of data.

(i) Interviews-respondents and qualified staff.

Step one.
The interview notes were written up at the end of the interview or at the end of the day. The taped interviews were transcribed into written data.

Step two.
The written data for each interview were collated by colour coding into the three main areas of interest identified by the respondents at the first interviews:

Working in the clinical areas - pink.
Being in the School - green.
Social, leisure activities - blue.

Step three.
All colour coded data pertaining to one area in one respondent's interview were transferred from the interview records to cards. Each card was marked with the respondent and interview number and identified with the appropriate colour. The female respondents' responses were separated from the male respondents for ease of access.

Step four.
The data for the same area of interest for each respondent was analysed for manifest and latent content (Fox 1982), and the results recorded on a sheet of paper. The
headings on this paper were the categories identified from the data about each area of interest.

Step five.

An information sheet for each set of interviews was prepared stating:

- the questions asked.
- the three main areas and the number of "similar" and "dissimilar" comments made by the male and female respondents in each of the categories in each area.
- the respondents identified whose quotes were to be used to illuminate or make a point.

(ii) Personal biography.

The "snakes" were written during the second year following three clinical placements. The data from the "snakes" were coded into the three main areas:

- working in the clinical areas
- being in the school
- social and leisure activities.

This data was included in the responses from the interviews for each respondent. The data were also collated separately under the headings:

- Why the respondent entered nursing.
- Positive comments about experiences.
- Negative comments about experiences

The responses were analysed and comments placed into clusters which were grouped into categories. Quotes to be used were identified.

(iii) Repertory Grid - end of course.
The grids were completed individually by the respondents and were collected and scrutinised and following discussion with the tutor, it was discovered that the rating scale had been used the opposite way round, e.g. 1 equalled low and 5 high. The researcher confirmed this then changed the numbers when the information was fed into the computer programme (Shaw M. RepGrid 2V2.0A - Centre for Person Computer Studies 1991). An experienced researcher checked that the translation of the numbers was accurate and that this made no difference to the accuracy of the information.

The computer RepGrid Focus analysis enabled the elements and constructs to be clustered hierarchically in a graphic and text form, for example to demonstrate the cluster of the types of people from whom one respondent believed he/she learned nursing which could then be compared with others.

Pope and Keen (1981 p.56) warn not to equate numerical analysis with absolute truth and that numbers in grids and computer programmes must be treated with caution. The researcher used both the original grids and the computer printouts in analysing the data to make comparisons and to check for meanings.

(iv) Written questionnaires - at the beginning and end of the course.

The responses to each of the questions were grouped into categories according to like content and the number of responses from the men and the women in each category indicated. Specific comments from the respondents were highlighted.

(v) Evaluations of the introductory course and some study sessions

The evaluation of study sessions was part of the usual process used for all sets in the school. The format of the evaluation was determined by the senior tutor and tutors to the part of the curriculum being studied and these written evaluations were circulated to the Principal as a routine. These evaluations could be anonymous, and were received from all the sets. The written evaluations to be used in this research were received from the respondents for the introductory course, and study sessions 3, 5, 6, 7, 8, 9, 10, 11, 12 and 13. A written summary of the set evaluations was received for study sessions 14 and 15.
Each of the evaluations was divided into "positive" and "negative" comments and grouped into categories, and the number of respondents making the same or similar comments in each category was noted. As occurred in all the analyses particular statements were highlighted to provide illumination and clarification.

Summary.

This chapter has documented the diary of events and has identified the methods selected to collect data to answer the questions

• do perceptions about nursing and the role of the nurse change as the respondents were prepared to become nurses?

• do these perceptions alter after qualification?

The next chapter will begin to illustrate the answers to these questions by further analysis of the data.
Chapter Five.

Student respondents - 1st.year.

Learning to become a nurse is accomplished through a process called socialization during which new values and behaviors appropriate to adult positions and group memberships are inculcated into the aspirant. Of the many roles that the modern adult is called upon to perform, few exceed in importance the acquisition of requisite skills and aptitudes for occupations.


Introduction.

This chapter incorporates the analysis from the data for the first year of the scheme of training for the cohort of 2IF and 6M student respondents. Data collection method:

- the open ended questionnaire completed on the first day
- the written evaluations of the seven week introductory course and three study sessions
- three interview sessions.

The outcomes are described in the three areas perceived as being of main interest by the respondents in the first interview, but they are debated as a totality at the end of this chapter. These three areas are not discrete as some topics and themes overlap areas. The respondents' perceptions of the totality of their experiences at a later date, that is after completing the course and as qualified nurses will be discussed in later chapters.

Simpson (1979) warns that there is a temptation to view socialization as consisting of discrete slices of time one after the other. She writes (1979 p.16) "To do so is risky, for the observer may think a series of delimited time-bound events adds up to the whole process". One of the techniques used in this study was to ask questions on a
topic discussed by some respondents at one time in the following interviews. This enabled themes to be developed with perceptions about the same subjects from all the respondents discovered over time.

As this study is about the feelings and views of the respondents on nursing and the role of the nurse, it is important to place the cohort within the context of the situations they experienced during the first year of their education and training programme.

1. **Context - first year.**

The cohort. (Appendix 4.)

The 21 women and 6 men in the cohort came from different ethnic backgrounds. 13 women and 4 men were of English ethnicity, 4 women were West Indian, 3 women and one man Irish, with one Nigerian woman and one Ghanaian man. The majority of the women (11) were in the 18 - 19 age range at entry to the scheme, 7 in the 20 - 25 age range, 2 in the 26 -35 age range, and one woman was 36. One man entered the scheme at age 19, 3 between the ages of 20 - 25, with 2 aged between 26-35. The educational entry qualifications for the women ranged from 5 or more O levels or equivalent, to 3 A levels, and one held a degree. 4 women entered via the Access course the first entrants from this scheme. The educational entry qualifications for the men ranged from 5 or more O levels to 2 A levels with one holding a degree. The cohort entered the seven week introductory period from a variety of previous work experiences. 15 women and 4 men were resident, the remainder lived at home or in flats or houses shared with friends.

During this period the respondents elected a set leader and deputy and were allocated personal tutors. The senior nurse allocator saw the group to explain the system of planned allocations to the clinical areas, and how to contact the allocation department to make requests or to discuss their placements.

Following the introductory period the respondents were allocated to wards situated on two sites, and concerned with the care and welfare of acutely ill adults, and of the elderly person. Night duty was undertaken in the wards for the acutely ill during the second part of the year. The respondents' clinical competencies were assessed during each ward placement (see Chapter Two).

The study sessions were planned to help prepare the respondents for these
experiences, and to consolidate their learning. Because the number of respondents exceeded the number of appropriate wards some may have had the experience prior to the related study session.

Study session number and content. (Appendix 3.)

1 and 2. Care of the patient with cardiovascular and respiratory disorders.
3. Introduction to the physical, psychological and social needs of the elderly.
4. To identify the problems of a patient with a locomotor disorder.
5. To identify the problems of a patient with a urological disorder.
6. Introduction to the physical psychological and social needs of the patient with a gastrointestinal disorder.


2.1. Respondents' reasons for wishing to become a nurse and their perceptions of nursing and the role of the nurse. (Appendix 6.)

(i) The reasons for becoming a nurse are grouped into three main categories:

a) caring for others
b) nursing is a profession/career
c) the attributes offered to, and learned from nursing.

a) Caring for others.

All but one of the respondents mentioned that caring for others in one way or another was one of the main reasons for wishing to become a nurse. The one who did not mention care in any way left prior to completion of the scheme. 5 respondents mentioned previously working in a caring role e.g. looking after the handicapped, or children. One woman wrote that
I wish to become a nurse as since I left school, I have worked as a care attendant, dealing with old people and the physically handicapped as well as with children. Whilst employed as a care attendant I came into contact with several nurses and after talking with them and caring for people I decided nursing was exactly what I wanted to do. I think you either love that kind of work or hate it, and now I think I would be unhappy doing anything else.

b) Nursing is a profession/career.

14 women and 4 men considered nursing to be a challenging and rewarding profession leading to a specialised career.

c) Attributes offered to, or learned from nursing.

7 women and 2 men stated that the personal attributes they could offer nursing included a caring and mature approach, while 4 women and one man wrote that nursing teaches self confidence, and discipline. The man wrote:

I have always felt caring for people to be the most important job as opposed for example to banking. As this was always my first interest I naturally looked for a job or training dealing with the care of people. I looked at several different jobs but nursing appealed to me as it both offered training and direct contact with people. I also felt that with the present situation in nursing that I would be of more help in the nursing profession. I also feel that I get on with people very well and in nursing this must be considered an important factor.

(ii) The responses to the question "What do you understand by nursing ?" were grouped under three main categories: nursing meaning-
a) looking after people in an holistic way.
b) a way of life.
c) requiring knowledge and study.

a) Looking after people.

All the respondents mentioned looking after people, the majority the giving of care and support in an holistic way inside and outside hospitals. One woman wrote:

Nursing I see as a profession of carers who help promote health and recovery, as far as possible, of an individual in both the community and the hospital environments.

b) Statements like "nursing is a way of life more than a job" were made by 4 women and one man. The man considered that:

The profession is a way of life which helps others to attain the best health possible for them. By treating each patient according to his/her needs, as an individual - being aware of each patient's physical and also mental/psychological needs and particular cultural background - to therefore enable the nurse to give the patient the care he/she deserves.

c) 6 women mentioned that nursing requires knowledge and study.

(iii) The role of the nurse. The responses were placed into four main categories:

a) meeting patient needs
b) promotion of health and educating people
c) qualities of the nurse
a) Meeting patient needs.

All the respondents except one man (who left prior to completion of the course) indicated that meeting patient needs - making them comfortable, helping the patient and relatives cope with illness - was one of the prime functions of the nurse. Two women stated that taking responsibility for patients was important. One wrote:

[The nurse] is a person who feels he or she is capable of working hard and taking a great deal of responsibilities. The nurse cares for people who are ill ensuring they are happy at all times. A nurse works on wards giving injections, bathing patients, making beds, helping feed people....Also the nurse is an assistant to the doctor.

b) Promotion of health.

3 women and 2 men (from the cohort of 21 women and six men) stated that educating patients and promoting health was an important function of the nurse.

c) The qualities of a nurse eg. being pleasant, a good listener were mentioned by 3 respondents - 2 women and one man.

d) 8 women and 3 men highlighted the carrying out of medical requests and treatments in their responses. One man suggested that:

[The nurse is] a person who has direct contact with patients. Who administers medication under order from senior medical staff. Who washes and bathes patients. Who maintains hygiene on the ward. Who takes an active part in patient rehabilitation.
2.2. The interviews - during the first year.

(i) The first interview.

The aims of the first interview (approximately five months into the scheme) were to enable the respondents to get to know and relax with the researcher and to enable them to share their areas of interest.

The question "How are you getting on?" led to discussions about their friends and the residences, about being in the school and working in the wards. The data were grouped into the three main areas of interest following these interviews and are discussed below.

a) Social/leisure.

The majority of the respondents felt they had established relationships within the set, although 12 women and 2 men indicated that there were a few members with whom they did not feel comfortable. One of the older women commented "I am not on the same wavelength as the younger members". Another woman the oldest member in the set said "There is an age gap and social class differences. Both these women were non resident from the beginning. One of the younger men who moved from the residence to share a flat with friends commented that "One or two relationships can become strained". One man and one woman mentioned their friends in other sets and in other professions e.g. physiotherapists, doctors. The respondents who were resident said that while they enjoyed the opportunities to be with their friends from the set, they found the facilities (cooking and laundry) most unacceptable. One woman stated that:

The kitchen and bathrooms are disgusting but I enjoy being resident as I am with friends.

b) Being in the school.

The introductory course was enjoyed by all the respondents with one woman wanting
to get into the wards to work nearing the end of the seven weeks. One thought the whole period was "too crammed", and another that the sessions were "too fast". Three activities mentioned by the majority as being positive experiences were being in the community, group work and discussions, and anatomy and physiology sessions. 11 women and 3 men enjoyed the community week e.g. investigating the services for the homeless and handicapped, but one woman (the same one who wanted to get to wards more quickly) disliked it stating that it was a waste of time. Half the cohort stated the group work was interesting, one said "we learn from each other and can share experiences". 4 women and 2 men found the anatomy and physiology sessions difficult to follow as they had not studied the subjects before, but 5 found the classes to be revision because the subjects had been studied at O and/or A level.

The study sessions were appreciated by all the respondents. 3 indicated that the second one was of more value, and one suggested it was "probably because it came after our holiday", and another said "they helped everything fall into place".

c) Working in the clinical areas.

All the respondents mentioned they found the practical classes during the introductory course beneficial. In these sessions they learned certain skills e.g. moving people from the beds to chairs, in the school and then went to the wards to practise these essential skills. The majority believed their confidence increased with practice but said they needed constant supervision in the wards.

10 women and 3 men "enjoyed and loved" their first ward experience, stating they were welcomed and supervised. On the other hand, 11 women and 3 men expressed some reservations about their first wards, most of these being about the attitudes of the trained staff and lack of supervision. Some of the comments made by the women included: "one staff nurse had no time for students"; "one staff nurse seemed to have no time for the students who have no knowledge of orthopaedics", while another reported that "one staff nurse did not treat me right". This woman went on to explain that the trained staff did not go out of their way to assist her and that she always had to ask for help, but even then one particular staff nurse ignored her. One found the trained staff "so overpowering" that she could not ask for help, while another stated that she felt she was "just a pair of hands" for the first week when the sister was off sick. This sister then left and was replaced by a charge nurse and the amount of
support increased. This woman commented that she would have left if she had been younger. One asked to see the sister about not feeling supported, and the sister acknowledged that there was a problem, but then told her "not to be overconfident" and to ask for help more.

3 men felt supported in the wards, but of the others one worked with the sister for a week and was then left to work by himself with no feedback on his performance, another had "problems" with a staff nurse. The third found that the trained staff were rather abrupt and formed a "clique" from which the students were excluded.

Other comments were about the informative teaching sessions given on the ward by the ward sister, and the rumours that existed about sisters. 2 women had heard rumours prior to arriving in the wards. These rumours were that the wards were "difficult wards", and that the sisters were "not easy to get on with", which they discovered not to be true in reality and both enjoyed their experiences. One man expressed concern about his next placement because of the rumours he had heard about the sister.

2 respondents stated they had worked with a tutor during this first placement, and that they had found this most helpful because "you could ask things".

(ii) The second interview-approximately 8 months into the scheme.(Appendix 7).

During the time between the first and this second interview one woman resigned and left the group. 20 women and 6 men remained in the cohort. The profiles of the respondents who left the scheme are recorded and discussed in Chapter 8.

a) Social/leisure.

The issue of the poor facilities in the residences raised in the last interviews still had not been resolved. Several respondents commented that although representation had been made to the proper authority, the laundry machines had not been functioning adequately for the past six months. Some also found the residence noisy which impeded study. 2 women had moved out, one to share with another student the other with professionals who were not nurses. One man had moved out to live at home, and 4 had placed their names on the council list for flats.
All the respondents had made nursing friends both inside and outside their set and one commented on the difficulty of keeping contact with the group because she was non-resident and also worked on a different site. Others found that working different shift hours meant that meeting with their friends regularly was difficult. One woman who had previously commented on the difference in wavelength between age groups, believed the set was not as friendly, and also asked "Why is there bitchiness among nurses - even students are becoming like it?". A man thought the set was not as cohesive as a group. 3 women stated they had lost contact with friends at home, partly because of the hours worked, and, as one said "they all seem to be getting married".

During the first interview one woman had commented that she shared her problems with her family. In this interview in response to the question "to whom would you go if you had a problem?", 14 of the women would go to their friends (two specifying boyfriends) regardless of the type of problem, 3 to their family, with another going to "anyone around". The other said "I am not sure, but I would not go to someone in the ward because the news would spread". One would go to the personal tutor because "she is so experienced". 5 of the men would go to their friends, with the other one going to see his mother or father.

7 women kept up their hobbies like swimming, cycling and sewing, while 2 men still played football or went swimming, but the remainder said they had "no time for hobbies".

b) Being in school.

All the respondents were keeping in contact with their personal tutors who were said to be "approachable and supportive". Some met with the tutor on regular occasions, others rarely. One did not like her tutor, stating "she asks me to see her a lot", and the woman did not think she needed to do this. Several mentioned that if their tutor was off sick they would book to see another one, and as one said "this would not cause a problem".

The study session on the care and welfare of the elderly was appreciated by all except 2 women, who found the session lacking in interest, "boring and I did not learn a great deal" was one statement. One woman was "surprised I enjoyed it, it was interesting when I thought it would be boring", while another said "I enjoyed it but caring for the elderly is not for me". One man's mother worked in an old peoples'
home, and he found the content of this session familiar but relevant.

c) Working in the clinical areas.

Half the cohort had expressed their worries about their first ward experiences, so in this interview the respondents were asked about their current wards. 15 women and 2 men stated that they had "enjoyed" their previous ward experiences - reasons given included:

- brilliant, it was well organised and I always knew where things were.
- sister takes me to oneside to speak and is always supportive.
- brilliant, because the staff were supportive and took time to listen.
- there is no difference between them and us.

One woman felt "fulfilled" because she had given total care to "her" patient who died. This was the first cardiac arrest she had experienced, and the trained staff "cared" for her and enabled her to talk freely about her feelings. Other reasons given by the group included: the staff taking time to stop work and listen to them; teaching sessions which were held on the ward, and the support of other students.

The reasons given by the 5 women who did not enjoy the experience included:

- sister picked on the ones with no confidence.
- treated me as if I didn't know anything.
- staff nurse did not feel she should teach, and she had a condescending manner.

One said that although the atmosphere was friendly, she was "too busy to be a student". She had asked for help but the staff nurses said they were too busy. This respondent said she felt a great responsibility, because "the ward is so dangerous, patients with angina could arrest". Reasons given by the men included:

- there was an "us and them attitude".
- they [the staff nurses] had personality problems.
- the sister was distanced from the
students.
she picked on little things, and I was unable to communicate with her.
Other reasons given by all the respondents included no formal teaching; ward was "too rushed" and little or no supervision by the trained staff.

(iii) Third interview at the end of first year.

Prior to this interview, one woman and two men resigned from student nurse training, leaving 19 women and 4 men in the cohort.

a) Social/leisure.

At the end of the first year, 10 women and two men lived in residence. 3 women and one man had moved from the original residence to one in which two rooms were served by one central bathroom, and each floor had dining and cooking facilities. This move was appreciated by all particularly because there was more privacy.

One respondent remaining in the "old" residence was delighted the washing machines were working, but she was despondent because the cookers were not. She and a friend had bought a microwave between them. Another, although concerned about the lack of working facilities, found the residence "not bad, it is nice to chat with someone when coming off duty". One who moved out, found that fish heads blocking the sink were the last straw.

During the last interviews, one woman talked with sadness about her friend who was leaving. In this interview in response to the question "How are the members of the set getting on?" the majority of the respondents believed that the set would not be disrupted by members leaving. One woman thought that because one particular man was leaving the set would become more of a "clique". Two others stated that the loss of this same man would make a difference as he was a supportive person. Another woman stated that the difference in the set could be positive because one man who had left was "overpowering". Comments about the set included "we all know each other well", and "it is a cohesive group".

The majority of the women stated they had made certain friends in the set, but were
friendly with all the members. One who was non-resident, stated that although she was on good terms with the set, "my friends are outside". Another said she did not have any leisure time with children to bring up although she did see friends from the "Access" entry. One older woman said she felt she was not too close to set members as she had got married and lived out with her family. The woman who had joined the group following the introductory course, said she was gradually making more friends in the set even though she was non-resident, but most of her friends came from outside the set and the profession.

The men spent most of their time with friends outside the set, one had made particular friends but spent a lot of time by himself in his room. Two went to their homes on days off to see their families and friends.

Apart from the respondents who lived out with their families, the others appeared to spend much of their leisure time going out to eat or meeting with their friends in the pub. The set threw a party for someone who was leaving and the majority of the group attended.

b) Being in the school.

In responding to a question "How are you getting on in school?", the thrust of the replies was that school provided a useful function in providing the theory to "back up" practice, and to provide a welcome break from the clinical areas. The majority of the respondents believed that they gained knowledge mostly from the wards. The knowledge learned from the school was viewed as "useful but skeletal", and "at basic level". One woman stated that:

you get a base line of knowledge from school, and experience from the ward.
The problem is that the theory sometimes comes after the practice. 
There is not a great divide though, between service and education.

Another woman said

I get knowledge from school and learn how to be a professional. We learn the principles of care.
One man commented that:

I assimilate knowledge all the time, in school and wards - particularly from the handover period. [A time when the staff gather to "handover" information to each other about the patients].

In discussing the teaching and teachers in the school, all the respondents except one made positive comments. One stated that a tutor had worked with her on the ward which was "fine, she took time to do and explain things". Another was pleased to have a tutor give a formal teaching session on the ward because it had helped explain the care. 4 respondents commented that the tutors did not teach practical skills, and that tutors were rarely seen on the wards. One man stated that he thought the tutors presented "idealised teaching", different at times from the ward practices. He suggested that not all patients required this "ideal care". One stated that procedures could be carried out in the wards as taught in the school "but sometimes a few corners are cut because of time, but it is not dangerous".

One woman was concerned that "teachers put you down if you have done something wrong". She believed that some tutors were not supportive in helping with more information which was needed to clarify a topic.

All except 2 women found the personal tutors supportive and available when needed. One man said he did not see his tutor often [his choice], and one woman exhibited mixed feelings stating

She is OK and helps, but if you don't ask her she won't put herself out.

One woman said that she did not get on with her tutor, "we don't relate", but, when asked, did not think she would ask to change tutors at that time. Another wished to change tutors and was in the process of doing so.

c) Working in the clinical areas.
In response to a question "How do you relate with other staff on the ward?", the people mentioned by the respondents were auxiliaries, student nurses, doctors, trained nursing staff and physiotherapists.

12 women and 3 men made positive statements about auxiliaries, e.g. they were supportive and helpful, they know a lot about the ward, with an occasional qualified comment, such as "they are OK, but sometimes the older ones resent being told how to do things". The negative comments were about the auxiliaries in the care of the elderly wards, such as "they were rigid, and have their own ways of working", and "they seemed to resent students", with one woman stating that

I had a bad experience. One auxiliary told the ward sister that I was not pulling my weight. Sister did not see me, therefore I felt she understood I did work.

One woman said she thought the auxiliaries with whom she worked were "brilliant and most helpful. Some students say they cannot understand their accents, but they need to listen".

The majority of respondents (14 women and 3 men) felt supported by other students with whom they were mostly linked in the wards to deliver care, and to receive feedback on their progress. Often the respondents would be working by themselves (5 women and one man), and on occasions with an auxiliary. One said "the students stick together, its the best support system there is". One older man felt that the students "are generally all right, but some are patronising. One junior on her first ward felt she knew it all".

In speaking about the trained staff the focus was on their role, and both sisters/charge nurses and staff nurses were perceived as managing the ward. One said "they do the paper work, working out the rota", with one stating that she had been linked with a staff nurse, "but the trained staff only give reports, and write care plans, and the students are not able to participate". Two men believed that others also managed the ward. One indicated that everyone manages but "they report to the staff nurse who reports to sister". The other thought that the sister should manage, "but I do because of my patient contact". 13 respondents stated they received feedback on their progress from the staff nurses, 5 mentioned they had worked with a staff nurse and 4 had received feedback from the sister. One woman commented that:

I fought hard to sit with the patients but one staff nurse dragged me away from
talking with them. It is seen as skiving.

Several others mentioned that they were not able to talk with the patients, or felt guilty if they did so.

In discussions on how the care was planned in the wards, all stated that individual patient care was practised in the wards, but 9 were concerned that the care plans were either not used or not used correctly. Comments included:

- Individual patient care is given, but the care plans are not working because it is too much paper work.
- Individual care is given, but the care plans are used only by trained staff.
- I tried to change the plans so that they were by the bed. I don't like the idea of walking around and reporting, it may alienate patients. They have enough with medical rounds.

The doctors were viewed positively by 7 women and 2 men, particularly in the wards for the care of the elderly. Here they were viewed as friendly and approachable, treating the respondents as colleagues. One comment made was that "doctors will answer questions, and do not treat me as a slave". 6 women and one man expressed different views to the above. The doctors were perceived by them as condescending in manner, and tended to ignore the respondents, although expecting students to clear up after them. One respondent was unhappy that the doctors talked to the patients "as if they are deaf". 5 women and one man expressed their mixed feelings, commenting that some doctors ignored the students but some were all right. The doctors in care of the elderly wards were fine, but as one stated "elsewhere, students are treated like dirt."

The physiotherapists were mentioned by half the cohort who saw them as helpful and supportive, treating students as team members. In the wards for the elderly they taught some of the respondents certain skills e.g. how to lift the immobile patients.
In response to the question "who do you believe taught you (from whom did you learn) nursing skills?" the majority considered that they learned communication and relationship skills primarily from the patients, practical skills from trained staff and students, teamwork mostly from students and qualified staff, social skills equally from the patients and students, and management primarily from the qualified nurses. The tutor was only mentioned in two dimensions, communication and practical skills. Auxillaries were mentioned by a small number of respondents in all dimensions except management.

One woman stated:

I felt very good, I sat and talked with a male patient who was very worried about himself. I felt it helped him and me.

One woman felt she had helped when she had talked with a lady who was having a therapeutic abortion; the foetus had hydrocephalus. She was asked by the sister if she wanted to be present to help give care before, during and after the procedure, and this she wanted to do. She talked with the chaplain who, she said, "spoke brilliantly with the family". This woman believed she had helped the patient by listening to her and was comforted by this.

2.3 Written evaluations.

These written evaluations which were not required to be signed by the students provide further insights into the perceptions of the respondents about their introductory course and study sessions, and enhances the data from the interviews.

a) Introductory course.

All the respondents enjoyed the introductory course and found the different teaching/learning methods stimulating, which prevented the sessions from being boring. Some commented there was a lot crammed in too short a time, but regretted that there was not more time allocated to developing practical skills, such as giving injections. The
use of workshops, with individuals reading and "researching" a subject was welcomed, but 2 felt that learning was gained only from the "research", and that too much reading was needed to fill in the gaps. One believed the tutor should be prepared to do this. The choosing to miss a session if it covered a known subject was mentioned in a positive way by one. All considered that the classroom teaching had prepared them to a degree for the ward visits, but many expressed their feelings of nervousness at going into the ward and feeling useless.

One comment:

The teaching to some extent did prepare me ....although obviously it was a very frightening and anxious time- when bathing a patient for the first time. Most of the work done in the classroom was, I feel, very good and made me less lost when going on the ward.

Another:

The classroom teaching does not prepare us very well for the ward visit. I do not think this is because the lessons weren't good enough, but being actually on the ward is so different from the classroom setting.

The majority of responses indicated that previous knowledge and skills e.g. biology, communication in drama, experience as a patient or auxiliary, had helped in the understanding of teaching sessions, or in the development of practical skills.

One comment:

Yes, I feel more confident in conversing with the patients and this in itself was very useful. If you have this ability, you never feel lonely on a ward, and it is easier to fit in.

The respondents believed that guidance and support was available during the course, and many commented that members of the group provided a great deal of support. One wrote "if you do have a bad day - you always feel you can go to moan to someone." Another wrote:

Yes, as if our tutors would not give us
support! I felt that a great deal of support and guidance was available and if any of us were in trouble we know the tutors would be most willing to help.

Another on this topic of tutor support:

Yes, but you only found out where it was after the problem was solved. It takes a little time to settle down and find out where everyone is and how they can help you especially if you live out.

Two wrote on the practice of splitting the set into smaller groups for teaching purposes. One felt there was a danger that this could cause "cliques" to form at the start of the training. The other wondered if the set should be divided into groups according to previous theoretical knowledge believing this may make it more interesting for those who had deeper knowledge, and easier for the tutor.

b) Study sessions.

There were no further comments to add to those made at the interview for the session on the care and welfare of the elderly. The content in study session 5 (patients with urological disorders) was relevant, but some sessions were too rushed, and some respondents found the lecture by a pharmacist "heavy going". There were comments that a handout would have been helpful. The visit to the dialysis unit was valued. The timetable was criticised for having "too many gaps". Study session six on the needs of the patient with a gastrointestinal disorder also had too many rushed sessions, but the work book provided was thought to be "excellent". More handouts and case histories for discussion were requested.

3. Discussion on first year data.

The respondents entered their programme with varied past experiences and some knowledge on which to build the elements of nursing, which they found helpful in developing a sense of security in strange situations. As one had discovered exhibiting a degree of skill can engender a feeling of worth, and of being part of a team. It gives
credence to the schools which encourage prospective candidates to continue with higher education, and to gain some experience in caring situations.

