A QUALITATIVE STUDY OF THE CONTINUED PROFESSIONAL LEARNING OF PROJECT 2000 DIPLOMATES

Sylvie Marshall-Lucette

Thesis presented to the University of Surrey in partial fulfilment of the requirements for the degree of Doctor of Philosophy
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This study is concerned with an understanding of the Continued Professional Learning (CPL) of Project 2000 (P2K) diplomates' from one college of nursing in England. A longitudinal case study design using qualitative methods was chosen to ascertain the extent to which the diplomates' notion and construction of professional learning evolved in the first two years of their registered practice.

A judgemental sampling technique was used to select sixteen diplomates and six lecturers who were involved in the education of these nurses. The main method used to gather data was in-depth, open-ended interviews. Relevant fieldnotes of the interviews complemented by relevant educational documentary evidence also produced useful data. An inductive analytic approach was adopted to analyse the data.

The findings highlight a philosophy of continued learning which is embedded in the aims of the P2K course. The diplomates defined professional learning as a dynamic learning process which suggests some of the ideals of professionalism and that learning on the P2K course equipped them with a fundamental framework for their professional learning once qualified.

A developmental process of the diplomates' professional learning emerged from the data. It demonstrates the manner in which these nurses attempted to make sense of what they were learning and how they were developing professionally which clearly reflected a change from the apprenticeship model of professional learning.

However, tension between P2K and the traditional notion of professional learning in nursing was evident. Most of the conflicts were found to be due to the disparity in nursing values and care philosophy which had an effect on the diplomates' learning at various points of their work role transitions. Taking a transitions' perspective in the understanding of these nurses' professional learning demonstrated that such an approach has the potential for restructuring the thinking on the education of future nurses while providing scope for their continued professional development.

A dominant and recurrent theme which emerged from the demands of the diplomates' role development was the affective domain of learning which was found embedded within the process of their CPL. Thus, the continuous peer support network which had empowered the diplomates to resolve their problems of adjustments to the staff nurse role could be of value to all nurses as well as the conceptualization of the stages of professional learning which emerged from this study.
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A study of this kind naturally owes much to a great many people.

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Dedication

To my brother Claud, my godson David and my (late) Dad, Joe,

who did not live to see the end product of this thesis.
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INTRODUCTION

My personal and professional interest in the professional development of nurses evolved as a result of conducting a previous study which examined the continuing education of a group of nurses in one Health Authority (Marshall 1989) whilst I was working as a nurse tutor in the Department of Continuing Education. At that time the importance of continuing education was clearly recognised by the statutory bodies responsible for nursing in the United Kingdom. These bodies include the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) who issued a Code of Professional Conduct (1984: 3) which stated:

"Each registered nurse, midwife or health visitor is accountable for his or her practice and in the exercise of professional accountability shall take every reasonable opportunity to maintain and improve professional knowledge and competence".

This clause clearly placed the responsibility for professional continuing education on the individual nurse practitioner. Nevertheless, there was evidence to suggest that there were many nurses who did not update their professional knowledge, formally or informally (Kershaw 1984, Chiarella 1990).

The UKCC had identified 1988 as the date after which individual nurses, upon re-registration, would need to demonstrate that they had taken the opportunity to maintain and improve their own knowledge and skills. In addition, the UKCC (1986) stated that this did not just refer to attendance at courses but that practitioners would also need to be responsible for their own professional development. The aim of this UKCC requirement was to ensure that every registered nurse maintains updated nursing knowledge and skills throughout their career.
A change of job in 1990 enabled me to return to pre-registration nurse education and in the same year I became involved in the planning of a Project 2000 (P2K) curriculum (see Chapter one, p.5) which was implemented in January of the following year at the College of Nursing where I worked. At that time preliminary evaluative research findings of the implementation of the P2K courses, which commenced in 1989, had started to appear in the nursing journals. When the opportunity to conduct a research study arose, my interest was to go beyond these studies on implementing the P2K courses and address the educational effects of P2K at post-registration. Thus, my decision was a natural one and evolved from an on-going personal and professional interest in the nature of continuing professional education (CPE) for nurses. Little was known about this new subject area. I felt that it was appropriate to seek some understanding of the continuing education of these P2K nurses whose Diploma in Higher Education nursing course had a very different focus and philosophy from that of their traditional nursing colleagues.