The cohort remained as a discrete group during the introductory seven week period and in the study sessions, and although not isolated from the patient areas and the rest of the Health District, the respondents developed a sense of cohesiveness as a set. The set provided a supportive network to the members, as suggested by Macguire (1968). The group appeared to cope with the loss of several members, and as one member stated "we are a stable group". This "sense of belonging" was evidenced by the number of set members who appreciated group activities and learning, and found the sharing of experiences meaningful. The respondents also identified their friends as the people to whom they would go with a problem. The non-residents experienced some difficulties in relating with the set as a group, because of their need to travel and the "pull" of home. Discussions with colleagues and the sharing of feelings about their experiences were sometimes not possible for them. Once started on the wards, all members of the set found difficulties in keeping contact because of working different hours in the shift system. They felt tired after working in the clinical areas, and had to make an effort to maintain relationships. Some could not keep up their hobbies. One woman who was non resident, and had joined the set after the introductory course, found it had taken her almost a year to establish friends in the set. She commented that her bonding was with the group with whom she had commenced training.

Many of the residents experienced "culture shock" (Kramer 1974), not having lived in a communal setting, and found the noise and lack of privacy not conducive to sleep or study. This - compounded by poor facilities - persuaded some to plan to live away from their work situation, although they acknowledged they would miss the friendliness and security of the residence.

The respondents experienced "reality shock" (Kramer 1974) on entering the clinical areas to find themselves working with other students from whom they gained support and feedback on performance, or by themselves, rather than being directly supervised by trained nurses. Expressions of concern about the lack of supervision and the attitudes of some of the trained staff had decreased to a degree following the first ward. This first clinical experience is the time when students are at their most vulnerable, in a strange environment, expected to participate in giving care to patients who may be the same age or older than themselves.

The perceptions of the group on the role of the nurse on the first day of training were that the nurse gave care to patients in a physical and psychological sense. Their
perceptions on the roles of the sisters and staff nurses were that these nurses were managers and administrators, not involved personally in direct patient care which was largely carried out by the students. Individual patient care was seen to be practised, but written care plans were either not used or used inappropriately.

At this stage of their training the respondents appreciated the work of the auxiliaries as part of the nursing team, and the physiotherapists and doctors as part of the multidisciplinary team. They had mixed views on the attitudes of some of the doctors to student nurses. Some doctors were viewed as "condescending" and abrupt in manner, others, particularly in the wards for the elderly, were considered to be supportive and helpful.

The support and help of the personal tutor was appreciated by all the respondents, but the need to see them varied between individuals. It will be interesting to note if this contact persists as the cohort becomes more senior.

Summary.

This chapter places the respondents within the context of their environments. The perceptions of the cohort on nursing and the role of the nurse in the first year of student nurse preparation are described. At the end of this first year, two women and two men had left the training scheme, leaving 19 women and 4 men in the cohort.

The discussion at the end of this chapter highlights some of the findings arising from the data. These issues and others arising will be explored further, together with the findings from the data in the second and third years, in order to demonstrate some of the influences which effect the cohort's perceptions of nursing and the role of the nurse.

The respondents completed a brief retrospective biography (snake) at the end of the first year, the findings of which will be described in the next chapter which is concerned with the progress of the respondents through the second year of their education and training programme.
Chapter Six.

**Student respondents - 2nd.year.**

Some of the most effective teaching is done by those, whoever they may be, who set an example by their own good practice, and remember to bring to the learners' attention what to anticipate and observe during nursing care.


**Introduction.**

This chapter is concerned with the analysis from the data from the retrospective biography exercise (snake), three interview sessions with the cohort of student respondents (in the first of these the "snakes" were discussed), and the written evaluations of study sessions 7 - 13. The findings will be described in the three main areas discussed in the previous chapter - social/leisure, being in the school and working in the clinical areas.

1. **Context-second year.**

Since the last interviews, one woman had left the scheme, and of the 22 respondents left in the cohort, 10 women and 2 men remained in residential accommodation. 8 women and 2 men lived in their own homes or shared flats.

The cohort (18 women and four men) continued to gain clinical experiences on three sites in the care and welfare of acutely ill adults, learning to give 24 hour nursing care to these patients. The respondents also gained experience in the care of the mentally disordered, and in the nursing of children. Some gained this experience in nursing children in the community, others in wards in their "host" hospitals, the remainder in a hospital in another district outside the authority of the school. They continued to be assessed in the clinical competencies during these clinical placements. The
respondents attended 7 study sessions in the school.

Study sessions, Number and Title.

7. Care of the patient with cardiovascular and respiratory disorders - undergoing surgery. Care of the person with a mental disorder.
8. Community care and health education.
9. Care of the patient with a mental or endocrine disorder.
10. Care of the patient with a neurological disorder.
11. Care and welfare of children.
12. Care of people with cancer and terminal illness.

Formal written assessments of knowledge were held in study sessions 7 and 10. During the times in the school the respondents were taught by a variety of teachers, and met with their personal tutors and the senior nurse allocation.


2.1 A retrospective look at critical incidents. (Appendix.8.)

The findings are described under three main headings - the reasons why the respondents entered nursing training, and the positive and negative influences on this training. One of the men decided not to participate in this exercise, he did not give a reason.

(i) The reasons why the respondents entered student nurse training.

a) Female respondents.
5 believed that doing voluntary work of a caring nature confirmed their wish to become nurses. One had been working as a community services volunteer, caring for a disabled lady in her own flat. 3 had started an educational course, or another field of work. One of these did not enjoy the theoretical part of a social science degree, 2 heard about the Access to Nursing course. 4 had taken advice from family or friends. The remaining 4 had wanted to do something worthwhile involving a professional caring education, one with travel in mind. Another had her positive feelings reinforced about nursing when visiting her grandmother in hospital.

b) Male respondents.

One had attended a paramedical institute in another country, and having looked into other prospects decided to become a nurse. One was qualified in another field of work and decided to change to a caring career. The remaining one had thought about different careers, and his family was supportive when he decided on nursing.

The group identified both positive and negative experiences in three main areas, a) the students b) the school c) the wards and trained nursing staff.

(ii) Positive experiences.

a) The students: 6 women mentioned that other students were friendly and supportive. One wrote that it was great to have made friends "who are good fun and supportive to each other".

b) The school: 3 women wrote that the school was "OK", and in particular the introductory course was enjoyable. One wrote "the introductory course confirmed what I thought nursing to be, for example total patient care."

c) The wards and trained nursing staff: 16 women and 3 men identified specific ward experiences which had been memorable, 6 mentioned the first ward: because the staff had been helpful and supportive; teaching sessions were held; there was rapport
between all the staff; the respondents were made to feel part of the team, and the ward had a relaxed atmosphere.

One woman wrote:

A good ward for a first warder. Staff were very helpful. [I was] made to feel part of the working team.

One man wrote:

Influence of charge nurse on... ward. Gave me constructive criticism. 1st time felt BARS had been helpful to me personally.

(BARS = behaviourally anchored rating scales, the method used to record the assessment of clinical competencies.)

Other incidents mentioned by one woman were moving into a flat, and going on a specific holiday with friends outside nursing which she enjoyed.

(iii) Negative experiences.

a) Students: One woman identified that one of her closest friends leaving the set was distressing.

b) The school: 2 men and 2 women identified the written assessments, one had been referred and was fearful of failing the next time. One woman wrote that the assessment was a "shock to the system", and that she would have a lot of work to do - "[I] feel a bit unsure of myself". One woman commented that she had not been given sufficient encouragement by her previous personal tutor.

c) The wards and trained staff: experience in the care of the elderly was mentioned by one man and six women. Comments included: "treated like a pair of hands", "this experience was exhausting", "having to do dirty tasks", "I was disillusioned, there was a lack of concern from the hierarchy".

8 women identified negative experiences during the first ward: "feeling frustrated and
not knowing", "trained staff expected a lot, and were condescending", "sister having a
go because of something forgotten". One mentioned the shock she experienced
because of the difference between the ideal and reality. She was left to work by
herself for a few hours on an early shift, and was unsure what to do. 3 women wrote
of the shock and fear experienced when patients were dying, and when they died. One
wrote:

Three patients all died on the same night
within minutes of each other. I felt like
giving up nursing that night.

2 women and one man identified the prospect of entering the next ward placement as
being of concern: one had heard rumours about the sister, and one was anxious about
a different type of experience and the prospect of night duty. One man identified
problems with the hierarchical system:

I am not sure if I like it but I know I will
have to get used to the hierarchical
system. On a few wards I have found
the students and staff competing against
each other rather than working together.
Sometimes I feel the staff nurses think
that I as a student don't have a point of
view.

2 women noted that the doctors gave them concern. One because the doctor initially
refused to get up during the night to give an intravenous drug. Another because a
doctor made the respondent cry when she took him a bottle of intravenous fluid
different from that requested. She commented "he tore me off a strip". This woman
added that the sister then told the doctor off.

(iv) Other areas which were mentioned included, concern over their own sickness (2
women and one man), a friend's sickness, poor pay and her anxiety about being
overdrawn at the bank, and "hassles with a change of flat mates".

2.2. The interviews.
The fourth interview - approximately 14 months into the preparatory programme.

a) Social/leisure.

One of the topics discussed was about the person or persons thought by the respondents to have influenced them during their nursing training. The greatest number (9 women and one man) mentioned the ward sisters/charge nurses, with positive comments on their approachability; one woman mentioned that two sisters she had met had authority and "knew how to use it without belittling the students", while another stated "you can ask them [two sisters and one charge nurse] anything, and they ask you to find out and then it [topic] is discussed." The man considered that a charge nurse was enthusiastic with an extremely well run ward. The only negative comment about ward sisters/charge nurses was made by one woman who believed one ward sister to be incompetent in running her ward.

4 women and one man found that staff nurses had positive influences on them, with one woman commenting "she was the caring nurse, and taught a lot". 5 women and one man mentioned staff nurses in a negative way, with lack of communication and condescending attitudes given as the reasons.

3 women found their personal tutors to be approachable, and one stated "she tells me where I am going wrong".

One woman believed a student on her first ward had helped and supported her, while another said some students did not care about their patients.

One woman believed that an outside Christian organisation had the most influence on her, while 4 women and 2 men did not believe anyone in particular had exerted an influence on them.

In talking about their relationships within the set, 15 women and 3 men commented they had made particular friends. One woman stated she went home to forget nursing and she had developed different interests from the set. Another "floated in and out", and one woman spent more time with another "community". One man lived out, and while friendly with the set, spent most of his time with his family and outside friends while noting that "the action is here". 6 women and 3 men considered that they spent more of their leisure time with friends outside the set, while 5 women and a man believed they spent as much time with friends in the set as with other friends. Leisure
time with friends was spent in going for a drink, or meals, and going to another's flat to have a "natter". One woman worked one evening a week in a local public house "to earn a bit and meet with other people". One man had invited members from the set to join him to discuss work but no one had taken up the offer.

3 women remained in their original residence, 7 had moved into the more up to date one. One commented that this residence was "more private, and you can sit around a table to dine with your friends." One man was resident in the more modern unit the other in the older residence. One of these men described his decision not to cook his traditionally spicy dishes because he worried that others might not like the smell.

b) Being in the school.

2 women wanted to change their personal tutor, one because she believed that she was not supported, the other needed someone "to make me do things". One woman and one man were not seeing their tutor very often, because they did not perceive the need. The remaining members of the cohort saw their personal tutors regularly.

All the respondents felt they were making average to good progress in their training, except one man who stated "it is difficult to judge myself". A number had been referred in a written assessment, and comments ranged from not being suprised and not being good at exams, to "I need to buckle down to the theory". One woman expressed surprise that she had achieved such high marks (in the 60% range). One man said he was not good at examinations and this worried him so that it became "a vicious circle".

All the respondents enjoyed the community and health education week, particularly meeting people in their own homes, and being able to understand further the roles of the primary care team. One felt that the health visitor had to do too much paper work, another enjoyed the week but now believed working in the community was not for him.

In one of the study weeks attendance at the teaching sessions was optional, with everybody knowing the learning objectives for the week. All but one believed this was the correct system, stating that "we were treated like adults", and "as a consequence we went to everything". The one woman who expressed reservations commented that "it was probably all right for some, but I need to be pushed to attend". Another woman wondered if some may have taken unfair advantage of the
system, although it was the right way to learn. One woman did not like school, although she had enjoyed the last study sessions. She went on to explain that she did not like group activities, preferring the tutor to do the teaching. Another stated she got bored having to sit and listen, "especially when the topic has been covered before."

One woman believed that there was no difference between what was learned in the school and practised in the wards, but 5 women believed that corners were cut in the clinical areas because of lack of time, and/or staff. They stated that the standards of care continued to be maintained. 4 women and one man stated that teaching in the school was different from that practised in the wards, with one woman specifying:

At times things are different in the school and the ward, for example oxygen on pressure sores. The school says no, the ward says yes.

This respondent went on to say that she felt she could cope with the difference if explanations were given, but this did not always happen. Another believed she could put into practice in the wards what she had been taught when there were sufficient resources available to enable it to happen.

c) Working in the clinical areas.

5 women had heard rumours about their next ward experience, 3 about the ward sister. One heard that sister expected people to laugh at her jokes, another that sister shouted at people, and the third that the sister took time to listen and explain. These respondents felt these rumours to have some substance. The other two had heard the wards were very heavy and busy with a poor atmosphere, which they did not experience when they were on duty.

6 women and one man commented on the ways they had been treated by the doctors, the man had learned from the doctors, but 5 women believed that the doctors ignored them, or were rude. One said:

I want to obtain a mauve dress, the doctors would take notice then. [A mauve uniform was worn by the staff nurse].

The sixth woman had found that a woman doctor had been very supportive when a patient had died on the ward, and she (the respondent) had cried with the patient. The
respondent had felt assured and comforted.

(ii) The fifth interview.

a) Social/leisure.

Varying examples were quoted of leisure activities. A party had been held for one of the men who had left, and most of the cohort went to it. They met with their friends in the set, and some had become non-resident, sharing a flat together. Those who entered via the Access scheme tended to keep in touch with each other, but as they were women with families found it difficult to maintain contact. The woman who had entered the scheme after the introductory course found the set cohesive and felt a "bit out of things". One was not feeling very well, because she had been looking after a relative who had had an operation during her annual leave, and was tired. Another was desolated by a friend's death.

The two men who were resident kept in touch with each other, but the one who remained in the old residence felt isolated from the set; one who was non-resident sometimes kept in touch with members of the group by telephone; the other non-resident was worried about a relative who had ill health, and also felt very tired from the travelling to and from work.

All commented they enjoyed nursing - caring for people - but two women were going to leave. Another woman stated that although she enjoyed nursing:

    I am not one to love nursing. About two months ago I felt like chucking it in, I was fed up with the hours and lectures.

She had moved into a house with friends, and was experiencing problems with a leaking roof. She said she felt "this probably may have something to do with my feelings".

b) Being in the school.

The respondents commented on the difference between the two study session weeks,
one was described as "heavy going and a lot to learn but enjoyable" [care of the patient with a neurological disorder]. However the session on the care of the child was described as too superficial, with no consideration given to the fact that some members of the group had relevant experiences to share. The group (14 women and four men) believed they had been treated as adults in the first session with rapport between the group and tutors, but as children in the second session with little or no interaction between the tutor and the set. One woman stated that in the neurological sessions:

The tutor was knowledgeable and had a sense of humour. She understood the level of our knowledge and the atmosphere was relaxed.

One woman had opted out of the verbal evaluation of the session on the care of children, because she thought it was going to be difficult.

The respondents who had changed their personal tutors said the move had been vindicated, because their needs were being met. One man who journeyed to work stressed that he liked a structured day, and did not appreciate time being allocated to "free study", particularly first thing in the time table. One woman did not like being made to feel responsible for students who had not turned up for a session, and commented that it was not right when the tutor "told off" the ones who were present.

c) Working in the wards.

All the women gained from the experience in the care of the mentally ill, although one decided she did not wish to become a psychiatric nurse as she found it disturbing that, in her experience, the patients did not seem to improve. The men all enjoyed this experience with one commenting that there seemed to be a fine dividing line between patients and other people. The positive comments on this experience included: "I felt what I had to say was important", "holistic care was given", "patients were treated as persons".

There were expressions of concern about the trained staff in some areas who were seen as apathetic with the students taking the group sessions. One respondent said:

I'm not sure what psychiatric nursing is, the staff were in the office, only came out for [giving of] drugs.
One woman believed she had gained from the experience, but did not enjoy it, "it was all talk and no action", and she did not think sufficient explanations were given to the students.

On being asked what they believed they personally had achieved from this experience, the replies included these from two of the women:

I can go to someone to chat, I found this difficult in the general wards.
I will be more sympathetic than before, I thought it was their fault- and I won't be frightened to talk with [mentally ill] patients. I won't label people.

One man believed he had gained more experience to:

Treat patients as individuals, there is a tendency to label and isolate them [the mentally ill] in general wards.

Others considered they had improved their communication and relationship skills and the ability to empathise with others. One woman stated that she felt she could confront people when talking with them about their illness, "in a non threatening way".

(iii) The sixth interview. (Appendix 9.)

This took place near the end of the second year when two women had left the scheme, 16 women and 4 men remained.

a) Social/leisure.

In discussion about the set, 14 women stated that they met up with a friend or friends from the group between the times in the school, one lived at home and found contact difficult, the other felt closer to the original set with whom she had commenced training. The 4 men saw others from the group occasionally.

One man at times cooked meals for one of his colleagues from the group and a friend from another set, and was disappointed that some others did not join them, but felt it was because they did not like his spicy food.
12 women and 3 men believed the set to be cohesive and supportive - that there was group "empathy" - with the remainder stating that the set had fragmented into friendship groups and that "cliques" had formed.

The majority of the cohort did not actively belong to a group or organisation, as there was no time or interest. 2 men and 4 women were active, playing football, keeping fit and in Christian, and trade unions. One woman described how she had wanted to start a netball team, but the numbers dropped from 20 to 9, then 3 and it was discontinued.

b) Being in school.

12 women were seeing their personal tutors regularly, 3 writing essays to be discussed. 3 did not meet with their tutors often, because they felt there was no need. One woman was in the process of changing her tutor, as she was not always free to see the respondent.

2 men met with their personal tutors at regular intervals, one felt there was a lack of understanding by his tutor, and he did not see her often although he had made no move to change to another. The fourth had "personal problems" which he did not wish to discuss with his tutor.

The possibility of the school amalgamating with another had been rumoured, and had been discussed with the set during a study session. This was mentioned by two respondents during their interviews. It seemed to be a matter of great interest, not unexpectedly, and so it was discussed with everybody. 10 women and 3 men believed the proposed amalgamation to be "a good thing", because it would be good to mix with others, and have other experiences of care. 2 women and one man believed a change would not be beneficial to the school, because standards would be "lowered or diluted"; the man believed "that everyone felt this way, but would not acknowledge it".

One woman in a previous interview, had spoken of a colleague who she believed was stressed. In these interviews, the question "What makes you concerned or worried?" was asked. 5 women and 3 men specified the attitudes of the trained staff caused them stress, mentioning "being talked down to", and staff being unapproachable. One man felt that the trained staff sometimes formed a wrong impression which could not be
corrected, "we only know each other at the end of the allocation". 4 women worried about their inability to maintain standards of care, with 2 others specifying low staffing levels in the wards. One woman was concerned about night duty, because she could not sleep during the day, and another worried about written assessments. 3 respondents believed they did not experience stress. One man was concerned about personal problems which he said were not to do with nursing.

c) Working in the clinical areas.

Everybody enjoyed giving care and being with children, stating that feedback on performance was from the children. 2 women and one man did not appreciate being in another hospital outside the District Health Authority, and experienced culture shock (Kramer1974). They considered there was a division between the staff there and the students from this own school, and a lack of "meaningful communication". They said that the formal teaching was good.

A number from the cohort who had practical experience in the care of children in the community considered that they had gained knowledge of the home conditions, the services provided, and experience in meeting people from different cultures. A number of respondents were placed in their own hospital wards, with one believing that in her ward the trained staff "felt superior because it is specialised work". The remainder had enjoyed the teaching and the praise given to them as students with one commenting that she learned by working with the staff nurses. One woman stated:

It is sometimes difficult with parents.
The parents of one child did not visit very often, and the staff resented this on behalf of the child.

One man:

I felt everyone wanted me to change nappies, but I asked for a session on drugs. The children thought I was a doctor because they were not used to male nurses.

At this point in time, 8 women and 3 men believed they learned nursing from other students. 4 women stated they learned from the staff nurses, and 4 women and one
man considered that they learned nursing and nursing skills from both the trained staff and other students.

6 women and one man stated they had formal teaching sessions on the wards (one stating with a tutor), and 3 women and one man felt they were taught informally through being shown techniques and by discussions about care. The remaining 3 women and 2 men commented they received little or no teaching.

In discussions on the delivery of hands-on-care: 12 of the cohort stated the staff nurses did give care, but 5 believed they spent all the time in the office, on the telephone, on ward rounds and with the doctors.

7 women and 2 men believed the sister/charge nurses to be approachable and supportive of the students, and organised in their work. One described a sister whom she believed to be good:

Sister is brilliant - she is organised and gets off on time and knows things will be OK. She asked how I was, and seemed to know if I was upset.

4 women had found the sisters to be unapproachable, some being inconsistent in approach. One commented:

One sister was inconsistent, one day students were wonderful, the next day not. Some students were anxious about giving the report, and they shouldn't feel like that.

The group discussed the system of going to meals, and 8 women commented that they and the trained staff went to breaks together, 2 mentioning the sister joined them. 3 women and 4 men stated that in their experience the students went to meals as a separate group. One stated that Christian names were used by all members of staff, "but we were still professional".

3. Written evaluations on the study sessions.

There were no additions to the comments already stated by the respondents on the sessions concerned with the care of the child, and of the patient with a neurological disorder. Further comments made on the community care and health education week,
included the growing awareness of the extent of the social deprivation in the district, and knowledge of the continuation of patient care into the community. Respondents stated they had become more aware of the different cultures in the local population.

Comments on the remaining study sessions included: more sessions were needed on the nursing care of patients with a cardiovascular disorder; the use of a nursing care plan to debate the care of persons with endocrine disorders was appreciated, and much was learned from experts coming to discuss care, such as ward sisters, and from patients who had had a mastectomy. The respondents considered that sometimes too much information was "packed into" a teaching session, but the use of video material to supplement a lecture was welcomed. Workshops, e.g. on stress, were felt to be of value particularly when the respondents were able to select the sessions to attend. A number believed there was too much time allocated to study, particularly when this was because an outside speaker had not turned up for the planned session.

4. Discussion.

During this second year the cohort appeared to be settling into a cohesive supportive group, although they had formed distinctive subgroups of friends who met together in their leisure time. Many had also made friends from outside the set, both outside and within the nursing profession. 8 women became non resident, some grouped together to share non residential accommodation, while others moved to a more modern residence with more privacy and quiet. The men and women who were non resident from the start, continued to experience some difficulty in maintaining relationships with others in the set, because for those with homes their families took precedence. Those who entered the scheme from the Access course tended to relate more readily with each other. This is not unexpected, because they knew each other prior to commencing the scheme, and shared common experiences. The respondent who recommenced training following the introductory course, and had therefore missed the initial seven week period with the group - at a time when individuals "bond" together for support and security - said she related more with the set with whom she had commenced training.

They all stated they still enjoyed and wanted to continue nursing, although two women had thought of leaving, having become disillusioned with some of the attitudes of the trained staff, the hours and poor pay. Two other women later left the
scheme, although not from a dislike of nursing. (see Chapter 8).

In retrospect, at the end of the first year, the respondents identified the first ward placement as a meaningful experience, this being the first time for contact with people as patients. 6 respondents remembered a supportive learning environment, but 8 experienced "reality shock" (Kramer 1974). The majority identified other specific experiences as being enjoyable with the atmosphere conducive to growth in learning - the care of children, the mentally ill, specific wards for acute care - with staff helpful in enabling the respondents to feel part of the team. The respondents experienced a lack of support from the trained nursing staff in the care and welfare of the elderly, but, in contrast, found the doctors in these wards to be involved with patients and willing to discuss treatments in a co-operative way. This was not always evidenced in other placements.

In the second year of the course, the ward sisters/charge nurses, and to a lesser degree, the staff nurses were identified by the respondents as most significant in their experience of nursing. Nevertheless, the ward sisters/charge nurses continued to be seen as managers and administrators not involved in direct care. The respondents' perceptions of the role of the trained staff, and in particular the ward sisters as holders of power and authority, are reinforced by the apparent perceptions of others e.g. doctors and patients. It is factually correct that it is the ward sisters/charge nurses who run the ward, make decisions on patient care and on the conduct to be expected from the nursing staff. It was also some of these qualified staff who caused stress to the respondents through their "condescending" manner, and the treatment of some of their views as not worthy of consideration.

In the first year the staff nurses were perceived as managers. In this second they were seen to be more involved in patient care, although they did not work continually with the respondents who worked with other students. In the first year despite not being perceived as involved in direct patient care, the staff nurses were the main people from whom the respondents gained feedback on performance and learned practical skills. The respondents' view that the staff nurses provided feedback is not unexpected, because the stated policy is for each student to be linked to a mentor who is usually a staff nurse. Difficulties arise when formal feedback on performance is given by nurses who have not worked with the students - information may be sought by hearsay, but not based on evidence.

In the first ward placement - the care of the acutely ill either in medical and surgical wards - the staff nurses may have enabled the respondents to become familiar with the
ward environments and routines. In the second year, the patients, e.g. children, the mentally ill, required more specialist care in which the staff nurses may have been more directly involved. The respondents' perceptions of the staff nurses' role may have changed because of their observations of these different types of experiences.

During the second year the respondents continued to relate positively to their personal tutors, but several took the option to change. They learned in the school when they were treated as adults - not talked at, given choices, enabled to share through group work, identified by the cohort in the introductory course evaluations as being a most effective method of learning. One study session in the care of the child was identified as a non learning experience, except in a negative way.

One half of the cohort believed that what was taught in the school was not carried out in the ward, or what was taught was different from practice.

**Summary.**

The format of this chapter follows that of the fifth in placing the cohort within the theoretical and practical context of the working environments. The perceptions of the cohort about nursing and the role of the nurse continue to be identified and illustrated - with some findings from the data building on those from the first year - discussed at the end of the chapter. The next chapter is concerned with the final part of the cohort training scheme.
Chapter Seven.

Student respondents - 3rd.year.

Nurses undertake complex social action. They attend to the patient's feelings; they provide emotional support and they make links between the patient's family, social identity and the medical institution. All this is invisible to the institution, unrecognised in terms of pay or a career, but embodied within notions of the personal qualities required, a priori, for the job.


Introduction.

This chapter is concerned with the analysis of the findings from three interviews with the cohort, the open ended written questionnaire, the repertory grids undertaken near the end of the scheme, and summaries of the written evaluations of study sessions 14 and 15.

The findings will continue to be described in the three main areas discussed in the two previous chapters—social/leisure, being in the school and working in the clinical areas.


This final part of the course lasted for one year and ten weeks, and 16 women and 4 men entered this final stage as senior student nurses, gaining clinical experience in maternity care, wards for the acutely ill and in the emergency and accident and operating theatre departments on two sites. Night duty was undertaken in the wards for the acutely ill patients. They continued to be assessed on clinical competencies during each experience. 7 women and 2 men were residents.

Study session numbers and titles:
14. Care of the patient with multiple injuries.
15. Care of the patient with sensory loss/disorder.
16. Care and welfare of the elderly patient.
17. Concluding the curriculum.
18 & 19. Professional development.

During these sessions the respondents continued to meet with their personal tutors and the allocation officer. They were taught by tutors and experts from other disciplines e.g. the personnel officer. The ENB final written determinate examination of knowledge was taken approximately five months prior to course completion.

2. Findings.

2.1. The interviews.

(i) The seventh interview.

a) Social/leisure: in answer to a question on the perceived advantages of being resident, the women mentioned; not needing to travel to work; accommodation being relatively cheap compared to the rent and other costs, e.g. electricity of residential flats and houses. Also given as advantages were: being able to meet with friends who were resident, and the enjoyment of a social life. One woman who had moved back into a residence, stated that there, there were "no domestic hassles". The men thought along similar lines. One mentioned the convenience of being resident, and another who had just moved in from being non resident wished he had lived in initially. He said "I missed contact with the set.

Both men and women discussed the disadvantages: the lack of privacy; too focussed on work and hospital; too noisy particularly when sleep was needed during the day after working on night duty. One woman believed that living in a residence made people lazy, and "not independent like in the real world". Non residency offered individuals their own space, and enabled them to use their time as they wished, which
was seen as a specific advantage, along with privacy, and being away from work. Many non residents regretted they did not see or meet up with their set members between study sessions - the shift system and working on different sites mediated against this.

Leisure time for both the men and women was spent mostly with friends - in a public house having a drink, visiting for a meal, seeing films or going to the theatre. 11 women and one man spent more time with friends from the work situation, mostly from the nursing profession, but 2 women and one man spent more time with friends outside the workplace. 3 women and 2 men stated they shared their time equally between friends inside and outside the health district.

b) Being in school.

The question of preparing for a written assessment arose, and the majority of the cohort studied by themselves, only occasionally in a group of two or more, which usually occurred when the respondents shared a flat or house together. 2 women and 2 men stated they would never study in a group - "that would be too distracting". 2 women prepared a study plan, 11 read - a book, or essays, or notes made from lessons - and then wrote notes, or essays to be assessed by the tutor. 2 answered previous assessment questions, one read then used revision cards. One worked "only at the last minute when exams are imminent", and said she relied on a good memory. One non resident stated she read only when in the school. 2 mentioned that they "looked up" the care of patients they had nursed. 2 men read - one using a revision aid - then either wrote essays or planned essay headings; another read but did not write essays or notes because "you kid yourself you are actually learning". One man studied from books, his reading dictated by the type of patient he had nursed. One stated "I work best under pressure".

In reply to a question about the need to wear uniform, 14 women and 4 men liked wearing uniform, and wished to keep it. The reasons given included: the uniform enabled the respondents to feel like nurses; was easily identifiable; gave confidence to patients as well as to self; looked professional; gave a feeling of security; it meant no decisions had to be made on the type of clothes to be worn and it was cheaper to wear uniform. One man was adamant the uniform must be "worn correctly and look immaculate". Another stated he was not confused with a doctor "because I explain
One woman "hated uniform" thinking it offered a stereotype, and students were "branded as someone young and ignorant". She preferred an overall. One other woman disliked the formality and felt uniform should be optional. She considered that the uniform was not clean after the first wearing. Other disadvantages of uniforms were identified: they were hot, especially in the summer; they could form a barrier between the student and patient; "if questions are asked I would be expected to know". One man commented that he disliked ironing shirts, and his tie occasionally "flopped into the bedpan". 7 women believed that caps were an essential part of the uniform, although not of practical use. One said: "it would not look or feel right"; 7 thought they should be "done away with"; one believed they should be optional and one was unsure if caps should be worn or not.

c) Working in the clinical areas.

In answer to the question "how would you describe the role of the student?" everyone replied that it depended on the seniority of the student - which was divided into being junior (first and second year), - and senior which equated to being in the third year of training.

The women's views of the role of junior students included: "made to feel incapable of doing things"; "backbone of the ward"; "the workforce"; "worker rather than student"; "carry out patient care"; and "pairs of hands if busy". The men gave different answers: "they give care"; "juniors ask more questions"; "each thing is watched - feel intimidated"; and "more menial jobs". These responses indicate consensus regarding the role of the junior students as workers.

The views of both men and women on the role of the senior students were similar. They had more responsibility, and felt more "valuable" as a member of the team. The women said that in their role as senior students they were expected to: teach and support the juniors; head the team; act as a learning resource; act as a staff nurse, and to be involved more with management. The men considered that they were required to link juniors to staff nurses and to be more like "one of us" (referring to staff nurses). One man believed that the staff nurses treated him as a beginner, not as an experienced third year student, the other that being a male third year student made him "stand out" in the ward.
At the end of an interview the comment was made that there was no role description for a student nurse.

Referring to individual patient care with care planning fifteen respondents (12 women and 3 men) stated that it was practised in the wards, although three qualified this statement with -"it depends on the numbers of staff". 5 respondents (4 women and one man) believed that task allocation was the norm, because of pressure of work. One man stated there were benefits in task allocation, particularly in an orthopaedic ward, where certain tasks such as the giving of bed pans were routine.

The senior and junior students were allocated in teams to care for a group of patients, 5 of the cohort stated that the senior student nurses were allocated to the more acutely ill patients.

6 women gained most satisfaction from enabling the patients to get well, 4 from the practice of "hands on care" within an holistic framework, 3 from being part of a team, and 3 from teaching junior students. One commented she was "pleased to get through [the work] OK", and 3 stated that recognition of their worth and value was also important.

2 men gained satisfaction from the recognition of their contribution to care - "nice to have a thank you", and "to have respect and trust for what I am doing". One enjoyed the planning of care based on the assessment of needs and one from teaching junior students.

4 women gained least satisfaction from the lack of staff on the wards: others mentioned; "basic care is not challenging"; lack of communication in the wards; doing mundane tasks like washing bowls; not treated like students; not enough time to do things properly; not seeing positive results of their care with medically ill patients, and the "patients are not told their diagnosis".

The men were concerned about: "the trained (staff) give no credit for intelligence"; not able to work to the best of ability "because my face doesn't fit"; "too many managers doing too little", and not able to plan care effectively.

In the discussion of the make up of a "good" ward sister/charge nurse, the following attributes were quoted by the majority: "approachable, and supportive"; "tolerant, and flexible"; "straightforward and honest"; "confident and unflappable"; "communicates and listens (to both sides)" and has a "sense of humour".
When asked to define the role of the good ward sister the following responses were given: manages ward - picks up things on return as if (he/she) has not been away (4 women and two men); knows patients and staff, knows what is going on (4 women); has authority - can be strict, and tell someone off if necessary (2 women); spots problems before they occur (one man); organises teaching sessions (one woman); is one of team (one woman); sets standards (2 women); enables others to develop skills (one woman); receives ideas from others and acts on them (one man); gives care, and is not frightened to get hands dirty (one woman).

(ii) The eighth interview.

This was held approximately two years and seven months into the scheme. One woman one man were away and therefore they were not interviewed.

a) Social/leisure.

6 women and 2 men felt they had been well treated during their scheme of training, and 4 women and one man stated they were "quite well treated". 2 women were well treated. One stated "except for the first ward experience where work was criticised in an unconstructive way", the other found the staff unsupportive and uncaring in her first ward.

One woman stated:

I was treated fairly well. I have a quiet but assertive personality I won't take any flack.

another:

I was treated well, but I get infuriated when the doctor roots out the staff nurse when I am there.

One man:

I was treated well, but I get frustrated in school - there is peer pressure to tempt
[me] away from work. Better to work at home.

One woman who believed she had not been well treated stated that:

Allocation office - they are rude and don't give requests. Occupational health don't expect you to be ill, because you are a nurse.

One woman had mixed perceptions. In the first year she stated she felt "all at sea" and this had been a struggle, but things improved as she gained more knowledge and experience. This respondent was also concerned about becoming a staff nurse stating that "it's different when you put on a mauve dress". Another commented that a sister in her first ward had "mocked people's accents", this respondent had not joined in as she found it "insulting". She also had concerns about a night duty period when an incident concerning a broken hypodermic needle had occurred. She believed a report on this had been delayed.

One man had been well treated, but felt that the school and the clinical areas were "two different worlds", with little connection between the two. He believed that tutors should go into the wards, particularly to support the newly qualified staff nurses.

Responding to the question "are male students/nurses treated differently from females?" (which arose from a comment made by a woman in the previous interview), 10 women and 3 men stated that they believed the men were treated advantageously. 3 women thought the males were treated the same as females, but one believed they were disadvantaged. 4 women stated that some female patients would prefer to be nursed by women, e.g. when being bathed. One woman believed "they get away with a lot more, doctors seem to assume they are more intelligent". Another thought "the men were encouraged to look after number one", and that they stood up for themselves a bit more. 2 mentioned that although men were at an advantage, feelings about the male student/nurse could be polarised so that they were "seen as either very good or very bad". One thought because the male students stood out more they could be "picked on", and everything they did was noticed. The men commented:

the men are noticed more-the women are envious. There are no disadvantages for patients or staff.

it's a nice position to be in- if your work is average you are treated well. Male
patients like the men to talk with some female patients may be embarrassed. [we] have an advantage - we can smooth things over, and can influence the sister. Females can argue points with the sister and staff nurses.

b) Being in school.

10 women and 3 men felt they had gained basic knowledge from sessions in the school, and 4 women and 2 men commented that theory learned in the school and practice in the clinical areas was not always related either in the timing of study sessions or because of differences between what was taught in each. One woman believed that there was not enough anatomy and physiology "but lots of time given to psycho-social topics", another that principles were taught which had to be translated into practise. 2 commented that previous learning was not taken into account, and 2 women and one man thought that time was wasted - "you come in and immediately time is allocated for study". 4 women believed that sessions should be optional. 5 women stated that meeting and sharing with the set was an important part of school, while one welcomed the break from work [in the wards]. One woman thought the school was a good one "I am proud to be here", while another believed the teaching was better than at university, "the teachers here are human beings and we are encouraged to take responsibility [for own learning]".

Responses to the question "what is a good teacher?" included: involving students; using discussion methods; using various teaching techniques; knowledgeable and using research; using examples from experience; teaching holistic care; assertive, keeping control; interesting, enthusiastic and motivated and having optional sessions. Responses about what is an ineffectual teacher included: talked at the group, read from a paper; treated the students like children; no variety in teaching methods; disorganised; did not establish a rapport with the group; could not manage the group and lacked confidence.

12 women and 3 men believed the role of the personal tutor was one of support and advice, with the tutor being approachable. 8 women believed the tutor should be available for help when needed, and 8 women and one man wanted the tutor to go through essays and advise on work. 3 women believed the tutor should visit them on
the wards, while 2 stated they did not use the tutor much. 2 women wished the tutor would "crack the whip a bit". One commented that the tutor gave "holistic care to the student -relationship similar to the nurse/patient one".

12 women and 3 men had worked with tutors, but only on one or two occasions during the first or second ward experiences. 2 women thought that work took much longer when working with a tutor "it is a hindrance when busy, it interferes with the work". 6 women had had an occasional formal teaching session on the ward from the tutors, the 3 men believed this a rare occurrence. The teaching sessions on the ward were given mostly by the staff nurses, occasionally by the sister/charge nurse or other students, but were not given on a regular basis.

c) Working in the clinical areas.

13 women believed that reputations about a ward or a person occurred through word of mouth - friends having had a good or poor time in the area or with a person. The reputations were mostly about a ward being heavy or light - according to the type of care the patients needed. A ward for immobile patients who had to remain in hospital for a long period was termed "heavy". The rumours about people usually concerned the sister/charge nurse and whether they were considered approachable or not, or whether they stayed mostly in the office or in the ward area.

One woman said:

students are unhappy-rumours are passed on. Some are built on personality, or labelled according to the work load. [You] need to take the ward or sister on their own merits.

One man made the point that "the good are as good as the reputations, the bad are never as bad".

In discussions about perceptions of the staff nurse role 12 women and 3 men believed they managed and organised the ward and people. One woman believed they delegated the work and resources as effectively as possible. Another woman said "they are responsible for everything, cockroaches in the kitchen, Mrs.B's constipation. Five women and one man stated they had a teaching role. 4 women mentioned a supervisory/facilitator function. 4 women commented on the liaison role with other members of the ward team, and 2 women and one man stated the staff nurses kept the
ward a safe environment for the patients. 3 women stated that some staff nurses were involved in direct hands on care, but 3 others believed they were not involved in direct care, "although they should be". 5 believed that there should be more nursing staff on the wards - the staff nurses might then be involved in the giving of care.

In the previous interviews, 2 respondent had commented on what they wished to achieve as staff nurses. This led to the question "what would you like to implement on the ward as a staff nurse?". 5 women and one man stated that the staff nurses should give direct patient care. 4 women and one man would improve the staffing levels, 3 women would enable support systems for staff, one said "a regular support group arena to enable staff to express views". 2 mentioned a planned teaching programme, and 2 women and one man would implement a primary nursing model of care [i.e. a named nurse allocated to specific patients]. In addition to improving staffing levels, one woman was adamant she would get rid of all the flowers in the ward, "the water is never changed, and there is no room - they get in the way if a cardiac arrest occurs".

In response to the question "where and how do you learn nursing?", 12 women and 3 men stated they learned nursing in the clinical areas by observing other students and trained staff, and then by "doing". One women stated "by trial and error", and another that "one learns from mistakes". 4 women and one man commented that they applied theory learned in school to practice.

In discussions on the planning and giving of care, the respondents believed individual patient care to be care geared to the individual patient's needs. One commented "patients can have the same condition [illness], but have differing problems and different needs". Holistic care was mentioned "the full care from admission to discharge". The involvement of the patients and relatives was mentioned, and one respondent commented "ideally it is the time to listen, and tell the patient and relatives about the situation". 2 women believed that on occasion, the psychological needs were not met, and one man thought that "patients are too subservient [in their care]".

In the discussion on previous experiences - whether they helped the respondents in
giving nursing care - 7 women and one man believed the communication skills they had learned doing voluntary and previous caring work had helped them, particularly when they had been involved with other professionals. 2 women and one man believed being previously employed had enabled them to deal more effectively with problems - taking orders - and in dealing with people and equipment. One woman found her experience of lifting elderly people enabled her to gain confidence more quickly, and 2 women believed experience of working in a team had helped them settle into the wards. One commented that her knowledge of anatomy and physiology had been built on during teaching sessions. 3 women did not believe their previous experiences had helped them at all.

(iii) The ninth and last interview with the student respondents-at the end of three years.

a) Social/leisure.

In response to a question about their professional futures "where do you see yourself in about a years time?", 13 women and 4 men thought they would stay in the host Health District, working as staff nurses for approximately six months before moving either to another District, going abroad, or undertaking a nationally recognised post registration course e.g. a six month course in oncology nursing.

3 women stated they would probably be leaving, either wanting to go abroad as a friend made a packet, or to work in specialised areas such as caring for terminally ill patients, or those who were addicted to drugs.

When discussing their leisure time and activities, 9 women and 3 men stated they had spent their leisure time with friends from the set and the nursing profession, 3 women stated they spent more time with friends outside the nursing profession, while 4 women and one man spent an equal amount of time with friends inside and outside nursing. 13 women and 3 men believed that working the shift system of hours interfered with their social lives. One woman stated she had lost touch with friends at home because of these hours, another commented that when on night duty she could not sleep during the day and was like a "zombie". 11 women and 3 men were members of a trade union, but only one woman was active in this field. One woman stated she had to take two days off and reported sick because she could not bear the
ward sister "going on" about things, another believed that occasionally her social life impinged on the professional -she came to work in a "blurred state".

One theme developed through the interviews was the question of gender. In response to the question "Is there any difference in the way or manner men and women students are treated?", 5 women believed that male students were treated more positively than the female students. One commented that they were favoured by the sisters and doctors although they did not work so hard. Another believed they were enabled to express their views "and were listened to by the trained staff". 2 women stated the doctors treated the male students more as equals, 3 women believed the men were not as efficient as the women - one commented "they are lazy and get away with blue murder". Another woman believed that male students did not have "the same sort of touch, for example, checking to see if the patient is warm enough". 2 women and one man believed there was no difference in the way the men were treated, and the care they delivered was no different from that given by women, "as always - it depends on the person". 2 women and 2 men believed that feelings about male students were polarised. One man considered the male students were categorised as "either very good or very bad and this is not true". One woman stated the female patients particularly the elderly "loved them", while one woman and one man believed that some female patients preferred to be cared for by female nursing staff - the man specifying the younger patients particularly. One man was adamant there were two categories of male students:

They are either first class or diabolical, and definitely treated differently. The men get round people - for example the sister. First names are often used, and the doctors are more cooperative.

He himself claimed that he had not experienced any difficulties with female patients, "it is the approach that matters". He did not like to work with other male students because he believed that there was no rapport with them.

b) Being in the school.

In response to the invitation "share with me [researcher] your thoughts on your time in school": 8 women and 4 men stated they had enjoyed being in the school, liking the atmosphere and approach to learning. 3 women stated they did not enjoy the
experiences since they learned best on the wards and considered school to be time wasted. One woman stated that:

I enjoyed school and studying most of the time we were treated like adults.
Choice is important but I had to go to sessions when you know more in depth than is [being taught] in the session.

One man commented:

I enjoyed school, a relaxed atmosphere.
Some sessions could be condensed,
others were fine - the students were active.

Two other comments from women were:

Not much help in some areas - some sessions were helpful some boring.
Should stress policies and accountability.
It was good to meet with the set.
Everything I learned was from books and my experiences.

4 women and one man commented on the time wasted in school particularly when the arranged speakers did not turn up, and no contingency arrangements had been made by the tutors. 6 women and one man commented on the difference between what was taught in the school and practised in the clinical areas, but one man believed there was no difference. Nevertheless he claimed that the school was too far from the clinical and practical areas. Examples were given of the perceived differences in post operative care, and in "teaching about the stages of epilepsy". One woman believed the tutors taught the "ideal", and there was no way this could be carried out in the wards, but she went on to state that students needed to learn the ideal, to understand what was correct and proper.

3 women and one man commented they enjoyed having a break from the work in the wards, and welcomed the opportunities to meet with the set.

In response to a question on what improvements they would like to see achieved in the school, 5 women and one man emphasised choice in attending sessions, but one
woman believed this should only be for senior students. 4 women and one man wanted more practical sessions. 3 women and 2 men wanted contingency plans if speakers did not arrive but considered these should not include study sessions. One man believed study should "be in our own time - teaching should take place, not self directed study". 3 women wanted more details on the time tables, and other areas mentioned were: bandaging; rooms for study; study days; case study and seminar approaches to teaching and learning.

In answering a question on the types of teaching methods used, 10 women and 3 men believed a variety of methods were used by the tutors. 6 women stated they did not like a teacher to "talk at them for an hour reading from an overhead transparency", while 2 others liked lectures. One stated:

I do not like group work. I'm not used to it-I'm used to sitting behind the desk listening to someone preaching.

One woman found the standard of teaching good, and self directed study "stimulating". But another man believed there had been too much self directed study, which he believed to be wasted time.

14 women and four men considered their personal tutors had been supportive, and that this system of support should be continued. 2 women had not used their personal tutors, one stating "I prefer to work by myself-I have my own support system". Both of them stated that the system was correct.

12 women and 2 men would go to friends if they had a personal problem, one woman to her mother, and one woman and one man would discuss the problem with their personal tutors.

c) Working in the clinical areas.

In reply to the question "what do you believe you have gained from your training?", 8 women and 3 men replied "confidence" - confidence in themselves as individuals and as students. One replied that she had gained self knowledge of her strengths and limitations as a nurse and as a person, another had gained confidence in coping with illness and death. One believed he had confidence to make decisions and was able to "see self" and was more tolerant as a person. 4 women and one man believed they had
grown up, had become more mature - more responsible. One stated she had become less cynical, and had seen herself change - she could pre-empt patients' needs. 3 women mentioned they would achieve a professional qualification, others mentioned meeting different cultures, and interpersonal, communication and assertiveness skills. 3 women and 2 men stated that they had gained new friends, which they valued.

All the cohort had enjoyed most of their training experiences. 8 women and 4 men had found nursing to be as they expected, and were not disappointed. One man commented that he loved it, and it was as he expected it to be - and "I would do it for nothing - I would only leave if I couldn't support my family". 5 women had discovered nursing to be more demanding than they had envisaged it to be, 2 mentioned having more responsibility for patient care than expected with one believing this responsibility had come too soon for her; another believed nursing was concerned with "bedside care - not all this paper work". One stated she had not expected nursing to be so demanding and stressful, and went on to talk about three patients who had died during her first ward experience. 2 women could not remember what they had expected nursing to be like, one stated "I can't remember what I expected - I am surprised I enjoyed it so much", but one woman stated nursing was not what she had expected - "there was more theory - I thought nursing was more simple."

In discussion on the positive aspects of clinical learning experiences, 7 women and 3 men believed they were able to ask for information, and question practices. Specific wards were identified by two women and one man as examples of "good " environments; 3 women mentioned that primary and team systems of care had developed and had improved care and communications for example in written care plans; 2 women believed that they had witnessed "good care" of dying patients; one woman and one man commented that they had met individuals they had used or could use as role models- the woman stated "it's nice to meet someone, and think I'd like to be like that".

In discussion on the negative aspects, 3 women and 2 men stated that some trained nursing staff attitudes caused them concern; one commented that staff nurses should have more patience with first year students; one woman commented there was a hierarchy and nurse managers made impossible demands. She referred to a staff nurse being moved from the ward to another because that ward was "short staffed". 2 men commented on the attitudes of junior students, one stated "the new students have
different attitudes - they don't seem interested", the other believed that the older students did not like being told what to do by younger, but more senior students. 3 women and one man commented on the lack of formal teaching, one woman and 2 men felt they had been treated as "pairs of hands", 3 women believed that students were given "too much responsibility", and 2 women and one man commented on "poor staffing levels". One man stated:

I am asked to do things I don't know. I am not brave enough to ask why me? The trained staff give the best care but they don't often do it.

In a discussion on what could improve matters, 8 women and one man stated that more supervision of students was required which was in some instances linked to improved staffing levels; 2 women and one man believed that trained staff should give more "hands on care". One woman stated:

I felt bad, I seemed to be doing three peoples' work. One patient was being barrier nursed-it took me ages to gown, and there was no time to talk and listen.

More formal teaching (lectures/discussions on care and treatments) was mentioned by 3 women and one man. However 3 other women and one man believed that teaching in the clinical areas was good. One of them stated it was important to have time to discuss patient care in depth. 8 women and 2 men believed that the teaching was "average" - more time was needed as it was not always possible to attend the formal teaching sessions which were mostly given by staff nurses and ward sister/charge nurses. 5 women stated that there was little teaching in the wards, one commenting that "it varies - it could be planned better". 7 women and 2 men believed that the tutors should spend more time on the wards, becoming involved with hands on care particularly during the first year of the students' training, and in giving formal teaching sessions. 2 women commented that working with a tutor meant that more time was needed to give the care. 2 others believed that the tutors should work with the newly qualified staff nurses - to give them confidence.

3 women and one man believed the system of mentorship by a trained nurse worked effectively in their role of teaching, assessing, and supporting students. They stated that feedback was given to them about their performance, but the man stated it was
more effective when the mentor actually worked with the student. 6 women and one man stated it did not work. One woman stated:

it does not work-the mentor is not objective, isolated incidents could colour the assessment.

3 women and 2 men believed that personal feelings of the mentor could influence the ratings used in the assessment, e.g. liking the student could mean higher levels being achieved. 3 men and 2 women believed the system worked more efficiently when primary nursing was practised, and six women commented that the system could be improved by the student having two mentors - increasing the possibility of the student and one mentor being on the same shift together. The cohort believed that a system of mentorship should continue - it was important to have a designated person to whom the student could relate.

3. Evaluations of study sessions.

The summaries of the evaluations of the study sessions indicated that the sessions were found to be relevant and provided a good preparation for clinical experiences—particularly for working in the emergency and accident departments. In one evaluation, the comment was made that the respondents believed they were treated as adults, and the information gained was clear and precise. Outside speakers were appreciated, and the revision of anatomy and physiology was welcomed. The respondents stated they would have welcomed more emphasis on the diseases of the ear nose and throat and the care required for these patients. The updating of the nursing care for people with trauma was welcomed.

4. Written Questionnaire-end of three years.(Appendix 10)

This second questionnaire was completed by 12 women and 4 men. 4 women did not complete the questionnaire, two of whom were absent due to illness.

6 women and 4 men gave caring for people as the reason for becoming nurses. 2 women mentioned previously working in a caring role; 4 the possibility of travel or to
work in a specialised sphere; 2 could not remember, but believed they had always wanted to nurse.

In response to the question "what do you understand by nursing?" everyone mentioned giving care in hospital and community, this care being geared to the individual, and helping patients to a dignified death. 4 women mentioned promotion of health and disease prevention, while one woman and one man stated the advocacy of the patients' rights.

In response to the question on the role of the nurse: 5 women and 2 men specified the assessment of patients' needs, planning and giving care as part of the role. 3 women and 2 men mentioned managing the ward environment and care. 6 women and one man stated being a health educator and promoting health, while 6 women and one man stated being a teacher and role model. 6 women and one man believed that being the patient's advocate formed an important part of the nurse's role. 5 women and one man specified being a team member, and 3 women the supporting of other staff.

6 women and 3 men considered that the specific skills developed by the nurse were listening and communicating and counselling, whereas practical skills, e.g. giving of medicines were stated by 2 of the women. One woman specified the identification and setting of standards as an important part of the nurse's role.

One woman said:

the role of the nurse is to be a good listener, a comfort to her patients, some one who is able to communicate with the medical team as well as patients and relatives. The role of the nurse is to put points on a matter forward, and see that the proper care is given to each individual patient.

One man made the point:

to be a friend and organiser for his/her patients - to give advice help and support, to overcome or come to terms with crises in their lives - at a time when they feel they may be at their lowest ebb.

The responses to the question on where the respondents viewed themselves one year
following qualification, produced:

<table>
<thead>
<tr>
<th>Response</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gained or gaining further qualification eg ENB course(theatre) Health Visiting</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Working in same hospital as staff nurses</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Working in another hospital(Great Britain)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Working in another country</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Starting a different career</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Progression to a charge nurse</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

5. Repertory grids. (Appendix 11)

Repertory grids were completed by the respondents in response to the question "Who do you believe helped you to learn nursing?". The analysis of these grids enabled comparisons to be made between the respondents' perceptions, but the constructs were specific to the individual.

Discussion.

11 women and 3 men paired students and staff nurses at a high level of commonality. The constructs in which these elements were rated at a high level indicated that students and staff nurses were involved in patient care, had contact with the respondents, and were approachable. 7 women and 3 men wrote words and phrases which included the learning of skills, feedback on performance, and teaching, e.g. "learnt nursing care", "learnt practical skills and discharge planning", "gave feedback, supervised teaching session". This finding is similar to the findings of the data from the interviews during the latter part of the cohort's training.

2 women linked staff nurses with sisters and the constructs indicated their involvement with discharge planning, and administration. Sisters/charge nurses were linked to the student/staff nurse pairing by 5 women and one man, but did not achieve
such a high rating in the same constructs. One woman wrote the sister had little patient contact, another that "the sister and charge nurse don't make time to explain and demonstrate things to the student--".

7 women and 2 men indicated that the patient and, to a lesser degree the relatives, were directly involved with students, and were met frequently in the clinical situation-phrases such as approachable, gave support and information, were used in the constructs. This would concur with the evidence from interviews in the first year, when patients were perceived as helping the respondents learn social and communication skills.

11 women and 2 men indicated in their constructs that the tutors were not seen in the wards, but were in the school and taught knowledge and theory. One woman linked the tutor, clinical teacher and senior nurse as "involved in policy".

The clinical teacher was rated at a low level in the constructs concerned with involvement with the respondents. Phrases used included "does not work with pupil and clinical teacher". One man rated the clinical teacher and tutor highly for research based teaching. One woman wrote that she had not seen a clinical teacher, except in her first ward, where the clinical teacher "was excellent". These findings are similar to those gained from the interviews.

Auxiliaries were rated highly by 6 women and 1 man in constructs concerned with basic care- "taught basic care", and "learnt practical skills". This would concur with comments made by the respondents during the interviews, during which the help from auxiliaries in learning the ways of the sisters was also acknowledged.

It would appear from the ratings given to pupil and enrolled nurses, that the respondents did not have much contact with them. This is not unexpected, because pupil training had been discontinued and there were consequently few pupils in the wards, which either had one enrolled nurse on the establishment, or none. 3 women rated enrolled nurses at a high level with constructs specifying, for example - "approachable, in contact", "learnt basic care", and also indicated pupils were involved in patient care and used basic skills.

The senior nurse was given low ratings for constructs indicating approachability, involvement in care. 3 women wrote that they had not seen a senior nurse, another that "senior nurses only come to wards to ignore students-find faults--". This finding is not unexpected, because the senior nurse would relate more with the qualified staff in the wards.
The ward clerk was rated highly in constructs concerned with paper work and administration by 4 women and one man. respondent, and linked with the staff nurse and sister/charge nurse in "taught discharge planning", by 2 women.

Doctors were rated highly in constructs concerned with teaching about illness and medical knowledge, by 6 women and one man. One woman ranked the doctor with the sister and senior nurse as being "superior" to students.

7 women and 2 men rated "own friends" highly in constructs specifying support help and advice, and this was the essence of their views from the interviews.

The domestic was not rated in the constructs by the cohort, one wrote that she was not involved with domestics. The domestics in wards were not managed by the nursing staff, and their work involved mostly cleaning the wards. Although not directly involved in care, many domestics talk with patients, and occasionally get them shopping.

2 women added elements, both included physiotherapists, one the chaplains. The physiotherapists rated highly in teaching, and in information about back pain, the chaplains in "insight into spiritual needs". The finding about the physiotherapists reflects the positive comments made by a number of respondents during the interviews. It is possible the cohort had not come into direct contact with the chaplains in the wards, although the chaplains went into the school to discuss their roles.

6. Discussion of findings.

The cohort had enjoyed most of their training period, with half discovering nursing to be as they had expected - and 5 that it was more demanding, either in the clinical situations or in the theory and knowledge demanded from them. The majority of the cohort stated they had gained confidence in themselves and had matured as individuals.

The cohort continued to be a cohesive group - with individuals making particular friends within the set - and some friendships developed by the sharing of non residential accommodation. Most of the cohort had made friends inside and outside the nursing profession during the past three years. Many of the respondents tried to meet up together between the study sessions held in the school, often going for a
drink in a public house or to share a meal, but working different shift hours and on
different sites mitigated against this happening frequently. Several had moved back
into residency because of problems in sharing with others, or because of the amount of
time needed for travelling. The respondents who lived at home or were non resident
from the outset of training and the woman who had joined the set following the
introductory course appeared to have established firmer relationships with some
members of the set during this third year.

One man described the cohesiveness of the set when he told how the group in one
study session had refused to participate - became silent - because they believed one
member had been "picked on" by the tutor.

Previous learning - for example communication skills, abilities to work harmoniously
with others - was found to be beneficial in working as team members involved in
patient care.