It soon became clear that continuing education was a rather broad topic which necessitated a more refined orientation. An initial perusal of the literature on CPE revealed that little had been written about the learning process and pattern of British nurses from the time they qualified. Such an observation confirmed the appropriateness for this research to focus on the issue of P2K diplomates' continued learning within the context of their CPE. Although at the time it was very tempting to do a comparative study of P2K diplomates and the traditionally trained nurses, in view of the major changes which were taking place in nurse education it was felt that it would be beneficial to focus only on the P2K nurses. Subsequently, the formulation of a more precise set of research questions was elicited from my personal experiences of teaching on the pre-registration P2K nursing course at a time when the impact and intended outcome of the course had just begun to be studied.
This study is therefore concerned with an understanding of the continued professional learning of Project 2000 nurses from one college of nursing. Once the aim of the study was established and became clearer, I felt that it was necessary to define areas of focus due to the time constraint within which I had to complete the study and the multifaceted nature of my subject area of interest. Thus, in order to set some boundaries for the study, I identified five objectives which I considered were appropriate and realistic to achieve during the two years I had anticipated to collect the data:

* to examine the extent to which the diploma P2K course equips nurses for continued professional learning
* to ascertain to what extent nurse educators contribute to the post-registration professional learning of P2K nurses
* to examine the perception and commitment of P2K nurses to continued professional learning once qualified
* to explore the nature of P2K nurses' professional learning during the first two years of registered practice
* to identify the way in which P2K nurses plan and organise their professional learning

The structure of the thesis

The aim of this section is to present a synopsis of the various sections of this thesis which comprises an introductory section and nine chapters. The thesis thus begins with an introduction of the research topic and justification of the study. This section also includes a biographical background to the study as well as the overall purpose of the research and selected objectives as stated above.

Chapter one discusses the research in the context of nurse education from a
developmental perspective to its current context at the time of the study. It also emphasises the emergence of the P2K course and the Continuing Professional Education of nurses in the UK. Chapter two initially reviews some of the relevant literature related to the CPE of nurses, then the pertinent theoretical perspectives and relevant concepts which emerged from the data during data collection and analysis.

In chapter three the research design and methodology chosen for this study are discussed in detail. This provides an audit trail (Lincoln & Guba 1985) of the methods and the sequencing of the study which can be followed through several sub-sections with details of each step involved. These include a discussion on the research approach used, the strategies and procedures of data collection, the sampling technique employed, theoretical and ethical considerations and a description of the process adopted to organize and analyse the data. Chapter four presents examples of how the data collected for the study were analyzed systematically.

Chapter five, six and seven offer a comprehensive descriptive account of the main findings from the different perspectives of professional learning in nursing whereas Chapter eight discusses the emergent key findings presented in the three previous chapters. Chapter nine draws conclusions on the research findings and links them with appropriate implications and recommendations for nursing education and further studies. Finally, the concluding sections include reflections on the research. A critical stance was felt appropriate here in order to demonstrate the way in which the research could be illuminated from another angle. It also points to some of the limitations which were not made explicit in the body of the research. This approach demonstrates personal and professional insights gained as a researcher through undertaking this qualitative study.
CHAPTER 1: THE RESEARCH CONTEXT

1.1 Introduction

This chapter consists of two parts. It firstly examines the context for change within nurse education by a discussion of the historical perspectives and the cultural position of P2K. It is felt important for the understanding of the professional learning of a group of P2K nurses and their shared experiences to give an overview of the College of Nursing within which the participants of this research were educated. This section is followed by a discussion of the way the P2K course was interpreted, implemented and organised for these nurses at the time of the study including the teaching and learning strategies specific to their college of nursing. An account of the participants’ workplace where professional learning took place during their two years of registered practice concludes the first section.

The second part of the chapter addresses Continuing Professional Education (CPE) in nursing since the focus of the research is on post-registration learning. The discussion therefore includes the development and nature of CPE for nurses in the UK and how it is defined within the context of Continuing Professional Development (CPD). Then a discussion on post-registration education and practice (PREP) in nursing concludes this chapter.

1.2 Changes in nurse education: The development of Project 2000

The launch of a major reform in the education of nurses was a significant event for nursing in 1989 with the advent of the Project 2000 nursing course. There had been discussions for many years about how nurses were being trained and the many difficulties that were associated with the way the training had evolved. A succession of reports which recommended change
appeared from the Wood Report (1947), followed by, amongst others, the Platt Report (1964), the Briggs Report (DHSS1972) and finally the Judge Report (1985). Some of these changes could be found in the late 1960s when new nursing courses began to develop within a few Schools of Nursing in conjunction with Universities for selective entrants of above average educational attainment levels. These were degree-linked nursing courses which led to a non-nursing university degree and a nursing qualification. In 1973 MacGuire and Jackson reported that the expansion of such courses began in 1968/69 and were being approved by the then General Nursing Council for England and Wales. These authors also stated that nurses had been graduating from the University of Edinburgh since 1965. There were also a few other universities offering degrees in nursing to undergraduates. Thus the first degrees in nursing (Bachelor of Nursing) in the United Kingdom were officially awarded in 1969 by the University of Manchester (MacGuire 1970).