The findings in the first year that the cohort would approach their friends for help
with personal problems were confirmed at the end of training, but one man and one
woman specified they would turn to their personal tutor.

The majority of the cohort had joined a trade union during the first year of training,
but only one woman stated she was active as a member. The remainder apparently
believed it was beneficial to belong to something.

In retrospect, the majority of the respondents had enjoyed being in the school - and
believed they had gained basic knowledge and theory - as well as enjoying the break
from the wards and meeting up with the set. 3 women did not enjoy this learning
experience, believing it to be a waste of time as their learning was from giving care in
the wards.

The majority of the cohort continued to meet with their personal tutors, to discuss
their written work and times in the clinical areas. The respondents continued to state
they believed it would be advantageous for the tutors to work in the clinical areas,
e.g. to give teaching sessions, to work with junior students. Some stated that the tutors
should also advise and support the newly qualified staff nurses, these comments were
made as the cohort neared the time when they themselves would become qualified
nurses. One woman put into words her anxieties about the forthcoming change in role,
epitomised by the change to a distinctive coloured uniform which made the difference
in role visible to everyone.

One woman disliked the wearing of uniform, believing it "stereotyped" her as a nurse,
and that in some way it affected her identity as a person. Students of nursing are expected to conform to certain norms of behaviour, and some experience difficulty in coping with the demands on them as students and their own need to be recognised as individuals. The remainder of the cohort believed that the wearing of a uniform gave them and the patients confidence and a feeling of security, although half the women stated the cap was not essential and provided no useful function.

The analysis from the repertory grids illuminated the fact that the tutors were viewed as being in the school and teaching theory. The perceptions of a number of both men and women throughout their training were that the teaching in the school was different from that practised in the clinical areas. These differences appeared to be that on occasions the ideal was taught in the school which could not be achieved in the wards - often due to lack of staff - and often "corners were cut" in the clinical areas. At times it appeared that the teaching of a topic was different from that taught or practised in the wards, e.g. post operative care, and lastly that teaching in the school was unrelated to the respondents' current clinical practises. This theme will be discussed more fully in the next chapter.

The respondents stated that the tutors used a variety of methods in their teaching, and the students appreciated being active in their own learning. The majority of the women did not appreciate the didactic approach, but two preferred lectures as a teaching method - one because this was what she had been used to previously. The sharing of experiences and learning did not extend to group studying for written assessments - the majority preferred to study by themselves - reading and making notes, and writing essays.

The respondents perceived that the role of the student depended on their seniority - students in the first and second year being designated junior and viewed as the workforce, and sometimes treated as "pairs of hands". The senior students in their third year were viewed as having more responsibility and were more valued as part of the ward team.

Contrary to the perceptions in their first year, they stated that individual patient care was practised and care plans were used in the wards. This difference in their perceptions might be because as senior students - members of a team giving patient care in wards for the care of acutely ill patients - the respondents were more involved in the writing of care plans and in the discussions with junior students on patient care.

The perceptions of the cohort on the role of ward sisters/charge nurses as illuminated by the repertory grid, continued to be that of managing the environment, but more
perceived them as having more direct patient contact. The staff nurses were perceived as managing the wards, having a teaching role, and being more involved in caring for patients. The respondents learnt nursing by observing other students and staff nurses in the clinical areas giving care and then by giving care themselves.

The attitudes of some trained staff were still perceived by some respondents to be negative - not conducive to rapport being established or a productive learning environment. One woman stated she had taken two days off as sick time to avoid a sister and a possibly destructive (to her) situation.

The existing system of mentorship, with one trained member of staff allocated to one student, was not perceived as working effectively. The mentor did give feedback on performance, but some respondents believed that personal feelings could influence the assessment levels. It was only on some occasions that the mentor and student worked together on the same shift. Feedback on performance was gained as much from other students as from the mentors. Two mentors were viewed by some as providing a solution to the experienced difficulties - because the concept of mentorship was perceived as valuable and necessary.

The majority of both men and women believed that male students were treated differently from the female students. The men were perceived as being treated advantageously by others - particularly by some of the trained staff. "The views of the men were listened to", and "doctors treated them more as equals", were statements made. 2 women and 2 men believed that the views of others were polarised - the male students were either very good, or very poor students. These perceptions will be compared with those of tutors and ward sisters in later chapters.

Summary.

This chapter has followed the format of the previous two chapters in placing the cohort within the context of the working environments. The perceptions of 16 women and 4 men on nursing and the role of the nurse continue to be explored with some findings built on those from the first and second years.

The next chapter presents a further analysis of the perceptions of the cohort on nursing and the role of the nurse, and a profile of the respondents who left prior to the completion of the scheme.
Chapter Eight.

Analysis of findings - end of training.

Profile of the leavers.

Teachers should continue to warn student nurses that practices taught in the classroom may sometimes not be possible on the wards. There is a need, however, for teachers to decide what constitutes adequate (rather than ideal) care and to demonstrate their decisions in the workplace.

Gott 1984 p.103.

Introduction.

This chapter starts with an analysis of the student respondents' perceptions about nursing and the role of the nurse, and continues with a profile of the respondents who did not complete the scheme of training to become registered general nurses.

1. Analysis of the student respondents' perceptions.

(i) Reasons for entry into a scheme of nursing training.

The respondents in this study entered nursing training with knowledge, skills, values and expectations of nursing, derived from their past experiences of life, including work. These values - beliefs that some things are good, worthwhile and worth striving for, (Haralambos 1987 p.6), were exemplified by all except one respondent offering "caring for others" as the main reason for having entered a scheme of preparation to become qualified nurses. These may have been socially-orientated acceptable responses given to please the researcher, and may have been influenced by the need to obtain jobs in a time of recession, but they may also have been perceived as true by the respondents. At the end of training, this reason had not changed. This finding is not unexpected. Collings (1980) in comparing 300 nursing students with other
students in fields such as social work, teaching, health sciences, physical and biological sciences discovered that:

over three-quarters of the nurses consider working with people rather than things an essential aspect of their ideal job and over one-half consider being helpful to others essential.

Collings (1980 p.1896.)

(ii) Cohesion of the group.

One of the main themes developed throughout the interviews was the cohesion of the group or set. This cohesiveness appeared to be felt throughout the training period, despite 7 respondents leaving prior to completion and sickness disrupting some study sessions.

Although having had some previous experiences and learning in common, the men and women entered training and the set from different socio-ethnic backgrounds, at different ages, with some women having families to care for at home. All had experienced a degree of independence, and then entered a scheme of general training with prescribed rules for different environments, the school, the clinical areas and for some respondents, the residences. These rules were concerned, for example, with method and type of dress, restrictions on time and expectations of certain types of behaviour considered appropriate for the settings. MacGuire (1968 pp.277) considers that a latent but partially recognised function of the set is to provide "an ongoing membership and reference group for student nurses", (see Chapter One). The respondents in this study considered their set a focus for sharing experiences and opinions about the types of wards and trained staff they had met. They acknowledged that rumours about certain wards and sisters/charge nurses "went around", and discovered that comments made about sisters were often found to be true in reality. The set enabled a secure environment for "moans and groans" to be expressed, and enabled respondents to check if their perceptions about certain experiences were unique or shared. One certainty for the cohort was that the set always met at known prescribed times when study sessions were held, so that friendships could be reconfirmed, or reconsidered. Wilson and Startup (1991 p.1479) discovered that:

Most students found that the student body helped them to develop their
practical skills, prepare for ward based assessments, be informed of sister's "likes and dislikes", ward lore, and to a certain extent, assist with an understanding of theory.

The respondents in this study learned a great deal about nursing from their peers (to be discussed later). Despite the majority preference for group work and activities in school, they did not tend to study in small groups, the preference being given to working by themselves, reading textbooks, and being active in their learning by writing notes and/or essays.

MacGuire (1968 p.278) suggests that bonds of friendship may form between pairs and cliques are formed in sets. This was borne out in this study. A number initially expressed doubts about one or two members (not necessarily the same people), but friendship groups were formed during the first year. A third of the cohort expressed concerns that cliques had formed during the second year, but there was no evidence that there was disruptive behaviour by members of the group, or that individuals became isolated or rejected. The respondents who had families and/or were non resident from the start of the scheme, experienced difficulties in establishing and maintaining relationships with members of the set, because priorities were given to the home and family. The woman who joined the set late, discovered that it took a long time to relate to the others and to identify herself as one of that set. The importance of this initial period in meeting others and being together to share experiences of the unknown, was also identified by the man who left the set following the introductory period during the first year, and returned to join another set. He talked about the "bonding" which he believed had occurred between him and his original set, which he had not experienced with his current group, and the feelings of loss he had experienced. Although he met with his friends on his return, it was not quite the same because he was not specifically identified with the set.

The hours worked in the shift system in the clinical areas, working on different sites and the need to travel mitigated particularly against the non resident respondents keeping contact with others between study sessions. The residents also found the hours of work a problem, but it was easier if necessary, to see friends who were in the same residence, it was less easy to avoid people. Some of the women chose to live out, moving from residential accommodation to sharing flats or houses with others from the set, or with other friends. During the first year, all but 2 women and all the men,
spent most of their time with friends in the set. This pattern changed during the second year and third years, when the majority of the respondents made friends with nurses and others from the district in which they worked. The majority of their leisure time was spent with these people and their friends from the set, drinking in the local public houses, eating in their homes or in restaurants, watching films or going to the theatre. The exceptions to this trend, were two women and one man who spent more of their time with friends who did not work in the district. Despite the formation of friendship groups, the set remained as a cohesive unit, phrases like "group empathy" and group "cohesiveness" being used by the group nearing the end of the second year.

The findings of Wyatt (1978) and Parker (1981) that students would turn to their friends for help and support with personal problems are confirmed in this study. Friends and relatives were the people identified by the majority of the respondents, and these views remained largely unchanged during the training period. Only one man and one woman in the third year stated they would go to their personal tutors. Students may be wary of sharing their problems with authority figures, in case in some way, their formal training may be inadvertently affected. One woman said "word may be spread around", and this may be damaging to the individual's self esteem as well as an invasion of privacy. Students might try to keep their private and professional lives "separate" to help them cope with their relationships, and to help them retain their self identity. As one man indicated during an interview, although he was a student of nursing, he was also a person with his own needs and rights.

The findings in this study suggest that the set was a major influence in the socialization of the respondents into nursing.

(iii) Gender.

The majority of the respondents perceived that male students were treated differently from the female students, usually more advantageously in the wards. 2 women and one man considered they were treated in similar ways. The women considered the men were "noticed more" and "get away with more", and the doctors "seemed to assume they are more intelligent". Some stated that sometimes feelings about the men were polarised, either a man was very good or very bad. The 3 men agreed with the women, one commented that he thought men "could smooth things over" in the wards
when differences occurred between the sisters and students. This theme generated a
deal of discussion during the interviews, and some of the women obviously felt quite
strongly about the "advantages" male students appeared to enjoy, regardless of merit.

(iv) Learning to nurse-working in the clinical areas.

A major theme developed throughout this study was where, how and from whom did
the respondents perceive they learned nursing. They commented on the wards in their
first interviews, and continued to express their views about care and the people
involved in the giving of this care. They were vocal in sharing their perceptions about
"good" and "poor" experiences in the clinical areas.

a) Nursing and nursing roles.

The problems in defining nursing were highlighted in Chapter two. Vaughan (1992
p.162) writes of the "intensively private nature of nursing", the acts in this private
domain that go on but are not discussed in public such as making the patient clean
after a bout of incontinence, the giving of bedpans, commodes. The formal curriculum
followed by the cohort in this study, was devised to enable the respondents to learn
about nursing both in the school, and in the clinical areas while involved in the
delivery of care under qualified staff supervision. They were assessed in the clinical
areas by these qualified nurses in six defined competencies of nursing- practical,
social, communication, teaching, teamwork and management (Dunn 1986).

The respondents'statements about nursing and the role of the nurse made in the
written questionnaires at the beginning and end of their training would suggest that
many of their perceptions had not changed e.g. the nurse looks after people in an
holistic way and promotes health. The effect of growth and learning however, may be
detected in their perceptions at the end of training. The responses to the same question
at that stage included the use of the nursing process, acting as the patients'
advocate, and being role models and managers of care. At the end of the course,
phrases like "carrying out medical treatments and requests" (which perhaps reflected
the lay person's stereotype of the nurse always carrying out the doctors' orders) were
replaced by nursing skills, e.g. practical, counselling.
b) Role of the student nurse.

The respondents perceived the role of the student nurse as divided into two distinct phases, the junior student who provided the "work force" and "pairs of hands" during the first two years, and the senior student in the third year who was valued and had "more responsibilities". During the first and second years, they spent 8-12 weeks in the wards, firstly learning to care for acutely ill adults in medical and surgical wards, and the elderly, and later in the specialised care of children and mentally ill people. This meant that the respondents were in the wards for relatively short periods, having to adapt to different patients, staff and management styles of the sisters/charge nurses. The patients and permanent staff also had to adjust to different students with varying degrees of knowledge and skills. Melia (1987 p.102) examined this "transient nature" of the students' encounters which:

leads to several consequences for the students themselves, the permanent staff and, necessarily, the social organisation of nursing on the wards.

She argues that the students in her study utilized transience in order to "get through" their training, and it enabled them to escape long term responsibility for their actions because they were a moving population.

In this study, the respondents' views on the length of time spent in the clinical areas depended on their overall enjoyment of the experience, e.g. some wished they had spent longer in the care of the mentally ill, or the child. They perceived they were "pairs of hands" in the first wards because they were involved in the giving of essential care. This may have been because in the early stages the respondents were learning, and their knowledge and skills were limited to the "private nature of nursing" (Vaughan 1992) in the acute wards and care of the elderly. In the specialised experiences later in the second year, the patients' needs might dictate that the qualified nurse delivered care e.g. Registered Sick Childrens Nurse (RSCN). Unlike the students in Melia's study (1987) the respondents did not mention they were moved from their place of allocation to fill gaps in the establishments of other wards. The respondents as students felt responsible for their actions, but the qualified nurses were accountable for their own and the students' behaviour.

Many experienced "reality shock" (Kramer 1974) particularly during the first ward
placement, when, for the first time, they worked in the care situation as students identified by the uniform, and called "nurses". Half the cohort enjoyed this experience, whereas half expressed anxieties about their perceived lack of supervision and "negative" attitudes of some of the qualified staff. The respondents considered that some staff nurses acted as if they had no time for the respondents, other staff nurses appeared to expect too much in terms of practical abilities. At the end of the first year, eight women still remembered this as a "negative" learning experience.

The students perceived they learned nursing primarily in the clinical areas, with other students perceived as one of the main groups from whom they learned nursing skills. The importance of other students as socializing agents in the learning environment, is evidenced by the responses given by the respondents. They instanced as important learning opportunities working with, observing and gaining feedback from other students, particularly in the first two years. In the third year, the respondents as senior students, worked with other students, often "junior" whom they stated they would support and teach when giving care to seriously ill patients. This learning from other student nurses is not new, (McGuire 1968, Melia 1987, Wilson and Startup 1991) and not unexpected, as the numbers of students in any one shift tend to be greater than the numbers of qualified staff, and students share a common culture, and uniform.

c) The cohort's perceptions of the role of ward sisters/charge nurses.

The respondents in their roles as students had many interactions with others in what Merton (1957 p.369.) describes as "role set" e.g. patients, qualified staff, auxiliaries, doctors, paramedical staff as well as peers. In this context, ward sisters/charge nurses are key people, managing the patients' care and the environment, determining the philosophy of care and, to a large extent enabling staff relationships to develop and be maintained in a professional and social context. There is evidence that the style and approach of sisters/charge nurses influences the students' enjoyment of the clinical placement, (Ogier 1982, Wilson and Startup 1991). In this study the ward sisters/charge nurses were perceived by almost half the respondents (nine women and one man) as exerting positive influences on them, being viewed as approachable and demonstrating authority, but unlike the aforestated studies, the respondents did not differentiate between medical and surgical ward sisters. A number of respondents viewed the sisters/charge nurses as giving feedback on their performances, possibly because some sisters were mentors and this would be part of the accepted role, but the
prime function was seen as managing the patient care and environment.

At the end of the training period, the respondents perceived direct patient contact, and teaching coming into the role. The "good" ward sister/charge nurse was identified as knowledgeable about patients and staff, managing the ward with authority, with an approachable, honest and confident manner. The evidence in this study suggests that not only was the sister/charge nurse the formal ward leader, but the style of leadership adopted directly influenced the students' perceptions of the ward as well as the sister/charge nurse. Rumours were spread through the student group about sisters/charge nurses, their manners and personalities, and some of the respondents' experiences confirmed these rumours. In some wards the sisters/charge nurses were perceived to have a humanist style, while others had a more authoritarian, distancing style and approach, personified, for example, by the organisation of meal breaks. Some sisters enabled a mix of students and qualified staff to go to a break together, the others ensured that the staff kept in separate groups. The newly qualified first level nurse is called the staff nurse, and a number of the newly qualified and more experienced staff nurses together with enrolled nurses and auxiliaries make up the permanent staff in a ward to provide 24 hour care to the patients.

d) The cohort's perceptions of the role of the staff nurse.

The perceptions appeared to change during the three year period, as the respondents themselves became more senior. Ogier and Barnett (1986) found that learners looked to staff nurses for personal supportive and interpersonal skills. In this study during the first year, the respondents received feedback on their performance, and learned practical, teamwork and management skills from the staff nurses, although not working with them frequently on a one to one basis. As discussed in Chapter Two, the staff nurses were designated the official mentors to the respondents, and part of the role was giving feedback to them on their development and progress. It is argued there are inherent difficulties in obtaining accurate and unbiased feedback from others, particularly if the mentors had not worked directly with the respondents, or on the same shifts. It is difficult to understand how different perceptions of performance could be reconciled e.g., a number of respondents believed that mentors could be influenced by "personality clashes". One suggestion made was that there should be two mentors in the wards for each student.
The respondents' perceptions of the role of the staff nurse changed. In the first year they perceived the role as being primarily concerned with administration and management. In later years, the staff nurse was perceived as having more direct involvement with patient care, and a teaching as well as a management role. As previously discussed, this modification in views may have been influenced by the respondents working mostly with other students or by themselves at the beginning of training, and the staff nurses giving specialised care e.g. to children as registered sick children nurses, or in operating theatres during the second and third years. They stated they learned by observation, and this, together with their own growth in skills and self confidence may have enabled the respondents to ask questions and challenge practices. They commented on "low staff numbers" on a number of occasions, therefore the roles may have varied from day to day, depending on staff numbers. In consequence, the staff nurses may have either been involved only in managing the ward, or in giving direct patient care, with them either giving direct care or acting as staff nurses.

e) Planning of care in the wards.

The way care was organised in the wards depended on the philosophy of nursing determined by the ward sisters/charge nurses and staff nurses. In the first year, the respondents considered individual patient care was practised in most wards but this often depended on the number of staff. A decrease in number meant that sometimes task allocation was reverted to in care delivery. In certain wards, for example in the care of patients with orthopaedic problems, task allocation appeared to be the norm. This was approved of by one man and seen as beneficial - "gets work done". Written care plans which form an integral part of the communication systems between staff were not perceived as being used in the first year but were by the third. This apparent anomaly may be explained by the respondents' use of the care plans as records and teaching tools as they became more senior. Alternatively, care plans might have been used more frequently and more effectively in the wards as time went on. The use of these plans as part of individualised care was in the stated nursing policy of the district, and the procedure and use had been taught in the school of nursing over a number of years.
f) Teaching sessions in the wards.

The respondents considered they learned nursing in the wards by working with and observing others involved in care. Formal teaching sessions when time was allocated for someone to teach or when discussions on care were held, appeared not to be planned on a regular basis. One third of the cohort considered they had attended such sessions, and a number mentioned informal discussions with members of staff. At the end of training, more than half the cohort considered they had been enabled to ask and question practices.

g) Other members of the ward team.

Other members of the cohort's "role set" included the patients and their relatives from whom the respondents considered they learned social and communication skills, and information about the patients and their medical conditions. The enrolled and pupil nurses were not encountered by the respondents in many wards, but when they were they learned basic care from them. Auxiliaries were considered in a positive light by the majority who learned practical skills and gained information about the ward from them. This concurred with the findings of Wyatt (1978), Melia (1987), Wilson and Startup (1991). Contrary to Melia (1987) the respondents in this study did not appear overtly concerned with the position and potential power of auxiliaries in the wards, although there was an exception in the wards for the care of elderly people where some found the auxiliaries rigid and resistant to new ideas. The students were not able therefore, to develop these because of their limited time in the wards.

The ward clerks were considered by many respondents to be concerned with administration, in particular discharge planning and were considered a source of information on this.

The senior nurses, who were responsible for a number of wards were not often seen by the cohort, but those who met a senior nurse received impressions of aloofness, and abruptness. This may have occurred because the senior nurse was more likely to visit a ward when there was a problem, e.g. staff off sick, which he/she was unable to solve to the ward staff's satisfaction.

The respondents' perceptions about doctors were mixed, they were viewed as sources
of information on illness, perceived to be responsive and approachable in the care of
the elderly wards but unapproachable and rude in other wards. It is possible that
doctors may have had more time to spend with students in wards for the elderly than
doctors in wards for the acutely ill. Pressures of work in these wards require speed
and efficiency - leading to brusque and apparent negative behaviour. It is also
possible that doctors specialising in the care of the elderly were concerned that
students gained a favourable impression of elderly care, in expectations that some
might be attracted to this acknowledged "cinderella" service.

The physiotherapists were viewed by half the cohort as members of the caring team,
who were keen to share their knowledge and skills particularly in the care of the
elderly. In these wards, they were viewed as helpful and supportive to the students,a
third of whom stated they experienced a lack of concern and support from the trained
nursing staff.

h) Uniform.

The uniforms the respondents wore when they began their first ward experiences were
overt symbols that marked the status passage of the respondents into the nursing field.
Hollowell and Penson (1987 p.238) suggest that:

The uniform is part of the system of
control. It inspires confidence in patients
who trust the wearers of the uniform....It
is part of the professional label which
sets the nurse apart and is a symbol of
authority and power......However, the
uniform can be taken too literally:it
makes the group of nurses uniform by
stressing similarities. This gives nurses a
focus of indentification with their
occupation and a commonality, a
"collective consciousness".

All the respondents except one preferred wearing uniforms, stating that the wearing of
them gave confidence to themselves as well as to the patients, and made identification
easier. The woman who disagreed, commented that the uniform performed no useful
function. Half the women would do away with the cap, which was viewed as
superfluous because it no longer fulfilled the hygienic function for which it was
designed, namely - to cover the hair. The uniform for the women was considered an attractive one distinctive to the hospital and unchanged in overall style over many years. It is difficult to predict how the students would have responded had it been the national uniform, which as the term suggests, conforms to a standard pattern. Some considered this uniform to be most unattractive in style.

(v) Learning to nurse-being in the school.

School was perceived as playing an important part in the respondents' training, being the place where the teachers enabled basic nursing knowledge to be gained, and where they could relax from the work in the wards in ordinary clothes, meet with the set and work specified hours. This concurs with Wyatt (1978) who found that the students valued highly the ability "to live a normal life". The respondents were taught the principles of nursing and nursing care by the tutors, and were supported by their personal tutors.

a) Personal tutors.

The system of being linked to a specific tutor for the length of the training period for help and support, particularly with problems or difficulties with academic or clinical areas, was welcomed by the respondents. The 3 who made little use of their tutors still believed the system was correct. Three others exercised their right to change their personal tutors, and these stated they benefited from this change. The majority of the cohort would not go to these tutors for advice and help with personal problems, although they expressed warmth about their relationships.

b) Teaching and teachers.

The respondents were adults with years of life experiences, and enjoyed being treated as such: they did not appreciate being treated "like children", and "being talked down to" as appeared to happen in a particular study session (the care of children). Several commented that their specific experiences were not recognised and used, e.g. one was
a nursery nurse and could have shared her skills in dealing with children with her peers.

The amount of time perceived as being wasted was condemned, e.g. when speakers did not arrive and there was no planned replacement work, inappropriate time tabling of teaching sessions which started at a later time than the official start of the day and the respondents were expected to be present to study. Some respondents commented that half an hour or hour periods were not long enough for meaningful study. The majority considered that most of the teachers used a variety of teaching methods, and welcomed the optional sessions although the majority attended them all. The respondents said that being given the choice was important to them. More teaching on nursing and practical skills by the tutors would have been welcomed by a number.

A number of respondents considered the tutors should spend time in the clinical areas working particularly with students in the first year and as a support to the newly qualified staff nurse. Most of the cohort had encountered a tutor in a ward, but this was mostly on one or two occasions during the first or second ward experience. Some commented that working with a tutor "took much longer", and stated "it interferes with the work of the ward". Many comments were made on the perceived differences between the school and ward teaching. In the arrangement of study sessions, some respondents welcomed knowledge pertaining to the particular care of patients prior to their actual clinical experience. Others found that having the clinical experience first was meaningful, knowledge as well as skills being gained from the practice area. Melia (1987 pp.54-55) found that the students in her study accepted that there were differences between the college ways of "doing nursing" and those of the permanent staff of the wards. This was an area of concern to some students in this study. The ideal was taught in school which could not always be achieved in the clinical situations, although the patients did not always require this "ideal" care. As with the students in Melia's (1987) study, the respondents appeared to accept that this was inevitable but considered the ideal needed to be taught, as long as this was recognised and the differences found in practice explained. The respondents were more concerned when the teaching in the school and in the wards was different, e.g. in the care of the post operative patient, and when nursing practice was taught differently. This gave rise to conflict because the ward was viewed as the practical, real life situation, but the tutors were seen as experienced nurses and teachers.

c) Assessments.
The respondents were assessed both in clinical competencies and in their knowledge base. One man and one woman were referred in the clinical skills assessment, and a number of respondents were referred in the formal written assessments. Some expressed their feelings of stress at these referrals, particularly during the first and second years. They knew their training was at risk if they continued to be unsuccessful. The personal tutors were involved in seeing their students who were experiencing difficulties, sometimes needing to go to the wards to discuss the assessment with the sister/charge nurse, and marking extra essays if this was deemed to be helpful to the students.

(vi) The hidden curriculum.

The respondents followed the formal curriculum planned, administered, assessed and taught by qualified staff in the school and clinical areas. As well as this formal curriculum, they were exposed to messages and cues about acceptable behaviour from a variety of people in a number of situations, - the hidden curriculum. Holloway and Penson (1987 p.236) write:

> The social organisation of nurse education is constructed to control nurses in various ways: it imposes particular beliefs about patients, colleagues and superiors; it also influences - though not determines - non-work activities and private lives.

In this study, there were differences between what was taught in the school and practised in the wards, and between one ward and another in the ways they were managed. The respondents had to comply with the views and practices being expressed in the situation they were in at the time. One woman was "told off" by the ward sister for talking with a patient. The hidden message here being that talking was time wasting, despite the fact that social and communication skills were considered important components of the nursing care of patients, and were formally assessed. Individual patient care was the policy and was taught in the school, but at times task allocation was the norm in the wards.
The tutors were not perceived as being in the "real situation" where patients were cared for, but they were viewed as experienced nurses and teachers. This raises the issue that in nursing courses where the theory and practice of nursing takes place in different institutions, it is possible that conflict may arise by polarising the academic and the practical nurse.

The residences were the respondents' homes, but the covert message received by them was that they were not considered worthy of facilities that were clean and appropriate. The hours worked by the respondents restricted to a degree the way they spent their leisure time and with whom. It was difficult to keep up hobbies and to keep contact with friends, so that a comfortable residence in which they could relax and be themselves and which was "hassle free" was important.

Relevant past experience is a contributory factor in the selection of entrants to the school. These experiences were not always utilised in the teaching learning situations, although the respondents identified the usefulness of previously learned communication skills in the clinical areas. The importance of the recognition and understanding of the hidden curriculum is recognised by Treacy (1987 p.174). She writes

It is important that the hospital training school understands its hidden curriculum and the message it emits, otherwise outmoded practices are perpetuated as the hidden curriculum remains unnoticed, untouched and impervious to policy changes.

(vii) Growth as individuals.

Jarvis (1987 p.169) suggests that in the learning of knowledge skills and attitudes, adults may grow as human beings:

..not only has the potential of acquiring new knowledge and skills been experienced, but also the very process of engaging in thought and reaffirming the position held or learning a new one is a
fundamental mechanism of human growth.

At the end of the three year ten week preparatory period to become nurses, all the respondents stated they had enjoyed the majority of their experiences and had learned from them. On reflection they identified that they had grown and matured, gained in self confidence and in self awareness of their own identities as people as well as senior student nurses.

2. Profile of the leavers.

20 women and 6 men entered the preparatory programme to become registered general nurses. One woman re-entered training and joined the cohort following the introductory course. (Appendix 4.) During the scheme 7 of the 27 respondents left, 5 women and 2 men, a 26% wastage compared to an average wastage of 15% for the three year ten week schemes leading to first level registration as a general nurse in the school of nursing in this study.

(i) Wastage from the scheme showing the number leaving in each year.

<table>
<thead>
<tr>
<th>Gender</th>
<th>1st year</th>
<th>2nd year</th>
<th>3rd year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Women</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

The wastage per year of the cohort, compared to the average wastage for the other comparable schemes.