However, the Briggs Report (DHSS1972) provided the momentum for eventual change for all nurses with the forming of the Nurses, Midwives and Health Visiting Act in 1979. This created the United Kingdom Central Council (UKCC) and the four National Boards for England, Northern Ireland, Scotland and Wales. The UKCC addressed the difficulties within nurse training as one of their first tasks, since the Council's principal duty is to improve standards of education and training, practice and conduct in the public interest (UKCC 1994).

Several developments highlighted the need for a reformed nursing education. The Royal College of Nursing (RCN), and the profession in general, had recognised that the existing educational system was not the best arrangement to produce nurses who are adaptable and equipped to help meet the health needs of a rapidly changing society, in the 1990s and
Beyond. Thus in 1986 the UKCC launched Project 2000 (P2K). According to the RCN (1994), the UKCC summarised the case for educational change for nurses under the following headings:

- a system of education geared to meet future healthcare needs
- a group of professionals able and willing to adapt rapidly to change
- a better relationship between education and service
- a simpler overall pattern of preparation, whilst maintaining and improving standards
- a greater degree of professional unity and constructive participation in health policy.

Major changes in the health care needs of the population include the greater proportion of elderly people than ever before which has created an increasing demand for different health care services. At the same time, there has been a decline in the number of eighteen year olds who would have been suitably qualified and available to take up nursing as a career (Conroy and Stidston 1988) and efforts to recruit this age group had become increasingly competitive with other professions. Coupled with these changing demographic patterns were fundamental revisions and developments in health care services which meant that nurses would require different skills. These include a greater awareness and emphasis in health education and health promotion due to the on-going shift of health care provision into the community as outlined in the white papers, Working for Patients (DOH 1989a) and Caring for People: Community Care in the Next Decade and Beyond (DOH, 1989b). Consequently, shorter patients' stays in hospitals increased the amount and intensity of care required within the community setting. Changes within the management of the National Health Service has also brought greater financial accountability amongst other things, changing previous roles and ways of working within Area Health Authorities. This has
involved the development of directly managed Health Authorities and fund holding at a local level within the NHS Trusts which have been identified as providers of healthcare services.

Subsequently, such rapidly advancing organizational, social policy and legislative changes in society's health and welfare needs and in the British National Health Service necessitated a positive and imaginative response from the nursing profession in order to ensure the provision of appropriate nursing care (UKCC 1990). Furthermore, those responsible for the education and training of nurses - the UKCC and the National Boards - took the view that a radical revision of the entire programme of nursing education was necessary to ensure the continued provision of satisfactory care. Consequently, in 1988 the Government accepted and supported the UKCC’s proposals for the reform of basic nurse education and the first reformed nursing curriculum was implemented in 1989.

The major changes within these proposals involved:

- a three year period of education consisting of an eighteen month common foundation period for all branches of nursing followed by specialisation in a chosen branch of nursing
- a move from salaried to student status with students being supported by a non-means tested bursary
- courses taking place in colleges of nursing with established links with institutes of higher education
- nurses being educated to diploma standards and to be awarded a Diploma in Higher Education: Nursing Studies, since the previous nursing certificate had no academic recognition
- the discontinuation of the two year enrolled nursing course, thus having only one level of qualified nurses. Traditionally in the U.K. nurses could undertake a two year second level enrolled nursing or a three year first
level registered nursing course depending on their educational background

- the preparation of practitioners to work in both institutional and community settings
- moving the curriculum from a disease and dysfunction model of care to a health perspective and normal functioning.

These changes had major implications for the NHS management. There were concerns most markedly about training cost and the appropriateness of the academic qualifications of P2K nurses within the workforce. The main factors which influenced these debates included the reduction in the student labour which necessitated the recruitment of replacement staff and the gradual cessation of enrolled nurse training which was felt would not be compensated by an increase in first-level student nurses. Additionally, the emphasis on the academic-based curriculum was feared to be a mismatch between the supply of these newly qualified nurses and the workforce demands. These were increasingly focused on practice-based skills in the light of demographic trends, discussed above. Furthermore, the acute areas were also more demanding in terms of additional knowledge and specialist nursing skills. These concerns were accordingly addressed by the development of joint management between healthcare sectors and higher education, continued NHS control of student numbers and funding as well as NHS managers' involvement in academic validation processes.

Hence, it appears that whilst higher education was attempting to respond to employers' demands (DES 1987) with a move towards introducing more practice-based skills to balance theory, the trend in nurse education was going in the opposite direction with a more theoretical approach associated with rising professional status. Nevertheless, in the nurses' pursuit for occupational status and autonomy, Atkinsanya (1990) considered that the developments in nurse education were being placed where they should rightfully be, by which he meant in the mainstream of higher education. He
further argued that a mere establishment of links with higher education, as was initially alluded by the P2K proposal, was not sufficient for nurses to acquire educational experiences and qualifications comparable with other health professionals. However, upon successful completion of the course, all P2K nurses receive a nationally accredited higher education Diploma as well as a professional qualification. Such national academic recognition of nursing education outside the profession has long been sought and the status of nurses was enhanced by this joint academic and professional validation of nursing courses.