<table>
<thead>
<tr>
<th></th>
<th>1st year%</th>
<th>2nd year%</th>
<th>3rd year%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>15%</td>
</tr>
<tr>
<td>Cohort</td>
<td>15</td>
<td>11</td>
<td>0</td>
<td>26%</td>
</tr>
</tbody>
</table>

As can be seen, the cohort had a higher wastage than the other groups, but it is important to identify the reasons why the respondents left and these are given later. It
is of interest that there was no wastage during the third year, which differs from the usual pattern. It is not possible to state why the trend is different for this set, because there are so many factors which may have had some relevance e.g. motivation, personal circumstances.

(ii) Age range, and academic entry gate of the respondents who left prior to completion.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Gender</th>
<th>17½-19</th>
<th>20-25</th>
<th>26-35</th>
<th>35+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Academic entry gate</th>
<th>Gender</th>
<th>Access scheme</th>
<th>5+ O-level or equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

(iii) Work and voluntary experience in health related occupations prior to entry to the scheme.

All the respondents except one had experience in health care either in a voluntary or work capacity, e.g. in the care of the handicapped, working as an auxiliary. The woman who did not have this type of experience had worked in an office.

(iv) Reasons for leaving the scheme.

2 women went on maternity leave and did not return following this leave. One woman resigned for "personal reasons", and one because she was "disillusioned with nursing". One other resigned because of difficulties experienced in the practical and theoretical aspects of nursing.

One man resigned through "personal problems" the other because he had an opportunity to undertake some work with a friend and he believed this opportunity would not come again. This last respondent re-entered nursing training and joined
2.1 Information about those who left. These respondents shared information with the researcher.

Female respondents.

Both the women who went on maternity leave were non resident and lived at home. At the time of leaving both expressed an interest in returning to complete their training at a later date. One left during the first six months following a long period of sickness, the other in the 26-35 age range, in the second year. During the interview sessions, this woman had expressed some concerns about the negative attitudes of some of the trained staff in the clinical areas. She stated that she found some of the newly qualified staff nurses not supportive, "they put you down". This woman had made friends with a few members of the set and enjoyed meeting colleagues in school, but stated that the "set had changed for the worse, they are not so friendly". She had also commented on the lack of time she had to be with her family. The woman who resigned for "personal reasons" was in the 26-35 year age range and lived at home with her family. During interviews she commented on her enjoyment of the Access scheme, but stated that she had "no time for hobbies now, I need to sleep." This respondent saw her personal tutor on occasions, but did not feel she had any difficulties. She had made some friends in the set to whom she would go to discuss problems. This woman commented that in one ward, the sister "picked on the ones with no confidence".

In answer to the question "what do you understand by nursing?" completed on the first day of the scheme, this respondent had written:

Nursing is more than a career, it is more than just a job. It is a job that almost takes over your life. It would be impossible to go home and put that day's work out of your mind.

The woman (in the 20-25 age range) who was disillusioned with nursing and left during the first year had worked in an office. She was resident and had commented on the lack of facilities which she described as "awful. During her last interview she had no complaints about the teachers or the school, and stated that she related well with the
set and would miss them. In a previous interview, discussing the wards, she said "I was treated as if I didn't know anything" and while she found some of the staff supportive in another ward commented,"they said I looked morose all the time."

In answering the questionnaire "why do you wish to become a nurse?" she had written:

Difficult question! I think each one has reasons they can't quite define. Myself-I want a stimulating challenging career. Taking my good and bad points I feel I could do well in a job that requires discipline, teamwork, people contact and is interesting......It puts you in touch with reality and socially you'll be with others in the same boat. It is a definite "way of life" and depending on how you go about it, it can be a great profession to be in.

One woman was the oldest member of the set and lived at home with her family. She resigned because of some difficulties with the practical and theoretical aspects of training. She had gained previous experience in a health care role and through the Access scheme. In answer to the question "why do you wish to become a nurse?" she wrote:

I would like to become a nurse because I feel nursing is a very demanding job and as I have worked previously as a care assistant I think it would be a good idea to take up nursing professionally.

In response to another question she wrote "for a fact, I know nursing is very hard work, and I'm prepared to challenge it". In one interview session this woman had commented "people don't listen to me as I listen to them - patients understand me all right". She stated that a particular sister had been supportive "she tells me when I'm going wrong", and she also stated that it was not always possible to do things as taught in the school because the wards were "too busy". This woman had changed her personal tutor and saw her regularly and said she felt supported by her. In another interview this woman talked about her lack of leisure time because she was busy looking after her family. She said that she had no regrets over starting her training and that she hoped to start again at a later stage.
Male respondents.

The man (in the 20-25 age range) who left the scheme during the first year because of "personal worries", had had a previous job in a field unrelated to health care. He had worked with the handicapped in a voluntary capacity. At first he was resident, but then moved out to live with his family. In discussing his clinical experiences, this man commented that one ward was big and busy and the staff did not have much time for student support. He believed that some of the trained staff had "personality problems" on which he did not elaborate. He saw his tutor "for professional reasons only" and had made a few friends in the set, and had kept up with a few friends at home. He commented that he did not have so much of a social life since moving to his home, but felt supported primarily by his parents. In one interview this man indicated that he felt he was "unsuited to nursing". In the written response to the question "why do you wish to become a nurse?" he wrote:

I believe I have a caring nature. Nurse training can teach one a very good level of personal discipline.

The second man left was in the 20-25 age range, and then returned to recommence training with another set. He agreed to be interviewed on his return. This man was resident and had made many friends in his original set. On his return he said he believed "bonding occurs during the first few months in the set", and that he spent more time with his friends in the cohort than with the second set. He had not experienced any difficulties in the wards prior to leaving, and had met frequently with his personal tutor. He believed he had left training for a very good reason, but in retrospect regretted taking this period away from nursing.

The personal tutors to the 3 women and the man who left for reasons which were personal, academic and "disillusionment with nursing" were not surprised and had predicted these respondents might leave.

Conclusion.
The discussion has highlighted the findings from the respondents' perceptions on nursing and the role of the nurse over the whole course. They learned nursing primarily from other students and qualified staff in the clinical areas and gained basic knowledge and support from the personal tutors in the school. The reasons why 7 men and women left the scheme have been discussed. The next chapter will present findings from the perceptions of the respondents as staff nurses together with those of personal tutors, teachers, the allocation officer and some ward sisters.
Chapter Nine.

The cohort as staff nurses.

The perceptions of key people.

Each registered nurse, midwife and health visitor shall act, at all times, in such manner as to
* safeguard and promote the interests of individual patients and clients;
* serve the interests of society;
* justify public trust and confidence
and
* uphold and enhance the good standing and reputation of the profession.


Introduction.

This chapter provides an analysis from the data obtained from the respondents as staff nurses and from some of the key people involved in the respondents' training. These people by their frequency of contact and position of authority in the nursing hierarchy may be viewed as significant people in the respondents' socialization process. (see Chapter Two).

1. The cohort as staff nurses.

The 16 women and 4 men were interviewed as staff nurses approximately eight months following their qualification as first level registered nurses. They were appointed initially at Grade D in the clinical grading structure which enabled staff
nurses to:

- assess care needs develop programmes
- of care and/or implement and evaluate
- these programmes without direct
- supervision teach and supervise others.

More senior staff nurses could apply for Grade E posts and in addition to the above take charge of the ward. The wards would normally consist of a mix of staff nurses at these grades with a staff nurse at E grade being the mentor of a staff nurse at D grade.

The aim of the interviews was to record the perceptions of the respondents on their roles as staff nurses and, in retrospect on their preparation for the role. (Appendix 12.) The analysis of the findings from these interviews will be compared with the respondents' perceptions as students and with key people in their socialization process.

(i) The role of the staff nurse.

a) Responsibility and accountability.

In response to the question on the respondents' perceptions of the role of the staff nurse and the aspects they enjoyed the most, the role was viewed as one of responsibility and accountability for patient care, and for the safety of the ward environment. One woman who had left to work elsewhere wrote:

The role of the staff nurse is to have full responsibility of your patients. For the ward to be a safe environment for patients and whoever else may be on the ward. To continue to educate oneself (courses etc.) and to teach, help and support others (nurses etc) when appropriate. To work as a team. Must have a good knowledge e.g. drugs.

The majority of the cohort appeared to be enjoying this responsibility which was identified as being greater than when they were students.

One man viewed the roles of students and staff nurses as similar, saying that students
were responsible for their actions although under supervision. In his view staff nurses prescribed nursing care which they delegated to students, but retained overall responsibility for the delivery of that care.

6 women and 3 men mentioned that this feeling of being responsible was stressful at first. One woman said she had wanted to remain as a student nurse, but she was enjoying the role now although she still felt that "things might go wrong, and I won't cope". This respondent mentioned a supportive senior nurse with whom she could relate. Another woman said:

\[
\text{I never anticipated the amount of responsibility. I feel guilty when I leave the ward when it's time to go home. Sister will say if time is owing, it is not good management of time.}
\]

One man stated that he had changed work sites as well as wards on becoming a staff nurse and was the only male among a long established nursing team. He had a mentor who was one of the other staff nurses, but this only lasted a week and he was then left to his own devices. He said "I found out things by making mistakes". This respondent mentioned his concerns to the sister who "took me under her wing and guided me".

On occasion in particular wards, it appeared that newly qualified staff nurses were required to work as more senior staff nurses at grade E level. This was mentioned by 2 women, and one said initially the ward was short of qualified nurses and she enjoyed the responsibility of being left in charge of the ward, but then felt frustrated when the qualified staff numbers improved and she reverted back to her original role.

b) Teaching and supporting.

The teaching and support of others e.g. student nurses was mentioned by 10 women and 3 men as being an important part of the staff nurse role and one which was enjoyed. One man mentioned acting as a role model for student nurses, and said:

\[
\text{It took a few months to get used to the role. I have a certain responsibility for students, I stay close to them. More closely connected with staff nurses, they are there all the time, and it may seem "cliquey". Now I see how I felt as a}
\]
student. I am a role model for students, often I do not live up to that. There's not enough time to spend with students, problem is there is more emphasis on management rather than hands on care.

8 women and one man mentioned that they worked at times with student nurses involved in direct patient care, and giving feedback to the students. 2 respondents regretted that there were no students allocated to their wards, and two more stated that students only remained there for a week and said that it was "exhausting repeating things". 3 women were staff nurses in wards where primary nursing had been, or was being established and enjoyed this experience of being accountable for the care of a number of patients. One woman commented that as a student she thought the staff nurse "never talked with patients", but in primary nursing she believed that the patients felt "privileged talking with staff nurses". She went on to state that she found it difficult to get feedback from students and wondered if they felt lost, commenting "maybe I don't set myself objectives". This woman along with some others experienced difficulty in telling students what to do discovering that "correcting, having a word in their ears is not easy". A number of respondents commented they did not enjoy ordering things e.g. drugs because "this time could be spent with students".

Individual patient care was practised in the majority of wards although one respondent mentioned that she spent a deal of time giving out medicines to all the patients in the ward. In many wards the delivery of care was through teams of nursing staff responsible for a number of patients. Some qualified staff had begun or had developed primary nursing as the model of care delivery in their wards.

6 respondents mentioned that they worked with students and that being mentors to them was pleasurable. One woman found the role difficult because she had not been formally prepared and had not yet attended the preparatory course. This also meant she could not formally assess the student's competencies and complete the formal record. In her ward two mentors were allocated to a student prior to the student arriving. Although the student could ask to change mentors this respondent commented that it was difficult for the student to do so, and she thought that it might be preferable for the students to select mentors once they were established in the ward. Other respondents stated that two mentors for one student was now the usual practice and, as a consequence, communications had improved.
c) Gender.

The female staff nurses stated that the male staff nurses were treated no differently from the women, with one believing the men "complemented" the women. 2 men held different views, and felt they were isolated at times because they were the only men on the team. One man said that male staff nurses were seen to have more authority and were called when there were problems. 8 women stated that male students were treated differently to female students and in a more positive manner. One said, "Oh for sure, they get more respect and are listened to more". Another said that in her experience the male students tended to be older than the female and this was why they received more respect. One woman stated that in her view the men were more lazy preferring "management to practical work". 2 said that the men were treated the same as the women students while another said that it all really depended on their personalities.

d) Team member.

Half the respondents commented that another major difference between the student and staff nurse roles was that the students moved on after eight or more weeks in a ward, whereas the staff nurses were permanent staff members. One man commented that students were more "detached" from the ward and because they moved on, they were not "likely to give everything". He stated that the staff nurses would "give more" because they were there all the time and had more responsibilities.

Relationship with doctors.

One woman said:

I enjoy having the authority to act more openly as advocate for my patients and can therefore get hold of doctors when there is a problem. They are less likely to fob you off because you have assessed the situation.
This woman commented that the doctors took more notice of staff nurses than students except where primary nursing was practised and the doctors related with the team. The majority of the cohort, both the men and the women stated that doctors treated them with more respect and as people with knowledge and skills perhaps this was because they had more time to get to know the doctors on the wards. One woman commented that the change to a different colour uniform meant that she was acknowledged more by doctors and another woman said:

I'm in purple. Doctors are talking with me as if I'm a human being.

One man stated he mixed socially with some doctors and had no problems with them on the ward, "I tell them what I want and they do it". This man commented that some doctors will talk with student nurses but that "they worry that important things will not get passed on", and he concluded that this was the reason they preferred to talk with the staff nurses.

3 women expressed some reservations about their professional relationships with doctors. One of them stated that "they think we are handmaidens expect us to make them coffee". Another said that often "new" doctors did not appear confident themselves and because of this it was perhaps difficult for them to profess ignorance and to ask the staff nurses for help and to respect their professional knowledge.

Relationships with auxiliaries.

2 women commented that they experienced some difficulties with auxiliaries on the ward. One indicated that this was because the auxiliary was "one of the old school she does what she wants", the other said that the auxiliary had her own agenda and priorities "which were different to the staff nurses". The rest of the comments made about auxiliaries suggested they were looked on as mainstays in the wards, and of help to the staff nurses.

Relationships with other trained nursing staff.

2 men said they felt "isolated at times" and did "not fit in" because they were the only
male staff nurses on their wards. Another said there appeared to be some conflict among the staff nurses on his ward (there were no students on the establishment). He expressed his view that:

I expect work to be done as a team not as one standing against another.

The other man stated he felt he was a link between the students and the trained staff, because "everyone comes to me".

The women appeared to relate well to the other staff nurses although one commented that she thought there was sometimes a division about the management of care between members of the trained staff and that the students on the ward "felt" this.

On some wards there were two sisters, the senior with overall responsibility and the junior sister. 2 respondents commented that on their wards, these sisters appeared to disagree about care management. One woman commented that in her ward there was "a good atmosphere which comes from the sister". 2 respondents had a sister or charge nurse as their mentor and stated that this appeared to work satisfactorily. One woman said that the sister at her interview to become a staff nurse on her ward made it clear that she "wanted things out in the open with no bitchiness", and this was how the sister ran the ward. One woman who left and worked in a different hospital wrote that in her ward all the staff nurses:

get on extremely well, the sisters seem to be slightly apart from the rest, not in work but in the social life - they keep themselves separate.

7 women mentioned that the staff nurses and students went to meal breaks together, and the same number stated that sometimes trained staff and students went out socially together. One said that at first she was hesitant to communicate on a personal level with the sister "I was brought up to respect authority", but now she had the confidence to be able to relate with the sister professionally and socially.

Relationship with student nurses.

A number of the respondents expressed concern about the student nurses on their wards. One woman was concerned that some students needed more supervision than she was able to provide, another that the "first warders" might have felt lost and were unable to approach her because of the difference in dress. One woman expressed
concern that she did not receive feedback from the students, another said that she had
advised some students on her ward to speak with one sister they had "found
aggressive and intimidating, and I said they should say they did not like the way they
were spoken to in front of patients". This respondent talked with the sister in her
office and said that "she was grateful for it". Another woman said that the students
now were more "assertive" and they knew what they wanted, but at times she felt they
were talking down to her.

Relationships with other members of the ward team.

One man mentioned that he found the physiotherapists helpful with expert advice, and
2 women stated that the ward clerks were particularly helpful with advice on care and
discharge planning.

A number stated that patients treated them differently now they were staff nurses, and
one woman commented that they respected her as a staff nurse but "they are more
afraid. They don't say what they would to a student". One man said that the female
patients often preferred the men commenting:

Old ladies like the young gentlemen, not
for intimate care, but for a laugh and a
joke.

One woman said that patients talked with staff nurses "if they want something sorted
out." Onoother regretted that the patients did not talk with her about personal matters,
as they did when she was a student. She found that the patients would wait and ask
students for items such as urine bottles even though she was available.

Relationship with tutors.

The respondents who worked on the "general wards", had all seen or met with the
tutor linked to that ward. The respondents who worked in "specialised areas"
e.g. recovery room, or in a ward with no students allocated rarely met with a tutor. The
role of the tutor in the wards was perceived to be concerned with auditing the learning
environment, meeting with the trained staff if a student was experiencing problems
and teaching in the formal programme. The time the tutors spent in the wards varied
and comments were made that the tutor was not seen very often in a particular ward and that not all the qualified staff were involved but only the sisters e.g. in ward audits.

One woman said:

We had a mature student who went away to get married and on her return the models had changed and she didn't see it. She was advised to see her tutor who came to the ward to see her. This student went around miserable, she couldn't relate to young staff nurses.

(ii) Preparation for the role of staff nurse.

In answer to the question "do you feel you were prepared for the role of staff nurse?", 10 women and 3 men stated they were but qualified this statement with phrases such as:

- depends on the amount of management experience one has had.
- need more teaching on ordering drugs, equipment.
- need more experience "heading the rota".

One woman replied that she "felt I was prepared but nothing can prepare you for the actual role". Another stated the role was not so different from the student one except "you are acknowledged more".

5 women and one man stated they were not prepared. One man and one woman stated that the role was completely different from that of the student, and the man said "I was completely shattered at first", while the woman considered a list of the things a staff nurse had to do would be helpful, e.g. ordering drugs. One woman suggested that prior to commencing as a staff nurse a week was needed to be prepared for the role. This week could be spent in the ward gaining experience under supervision with some time in the school. One woman said that more help was needed with practical things such as ordering, but said that support was also needed in the ward area when one was newly qualified. She remembered that as a student "you were flung into the deep end". She said that:
looking back it didn't do us any harm, but at the time it was very stressful, a bit nail biting, a bit frightening.

(iii) Preparatory period.

On reflection, the cohort had enjoyed their training, but considered it might be enhanced by:

• more teaching on the ward relevant to patient care.
• more support by tutors in the clinical areas.
• application of theory to practice.

One woman considered the majority of her learning had been achieved in and from the clinical areas, and also said that "more administration and management experience" was needed.

(iv) Ongoing education.

All the members of the cohort had had time away from the clinical areas for study days or courses, as follows

<table>
<thead>
<tr>
<th>Title</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse development course</td>
<td>12</td>
</tr>
<tr>
<td>Mentorship course</td>
<td>3</td>
</tr>
<tr>
<td>Principles of management</td>
<td>2</td>
</tr>
<tr>
<td>Counselling</td>
<td>1</td>
</tr>
<tr>
<td>Stress management</td>
<td>1</td>
</tr>
<tr>
<td>Intravenous drugs</td>
<td>7</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>2</td>
</tr>
</tbody>
</table>

The majority of these took place in the school and comments were made on the
interest of the topics, meeting with old friends and that it "was good to have a break from work".

One man said:

   It was like going back to see an old friend. The faces there I know made me feel welcome. The study days were more relaxed, more adult. We were allowed to determine our own breaks.

9 respondents mentioned that research findings were used in some way in the wards, e.g. wound dressings, and that books and articles were available.

(v) Leisure time.

The majority of the cohort still saw or met with some of their friends from the set, but the comments indicated that this was not so much as during their training. A number still shared non-residential accommodation and the two women who were working elsewhere still met with a number of friends from the set. Working the hours in a shift pattern of work was identified as a problem. Meeting in the public house for a drink, eating out and going to the theatre or films were identified as leisure pursuits. 2 were learning to drive, others mentioned going to keep fit sessions, sewing and playing badminton as hobbies. 2 mentioned their need for sleep, and one man his need to play football and attend weight lifting sessions. One respondent who worked in another hospital said:

   Everyone made very special friendships in their nursing training, which is extremely important as you need them to get through the 3 years.

This woman wrote that the set was still a close one and that a large number would meet together when someone was leaving the hospital.

(vi) The future.

The respondents as staff nurses were asked how and where they saw their future.
Future

Abroad to nurse 4F
Work in another specialty 2F
Midwifery 1F
Courses e.g. oncology 6F + 2M
Stay in specialty 2F + 1M
Have a family-return to nursing 1F
Going home and will return to nurse 1F
Staying in nursing, not sure of field 1F + 1M
Seeking promotion 1M
Study for diploma or degree 3F
Involvement in research 1F

2 women mentioned that they were getting married at some time in the future, and another woman said she was buying a property elsewhere and would therefore be moving.

One woman said that she really had not wanted to be a nurse, but that her mother and aunt were nurses. She had enjoyed nursing much more than she had expected and was going to continue to nurse, probably in another country for about a year before returning to this country.

(vii) Participation in the study.

The respondents were asked if they believed that participation in this study had affected or influenced them in any way. 7 women replied that it had not, 7 women and the 4 men commented that participation had enabled them to take time to think about their work, to reflect and to share experiences. One man stated:

It has been beneficial, an opportunity to express myself in a confidential manner. Get things off my chest to someone who understands fully.
One woman:

I have enjoyed it. It has enabled me to question my changing attitudes to nursing. It has influenced me in a positive way nothing detrimental.

In response to being asked if they believed that they had shared their true feelings with me [the researcher], all the replies indicated that the respondents perceived they had.

Comments included:

- Yes, I have honestly.
- Tried to be as honest as I possibly can.
- At the beginning perhaps a bit intimidated, but as time went on it was all right. No point in not being honest really.
- Perhaps could be more blunt.

One woman:

I've tried to be as honest as I possibly can, there is no point not going to do you or myself any good. In this sort of study, there is no right or wrong answer really, is there? Just personal views and how they change really over four years.

2. Discussion on findings.

(i) The role of staff nurse.

The respondents' perceptions of their role were influenced by their particular work situation. Those who were staff nurses in wards with no students on the establishment and in specialised areas like the recovery room (where care was delivered to unconscious patients, with students spending just one week as observer/participants), perceived their role in certain ways differently from those respondents who worked as staff nurses in "general wards" with students as part of the establishment.
They perceived their roles as primarily being responsible for patient care and many emphasized that the degree of responsibility was different from that of students. They were accountable for their own and others' actions, and were permanent members of staff. Students were responsible for their behaviour, but it was perceived that the staff nurses had overall responsibility. The role encompassed such tasks as ordering drugs, but over one third of the respondents stated they were involved in direct patient care and working with, teaching and giving feedback to students. These findings are similar to the perceptions of the respondents as senior students. There was officially a difference between the role of a newly qualified Grade D staff nurse, and a more experienced Grade E staff nurse. Two respondents found in practice that on occasions and particularly when there was a shortage of qualified staff, the roles became interchangeable. This would appear to substantiate the theory mentioned in chapter eight that staffing levels and establishments may affect the performance of roles.

a) Teaching and supporting.

A number of respondents were mentors to students. Some of the concerns expressed by them about mentors during their training appeared to have been allayed by each student having two mentors. A number of respondents expressed concern that they did not know how to approach the teaching of students.

b) Management of care.

The way nursing care was organised depended on the type of ward and the problems of the patients, and the philosophy of the trained staff headed by the sister/charge. The respondents did not mention task allocation, except that one commented that she spent time in delivering drugs to all the patients, although individual patient care was practised.

c) Gender.

The student respondents' perceptions that male students were treated differently from
the female students, and usually with more respect, were reaffirmed by their perceptions as staff nurses. The female staff nurses stated that male staff nurses were treated the same as the female, but the male respondents considered that they were treated differently. There were not many men as staff nurses and this difference in perceptions might have arisen because the women did not perceive that the only man on the team might have felt out of things and apart from the group, particularly if feelings were unable to be expressed and shared.

d) Perceptions on the relationships and role as team members.

Qualified nursing staff.

The majority of the respondents stated their relationships with other staff nurses and the sister/charge nurse were harmonious, but two mentioned there appeared to be friction or a division between the trained staff, and were concerned about the potentially adverse effect on students.

The respondents were linked to a senior staff nurse or sister/charge who acted as their mentor. This appeared to work satisfactorily for the majority, but problems were identified by two. One mentor did not fulfil the role, and one man was left to his own devices after one week.

Auxiliaries.

The perceptions of the majority of the cohort as students that auxiliaries were helpful informed members of the team, were confirmed by their perceptions as staff nurses. Two staff nurses however, discovered the power long established auxiliaries may hold if they disagree with the views and policies of the trained staff.

Doctors.

The staff nurse respondents discovered that many doctors appeared to treat them as
knowledgeable professionals, and treated them with more respect than when they were students. Some said that the different uniform made them stand out, and they got to know the doctors more who were attached to their wards on a more permanent basis. Three women expressed reservations about the doctors' manners and abilities. Two experienced treatment mentioned by some respondents as students. This was that the nurse was there to ensure the doctors' physical comfort, and the "new" doctor was sometimes reluctant to expose his ignorance, particularly to a nurse.

Tutors.

The staff nurses retained their views they held as students that the tutors should be involved more in the clinical areas, but as staff nurses they were more aware of the different functions of the tutor role.

(ii) Preparatory period.

In retrospect there were mixed views about the respondents' preparation to become staff nurses. It is argued it is impossible to separate current experiences and knowledge from previous learning, particularly looking back from a time interval of eight months.

The change in role and status overtly expressed by the different uniform, gave rise to feelings of anxiety in many respondents at the start of their new role. Many had expressed anxiety about the role change as senior students, and these anxieties continued in the reality of the situation as staff nurses.

(iii) Ongoing education.

A number of the respondents mentioned their growth in confidence and abilities as they performed the staff nurse role, and they continued the development of their professional roles by attending courses and study days. The respondents had all received some form of ongoing education during the eight month period following qualification. This contrasts with the proposed minimum of five days in three years.
mandatory period being currently advocated by the UKCC. (Post Registration Education and Practice Project)

The enhancement of learning was enabled by articles and books being available in the wards and the use of research findings to aid nursing practice.

(iv) Future career pathway.

The perceptions of the majority of the cohort as students, that they would remain as staff nurses working in their host health district were born out. Two women worked in other hospitals, a reason one moved was because she received little support as a staff nurse. The other moved to gain experience in the care of specific patients, and stated that at first she felt perhaps it would have been to her advantage to have gained some staff nurse experience in the host district. This respondent made comment on her first difficult ward experience, "it hurts".

In contrast to Simpson's (1979) findings, the respondents' prediction about their future career pathways would indicate that their commitment to nursing was strong at this stage of their career. A follow up survey would be needed to determine if this commitment remained.

(v) Cohesion of the group.

The perceptions of the respondents during training that the group was a cohesive friendly one appeared to persist. Many staff nurses continued to meet with friends from the set including the two who had left the district. The only time however that the majority met together appeared to be when someone was about to leave. The importance of specific times for the set to meet e.g. in the school during study sessions is highlighted. Working different shifts, on different sites, and developing different interests mediate against the group meeting as such.

3. Placing the key people within the context of the study.

The personal tutors were qualified nurse teachers, who were responsible for the
support of a number of the respondents throughout their training. Initially there were four, but one left in the second year and the respondents in her care were reallocated to the remaining tutors, with the respondents given choice in this selection. The personal tutors also taught the respondents during the study sessions.

The personal tutors were interviewed once in each of the three years of the preparatory scheme, and at approximately eight months following the scheme's completion. One tutor had left at this time but agreed to be interviewed at her place of work.

The respondents came into contact with and were taught by, other tutors and the allocation officer, who were also involved with the planning and administration of the curriculum. All these people were important figures in the socialization process of the cohort, determining to a degree how and what teaching methods were employed and which clinical placements were used for the respondents' practical experiences.

One senior tutor, one tutor and the allocation officer were interviewed once, at approximately eight months following the completion of the respondents' training. These tutors had experience as personal tutors to other sets.

Ward sisters are key people in the creation and maintainence of the clinical learning environments, in which patients receive care from the ward nursing team. The student respondents in this study had not necessarily gained practical experience with these ward sisters. These sisters were a random sample from amongst the senior and junior sisters who had worked with a staff nurse from the cohort, (as explained in Chapter Four). These sisters were interviewed once at approximately eight months following the qualification of the respondents as registered nurses.

The aim of the interviews of these qualified staff, was to endeavour to determine the perceptions of these significant others on topics and themes raised and discussed by the respondents, and to discover if the perceptions of these key people were similar to each other and to the perceptions of the respondents as students and as staff nurses.

4. Interviews—personal tutors. (Appendix 13)

a) The first interview.

The first interview with each of the personal tutors to the cohort established the role
of the researcher: answering queries about the study, and establishing rapport. This defined the researcher in a different role from that of the head of the school as it is usually perceived.

(i) The cohort.

Each tutor made comments about the set, i.e. how the tutors perceived relationships within the cohort, and how individuals were coping with their studies and clinical placements. The comments at this stage indicated that all the personal tutors considered the set to be a cohesive one. Some concerns were expressed by one tutor about one female respondent who did not appear to mix socially with the group. She considered she was "someone who feels she knows best" and used excuses not to meet with the personal tutor, (this respondent was one of the leavers). Comments were made about six women and two men who needed to study more, and concerns expressed that one man and one woman had been referred in their clinical assessments - in both instances the personal tutor had been to see them and the trained staff concerned.

(ii) Personal tutor role.

One theme which arose from comments made by the cohort, and discussed in all the interviews, was the support given to the cohort from the tutors in their specific role as personal tutors. The role was perceived as being that of counsellor mentor, facilitator and supporter to the students. One tutor stated her role was "to ensure the student becomes questioning, reasoning and a lateral thinker". Another said that:

I'm a mentor - someone to talk to, yell at, bounce ideas off. More a partner than guide. We go through problems, I advise and occasionally lead.

Another personal tutor gave guidance on theoretical needs and future professional development. The three personal tutors in the last interviews all considered that they met with respondents at their request to discuss their personal problems, although one stated that not many came to her for this reason. The three tutors stated that they did see the respondents in the clinical areas, but that this mostly occurred if there were
specific difficulties, or if the respondents worked in the ward where the personal tutor was the link tutor. The respondents mostly made appointments to meet with their personal tutors individually in their offices. The tutors also met with "their respondents" as a group during some of the study sessions.

(iii) Set cohesion.

Another theme discussed during the interviews was the cohesiveness of the cohort. The perceptions were of an integrated group who mixed together well. One tutor considered "they have a caring attitude, which comes across in the group". Another stated that they were not quite the same as other groups because of the age range and differing backgrounds, and said "they came across as more mature, sensible people". This tutor considered it depended on how the introductory course was perceived by the group, and that they also needed to know that the personal tutors cared about them. In the fourth interview the three personal tutors discussed this cohesiveness of the cohort further, and considered that there had been one or two dominant people, but this had not caused conflict. One stated that the set was not so "cliquey" as other sets, although there were distinctive friendship groups within it. This tutor considered that people leaving the set had had an effect on the tutor groups (the tutors met with their personal students as groups, usually during study sessions), with these groups becoming more significant to the members; another tutor stated that the group had not been disrupted by people leaving and the set had not "split into nasty little groups". One said:

Initially it was a cohesive set and stayed that way. They had their groups of friends, but they did help each other out. In that group, there were not so many factions as you can have in other sets.

Two personal tutors at the last interview stated that the cohort at one period early in the scheme, had considered themselves "a bit special", because of their involvement in the study. Meeting with the researcher "made them feel a bit privileged". Both tutors considered this had not lasted and as one stated, "had not hindered the group". All three tutors had been invited out with the set, but could not attend because of previous appointments. One tutor organised a cross cultural group which met for social and educational purposes, and one woman and one man from the cohort were regular attenders and prominent in the organising of activities. One said she "bumped into
them at lunchtimes occasionally" and had a meal or a coffee, and one tutor considered "they do not see us as figureheads, but as helping hands". All three stated that since the respondents had qualified one or two had rung them up for advice, usually on what course to undertake next or about a career move.

(iv) Learning nursing.

Another topic discussed at two interviews was where and from whom did the respondents learn nursing? The tutors considered that practical skills were learned primarily from senior students, peers and staff nurses. Social, communication and teamwork skills from student nurses and the "ward team". Management skills from the sisters and staff nurses. At this stage teaching skills had been added to the competencies to be assessed, and the tutors considered these skills to be learned from senior students, tutors and the trained staff. One tutor considered the tutors taught communication skills during some study sessions. It followed that most of the learning was considered to be from nursing staff in the clinical areas, with some theoretical aspects taught in the school. One tutor stated that the respondents learned nursing in the clinical areas and theory from the tutors. Another commented that some of the respondents enjoyed group work others lectures - "it depends on their previous experiences". She considered that some found optional sessions "difficult, but they all went to them". This tutor considered that the cohort was generally treated in the school as "adults, but they don't always realise it".

In response to the question "what do you understand by nursing theory?", two considered it to be "the understanding of the how and why", and "the way things are meant to be done and why" and to enable the students to apply theory to their practice. Another commented that "you can get too wound up with what is, it can become too academic", and went on to state that the biological and social sciences informed both nursing theory and nursing practice.

In response to the question "how do you teach patient care?" three related their teaching to the clinical situation, using a patient centred approach. One taught individual patient care using a specific patient who had been cared for by a student as a model. She asked what the students would have done for the patient and why, conducting this in the form of a discussion. The others used problem centred approaches, one linking this with the activities of daily living. One stated she used
both the students and her own experiences in discussing the care. Another taught by different methods, e.g. group work or used a didactic approach if it was appropriate to the situation.

(v) Being in the school.

In discussing what they considered the respondents had gained from being in the school, one personal tutor stated that they learned to stand on their own two feet, and to identify their own learning needs, although she commented that some could not do this by themselves. One considered the respondents learned a "sound basis for making clinical judgements, and to cope with situations". Two stated that some insight and knowledge into carrying out skills was achieved in school, knowledge about the needs of individuals, and their own needs as students. Another stated that appropriate attitudes about nursing were "learned directly and indirectly from the tutors".

(vi) Working in the clinical areas.

In discussions about the clinical learning environments, the tutors considered the respondents learned: how to treat the patients as individuals, to put theory into practice, skill in handling people and situations, and that they gained companionship from working with others. One tutor stated "they learn how to fit in - if not they become the unpopular students", and she also considered at times they had to learn to curb their curiosity. Another considered that nursing expertise was learned from role models, along with the appropriate attitudes towards patients and other staff, and she considered that right and wrong habits might be learned in this way.

(vii) Mentorship.

In one interview mentorship in the wards was discussed, when a staff nurse was identified to support, teach and give feedback to a student. The three personal tutors considered each respondent should have been allocated a mentor who had been prepared for the role, but acknowledged difficulties arose when the respondent and mentor had to work on different shifts or the ward was very busy. The role was perceived as guiding and supporting the students and helping them to relate theory to
their practises.

(viii) Gender.

Gender was a theme which ran through the respondents' interviews and was discussed with the personal tutors in the third and the final interview. Their perceptions on how male and female students were treated had not changed. Three considered some men may be treated differently from women in the wards. One said "stereotyping may occur—all male nurses are inefficient". Another said that older male and female patients may have established firmer relationships with the men, but "other patients may have some problems establishing rapport with them". One tutor stated men from overseas found it difficult in their first ward, particularly if there were some problems with communication. One tutor considered men were socialized differently and this influenced the way they were perceived by others particularly older people:

they [the men have] a tendency to think
their judgement is the right way to go or
to think about things.

The female respondents this tutor commented, believed the men were treated more positively in the wards. One tutor considered that men were treated either more or less favourably than the women at the beginning, sometimes getting away with more but that "things changed as they became more senior, they were treated as nurses firstly".

(ix) Qualities as a nurse.

In the first interview the personal tutors were asked how they hoped the respondents would develop as nurses during their training. Comments made included: insight into the needs and feelings of patients, and compassion and understanding of human needs; appropriate skills to deliver and practise patient care; be able to maintain standards; be prepared to to able to challenge the doctors and to be able to delegate as the manager

(x) Preparation to become a staff nurse.
At the last interview the tutors were asked if in retrospect, the respondents had been prepared for the staff nurse role. One tutor commented that some were frightened about the extra responsibilities which came with the role and some lacked confidence. She considered some of the later study sessions could have been used to develop assertiveness and personal development skills rather than aspects of nursing. She commented that this cohort:

was no different from other sets who
realise the protective days are over.

The other two tutors considered the respondents had not been adequately prepared, one stated that more specific details needed to be taught, for example on dosages and side effects of drugs. The other said that more preparation for leadership skills was required particularly as the existing trained staff had a tendency to treat the newly qualified respondents as having more experience than they actually possess. This tutor referred back to the time when there were four statutory clinical assessments, one of which was managing a group of patients and their care. She commented that the trained staff were then aware of the need for the students to be given management experience whereas currently, this tended to be lost unless the respondents were assertive in asking for this experience. This tutor considered that senior students would benefit from working alongside experienced staff nurses together with some theoretical input to help in this preparation for the role of staff nurse.

5. Interviews with the tutors.

(i) The cohort.

Both the senior tutor and tutor remembered the cohort, and both had taught them. They commented that the set appeared to be cooperative interested and friendly. The tutor stated the men stood out more than the women, and said that one man particularly was more vocal. The senior tutor considered the set was not fragmented into smaller groups, but appeared to be one cohesive small group.

(ii) Personal tutor role.
In discussion on their roles as personal tutors, both stated they did not "chase them up", they considered that students should contact their tutor when they needed assistance and advice. The senior tutor recognised that some needed to be contacted, and at times she wrote or telephoned them to let them know she was available, or had returned from sickness. The tutor considered the role to be one of guidance, to help develop but "not to smother" the students. The senior tutor commented that the role included counselling and being friendly (but not over friendly), listening and motivating and encouraging the students. She included marking assignments and a disciplinary function when needed.

(iii) Learning nursing.

Both these tutors considered students learned nursing mostly in the wards, with the tutors teaching the principles of caring and helping students to identify patients' problems. The senior tutor considered "we encourage reflection more than we think we do". She also mentioned that the students learned in various ways in the school e.g. through lectures and discussions. Both tutors spent some time in the wards, the senior linked with the sister on a particular ward who she went to see once every two weeks. She tried to visit the ward every week "to help sort out professional issues" and to talk with the trained staff. The tutor sometimes "put on a white dress and gave hands on care", and commented that "there was no harm in the ward staff seeing you give a bed pan". She stated her role in the clinical areas was to support the trained staff as well as the students.

(iv) Mentorship.

In discussions on mentors used in the clinical situations the senior tutor commented the system worked quite well if the students were allowed to choose their mentor. Problems arose if the mentor did not "get on with the student or vice versa". If difficulties did arise, the personal tutor was contacted. The tutor considered that each student should have two mentors, one primary and one secondary. The primary mentor would be the senior staff nurse who supervised both the student and the
secondary mentor, (a newly qualified or junior staff nurse). The role of the mentor was to develop the student's nursing skills, to act as a role model and to supervise practice. The tutor commented that the mentor often certified the assessment of clinical competencies of the student without seeing the student perform and considered this "an unfair assessment".

(v) Gender.

In answering the question whether male students were treated the same as female students the senior tutor considered that they were in the school, but in the wards were often treated differently, e.g. "when a strong pair of arms are needed to move things". The tutor replied that "I would not like to think so, but I get hearsay back". She heard that sometimes the men lifted patients by themselves, and:

\[
\text{this is hearsay, that he has blue eyes and had the weekend off, that sort of thing.}
\]

This tutor commented that the men who came to see her as their personal tutor were often older than the women and more mature, and had different needs. The women sometimes needed a "female counselling role when they discussed their boy friends".

6. Interview with the senior nurse-allocation.

(i) The cohort.

The senior nurse considered the cohort to have been no different from any other set no names "popped out" or were remembered for any particular reason. She considered the group to be "no more or less demanding" in making requests than other sets:

\[
\text{in fact, probably less because I don't remember requests for long annual leave periods to go overseas.}
\]

This senior nurse remembered speaking to the set as a group, but not the details therefore she considered that "it was not a rough ride".

In many of the wards, there were two sisters/charge nurses, one designated the senior, the other the junior sister. In this study interviews were held with four senior sisters, and three junior sisters from different wards all of whom are women. (Appendix 14).

(i) The role of the sister.

The roles of both the senior and junior sister were discussed with all the sisters.

The senior sister role was perceived as the leader of the team with overall 24 hour management responsibility for the ward. As one senior sister said "the buck stops with me". One senior sister also managed the budget for the ward and was the budget holder. Other aspects of the role included the development of the junior sister and staff nurses, and liaison and communication with others members of the multidisciplinary team e.g. doctors, physiotherapists. The sisters also included other aspects:

- monitor of nursing standards
- co-ordinator of care
- teacher, supervisor and role model
- appraiser of the performance of qualified staff.

One acted at times as the nursing manager of the hospital when the official nursing managers were off duty. This function meant she might be called on to deal with queries about staff shortages, and problems about, and with patients and their relatives and spend time away from her ward. One senior sister said:

It is a multi-faceted role, and has changed over the years. When I first started it was more clinical-involved directly with care. Worked with learners all the time. Now it is office based, I delegate the practical work to the staff nurses and learners.

The junior sister role was perceived as being "half way between the staff nurses and
senior sister, acting as the deputy and support to the senior sister. One junior sister talked about "floating ideas on care" for discussion with the other sister and helping to develop and maintain team identity. The junior sister often was allocated a specific function like arranging the teaching programmes, being more directly involved with clinical care, or being the formal link with the school.

Other aspects of the role mentioned included:

- teacher and role model
- appraiser of the staff nurses
- supervisor of staff nurses and students

In one ward where primary nursing was the model of nursing care one junior sister acted as a primary nurse. One sister said:

I have a supporting role I'm the clinician, she is the manager. We make long term decisions together. It is more her ward than mine, this is fine, I learn from her.... she has ideas I do more footwork. She sees nice things I see other areas. Personality wise it's OK a good relationship.

One junior sister commented that when she was first appointed she felt the staff nurses formed cliques, "which made things difficult for me". She found it took a while to develop relationships, then said "but the students made it feel good" and helped her to feel more secure.

(ii) The role of the staff nurse.

The role of the staff nurse was perceived as being different and according to the grade. The senior Grade E staff nurses were in charge of the ward on the occasions the sisters were off duty, and were viewed as being prepared for a management role. Some of these staff nurses acted as mentors to the more junior staff nurses, as well as to students. They were viewed as having more responsibilities than the grade D staff nurses, who were seen as "consolidating their training", heading a nursing team and involved in care, and learning to administer and manage, e.g. overseeing and ordering supplies. One sister recognised that the transition from being student to staff nurse was difficult, and said that "it takes a while to adjust to the new role". Another senior
To go from third year student to staff nurse is devastating for them. Some think because they wear a purple dress they can do it, take on everything.

All the sisters stated that as qualified nurses, all the staff nurses were responsible for their actions and all had a role in supporting and teaching students.

The sisters all mentioned that the staff nurses were linked to mentors, sometimes the senior staff nurses would act as mentors to the more junior, with the sisters often acting as mentors to both senior and junior staff nurses. Formal appraisal sessions when the developmental needs of the staff were assessed were either practised or about to be implemented. The magazine which came from the school at regular intervals and gave information on available study days and courses for trained staff, was used to discuss the appropriate scheme to be undertaken by the staff nurses. One sister stated that she would like to see the tutors coming to the wards to help support and advise the newly qualified staff nurses, "they feel lost at times".

(iii) The sisters' role in the teaching and supervision of student nurses.

In the discussions with sisters and their role regarding the students who came to the wards to gain experience in the care of patients, all the sisters considered that nursing and nursing care was learned in the wards and that their role was to enable this to happen. They stated that the students "learned skills in assessing the needs of patients and the skills needed to give the required care". Two sisters commented the students learned from other students by working together to give care. Another said:

They mostly learn from other students
the junior from the third year student.
The third years will watch the staff nurses it’s almost like osmosis as you go on. They learn by example. I like to think they go away and look thing up. They learn more if they are enthusiastic. I'm realistic, they probably don’t do this.

The sisters considered that the students learned basic knowledge and the principles of care in the school which they then "tried to turn into the real situation".
The principles are there, but the ward is a different environment. People are under different pressures. You ask them what they have learned, and its actually what they have learned in school the application is in the ward.

Four sisters commented that students who came to their wards in first clinical placements, were not prepared adequately in the school for this experience. One stated the students were not able to blanket bath properly, or test urines, or appreciate changes in blood pressure recordings. Two sisters commented that knowledge of anatomy and physiology was scanty. One of these said:

Many think they have been taught, but I don't know what they do with it. I pick up a femur and they don't know what it is. It is important to know the normal body first.

Another said:

I sometimes wonder what is taught. They seem unprepared for their role. We have to start from scratch-how to give washes, take temperatures. I would have thought this should have been included in the introductory course.

Another sister, whose ward had patients with carcinoma, spoke about the students coming to her ward (not as a first experience), and commented that their skills depended on where they had worked before. She said:

They can be prepared so far, the rest is up to the individual. The more senior are more clinically competent. There are strong emotional demands from patients and relatives. For the junior students, this can be quite traumatic. If they have had cancer in the family it can bring back memories. They need close monitoring.

Three sisters mentioned that junior students in their first and second wards sometimes had difficulties in communicating. This the sisters said, was possibly due to the "specialist language" used and "perhaps we talk too quickly". They also suggested that students who had English as a second language experienced particular problems.
These sisters emphasised the need for students to have identified people to whom they could relate.

All the sisters had mentorship schemes in operation in their wards and said they were effective. The usual practice was for each student to have two mentors, a primary and a secondary. One sister stated:

What we do is to say to students in their first two weeks, pick someone they like and feel they can talk to, or work with.

Six sisters had developed formal teaching programmes in their wards e.g. once a week or every two weeks, planning a time for discussion or a talk from a staff nurse or another member of the care team such as the chaplain or a tutor. Sometimes students were asked to discuss the care of a patient they had nursed. One sister said:

The students have ongoing teaching. For example, discussions on care planning at the midday report. We have a room, with books and leaflets where they can go. We impress it is a two way process, they must push for learning resources.

One sister expressed dismay that she had been unable to establish teaching programmes on her ward. She had wanted to improve the students enthusiasm to learn particularly at weekends when the ward was not so busy. She commented:

They are unenthusiastic many want to get off early and if the ward is not busy, why not? I didn't get anywhere with a formal programme.

(iv) Ward management.

Patient care.

All the sisters indicated that individual patient care was practised in their wards, and four were thinking about the possibility of introducing primary nursing. One ward had this model implemented, but one sister did not believe it was appropriate for her ward, "it wouldn't work there is insufficient staffing". One sister had team nursing:
I put one of the qualified staff to each side of the ward and guarantee students will be working alongside, or have close liaison with the staff nurse. On occasions the students work together, the staff nurses support them.

A number of sisters commented that research findings were used, and articles available on the wards to enable knowledge to keep updated.

Ward staff.

In the management of the staff, three sisters stated they enabled trained staff and students to go to breaks together, while the remainder sent the students to breaks together. Three also said that the trained and student members of staff went out socially together. One said:

It is important to have a life outside nursing. Important they think we are not just colleagues but friends I work with. If the ward is stressed we go out for a meal. It is not a problem, discipline wise.

(v) Relationship with the tutors.

Five sisters mentioned they met with the link tutor to the wards, but not on a regular basis. They wanted to see and meet with the tutors more because "they are always welcome and they are needed here". Two said they enjoyed an "excellent relationship" with the tutors coming regularly to see students and to give teaching sessions.

One said:

The tutor is here to facilitate what I want. He does teaching sessions, for students and staff nurses but he is not here all the time. Students know where he is and can contact him.
(vi) Relationships with doctors.

In discussion on the nursing team's relationships with doctors, six sisters identified they had a "good professional relationship". One sister said that when she was new on the ward some doctors did not listen to "what I had to say about patients". The sisters considered that they were treated as equals by doctors, discussing with them patient management and treatment. One sister commented that sisters and staff nurses were treated in similar positive ways, but another stated there was a difference, "they tell me more". One considered that male doctors related more easily with male staff nurses and said:

They speak more easily together, and are relaxed. It is a natural relationship.

All the sisters perceived there were differences in the relationships between the doctors and male and female students. One said that the students "fly if they see a doctor coming". The comments by the sisters suggested that the uniform made a difference. They stated that the doctors assumed the sisters and staff nurses were more knowledgeable about the patients even though the students were involved directly with the care.

(vii) Gender.

Two of the sisters had one male staff nurse on their establishments, and considered they were treated in a similar way to female staff nurses. One said:

One I have who is very ambitious. He has a different outlook. He is not treated differently, not at ward level or by me. We provide a service and need to reflect the sexes in the work force.

Four sisters considered that male students were treated more favourably than female students. One commented "they are spoiled rotten", another said they "had an easier time because they are men", and one commented that "they expect to get away with things". One commented:

Male students often have an easier time. They are much more visible. I hate to say this, but it's almost a flirtatious relationship which develops. A lot of the
men seem to get away with things which
you wouldn't allow a female student to
do.

Two sisters said that on occasion in their wards, a female patient had not wanted a
male student to wash her, and that this was understood and accepted by the men.

8. Discussion on the findings from the analysis of the perceptions of the qualified
nursing staff.

(i) The role of the sister.

The sisters shared the perceptions of the cohort that the sister is a key person in the
ward and influences the learning environment, concurring with the findings of
Fretwell 1980, Ogier 1982, Lewin and Leach 1982. The junior sisters accepted the
senior sisters had overall responsibility and managed the environment. These were the
sisters who in the end, made decisions on the allocation of work and the model of care
that was practised.

(ii) The role of the staff nurse.

The sisters and the cohort as staff nurses shared perceptions about the staff nurse role:
in heading a nursing team and managing the members; being involved in direct
patient care and in teaching students. The staff nurses did not perceive the differences
between the Grade E and Grade D roles as being as clear cut as did the sisters. On
occasion the roles appeared interchangeable. One staff nurse had to adopt the different
role of the higher grade and manage the ward in the absence of other more
experienced staff.

Despite the fact that the senior sister had responsibility for overall 24 hour care, in
fact, the junior sisters and staff nurses - no matter what grade - felt the weight of
responsibility for the ward. This is understandable, but the newly qualified staff nurses
are most vulnerable and need support in these posts.

The tutors shared the perceptions of some of the cohort that preparation for the staff
nurse role might be enhanced by further "management" experience and leadership
development. One tutor agreed with the views of one respondent that working with a staff nurse for a period before taking up the role formally would be helpful, and might assuage some of the fears felt by the cohort and perceived and understood by the tutors and sisters.

(iii) Learning about nursing.

There appeared to be consensus among the teaching staff and ward sisters that nursing and the skills of nursing were learned primarily in the wards by the students working with other students, and on occasions staff nurses. This agreed with the perceptions of the respondents as students and staff nurses.

The first ward experience had been identified as a traumatic time by half the student cohort, and the sisters shared the view that this was a vulnerable period for students. They expressed concern that the students were not adequately prepared for this in terms of specific knowledge and skills and helped in the translation of this learning into practice. There appeared to be consensus among all the trained staff that basic theory and principles of care were learned in the school which concurred with the views of the respondents. It would appear that there are misconceptions between the ward and tutorial staff about the amount of knowledge and degree of practical skills the students gained from the introductory course, where clinical skills were learned, and in exactly what nursing the students were able to perform in the initial experience in a strange environment.

The views of the ward sisters were that individual patient care was practised and these views were shared by the respondents as students and as staff nurses.

A number of sisters acknowledged that sometimes they used "jargon" and spoke too quickly. Some problems in communication identified by the sisters might have occurred because students felt inhibited in asking staff to repeat instructions, or by interrupting if the sisters were talking together or were on the telephone.

(iv) The role of the tutor.

The personal tutors and student respondents shared perceptions about the role of the personal tutor in supporting and advising students. There was disagreement about the
sharing of personal problems. The respondents stated they would not go to the personal tutors. This difference in perceptions may be explained by the respondents not wanting to admit to the researcher that they needed professional help. Alternatively the tutors and respondents might have shared different interpretations about what constituted "personal problems". This was a similar finding to Wyatt (1978) who discovered that most of the students would not turn to the tutors for personal counselling but viewed their own peer group as a source of guidance and help. This contrasted with the tutors' views that their roles included counselling the students.

The sisters and the student respondents shared the view that the tutors should be available in the clinical areas to work with junior students. The tutors stated they went at the request of trained staff to meet students who were experiencing difficulties in the wards, and this was acknowledged as valuable by the ward staff. The amount of time the tutors spent in the wards appeared to vary between tutors and this might be accounted for by their other commitments in the school. It is possible that students and trained staff missed seeing tutors because of working shifts. One tutor stated that she occasionally worked with students giving care, but the only other times tutors worked with students giving direct patient care appeared to be on certain occasions during the introductory course and the students' first or second ward experiences.

(v) Supervision and teaching in the wards.

The sisters and staff nurses identified their role in teaching and assessing student nurses. The respondents' views that students being allocated to one mentor did not work was shared by a tutor. The system had changed to having two mentors responsible for one student, and this appeared to work.

Formal teaching programmes had been arranged in most of the wards and like the mentorship system, may have developed over time. The student respondents' perceptions were that there was little or no formal teaching.

(vi) Relationships with doctors.

The perceptions of the student respondents that many doctors ignored them as
students contributing to care, was supported by the sisters. The respondents as staff nurses continued to hold this view. It was postulated by one respondent that doctors might be concerned that students may not understand instructions and this might be a reason for their attitudes. It might be expected that doctors would rely on permanent staff whom they know rather than students, but this does not explain the "rudeness" of some.

(vii) Gender.

The perceptions of the respondents that male students might be noticed more and treated more favourably by trained staff in the wards were shared by the sisters and tutors. On the other hand, the female staff nurses and sisters stated that the men as staff nurses were treated in a similar fashion to the women. The establishment would usually include one man, and it is possible that the permanent female staff tried to ensure he was a part of the group, but he might have found it difficult to acknowledge if all was not well. The men might be reluctant to share their concerns and to be seen to be "awkward", in case the cause for more men on the staff was lost!

(viii) Cohesion.

The ward sisters were not asked about the respondents as individuals or about them as a group. The personal and other tutors shared the view the set was a cohesive one, being seen as mature and caring in attitude to each other and to their learning.

Summary.

This chapter has discussed the findings obtained from the respondents as staff nurses and some of the key people in the learning environments. The next chapter discusses the socialization of the respondents into the role of the staff nurse.
Chapter Ten.

Socialization of the cohort.

---during training the student nurse will anticipate his future role as a qualified professional by acting out that role during training. He will at first "play nurse" rather than be a "real nurse" and hope that those watching him will approve the performance.

Bond and Bond 1986 p.123.

Introduction.

The focus of this chapter is on the socialization of the respondents into nursing and the role of the staff nurse. At the beginning and during this study, questions were asked to discover the views of the cohort about their experiences and if they changed over time. The questions posed at the beginning of this study were:

Do the perceptions of the cohort about nursing and the role of the nurse change during the preparation to become qualified nurses, and once they are registered general nurses?

If these perceptions change, when, why and how do they change? What relevance do age, gender and previous educational attainment have on these perceptions?

1. The questions answered.

The perceptions of the cohort on nursing and the role of the nurse were established on the second day of the course. These were that the patients' needs were met in a caring and holistic way, by nurses who helped both patients and their relatives cope with illness. Nursing was also perceived as leading to a specialised career in a rewarding and challenging profession.

These perceptions were influenced by previous experiences and knowledge gained from schooling, paid or voluntary work e.g.caring for children, the mass media, and
The perceptions of the respondents about nursing did not appear to change over their training period, although their knowledge and skills in the organisation of nursing care developed over time. They learned nursing by observing and working with their peers, and staff nurses, who were key people in their socialization process. Their perceptions about the role of the staff nurse changed from one involved in administration and management, to more involvement in direct patient care.

Age, gender and previous educational achievements did not appear to influence the perceptions of the respondents about nursing and the role of the nurse. A combination of these variables might have affected the socialization of some respondents into nursing, because of their own and others perceived attitudes of their roles as students, and the realities of the situations in which they lived and worked.

2. Discussion: the outcomes of the study.

Brim (1966 p.25) suggests that to perform satisfactorily in roles, people have to know what is expected of them and be able meet the role requirements, and desire to practise the behaviour and pursue the appropriate ends. In this study, the respondents were placed into 13 or 14 different wards or departments for periods of 8 - 12 weeks. Each of these clinical areas had different people - patients and staff - with different needs, organisational styles and expectations of the respondents as students. The respondents had to learn very quickly how to recognise, adapt and conform to these different cultures. This ward culture was determined primarily by the ward sister/charge nurses, who were acknowledged and identified by the respondents during their first year as key, influential people. This was confirmed by statements in the repertory grids acknowledging the sisters as leaders of the ward teams, even though the respondents did not come into direct contact with them very often during the early years. The management styles adopted by the sisters/charge nurses, the way they organise patient care and the breaks for meals and social activities, all establish the social climate, the overall "feeling tone" of the wards. (Wheeler 1966 p.81). The expectations of the sisters about the abilities of the students did not always match up to those of the respondents or their tutors. The initial expectations of the respondents were that they would be supervised and work with qualified staff, but these
expectations were not met. Half the respondents expressed concerns about the lack of supervision and the attitudes of some trained staff in their first ward experiences, which, to them, indicated a lack of interest and awareness of the respondents' needs. Entering the first ward was the formal transition from being individuals and students, to "playing the nurse" (Bond and Bond 1986 p.123). This stage was formally marked by the wearing of uniforms indistinguishable from those worn by other more senior students. These uniforms also identified the respondents as people with certain knowledge and skills, belonging to the profession of nursing. Patients and other members of the nursing and health care teams also had certain expectations of the respondents as student nurses, which were either met, or required the respondents to expose their ignorance. The respondents were conscious of their vulnerability and their newness, at a time when they were anxious to make good impressions, and when the words and actions of the trained staff were meaningful, and easily translated as praise or blame. The respondents also learned that what was officially part of the curriculum, was not always expected or accepted in practice. Talking with and listening to patients was part of the teaching in the school, but some ward sisters viewed this as time wasting, when there was "work to do". Formal teaching was expected to take place in the wards, but this did not always occur, although the interviews with the sisters indicated that this may have developed over time. The repertory grids helped identify the importance of auxiliaries and ward clerks in enabling the respondents to get to know the ways of the trained staff, and where equipment was kept. Other studies have noted the importance of auxiliaries in the student nurses learning e.g Wyatt (1978), Wilson and Startup (1991). Melia (1987 p.61) discovered that students in her study had mixed feeling about auxiliaries, because of the tension which existed between reliance on auxiliaries for help and the students' insistence upon some differentiation between auxiliary and nursing work. In this study, the majority of respondents identified auxiliaries in a positive way, as people from whom they gained knowledge and skills, and depended on for help in getting to know the ward environments and the likes and dislikes of the sister.