The practice of nursing and the way it is learned is clearly central to the P2K reforms. Students' practice placements are organised with an emphasis on learning rather than on the provision of a service to patients. Traditionally, nurse training had consisted of up to sixty per cent of rostered working time in clinical settings as opposed to the twenty per cent as recommended by the ENB (1986) for P2K student nurses. This was an attempt to move away from the previous apprenticeship model of nurse training. The RCN (1994) maintained that this student status for P2K student nurses was designed to give them more time to learn and to enable them to develop higher levels of analytical competence. Additionally, it was anticipated that such a status would help to develop knowledgeable nurses capable of working in both institutional and community settings.

Thus, it was inevitable that the educational relationship which had been forged with both higher education and those managers involved in a restructured health service had professional and financial consequences. It also led to the reorganisation of nursing curricula which involved the re-organisation of nursing knowledge. P2K educational programmes were therefore conceptualised and organised differently from the traditional courses.
1.3 The college and its interpretation and implementation of P2K

The College of Nursing and Midwifery where the participants in this study undertook their P2K course was formed in 1989 as a result of the amalgamation of two Schools of Nursing with a nearby College of Higher Education. It was made up of three faculties: Pre-registration, Midwifery and Post-registration. This was an interim arrangement to help academic staff familiarize themselves with the Higher Education structure. The P2K diploma course was taught in the Pre-registration Faculty of Healthcare Studies which had a population of about 750 pre-registration students. The Health Authorities which the College served are mostly densely populated metropolitan areas representing a diversity of ethnic cultures which were reflected in the student nurses and staff. The Project 2000 course commenced in January 1991 with a cohort of ninety-five students and it offered four branch programmes: Adult, Children's, Learning Disability and Mental Health nursing. The Adult and Mental Health Branch from which the participants were recruited had fifty and fifteen students respectively. The course was validated by the English National Board for Nursing, Midwifery and Health Visiting (ENB) and the Council for National Academic Awards (CNAA).

1.3.1 Course Framework

Students enrolled on a three year programme of academic and applied nursing practice. The course was designed as a continuous educational process through a Common Foundation Programme (CFP) for the first eighteen months, followed by a student-selected Branch Programme which focused on the specialist nature of nursing in either of the four nursing specialities mentioned above (Section 3). At the end of the course these nurses were registered on different parts of the UKCC register. Senior lecturers were appointed as Team Leaders and were responsible for the co-
ordination of a specific part of the course; for instance one senior lecturer was responsible for the CFP and four others for each of the Branch programmes.

The course consisted of integrated academic and clinical nursing practice programmes organised within a framework of nine units of learning: four in the CFP and five in the Branch Programmes. There were eight defined core subjects relating to nursing practice which were taught in each unit. These were: biology; interpersonal skills; nursing studies; philosophy and ethics; psychology; social policy; sociology and research awareness. All these core subjects, which were integrated with each other and related to nursing practice, were taught in each of the units. The students were expected to work a thirty-five hour week of which at least twenty hours were taught and fifteen hours were allocated for either private, self-directed, teacher-directed, guided studies or project work.

The integration of theoretical knowledge to the practice of nursing was emphasised throughout the course and learning took place in both hospital/institutional and community settings. Theory was related to practice in the first three units of the CFP by appropriate visits to the community; for example creches, housing facilities, magistrates court, play groups, schools, shops, sports centres and voluntary organisations. The rationale for such practical experience was to enable students to develop an understanding of the links between the individual, the environment, lifestyles and health. In the last of the four CFP units, the students were exposed to nursing experiences in a variety of settings and this experience was seen as a transitionary phase, acting "as a bridge between the CFP and the chosen Branch Programme" (Course Document 1990, 1:4). The more specific nursing experience took place in the Branch Programmes when students were allocated to two different Health Authorities. Nursing practice consisted of the health-related practical experiences, institutional and/or community-based practical
placements and rostered work experiences when students interacted with, and helped in, the care of patients or clients.

However, the actual work experience which enabled the students to work as part of a care team and to achieve the competencies necessary to become registered practitioner, did not take place until they were in their last two and a half units of the course. Students were encouraged to give feedback, suggestions and criticisms on their clinical placements and there was formal evaluation of both theoretical and practical learning experiences within each unit. These opportunities for student evaluation were seen as crucial in shaping the development of the programme (Course Document 1990, 1:74).