It was during their third year, when the respondents identified themselves as "senior students", that they were able to fit more easily into the nursing teams and establish their social and professional relationships. This growing confidence in themselves as people as well as student nurses, enabled some to predict how others would react to them and helped them to guide their own behaviour successfully. (Brim 1966 p.9.)
Other students were viewed by the cohort as important people in their learning of nursing and nursing skills. This learning during the first wards from peers, provided professional and social interactions with others who might be deemed to be non-threatening, because they had experienced, or were undergoing a similar process to the respondents. Wheeler (1966 p.63) suggests this "serial pattern of socialization " may be viewed as an acceptable method of learning by the socializing agents (the tutors and trained nursing staff), but as "disjunctive" by the students. In this study, the support, help and teaching from peers was appreciated and recognised as important to the respondents' development and progression as students. Only two respondents mentioned learning "by mistakes" and "by trial and error", which suggests that the majority were able to identify the learning opportunities offered by observing and working with role models.

It is to be expected that the wards existed as the primary reality - learning experiences for the cohort.(Orton 1981). The ward was placed first as the place where all the students learned about being a nurse in Wyatt's study (1978 p.266). These students in this study also identified they learned from, and depended upon their peers to a large extent. It is perhaps easy to understand why peers like working with each other, as they are members of a group with similar interests and goals. Reid (1985 pp. 169-170) suggests that in a hierarchical profession like nursing, it is natural for nurses to feel more comfortable with those of comparable grades.

As the respondents progressed through their training, they perceived that basic care (enabling patients to be comfortable, attending to hygiene needs, Vaughan 1992 ), was the province of junior nurses, "the work force", during the first and second years of training. The senior students in their third year were involved more in "management", the work of staff nurses which included heading a nursing team and giving out drugs as well as direct patient care. The use of students as "pairs of hands", and the reports which recommended changes to the nursing education system to remedy the situation,are highlighted in Chapter One. It might be assumed that high student and low trained staff numbers in wards contributed to these situations. Reid (1985) found that in practice, there was no relationship between staffing numbers and contact between students and trained staff. Often the trained staff maintained contact with senior rather than the first year students in the ward. The respondents in this study commented on what they perceived as "poor staffing levels", and on occasions, respondents in their third year acted as staff nurses. One women staff nurse
respondent talked about acting as a higher grade staff nurse because of a temporary reduction in trained staff in her ward.

Melia (1987 p.130) discovered that the students in her study, in discussions, appeared to differentiate between three forms of nursing, "real nursing" which occurred at speed, mostly on surgical wards and involved technical procedures or drug administration. "Just basic nursing care" was exclusively nursing care, and "not really really nursing" which was often used to describe the nursing in geriatric wards, or the elderly in other wards who were in need of social care. Nursing was certainly talked about by the respondents in this study, and seen to consist of both basic or essential care, and care which encompassed more technical procedures e.g. going on the drug rounds, which correspond to "just nursing care" and "real nursing " described by Melia (1987). A number of the respondents identified the care of the elderly experience as a "negative experience", because the patients primarily needed basic care given largely by students, and there was a lack of interest and involvement by the trained staff. It was not apparent that, in this study, respondents were dismissive of basic nursing care as the students appeared to be in Melia's study, but rather that they were concerned that trained staff were not always involved in providing this care. The respondents stated from the beginning that individual patient care was practised in most wards, but involvement in the totality of this care might depend on the experience and skills of the students and how the care was organised in the wards. It can be argued that senior students were knowledgeable and skilled, and more confident and secure in themselves than the junior students, and were perceived as such by the qualified nursing staff. They were able to gain different perceptions about the needs of patients, and could be more directly involved in the planning and assessment of care.

It was stated in Chapter One that the numbers of men entering general nursing were slowly increasing. In this study the men were in a minority in the wards and therefore highly visible. The perceptions of the respondents, tutors and sisters were that men as students were generally treated more favourably than women in the wards. It was stated by a number of respondents that views about a male student may be polarised, he was either very good or very bad, but never overlooked. It is suggested that the male respondents might have been keen to give favourable impressions of themselves working in predominantly female ward establishments. It is postulated that nursing is
viewed by many as women's work, the skills of caring coming more naturally to women. Because of this, it is possible that there was more overt acknowledgement of the men and their skills, an awareness that men might need encouragement to remain as nurses in predominately female working environments, coupled with the need to be seen to be fair. It is also possible that there was an increased awareness that legally people should not be discriminated against in their work on the grounds of sex. One sister highlighted the possible "flirtatious" nature of the relationships between the sexes, and the perceptions were that it was the trained female nurses who sometimes tended to treat male students more favourably than the female.

The respondents used both other students and staff nurses as role models, possibly learning both good and poor practices, depending on the knowledge, experience and standards held and practised by these "significant people in their working environment" (Bradshaw 1986 p.61). During their training the respondents' perceptions about the role of the staff nurse appeared to change from being primarily concerned with administration and management to becoming more directly involved with patient care and teaching student nurses. These perceptions were similar to the views expressed by the respondents as staff nurses and the sisters. These findings support the view of Buckenham (1988), that there is not a gradual development in the perceptions of students about the staff nurse role, which approximates closer each year to the actual role as perceived by staff nurses. It is argued that the role of the staff nurses must be viewed in the context of the ward in which they work, and the experience of the respondents as students. In the general medical and surgical wards in which the respondents gained experience during the first year, they were learning the basic skills needed to care for patients (bed bathing, taking temperatures, feeding patients). The staff nurses might have been more involved with "technical procedures" e.g. giving injections, and intravenous drugs, and in surgical wards ensuring that patients were identified correctly for operations. In wards where the patients required specialised nursing, the trained nurse with special skills might need to be more involved in direct care, e.g. in children's wards. In their third year, the respondents identified they had gained confidence, and perhaps because of this were able to ask questions and challenge practices. It is postulated they might have been able to observe and evaluate more clearly the role of the staff nurses, both as nurses directly involved in care, and in managing patient care and the environment. The balance between direct patient care involvement and management, it is suggested, depended on the situation, e.g. the patients to be nursed, the management
style of the senior sister and her approach to the organisation of care, and the number and experience of the staff nurses.

The change in the role and status from students to staff nurses, personified by a change in uniform and becoming permanent members of staff, was perceived as threatening and frightening by many of the respondents. This was recognised and understood by the tutors and ward sisters. As qualified nurses, the respondents were accepted more by the doctors, but, in some wards, were expected to operate as experienced in these roles by them, and by the other nursing staff. The respondents viewed themselves as responsible for the care of the patients and the environment, and felt the weight of this responsibility. Some expressed feelings of sadness about their loss of security, and bereavement about the loss of certain aspects of the student role which they enjoyed, e.g. the intimate relationships with patients. In retrospect, the respondents had mixed views about their preparation for the role, some stated they were prepared others not. Some respondents as senior students had headed a nursing team and had taught other students. Despite this experience, it is suggested, as one respondent commented, that it is only when the respondents actually became staff nurses that they understood what the role entailed, and what was expected and required from them by others. It has been argued that the role of staff nurses must be viewed within the working contexts in which the roles are performed. Evidence from the study suggests that respondents varied in confidence and security as they neared the end of training and were thinking about becoming staff nurses. For these reasons, it would be difficult if not impossible to prepare students totally for the change in role and responsibilities prior to qualification. The "new" staff nurse has to learn new routines, the ambience of the ward, and develop social as well as professional relationships with those previously perceived as authority figures. The respondents, tutors and sisters identified ways in which the curriculum might be modified to include emphasis on leadership skills, and to enable students to work with staff nurses for a period prior to being formally appointed. The respondents and sisters also identified the need for the continuation of support for staff nurses from tutors. All this could be built into a curriculum, but the responsibilities inherent in the staff nurse role are only truly known, understood and dealt with when the students actually become staff nurses.

The school had its own structure and systems of management, and students were expected to conform to certain prescribed patterns of behaviour e.g. signing a list
notifying presence in case of fire. As well as having to adapt to different ward cultures, the respondents also had to conform to this school culture, and to the different styles and approaches of teachers who might have different views about the position of students from the respondents' own. This was particularly apparent during the session on the care of the child, during which the respondents believed they were treated as children themselves rather than as responsible adults. They had previously identified their need to learn by sharing with each other and through group work in previous written evaluations, and hence didactic teaching proved to be a negative learning experience for the cohort.

The tutors and the ward sisters shared the respondents' views that basic knowledge e.g. about anatomy and physiology and illness, and the principles of care were learned from the tutors in the school, which a number of respondents were able to apply to their nursing in the wards. It would appear that the sequence of learning about patients and their conditions in the school, and the practice of nursing in the wards was not relevant for many respondents; but the differences between the teaching in the school and ward practice caused concerns. The ideal was perceived to be taught in the school, and this was not always carried out in the wards. Sometimes "corners were cut", because of staff shortages, at other times the "ideal" model of care was not appropriate for all the patients. This giving of ideal care to all patients regardless of their needs, might have been the reason that the tutors were seen to take too long and to interfere with the "real" work when they were involved in patient care. This "corner cutting" was accepted by the respondents as understandable, and part of the real situation, and not detrimental to patient care. They perceived that the "ideal" needed to be taught, otherwise there were no standards by which care could be measured.

It may be argued that despite the awareness of some respondents that the teaching from tutors about care was correct, students would comply with the practices implemented in the real situation in the wards. It might be difficult for student respondents to challenge the authority of sisters/charge nurses, who were perceived as influential people, with the power to affect the assessment of the students' clinical competences. At other times, the respondents viewed the teaching by the tutors either to be out of date, or incorrect.

The difference between teaching in the school and ward practices is highlighted in Chapter One, and has been demonstrated in many studies, e.g. Olesen and Whittaker (1968), Bendall (1975), Wyatt (1978), Gott (1984), Melia (1987).
Most students acknowledged that the overall aim of the teaching staff and sisters and charge nurses was to help them develop into safe and knowledgeable practitioners. However, their contributions were regarded as separate entities, the teaching staff being responsible for "the theory" whilst the sisters and charge nurses were responsible for the practical care.

Wilson and Startup (1991 pp.1480-1481)

They also discovered that practical skills were performed differently in the school and in the wards. In this study, the respondents said that "theory" was learned both in the school and in the wards, but nursing skills in the clinical areas. Practical skills appeared to be taught mainly in the introductory period in the school, and the respondents identified a need for more of these practical sessions to be taught by tutors in the school, and for tutors to work with junior students in the clinical areas. As evidenced by this study, tutors need to update their nursing knowledge and skills, and to keep themselves informed about current practices in the wards, and practice in the wards needs to be research based. The respondents as staff nurses and sisters identified that research findings were used in some wards, but this might be a development which has occurred over the four year period of this study.

The personal tutors were perceived as key, constant people to whom the majority of respondents would go to share problems related to studies and the ward areas. The respondents recognised the value of knowing one knowledgeable person within the nursing hierarchy, with whom they could relate socially as well as professionally. The value of choice in the selection of this personal tutor was evidenced by a number of respondents changing their tutors, which was acceptable to the tutors themselves.

The importance of the student culture is demonstrated in the studies by Becker et al (1961) and Olesen and Whittaker (1968), in which the students learned how to cope with the demands of the curriculum by adapting to current situations and negotiating
their way through the professional schools. In this study, the set played a vital and significant part in the respondents' socialization into nursing, providing a secure arena in which feelings and views about people and experiences could be shared. It was seen as a group within which the members could test out in safety their responses to learning, to different wards and people. This set cohesion was established in the introductory period, and continued throughout training, with friendship groups being established and maintained early on, despite the difficulties in meeting during the clinical placements. The importance of their set to them is evidenced from the respondents' perceptions that they would turn to their friends, or to their families, to share and discuss personal problems. In the early stages of the course, a number of respondents in the over 25 group, identified certain difficulties in relating to other members of the set. Two of the women made comments about the difference in ages, and that it was sometimes not easy to talk with others who were seen to be less mature than themselves. It is argued that it was not just age, but a combination of age, previous experiences and home and family commitments that affected the way some respondents coped with their training. It is suggested that the older person, with previous experience and independence, might cope with entering a different profession more easily than those who enter straight from school. Alternatively, the perceived invasions of privacy, and having to conform to rules of conduct in residences, school and wards might prove to be insurmountable problems. The respondents who lived at home with families to care for, found difficulties in finding time to spend with friends in the set, but still enjoyed meeting during the school times. While the set sometimes presented a united front against authority, e.g. becoming silent and refusing to respond when a member had been "attacked" by a tutor, it was not apparently used to help members negotiate their way through their training, in the manner described by Becker et al (1961) and Olesen and Whittaker (1968).

Doctors, the leaders of the health care team, were perceived in different ways by the respondents. In the repertory grids, they were identified as teachers who imparted their knowledge about illness, and were viewed as approachable in the elderly care wards. In other wards, mostly the acute medical and surgical, they ignored, or were "rude" to student respondents. This appeared to change when the respondents were staff nurses and qualified as professionals, and permanent members of the ward team, although this was not always the case. It is suggested that doctors in busy wards might prefer to talk with sister or staff nurses rather than students who were there for short periods. A newly qualified doctor might rely on these trained nurses for advice on
treatments. The doctors might not know the students, and the amount of knowledge and skills they possessed. One sister commented that sometimes students "ran" when they saw doctors, and it might be that doctors found the trained staff more accessible, as well as knowledgeable. The teaching in the school was that care was delivered by a health care team, made up of professionals who contributed their acknowledged particular skills in the ward setting. The cues and messages received by the respondents might have indicated that the doctors viewed themselves outside the team, dictating how treatment and care should be delivered by the nursing staff. In this study, the rules of the doctor- nurse game to prevent open disagreement between the players at all costs were not always observed, but at least some free discussion ensued. (Stein 1978 pp.107-117, in Dingwall and McIntosh).

3. The cohort compared with other sets.

The cohort's career may be viewed in relation to other sets in the school, but such comparisons are not always meaningful. The membership of the sets differ, the personal tutors and teachers and clinical experiences vary, and the meanings and learning gained from all the experiences will be differently perceived by the set members.

(i) Sickness/absence.

The English National Board states that 21 days may be taken during a three year programme, before time has to be made up prior to qualification. The respondents as a set had 35% sickness for the training period, compared to a range of 23%-35% for other groups who prepared to become registered general nurses-RGN.

It can be seen that the respondents had a fairly high level of sickness as a set during training, but a number of respondents had long periods of sickness due to surgery, or treatment.

(ii) Wastage.
The cohort had 26% wastage from the scheme, compared to an average of 15% in comparable groups. Eight months following qualification, 18 respondents out of 20 (90% of those completing training) remained in the host district. Figures for other sets are not available.

The wastage from the cohort has been previously discussed in some detail. It is not known if these respondents re-entered, or might re-enter training in another nursing school, in the future.

(iii) Success in the final determinant examination.

17 out of 20 students in the cohort passed the examination at the first attempt, an 85% success rate. The remaining three passed at the second attempt. This compares with a range of 80%-90% pass rate in the first attempt for comparable groups.

Conclusion.

It is argued that from the evidence of this study, anticipatory socialization into the role of staff nurses did occur for most of the respondents. The respondents' commitment to nursing may be inferred by their remaining as staff nurse eight months following qualification.

The next chapter considers some of the issues raised, and some of the strengths and weaknesses of this study.
Chapter Eleven.

Conclusion.

The way forward.

It is essential to build and maintain a pool of qualified and experienced nurses and teachers who are able to provide care, assist students to learn, and act as role models. Without such a pool, little progress can be made in the provision of appropriate nursing education to prepare nurses to provide improved patient and client care.

Jolley and Allan 1989 p.25.

Introduction.

This study reflects the finding of Wilson and Startup (1991), that student nurses do not undergo an integrated and homogeneous socialization process. One cannot generalise from this particular study, and apply the findings to nursing education in general, but it is possible to identify some lessons which might be learned.

1. The findings.

The process of socialization was heterogenous, with the respondents exposed to the different styles of management and organisation of care in different wards, perceived as the primary areas for learning nursing. Overt as well as covert messages produced degrees of conflict for many respondents, who conformed to the expectations of the nursing staff in the wards when there were differences in teaching between the school and wards. The respondents appeared to relate more to the expectations of the ward staff, perceived as being in the real care situations.
2. Issues raised from the findings.

(i) This study demonstrates that the respondents considered that the theory and practice of nursing took place in different organisations, the school and the clinical areas. The school had its own hierarchial system and structures, which was different from that in each of the wards, which also varied in organisational methods and social climate. When there were conflicting teachings between the school and the ward e.g.post-operative care, the respondents conformed to the real situation, the wards where patients received care. The tutors, although recognised as experienced nurses and teachers, were not perceived as being part of this real situation.

In the future, when schools of nursing become part of the higher education system, there is a danger that students might polarise nurses into the "academic" and the "practical" nurses. The dangers would be increased if they are not exposed to the care of patients early in their programme, and if the tutors were not seen in the wards and community.

Charles-Edwards (1992) and McCaugherty (1992) suggest that tutors may help bridge the theory-practice gap by enabling students to reflect on, and learn by and from their experiences. This learning could take place in any environment, but this study suggests that students benefit from having a break from the clinical areas. It suggests that tutors would require time, resources and motivation to keep themselves updated on nursing practices.

(ii) This study illustrates the anxieties of some respondents prior to, and following, the formal adoption of the role of staff nurses. This anxiety was engendered by the uncertainty about the expectations of others about the roles. It was increased by a lack of knowledge about the role required in a particular ward, as wards differed in the organisation of care, and shortages of staff meant that occasionally more senior roles had to be adopted. Ways of enhancing the curriculum were suggested e.g. more teaching on leadership skills, working with an experienced staff nurse prior to formal adoption of the post. However, as one staff nurse respondent stated, it is only by doing, by being the person in the role, that full recognition and understanding of all the facets and responsibilities become apparent. This would indicate that it is necessary to support newly qualified staff nurses in their roles by designated and prepared nurses.
(iii) The change in status from being part of a cohesive group in a secure school environment to becoming a "learner nurse", in uniform in a strange environment where there were different official and unofficial rules, and real people as patients, gave rise to feeling of stress and loss in many respondents. This was apparent particularly in the first wards. The sisters identified certain communication problems with students in their first wards, e.g. jargon and quickness of speech, which might be exacerbated if English is not the student's first language. There was an apparent lack of understanding and agreement between the tutors and ward nursing staff about the expected outcomes from the introductory period. The sisters expected the respondents to be skilled in aspects of essential care, while the tutors considered this practical learning should take place in the clinical areas. The need for all involved in the education of nursing students to participate directly and consistently in the planning and evaluating of the curriculum, has been raised. The definition of "supervision" in relation to the students, needs to be agreed and made explicit, not only to the trained staff, but, most importantly, to the students.

(iv) The importance of the set, and the other people with whom the respondents as students came into contact in their socialization process has been highlighted. Role models are influential agents from whom the students might learn attitudes and the values embodied in nursing, whilst learning nursing skills. Positive and negative aspects might be learned from these role models. It is suggested that auxiliaries and ward clerks need inservice preparation and follow up, as well as the qualified nursing staff.

(v) Much of the respondents' learning came from their peers, and this has implications for the planning and development of all curricula, both in nursing and general education.

(vi) People who socialize together may exert a social force, and the group may be used as a safe environment in which to express and share opinions which might be viewed as unacceptable to the "establishment". In developing curricula where groups or sets are small enough to enable face to face encounters, the expectation that the group might use overt or covert pressure to modify or change parts of the curricula
should be realised. The sharing of personal problems with friends would appear to be an important function of the group.

(vii) The personal tutor role was viewed as essential by the respondents in this study. The selection and preparation of tutors to fulfil this role might be reconsidered. The personal tutors and respondents appeared to have different expectations of the role, and the role functions might need to be made explicit, and evaluated over time.

(viii) The respondents had to become socialized into the school, and into the different wards. In the future, students will need to adapt to the different cultures existing in the higher education institution, the school of nursing and the clinical areas, each with a different ethos and differing agendas.

3. Strengths and weaknesses of the study.

Throughout the study, the possibility of bias was in the fore-front of the researcher's mind, as head of the school. The respondents as staff nurses appeared to have believed they gave the researcher honest answers, particularly as the relationships developed. Two personal tutors noted the "halo" effect with the cohort, at a particularly early point in the study. The senior nurse allocation, found the set to be no different from other groups. It might be argued that the possibilities of bias are inherent in any qualitative study, and in retrospect, the advantages of the respondents getting to know the researcher over time, outweighed the possible disadvantages.

It is argued that one of the strengths is the use of the triangulation of data collection, with interviews being the main method, supported by the use of questionnaires, the repertory grids, and retrospective techniques. Simpson (1979 p.50) posed the same questions over time. She writes:

The data gotten at the different times are not independent. In the interests of rigor, we asked the same individuals the same questions six times - at entry into the school, at the end of each academic year, and after one year of work.
Conceivably, students may have remembered their earlier responses, but more likely they did not.

In this study, issues of interest raised by a number of respondents were explored with the remainder. This enabled themes to be developed over time.

The retrospective biography, with the respondents identifying their positive and negative learning experiences using "snakes", was discussed with the respondents at the following interview. In retrospect, it would have been helpful to follow this process with the repertory grids, so that clarifications or modifications could have been made.

It is argued that this methodological approach was preferable to the use of observational methods, which would have required more time, and the involvement of more people, with possible differences in perceptions about the observations.

Criticisms of the case study approach suggest there is a lack of methodology. Atkinson and Delamont (1985 p.31) write that sophistication in methodology is not a marked characteristic of case studies. The use of qualitative and quantitative data in this study, together with rigorous collection and analysis has enabled meaning to be given to the findings from the analysis of the data.

4. Suggestions for further research.

This research studied the process of socialization of a cohort of students as they prepared to become nurses, and when they became staff nurses. It is not, and was not meant to be, a study of the individuals who made up the cohort, although more details about the respondents who left prior to completion are given, because they were shared with the researcher. It would not have been possible, or correct for the researcher as head of the school, to ask or record personal details. It is suggested this might be the aim of another study.

It is also suggested that a comparative study between this research, and one with a cohort of Project 2000 students might prove fruitful. In a Project 2000 scheme where aims and outcomes are different, where there are different approaches to learning in the clinical areas, and experience is gained in both higher education and a school of nursing-are there differences in the students' perceptions of nursing and the role of the
Conclusion.

This study adds to the growing body of knowledge on occupational socialization, in this instance, on the socialization of students into a profession. Some of the findings from this study although peculiar to nursing and nursing education, might have relevance to the development of curricula in further education, and to the socialization processes into other professions.
1. INTRODUCTION

1.1. COURSE AIM

The Access to Nursing Course aims to prepare bi/multilingual applicants for Nurse Training by offering a one year programme at the end of which students will have reached levels of educational skill and achievement equivalent to the entry requirements for Registered General Nurse (RGN) training (minimum 5 'O' levels but increasingly pitched at 2 'A' levels).

1.2. TARGET GROUP

The course seeks to serve bi/multilingual men and women over 19 years of age whose previous educational experience has not given them the opportunity to acquire the normal entry qualifications required by Schools of Nursing, and the in particular. It is expected that recruitment will initially be predominantly from the Bangladeshi community in but applications from other bi/multilinguals such as Somalis, Chinese and Vietnamese will also be welcomed. has agreed to reserve 12 places for students who successfully complete the Access Course.

1.3. COURSE STRUCTURE AND CURRICULUM

It is intended to offer a full time one year course, beginning in September 1985, which will lead to entry to the School of Nursing from 1986. The curriculum will develop language, study and science process skills through the study of human biology and health, number (including computer literacy), interpersonal relationships and National & Community Health provision. The course will be taught by a small course team with the emphasis on the integration of all course components and learning experiences. Close attention will be paid to the development of the students' linguistic skills, including the use of the students' first language. has recently agreed a language policy for bi/multilingual students and is committed to the provision of language support across the curriculum. Much of the learning will be project-based but there will also be carefully controlled formal sessions to prepart for the study requirements of Nurse Training. The syllabus will be structured on a "wedging" model in order to focus on language and study skills in the earlier part of the year, leading to a programme forming an interface with nurse training towards the end of the course. Visits to observe various aspects of the work of the and will be arranged throughout the course.
1.5. **SELECTION & ASSESSMENT**

Initial selection, in-course and final assessment will be undertaken jointly by ---- and the ---------.

Applicants will be selected for the course on the basis of their motivation towards nursing as a career, their previous life experience and present educational achievement and their potential for learning rapidly within a one year programme.

In-course assessment will be continuous. Criteria for successful development, commitment to study and suitability for the nursing profession.

Note. The course has the approval in principle of the UKCC, for a three year period, as an alternative access course for persons to obtain entry to ------. UKCC is itself sponsoring research on alternative entry to nurse Training and wishes to pilot through this course tests which it is developing on a national basis. This indicates that the proposal which we are putting forward is breaking new ground and potentially has a contribution to make beyond the --------- area.

1.6. **COURSE ORGANISATION, MONITORING & DEVELOPMENT**

The course will be managed within the normal departmental structure and the day-to-day running will be in the hands of a Course Team, led by a Course Tutor, which will meet weekly. A representative of -------- has been nominated to liaise closely with the college throughout the course and to facilitate the use of ------------ as a resource wherever appropriate. A Steering Group will be set up, comprising representatives of ------ and the local community, to oversee the development of the course. The advice of community representatives will be sought at all stages in the planning, running and development of the course.
### Respondents - 146 Week Scheme Leading to Registration as a First Level Nurse - RCH

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### Key
- **I** = Introductory Course
- **S** = Study
- **A** = Annual Leave
- **CP** = Clinical Placement

### Note
- Study days are held during three of the Clinical Placements.
APPENDIX

CLINICAL PLACEMENT PLAN FOR 146 WEEK SCHEME FOR PART I

OF THE REGISTER (RGN)

1 ) Care and welfare of acutely ill adults
2 ) Care and welfare of acutely ill adults
3 ) Care and welfare of acutely ill adults
4 ) or
   Care and welfare of the elderly
5 ) Care and welfare of acutely ill adults
6 ) or
   Care and welfare of the mentally ill
7 ) Care and welfare of children
8 ) or
   Care and welfare of the adults
9 ) Maternity Care $4/52$ - O.P.D. $4/52$
10) Care of the acutely ill adults
11) Care and welfare of people involved in accidents
12) to include
   experience in E & A Department/Operating Theatres
13) Care and welfare of acutely ill adults
14) consolidation/elective
**Study Sessions 1 & 2**

Care of the patient with cardiovascular and respiratory disorders.

**Study Session 3**

Introduction to the physical, psychological and social needs of the elderly.

**Study Session 4**

To identify the problems of a patient with a locomotor disorder.

**Study Session 5**

To identify the problems of a patient with a urological disorder.

**Study Session 6**

Introduction to the physical, psychological and social needs of a patient with a gastrointestinal disorder.

**Study Session 7**

Care of the patient with cardiovascular and respiratory disorders who is undergoing surgery.

Care of the patient with a mental disorder.

**Study Session 8**

Community Care and Health Education.

**Study Session 9**

Care of the patient with a mental or endocrine disorder.

**Study Session 10**

Care of the patient with a neurological disorder.

**Study Session 11**

Care and Welfare of Children.

**Study Session 12**

Care of people with cancer and terminal illness.
146 Week Curriculum Study Sessions/cont

Study Session 13

Male and female disorders – including sexually transmitted disorders.

Study Session 14

Care of the patient with multiple injuries.

Study Session 15

Care of the patient with sensory loss/disorder.

Study Session 16

Care of the elderly patient.

Study Session 17

Concluding the curriculum.

Study Session 18 & 19

Professional Development.
### BACKGROUND - COHORT

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TRANSCRIPT OF FIRST QUESTIONNAIRE - FEMALE RESPONDENT

Thank you for participating in this project. Please answer the following questions in the space provided.

A. Why do you wish to become a Nurse?

I chose nursing because I feel it is an extremely satisfying job and a great deal of variety is involved. I also like to deal with a job that has a practical side to it as well as studying. I love working with people and caring for them making sure that people are happy and well.