1.3.2 Curriculum design and philosophy

A "spiral curriculum model" (Beattie 1987) was designed with a continuous increase of the students' level of competence throughout the three year course. However, an emphasis on the practice of nursing was the major component of the course and a sound knowledge base in both nursing and the biological, social and behavioural sciences underpinning it. An adaptation of Benner's (1984) work was used in the development of nursing skills and competence. The intention was for the students' levels of competence to develop in their learning of clinical practice by going through the stages of knowledgeable observer to supervised participant and from supervised practitioner to competent, accountable practitioner.

it was envisaged that this curriculum design would move the students from novice to advanced beginner before they became competent practitioners when they qualified as nurses, thereafter gaining substantial nursing experience in order to become experts as advocated by Benner (1984).
1.3.3 Teaching and learning strategies

The Curriculum Document (1990, 1:13) revealed an “andragogical approach” to learning with the student progressing from dependence to independence and encouraged to reflect, review and consolidate all experiences within the student group. A major feature identified in this curriculum was the development of learning skills which was intended “to help the newly qualified practitioners continue to learn throughout their nursing career” (Ibid:11). It is thus evident that the initial preparation of nurses did not only aim to produce competent nurse practitioners. It also strived for these nurses to become self-directed learners. This meant that these nurses would be capable of analysing their nursing practice and clinical environment. It was anticipated that learning from such an analysis would help the diplomas’ nursing practice to be continuously “relevant to the health needs of the care group in the years following the end of the course” (Ibid:13). Moreover, learning was seen as continuing beyond the end of the course to enable the qualified nurse to continue to develop professionally. This dynamic process of learning was felt crucial in recognition of the intrinsic dynamic nature of nursing. The emphasis was not only on achievements at the end of the course but also on the process of learning which was aimed to reflect student-centredness, enhancement of personal growth and the promotion of independent learning.

In order to promote an educational environment conducive to learning, the lecturer was seen as working in partnership with the student, facilitating learning and offering support, encouraging discussion and reflection. There was an emphasis on respect for individual students and the notions of cooperation, collaboration and autonomy. The curriculum also stated that consideration would be given to students’ existing knowledge and experience when planning individual learning needs.

In accordance with the course philosophy of adult teaching and learning,
various interactional methods were adopted. These included debates, discussions, experiential learning, group work, roleplay and seminars, as well as guided study, project work and some formal teaching such as lectures. Students were also expected to keep a record of their learning experiences and significant clinical skills acquisition in a journal. This was seen as a way of assisting them to become aware of their strengths and areas for development thus enabling these nurses to develop self-awareness skills as well as critical and reflective skills. Whilst a proportion of learning was self-directed, students were supported by tutorials and collaborative, or shared, peer group learning was also encouraged throughout the course. However, the curriculum document clearly indicated that the responsibility for learning was entirely the students.

1.3.4 Assessment of theory and practice

Bloom et al's (1956) cognitive taxonomy and the experiential taxonomy of Steinaker and Bell (1979) were used to identify levels of knowledge and understanding. Consequently, assessment criteria were developed to determine the students' standard of performance required in their academic work and in nursing practice on completion of each unit of study and at the end of the CFP and respective Branch Programme.

Regular feedback on performance was encouraged with planned, continued learning strategies to facilitate the students' improvement of their knowledge and skills.

However, the assessment strategy was developed to reflect an integrated curriculum which ensured that theory and practice were linked throughout the course and that learning took place in both hospital and community setting as well as in the College. The assessment involved educational measurements of the students' educational progress in their achievement of knowledge, skills
and attitudes. The assessment scheme also ensured that diploma level of nursing practice was assessed alongside the UKCC's competencies (1989).

There was a programme of continuous assessments in both theory and practice, with each assessment being designed appropriate to the subject matter and unit of learning which became more complex as the course progressed. The Curriculum Document (1990) and the students' Course Handbook (1991) clearly stated that each core subject would be developed throughout the course in increasing depth and that it would relate to nursing practice so that the goal of being a competent practitioner could be achieved in accordance with the spiral curriculum design.

Besides peer and self-assessments there were formative and summative assessment methods which related to both theory and practice. Formative assessments were considered to be crucial to the students' learning process and provided feedback on their progress throughout the course whilst summative assessments were carried out at the end of each part to make judgements and decisions about awarding academic credits after the learning experience has been achieved. Summative assessments also provided information, to the College staff and the curriculum development team, on which they could base decisions about changes in the approaches or content of future programmes.

1.4 Participants' workplace

All the participants in the study secured a staff nurse post one month after they qualified in their respective branches. They were employed in two Health Authorities which were in the process of becoming newly formed NHS Trusts hospitals as a result of the NHS and Community Care Act (DOH 1990). These hospitals had contributed to these nurses' clinical education by providing practice placements and mentors to teach and supervise them and
assess their clinical competencies.

Some of the participants chose to work on the wards where they had last gained their clinical experiences as student nurses; others applied in areas of special interests whilst the rest had to accept jobs where there were vacancies for newly qualified staff nurses. However, they were all familiar with the hospitals where they were working at the time of the study and worked in a variety of healthcare settings as illustrated in Appendix A.

1.5 The development of continued professional education in nursing

Historically schools of nursing have been accused of failing to emphasise the necessity for nurses to continue to learn throughout their working lives. In the 1960s and 1970s many authors challenged the view that the skills and knowledge acquired during the basic nurse education was adequate for a lifetime of professional practice (Nuttall 1965, Bell and Rix 1979, Gelpi 1979). Hence, Schools of Nursing attempted to address this by establishing Department of Continuing Education and in the early 1970s began to offer a variety of short, clinical certificated courses for nurses which were validated by the ENB. Nevertheless, Schoen (1979) suggested that the concept of continuing learning for professional practice should be incorporated into basic nursing curricula in order to expand the use of continuing education. Consequently, there has been a growing concern for continuing education in nursing and a lot of attention continues to focus on it. Continuing professional education (CPE) is thus believed to be one of the means of ensuring that nurses maintain their competency in their nursing practice and thereby continue to provide quality patient care.

However, in the 1980s when continuing education for nurses was then at its developmental stage, findings from research into basic nurse education provided indicators for continuing education, for instance Fretwell (1980),
Orton (1981), Alexander (1984) and Lewin and Leach (1983). Authors such as Charles (1982), Armstrong-Esther (1983) and Heath (1984) also advocated the need for continuous nurse education and viewed it as a necessary tool to maintain high standards of patient care. They also recommended that continuing education should commence as soon as nurses obtained their qualification. At that time the main concern was that there was not a recognized national system of continuing education for nurses in the United Kingdom and nurses were allowed to practice without showing evidence of continuing their education. Consequently, the updating of nursing competencies was done on an ad hoc basis and there was no recognized system to monitor and meet the continued educational needs of nurses. Hence, there was clearly a lack of a formal continuing education system. Although the UKCC (1983) had stated in its Code of Professional Conduct that every individual nurse is meant to assume responsibility for their own continuing education, it did not indicate how this should be done and the extent of individual nurses' responsibility.

The need for continuing education was also viewed as essential for nursing to become a profession (Rosendhal 1974). Schoen (1979) argued that a truly professional person is committed to lifelong learning and that the need for all practicing nurses to update and expand their professional knowledge and skills throughout their careers is unquestionable.

Olson and Kartha (1983) referred to the necessity of continuing education for professional survival. Thus the purpose of continuing education for nurses can also be viewed to some extent as a contributive factor to the professionalization of nursing depending on the level of educational development.
1.5.1 Defining Continuing Professional Education

An examination of the definitions of Continuing Professional Education (CPE) revealed that it seems to be used interchangeably with the term Continuing Professional Development (CPD). For instance, the 1984 American Nurses’ Association’s (ANA) definition of CPE which was adopted by the English National Board for Nursing, Midwifery and Health Visiting (ENB) for its higher award framework defines CPE as:

"Planned educational activities intended to build upon the educational and experimental bases of the professional nurse for the enhancement of practice, education, administration, research or theory development to the end of improving the health of the public"

(Crotty and Bignell 1987:40, Perry 1995:766). Madden and Mitchell's (1993) definition of CPD is related to the maintenance and enhancement of the knowledge, expertise and competence of professionals throughout their careers, according to a plan formulated with regard to the needs of the professional, the employer, the profession and society. Both of these definitions refer to planned educational activities for the enhancement of professional practice.

Although these two definitions seem to respond adequately to the professional needs of the practitioner, their managers as well as their consumers and can be regarded to be realistic in their approach, they are strictly based on intended or anticipated learning outcomes. Furthermore, these definitions imply that the planned activities consist of attendance at courses or other formal organized learning activities. These definitions do not seem to take account of the informal or incidental type of learning which may occur at any time of a nurse's career. For instance, Houle (1984) identified those nurses who have inquiring minds and whose learning Schoen (1979) argued occurred more on an incidental basis rather than planned learning. Hence, the emphasis at the time of these definitions was on planned, structured learning activities which were lacking in nursing. An
explanation for this omission could derive from the authors' interpretation of professional practice which may imply that it is about meaningful actions which are undertaken consciously in a specific field of practice and that nurses attempt to learn from practice in order to improve it constantly and become experts accordingly (Jarvis 1992). Nevertheless, one could argue that there are also instances of intentional unstructured learning which can take place in a formal setting such as the experiential approach to learning, as advocated by Kolb (1984) and Heron (1989), which are widely used in Colleges of Nursing in the UK.

However, by contrast, Fair (1995) describes CPD as identifying and making the most of the opportunities to learn that occur every day as well as seeking out one's own opportunities. He suggested that it is then essential to integrate what is learnt with one's practice. This definition adds another dimension to the other two discussed above in that it infers the extent to which learning should take place and the nature of education throughout one's professional career. Fair's definition also emphasises the learning process involved in professional development and education which is flexible and dynamic.