Not only is nursing an extremely satisfying job, but it is rewarding and I feel one gets a great deal of pleasure from the job. I also enjoy or I feel I would enjoy the variety in the hours of work rather than a 9 to 5, 5 day week working system. Therefore variety is certainly in nursing in both working hours and the work.

B. What do you understand by 'Nursing'?

Nursing is a profession which involves in looking after people, caring for them when they are ill and ensuring that they are happy when they are in hospital. Nursing also involves the understanding of health and cleanliness as well as understanding the body and how it works.
C. What do you understand by the role of the Nurse?

I feel that the role of the Nurse is a person who feels he or she is capable in working hard and taking on a great deal of responsibilities. The Nurse, I understand, cares for people who are ill ensuring they are happy at all times. A Nurse works on wards giving injections, bathing patients, making beds, help feed people, and bandaging wounds. Also the Nurse is an Assistant to the Doctor and a nurse must also learn to be able to lift patients in taking care that the patient is not in too much pain.

Thank you again. The responses are confidential, and you will not be identified by name.
TRANSCRIPT INTERVIEW Number two - with a female student respondent at approximately 8 months into scheme.
Notes made during interview, and written up the same day, by researcher.

1. Working in the clinical areas

Q. Talk with me about your ward experiences?
R. Last ward was "brilliant, because the staff were supportive, and took time to listen". The Sister took respondent on one side to speak with her, and give support by listening, and answering queries. The ward was well organised, and respondent always knew where things were kept, so this saved time. Due to Sister - who was well organised. Respondent worried about her current experience in the care and welfare of elderly at ------. She thinks "she will get through it". She finds ward "depressing". The work tends to be "routine and dull" - basic care e.g. washing, and feeding patients.

2. Being in the school

Q. How are you finding school?
R. Enjoyed the study session on care of the elderly. Enjoyed it - rather surprisingly, it was more interesting than expected. Enjoys participating in groups - and sharing learning experiences. It was helpful having study sessions prior to having clinical experience. Study session - patients with Locomotor disorder - Found some of this difficult to comprehend; but it 'came together' nearer the end of the week.
Sessions were 'very good' - teaching was varied - some lectures, some discussions. Treated like adults - able to participate in sessions, not made to 'feel ignorant' by tutor.

Q. Are you able to meet with your personal tutor?
R. Yes, but unfortunately she (tutor) is off sick at present, but respondent would go to another tutor, and has done so for advice on work.

Q. Why do you go to see your personal tutor?
R. Goes quite regularly - for help on work related matters, for example essays, or if there were problems in the ward.
Respondent would not go to personal tutor for help with personal problems - would go to friends. (in set).

3. Social/leisure activities

Q. Are you able to enjoy a social life? Are you able to keep up with your friends at home?
R. Managed to keep some hobbies - swimming. Uses hospital club pool. Did do yoga, but gave it up, felt 'too tired'.
Respondent has made some friends in set, and they meet together - not just during study sessions. One friend in set is leaving, and respondent is "very sorry about this, he is a good friend".
Has kept up with some friends at home, problem is - "they all seem to be getting married".
Has a Gran, who lives fairly near, in ----------.
Enjoys going home to ------- for holidays.
Is resident - no change in poor facilities.
Q. Are there any other comments or points you would like to share?
R. No - everything seems to be going quite well. Just concerned about elderly experience.

--------- names omitted.
NEGATIVE

Didn't get on with sister
No teaching sessions. Very old fashion ideas - No
suggestions or changes accepted

Boy friend involved in RTA,
6 weeks in ...........

...... left, one of my closest friends.

POSITIVE

Junior sister started on ward.
Tutor came down from school.
Things started to improve.

Enjoyed working with other members of my set.

2nd ward.
Questions encouraged.
Good atmosphere despite large no. of deaths.

First ward good.
Learning experience.

Voluntary work with the disabled for eighteen months while at College so decided to get some qualifications best way seemed RGN course.
TRANSCRIPT INTERVIEW  Number six with a male respondent, nearing the end of the second year.

Notes made during interview, and written up same day, by researcher.

1. Working in the clinical areas

Q. How are you enjoying the wards?
R. Did not enjoy -------- ward (a General Medical).
The respondent worked with a staff nurse on nights - "not approachable".
"Staff nurses seem to get purpilitis - and think they know everything".
Respondent had concerns about other students - not listening to him. "Some 1st warders only listen to staff nurse and sister".
"The doctor asked me to help with catheterisation. Told me to clear up - no please".
Respondent replied he was sorry - had to see to 2 patients, going to theatre. Doctor said "I am busy too". Another student offered to clear, but respondent said he would do so - wished to make his point.
Had enjoyed the experience in the care of children - own hospital. Teamwork was evidenced. Children were a pleasure to nurse and staff nurses gave care to sick children.

Q. From whom do you learn nursing?
R. Learned mostly from other students, and a night sister who was excellent at giving care, and gave some teaching sessions. Some staff nurses gave 'hands on' care, for example - in the children's ward. Felt he had learned ability to prioritise care - in the wards, and knew what he was doing,
which was not how he had felt in the first ward. (felt lost). At the end of the above general ward experience, respondent had enjoyed experience more; but there was little formal teaching during the day. More teaching in the childrens ward, by formal teaching sessions - usually from staff nurse or sister. The sister organised the general ward, so that students went to breaks together, and staff nurses together. Respondent had experienced this elsewhere.

2. **Being in the school**

Q. How are you finding school?
R. Sees personal tutor, when he feels he needs to - for advice or work.
Study sessions are 'quite good', and learns from them - some basic knowledge, and nursing care, "but this takes place in wards". 
Asked about the proposed amalgamation - thought it would be helpful to mix with others - experience "other ways of doing things".

3. **Social/Leisure activities**

Q. Are you able to enjoy a social life? Are you able to keep up with your friends at home?
R. Feels supported by friends (has 'outside' friends), and the set. The set is "O.K., but it has its own sub groups". Respondent lives out - in a large flat, which is very expensive shares with a relative.
Travel sometimes a problem - takes time. Difficult to meet with friends "outside study sessions", meets only occasionally.
Belongs to professional organisation - not active.
Asked what causes him concerns or stress, respondent replied that it is "being condescended to being talked down to" by people, particularly staff nurses. Treated as if he doesn't know anything by staff particularly in clinical areas.

Q. Anything else you would like to share?
R. No - stated it was nice to talk and share things.

-------- names omitted.
TRANSCRIPT OF SECOND QUESTIONNAIRE - FEMALE RESPONDENT

Thank you very much for all your help
Please answer the following questions in the space provided

A. Why did you wish to become a Nurse?

To make a complete break away from my 'career' -------
where I felt I was at a 'dead end' with my work being
unappreciated and generally unnoticed until something went
wrong.

I wanted to move into a sphere where I could gain more
contact with the general public and use 'caring' skills that I
know I possessed but that remained stagnant.

B. What do you understand by Nursing?

A two way process where each party can work together
and both gain from the experience.

A way in which I can help people understand and overcome
problems at that time and to help in any way possible.

C. What do you understand by the role of the Nurse?

To be a friend and organiser for his/her patient or
friend in the community to give advice, help and support
to overcome, come to terms with crises in their lives
at a time when they feel they may be at their lowest
ebb.
D. Where do you see yourself one year after qualifying?

I would like to remain in ---------- area as that is where my roots are, the area I like and know best.

Professionally I would like to be working as a staff nurse on the accident and emergency unit or Paediatric unit at ----------.

Very many thanks. The responses are confidential.

Good Luck in the Future.
Interview With A Female Respondent As A Staff Nurse

Q. Will you talk with me about your role as staff nurse, and the aspects you most and least enjoy?
R. The aspects I most enjoy is the involvement with junior students, and their teaching. I've enjoyed this throughout my training. The area I least enjoy is being the only qualified nurse on duty. I feel stressed about the responsibility - I've got to get things done. I'm afraid of not being able to cope; I think it might go wrong.

Q. Do you have a supportive senior nurse?
R. Yes, but er - the stress of responsibility really, it sometimes gets me down. He is very supportive, and has a good relationship with staff. Not that things have gone wrong, it's the thought that it might; but I know there is always someone there if I need them. When I was a student nurse, I didn't want to be a staff nurse, I wanted to remain as a student; but now I really enjoy it. Most aspects I really enjoy, and now I like the role and work. Often people say there is no hands on nursing but I get hands on nursing and management, as the ward is relatively well staffed, so it's a good mixture.

Q. How would you describe the role of staff nurse?
R. I think - one thing jumps to mind, is manager of the ward, not always as D Grade, although there is experience on night duty. Initially you are learning as D Grade, coming to terms with what it's like, with a different colour dress - and, er -- and being, how can I say, instead of you going up to someone, it's someone coming up to you, and you think O my God.

APPENDIX 12

TRANSCRIPT OF INTERVIEW (TAPED)
Q. Do you enjoy that?
R. Yes I do. I enjoy sharing my knowledge base and how it's increased with other members of staff since being a staff nurse.

Q. You mentioned teaching earlier?
R. Yes, I've always enjoyed teaching, not enough goes on - I've tried to be involved myself. Other staff are not as forthcoming. All teach the juniors; but they don't realise it. Teaching is not so much sitting down but working alongside them and they observe and learn. I think we could develop a teaching programme on the ward - we haven't done as much as we should.

Q. Do you have much contact with the link tutor?
R. Er - Yes, she has been around, for a ward audit recently. It could be developed more, if you know what I mean. She could sit down and discuss with all the staff, and ask what we thought - not just with sister - and ask our opinions. We are all involved, and we may be only juniors; but we work just as hard as seniors, and have as much right to want things as the more senior. The tutor could be there more. A couple of weeks ago, she said she would be there for a shift, maybe to work alongside learners, but it doesn't happen often enough. The tutor could involve herself practically. The role is supportive, and is the link with school, but unless you are doing a course, the link gets less. We are going to start P2000, and none of us know what is going on, like I know she could share, and relay more information.
One fear I have as a staff nurse, the students may find me unapproachable, I'm wearing a purple dress. I like to think I'm approachable, even though I won't go overboard to dispel these fears. I don't appear to be sitting on my bottom all day in the office drinking numerous cups of coffee. Students do view staff nurses like this, I know I used to. I know you can't be liked by everybody - only human nature. Um - I remember when I was first qualified, I was hesitant to communicate with sister, especially on a personal level. Talking only about ward things is easy to do. She is authority, and I was brought up to respect authority. Now I have become more confident, as role is changing and I'm more senior, can relate professionally and socially with senior members of staff, and sister. It was in my appraisal that I was hesitant to communicate with more senior.

Q. Is it better now?
R. Yes, I know I'm more confident. It's not that I will do that, I'm more questioning now if it doesn't sound right. Have confidence and knowledge base to say I don't agree with that, and what about this? Even though I'm a staff nurse, the doctors - they don't always respect my ideas. I experienced it recently. The doctor's actual words were "staff nurse without a brain"; but most of them are very nice, and we get on quite well.

Q. Do you have auxiliaries on the team?
R. Yes, an auxiliary, she's been there years, is very nice and supportive, and an excellent worker. But in the future, we'll have more auxiliaries, won't we? Um- one thing I have noted since being a staff nurse, patients will still seek out students if they have some sort of personal problem, and initially this hurt me at first. I remember, if as
a student I admitted patients, they related to you, not the staff nurse. It's still the same, they relate to students. We had a patient, with us a long time, and even though I wasn't doing anything, he asked student to get a bottle. As though it was a task beyond me - [Laugh] I found it quite hurtful really. Hopefully my attitude hasn't changed towards patients. Hm, I'm an easy going person, hopefully have good relationships with others, with students and other members of the team.

Q. Do you have any men on the staff?
R. We have a male staff nurse, the first one on this ward. He's very nice, easy to work with.

Q. Not treated differently?
R. No, not really. He has an easy going manner. Only thing that annoys me - a horrible thing to say - [Laugh] find him very sexist, and untidy, but I tell him. We have had some male students, a little bit older than average student, and have noticed a difference in the way they were received - so's to speak. The senior staff had more respect for them. Um - so may be they were a little different. The way they projected themselves came across as more mature.

Q. What about your future?
R. Funny you ask that question, I'm thinking of moving on quite soon. Not so much for professional reasons, for these reasons there is more happening in --- . More for personal reasons, buying property. There's no way myself and partner can buy here, it's cheaper out of ---- . I've been engaged a year, but not thinking of marriage yet.
Q. Is he in nursing or medical professional?
R. No, he is a ---- . We are moving for personal reasons, rather than professional. What want to do professionally is here. We have planned a move to ---, not too far away, and we have friends there. I have applied to hospitals, in this speciality, and am waiting for replies, until I decide what to do.

Q. Do you have much time for leisure?
R. Sleeping [Laugh]. I had a sewing machine for Christmas, and am getting into dress making. I find my leisure time has changed, since I've known my boyfriend. Tend to do things together. Um - yes - keep in touch with some members of the set. Two of my closest friends live in ---, one lives near. One recently moved to work at ----. I still see them. --- is living near, and its her birthday, and wel will be getting together on Saturday. Yes - I do keep in touch.

Q. Has participating in this activity with me influenced you in any way?
R. No - I've enjoyed it actually, its enabled me to question my changing attitudes to nursing. If it has influenced me, it is in a positive way, nothing detrimental.

Q. It has been put to me, people may give answers they feel I may want --- ?
R. I've tried to be as honest as I possibly can, there is no point - not going to do you or myself any good. Trouble is [Laugh] I can't remember answers I've given before. In this sort of study, there is no right or wrong answer really, is there - just personal views and how they change really, over four years.
Q. Have you been involved in any ongoing education activities?
R. Um - outside nursing, no. The staff nurse development course, so far, has good points and bad points. It also gives a break from ward, and this is needed [Laugh]. Need to continue education anyway, and I used to love coming into school, and it keeps the link up. The choice of subjects has been a bid "iffy" [Laugh]. Yesterday, we had a session on mentorship, and a learner tutor was excellent, and er, taught us lots of things about mentors and assessors. It was very good, we needed that input, we are all a bit sketchy on the subject. In the afternoon, we had a chap on self awareness um - didn't relate, we could all see what he was getting at, but it went over our heads. He was RMN, and aimed it above our heads. So, some subjects have been very good, some have not been related.

Q. Were you treated differently in school?
R. [Laugh] - that is what we were asked yesterday we all answered yes. On one or two occasions during training, the set was treated rather - can't think of a word - like school children. We covered adult learning yesterday, it was quite good, the subject came up then.

Q. Do you think sometimes people are treated that way because they may behave like schoolchildren?
R. Yes - we also discussed that yesterday as well. Yes, that's right. Some students coming into nursing now, for some reason they are different, different to what we were, some of them, I don't know, their attitudes to learning are very different to what ours were. As if they are not so serious about it - very sort of blase attitude.
Q. Are you able to keep up with reading, with journals?
R. Nursing Time [Laugh] about my limit. Did research as part of Staff Nurse Development programme, and feel rather guilty. I can see importance of it to nursing, and going into it in detail.

Q. Are research findings used in the ward?
R. One thing springs to mind at the moment, being a surgical ward, we have a pre-op assessment clinic, and its just been evaluated by a staff nurse who runs it, for one of the consultants. At the moment - in the past yes - no nursing research findings are used.

Q. Looking back, anything you would have liked to see modified, or changed in your training?
R. I think preparation for staff nurse should start early, and be ongoing. The role of staff nurse starts soon after the exam, and is intense. Need non nursing things to come across, like ordering. I don't know, nothing else springs to mind - er, sometimes as student, you were flung in to deep end in clinical areas. Need more support in the wards. Looking back, it didn't do us any harm, but at the time it was very stressful, a bit nailbiting, a bit frightening [Laugh]. I enjoyed my training, I'm glad I did it now, all those changes coming in. I'm very unsure what the training is going to be like in the future. I'm glad I did it when I did.

Q. Is there anything else you would like to share?
R. No, I don't think so.

End. Thank you very much indeed for sharing with me.

- names omitted.
TRANSCRIPT OF INTERVIEW (TAPED)

Last interview with a Personal Tutor to the cohort.

Q. Will you share your views about the set, compared to other sets you have been involved with?
R. As a set, I don't believe there was any real difference between this and other sets. Some came with quite high ideals about nursing, others with no idea about nursing and what they were letting themselves in for. So - from that point of view - no; but perhaps because they were smaller they were different, therefore they tended to become more cohesive faster, and there was an element of being er - some older ones among them tended to help them to be more mature and thinking in their attitudes etc. They were, in fact, a pleasure to teach, but that, I think, may have been because of their smallness as a group, which helped them to get to know one another, and to know us.

Q. As a set, were they more demanding?
R. Er - not particularly, but only perhaps in light of the fact that at one point they saw themselves as special, being used in a study. Occasionally it surfaced, but I don't think they used it. Every so often, they might say we are seeing -----------, but this did not hinder them in any way, or in any respect.

Q. You will remember a number left the set, seven in all. Did you feel this affected the set at all?
R. Only the groups within the group - er - I can't remember who it was - one of mine left. The tutor group became a more distinctive group. Whoever left, it didn't upset this group, they didn't
become dismayed, distraught that a member of that group had left.

Q. It was - who left, I think.
R. Yes --- that's right.

Q. Did they achieve as much as other sets?
R. That's quite interesting, because I think the best way to compare them is to a set who entered the same time last year. Past experience tells me that groups have different achievement levels depending on what time of the year they come in. I think this set achieved similarly to a group of a similar size, and given maturity, and similar academic achievements prior to entry to the course.

Q. Did the students from this set share personal problems with you?
R. Some of them, yes - they saw the role of personal tutor not just from the academic side, but as someone who could see things from a different light. But not many of them, they seemed to cope with their own problems ---

Q. Different from other groups?
R. Not really - no - about the same.

Q. Did you go out socially with the students?
R. No, I didn't. They did ask us at one time, I think all of us; but I couldn't go. I think they would have included us - I don't think they saw us as figure heads, as the teachers removed from them. In some measure I think they saw us as helping hands, as someone to meet on an ordinary level.
Q. You said you viewed them as a cohesive group - was this just because it was a small group?
R. Er -- I suppose overall - no, some groups are not particularly cohesive. When I think of another set, it was a big group, but they were a united group like this one was.

Q. Were there many you had concerns about, academically or clinically?
R. No, only one, she worked like a trojan, and was devasted when she was referred in an assessment. Another was a bid slow in developing, unsure of her own ability; but on the other hand, she knew it and could cope. Mine were OK in the clinical, and once they were over the first ward, had no problems. No one I was really concerned about in the wards.

Q. Do you think men and women are treated the same in the school, and in the clinical areas?
R. Well - I think - yes - differently, but I think this is partly because of our own socialization. There is no doubt about it, men are treated differently, not intentionally. Somehow or other it does influence the way they are treated, whether they are in the classroom, or clinical or even at the bus stop. This may be not so bad in up and coming generations, but those of us who are older, because of the socialization process there is a tendency ---.

Q. Treated more advantageously?
R. May be - yes - probably a little more, a tendency to think their judgement is the rightway to go or to think about things. Again, I'm sure its because of the socialization process - leads then to believe they are better, more able or whatever. Consequently, it effects how we react with them. Er - I know in the clinical areas they feel very
much, or rather, the girls feel very much the men are better treated [laugh] for want of a better way to put it. I can see it could be more of a problem there, than in a classroom.

Q. Do you think they were prepared adequately for their roles as staff nurses?

R. Well - not only them, it goes for a lot of them. I think they were not particularly well prepared, it's largely due to the constraints of the situation, whether its clinical or whether its theoretical - it also depends on them as individuals ---

Q. What would you change, or develop further?

R. In some respects, we don't want to go backwards, butremembering when we had the clinical assessments in four parts they all had to do management as part of their practical experience. At least, they had to identify a management situation, and were given opportunities. At least the clinical staff, the trained staff saw their need that so students coming up to registration they needed and were getting managerial experience. In the system now, it tends to get rather lost, and unless they are all aware of what their role will entail, or what they should be looking for, and unless they are assertive in asking, the management tends to get lost. I can think of - who would be diffident in asking, although she has blossomed in the last six months --

Q. - so it's management experience?

R. Yes, I think that is where we fall down, to a large extent. I know they are supposed to be supervised at Grade D - the real fact is they are thrown into the role, before they are ready for it.
Q. In practice, are the roles of Grades D and E different?
R. Again, reflecting on what happens, some trained staff see them as staff nurses, not recognise the difference, and that's not right. They can act as Grade D, act as E, without proper back up.

Q. Did you see any of the set in the clinical areas?
R. Not a lot - but from time to time, particularly when they were in ward. It was difficult, because they were in a group with other students. I saw them once or twice in ward when team nursing was set up, which gave them a bit more experience of management and decision making. This helped some to develop, but on the whole, I didn't see enough of them - to er - know if they were doing all right. You really needed to be with them on a shift.

Q. Is there anything you would change in the school - if you could wave a wand?
R. Change for their benefit [Laugh] yes, need more preparation for leadership, and their own responsibilities for learning. I know we try to start from day one, but somehow or other they don't all manage to pick it up. It is so necessary they have responsibility for their own learning. They need leadership skills; no sooner they leave one area, another group follows them and look up to them. Later, nearer the end, maybe they could work in tandem with staff nurses, having some theoretical input. This might help prepare them more for management issues, and leading a team. They find it daunting - I know we all did - to wear a mauve dress.
Q. Do the nurses keep contact with you?
R. No, I bump into them occasionally. The need might arise, when they will ring for career advice or for references. Some are self sufficient, the others know I'm not far removed.

Q. Is there anything else you would like to share?
R. I enjoyed them as a group, they seemed mature from day one. There was no apparent differences between them when I taught them. I didn't have any problems, they knew the tutors quite well, and were freer in sessions, more than a group who didn't know you. It might be because they were also smaller in size, and knew you better because they were smaller in size.

End. Thank you very much indeed for sharing with me.

- names omitted.
TRANSCRIPT OF INTERVIEW (TAPED)

Interview with a senior sister. Approximately 8 months following completion of the cohorts training.

Q. Will you talk with me about your role as a ward sister?
R. I'm pleased to do so. I've been here about 4 years. The change from the senior staff nurse role to sister was quite difficult at the beginning. My role is to maintain high standards of care for patients, and to supervise staff nurses and students. A large part of the role is teaching the staff nurses and students, and the appraisal of staff nurses. We all have to have very good communication skills, and liaise with the multidisciplinary team. It is a very closely knit team here, because it is - . On the rounds, all the multidisciplinary team is involved, plus the students and staff nurses, at all stages. I have to ensure the ward runs smoothly, that we keep within budget, and the ordering is up to date. It isn't just nursing, I have to think about everyone, the domestics and ward clerks, to see that they are happy, and they know what they have to do. It is important to welcome people, and have an 'approachable' atmosphere - it is part of the role.

Q. You are the senior sister, does that mean you have a junior sister?
R. Yes, she has only been here since May, I thought it might have been difficult; but it has been good, and worked out well. She has done a - course, and it is nice to see the junior sister develop in the role. She did appraisals and interviews with me. We'd come unstuck if we didn't get on. We have
different management styles, but complement each other and get on well.

Q. Is there a difference between the roles?
R. Yes - usually the senior does more ward management, the junior more clinical management; but not at the moment as she is still quite junior, hasn't done the off duty. Eventually, she'll go towards a G Grade. I manage the ward as a whole, she is beginning to think about it. She is learning, and I am helping to develop her skills in management. The staff nurses and patients appreciate it.

Q. How do you develop the staff nurse?
R. It starts with the interview, and I ask how they wish to develop, and give them support. They have a period of orientation, and they do what they want - they can't go straight in. They also have objectives, and appraisals every three months; they have individual objectives. They usually work with someone else who is qualified, then work by themselves at times. This good - they need to know what they have learned and that they are able to work by themselves. They need time to go through their worries and anxieties. They work with a mentor, on here, a higher Grade staff nurse, who gives time to let them get used to the role, and does the appraisals. I usually sit in on the interviews to give support. We go through -, and make sure the staff nurses have study days. After three months, they do more teaching on a more structured basis, they go into the teaching programme, and do BARS, and do a project on the ward. One did one on budgetting, one wants to look into primary nursing and is going to research that.
Q. How do you make decisions - about the philosophy of care for example?
R. I make decisions by talking with everyone. The philosophy of care was not just one person. I discuss things with the whole ward team.

Q. How do the doctors treat sisters, differently from staff nurses?
R. Yes, I think they do treat sisters differently, they talk with the sisters more than with staff nurses or students. It's a shame, I don't know why they do it. We have team nursing, and it is up to us to say so - that the patient is being looked after by a student or staff nurse. On ward rounds, we do try to involve the students and staff nurses. They do treat sisters as professionals, I have done - and - courses, and they recognise my experience and treat me as an equal.

Q. Do you have any male staff nurses, or male students on your staff?
R. We have had male students - yes. We have a male staff nurse, the first one, on orientation this week, I'm delighted. I think the only problem on here, the ladies do not like men washing them; but I haven't come across anything else. Each person is an individual, and I treat everyone the same.

Q. How do you organise nursing?
R. We have team nursing, and it works well now. A staff nurse stays at each end for one month, then they cross over. We are thinking about primary nursing, and - a staff nurse is going up the road to research it. It may be right to look elsewhere, out to other hospitals to see what other places are doing - has been on study days, and is very interested.
Q. Are you able to utilise research findings?
R. Yes, I do so for practical things, for example eusol and dressings, bowls upside down. The Nursing Times is used regularly, particularly for students, and Senior Nurse is used. More are doing the diploma, and they look up relevant research. They sometimes go to the RCN to look things up and find out - it's been good.

Q. Do you see or meet with tutors at all?
R. Yes -, he is here to facilitate anything I want. He will teach students, find things out for me, and do teaching sessions for staff nurses. He will see individual students and staff nurses. Don't want him around your neck all the time [laugh], he is there if we want him, and the students know where he is and can contact him. He is supportive to the ward.

Q. Do you go out together socially as a team?
R. Yes, we go out, including the students. It is good to get out, wear different clothes, get away from the hierarchical system.

Q. Do you have any problems with discipline?
R. [Laugh] If you had asked me four years ago, I would have answered differently, now I'm more confident, everyone calls me - when we go out together, and there's no difficulties. Problems are dealt with at the time, and everyone comes to me for help, or to someone else if I'm not here. Drug errors for example, are dealt with at the time. I hate any back biting if people can't get on.

Q. Do you have auxiliaries?
R. Yes, one -. She is part of the permanent staff, and is not treated differently, she is part of the ward team and fits in. She goes out with us.
Q. Do the staff nurses have different roles in your team?

R. Yes, the D Grades do not have the management and organisation skills when they first start. They don't look at the ward needs. They don't take on extra things to do; they would get too bogged down. There is a difference, they are more anxious on the ward and need guidance. This is OK as long as you know what is wrong. The E Grade have more management skills, and have extra bits, like sort out the off duty. This would not be for D Grades, it would throw them completely. They have to gradually build up skills, learn priorities of care and planning ahead.

Q. Do you feel the students are prepared adequately?

R. Sometimes I'm a bid concerned about their lack of knowledge of anatomy and physiology when we go through bones. - is a bit specialised, it is taught in school, but it is not so big an area as other medical conditions. They say they have been taught it, but I don't know what they do with it. I pick up a femur, and they don't know what it is. It is quite important to know the normal body first, before the abnormal. The students think this is a care of the elderly ward, that's the impression I get, and that it is not so interesting as it is. Mm - there are a lot of different patients with different conditions here - it is a pleasant surprise for them. The students learn nursing in the clinical area, watching their own colleagues and staff nurses, and working with somebody. Doing it on the ward is the way they learn. They need theory to go with it, and put it into practice.
Q. It is sometimes said there is a divide between theory and practice ------
R. [Laugh] The principles are there - the principles learnt in the school, but that is a different environment from the ward. People are under different pressures, in a different environment. Ask the students what they have learned, and it's actually what they have been taught and learned in school. It is the application in the ward.

Q. Have you experienced any difficulties with students here in their first ward?
R. The first warders do not always understand what we are talking about, at handovers. Perhaps we say things too quickly. I think perhaps some foreign students do not understand so clearly or too quickly. But after a few weeks, communication is improved.

Q. How do you plan the meal breaks?
R. The students and trained staff go together. If there is only one staff nurse, she cannot leave the ward, so students go by themselves. We have an excellent support group on Mondays, the students have time to themselves, to talk together, although it's with a staff nurse who is RMN. It is time for them to express their feelings.

Q. Is there anything you would like to share with me?
R. Um - in my role it is great to see people developing, the students and staff nurses, I love it. You need knowledge and skills to help them. I am doing a diploma in nursing at the moment, then I'd like to do a degree. It has given me a whole new outlook on life, able to help students, help them to find out things. I enjoy being here, in the role I've got, doing what I do, it is really nursing. It is lovely having students, staff nurses, and the lovely patients.
I'm pleased about PREPP - it is important to have further qualifications, and to keep up to date and keep notes for the record and for CV's. It is also important to meet with people from other disciplines, then think, it's not so bad what I am doing.

End. Thank you very much indeed for your time and sharing with me.

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