Similarly, when Jarvis (1987:50) modified his definition of education to specifically accommodate continuing education, he called it “lifelong education”. Although he too refers to “planned incidents”, he also acknowledges that these “activities could occur at any time in life and are directed towards the participants' learning and understanding”. His modified definition also implies that learning which takes place through CPE should involve self-direction and motivation of nurses to keep up to date but it does not specify the level of understanding which is required for meaningful learning to take place. It could then be argued that this definition implies that full understanding is not always required or even possible in all aspects of professional learning.
activities. Moreover, Marton et al (1984) and Ramsden (1988) refer to deep and surface approaches to learning. They found that surface learning is very common among students who concentrate on memorising factual information and consequently they have poor understanding and knowledge of details. Whereas, deep learning provides greater understanding of the subject matter since it encourages a reflective association between concepts and facts and the learner is able to distinguish principles from evidence and new information from the old. It thus combines both the content and process of learning. It also implies the various level of students' competence in their learning of clinical practice as adapted in this P2K course philosophy, Benner's (1985) framework from novice to expert.

1.5.2 The nature of continuing professional education in nursing

When Hinchliff (1994:20) discussed the continuing education of nurses she also described education as a process which involves "a journey with learning occurring at every step" of one's career in nursing. She further contrasted this with a product orientated approach in which, she argued, the emphasis is on an end point which is usually a qualification. Furthermore, Mezirow (1985) maintains that the purpose and process of learning is to understand the meaning of personal experiences. Thus, from these viewpoints education involves a learning process which consists of a series of educational events, and learning includes an unspecified level of understanding. Jarvis (1992) argues that not all learning is educational. Similarly Brown (1988) purports that the provision of educational opportunities does not always warrant learning and Illich (1971) argues that learning occurs as a result of participation in a meaningful environment and it does not necessarily follow a set of instructions. This dichotomy between learning and education has also been addressed by Carpenito (1991) who insisted that in order for education to facilitate meaningful learning the individual nurse should identify that learning is required and engage in it.
These arguments have implications for the CPE of nurses. Hence, the nature of CPE in nursing entails more than just attending post-registration courses and the undertaking of further studies in order to justify an individual nurse remaining in the profession and on the UKCC nursing register. The application of learning is clearly required. It can therefore be argued that during registered practice individual nurses' learning processes lie within continuing professional education from which professional, educational and individual development can be identified (Crotty and Bignell 1987, Hughes 1990) to enhance their ability to improve nursing practice.

1.5.3 Continuing professional education and PREP

As discussed in section 5 of this chapter, the need for CPE has long been recognised in nursing. In the UK, both the Briggs report (1972) and Judge report (1985) advised that the education of nurses should be a continuing process and recommendations were made for planned strategies for professional and personal development of nurses. Subsequently, in 1995 the UKCC with its responsibility for maintaining standards for education and practice, decided to make CPE mandatory for all qualified nurses after consultation with government health departments, the national boards for nurses (ENB), professional bodies (RCN) and the profession itself. Thus, central to this post-registration education and practice, which is commonly known as PREP (UKCC 1994), is the nurses' responsibility to identify their individual learning needs and knowledge deficits.

PREP is based on the assumption that the pre-registration of nurses does not allow for all the knowledge and skills a nurse requires to practice for the rest of their professional life (UKCC 1996). Keeping up to date was seen as being essential. Hence from April 1st 1995, it became a mandatory requirement for re-registration as a nurse that individual nurses demonstrate that they had kept their knowledge and nursing skills up to date through
The minimum requirement of the UKCC, relating to professional updating, is for nurses, midwives and health visitors to undertake five days equivalent to thirty five hours of continuing professional development over three years.

The UKCC considered PREP to be a flexible approach to continuing education despite its structured systematic re-registration requirements for nurses and the need for individual nurses to maintain a personal portfolio as evidence of participation in continuous education. It also maintains that it is up to individual nurses to choose the most appropriate mode of learning for their own needs and that studies can take place in the United Kingdom or abroad. Additionally, the council does not insist on formal learning activities. It suggests that learning activities could include:

- attendance at lectures, courses and seminars
- distance learning, including the educational exercises in professional journals
- visits to other areas of practice to observe techniques and procedures
- personal research, such as undertaking a literature search in a library


Thus, in keeping with the principle of CPE, PREP is very much about the individual nurse’s responsibility to take the necessary steps to keep themselves up to date with their knowledge and nursing skills throughout their professional careers. It is expected that every nurse on the nursing register meets the UKCC’s requirements on the basis that each individual nurse practitioner is personally accountable for their practice and that they should meet these updating requirements in a way that suits their own professional practice needs. However, the true value of PREP within the context of CPE will only be achieved when it is perceived by nurses as a learning process and not just to meet the UKCC’s mandatory requirement for re-registration. This clearly suggests that the existence of a positive attitude within nurses
towards CPE is required and it also implies that it is necessary for nurses to be capable of self-directed learning as a mode of fulfilling the UKCC's mandatory requirement.

The English National Boards for nurses, midwives and health visitors within its framework for CPE (ENB 1989) and the Royal College of Nursing emphasise the professional benefits for nurses in enhancing their nursing competences. These benefits consist of nurses' ability to accumulate credits for units of learning which contribute to a recognised educational award, such as the BSc. higher award degree in nursing studies. Madden and Mitchell (1993) identified two models of continued professional development within professions in the U.K: the sanctions model and the benefits model. The sanctions model implies that sanctions, such as the licence to practice, are applied if the professional fails to undertake the required number of days or hours of study. In nursing, PREP is an example of this as imposed by the UKCC statute. On the other hand, the benefits model rewards those who take their own initiative to maintain and enhance their competence. It is therefore evident that in nursing, midwifery and health visiting there is a mixture of both models (Hinchliff 1994).

From the above discussions it is evident that as a result of PREP, CPE not only involves the updating of knowledge and skills. There is also the process in which individuals need to take the initiative for their own learning which implies a self-directed mode of learning. Clark and Dickinson (1976) distinguished between other-directed learning and self-directed learning activities which are involved in continuing education. The former type of activities consist of conventional kinds of educational programmes such as courses, workshops and study days organized and managed by other people whilst the latter involves self-planned and self-managed learning situations such as reading and use of other human and material resources for learning.
1.6 Conclusion

This chapter took into account the historical and cultural context of the research as well as the immediate environment and physical location of the nurses studied. The pre-registration perspectives set the scene for the research and provided a background for the post-registration situation which is the main focus of the study. It also highlighted the connections between the pre- and post-registration learning for the nurses involved in this study. It has further clarified the significance of the study and the manner in which it relates to the general topic of CPE.

Having established the main focus of the study and its context, this chapter leads to an examination of how this research fits within the existing body of knowledge on the CPE of nurses. Thus contextual links will be made by a review of relevant literature in chapter two.
CHAPTER 2 THE LITERATURE REVIEW

2.1 Introduction

This chapter is presented in two parts. Part one contains a prospective review of the literature relating to the broader context of Continuing Professional Education (CPE) within the context of Continuing Professional Development (CPD) of nurses. It complements the historical developmental and cultural context of CPE in nursing discussed in the previous chapter, whereas part two is a retrospective review of the literature of written continuously as a result of key concepts which emerged during the data collection and analysis. This part offers a theoretical review of the literature.

Once the research question on the Project 2000 (P2K) diplomates' professional learning had been broadly identified during the initial stage of the study, a search for relevant literature was necessary to establish the level of knowledge that existed about the CPE of nurses followed by current trends and contemporary debates. This search for the literature indicated that previous research on CPE and CPD of nurses had already answered many questions. It was evident that those previous studies had identified the outcomes and/or the process of CPD and CPE.

However no literature was found which addressed continued professional learning of P2K nurses. This was to be expected since the first nurses who undertook the P2K programme (Diploma in Higher Education - Nursing Studies) were qualified in October 1992. Nevertheless, studies of the continuing professional development and education of traditional nurses and related studies of P2K nurses which were being undertaken at the same time as this study were found helpful "to set the boundaries" (Sandelowski et al 1989:78) for this investigation.
A way of focusing the study was through the search for related theoretical literature which was useful in conceptualising the assumptions emerging from the study during the collection and analysis of the data, and this helped to develop explanations and interpretation of the findings. For example a review of the literature on the role theory in relation to the professional socialisation of the nurse provided theoretical constructs, categories and their properties that were used to explain the findings of the data on the professional learning of the diplomates.

2.2 Continuing Professional Education of nurses: A review of the literature

A preliminary review of the British literature of nurses' continuing professional education within the context of CPD showed that previous studies tended to be surveys which focused on qualified nurses' career paths, career motivation and career patterns of non-P2K nurses. Montague & Herbert (1982) investigated the career paths' development of graduates from a degree-linked course and Hardy et al (1984) did a follow-up of the nursing careers of graduates from the University of Edinburgh from 1958-1975. These studies essentially produced data about the professional development of graduate nurses. Four further related studies, which the Department of Health had commissioned the King's College Nursing Research Unit to undertake were also identified. These studies explored nurses' careers after qualification and the factors which influenced their career moves. The projects were longitudinal career surveys of: two cohorts of midwives who qualified in 1979 and 1983; registered general nurses who qualified in 1990 and 1991; nursing graduates qualifying between 1981 and 1993 and careers of registered mental nurses qualifying between 1993 and 1994 (Robinson and Marsland 1994). Self-completion questionnaires were sent to large samples of nurses ranging from 500 to 1265, to investigate a number of issues relevant to career patterns including opportunities for continuing professional education.
Lathlean et al. (1986) evaluated three post-registration development schemes over a three-year period, a project funded by the Department of Health and Social Security (DHSS). These schemes involved the professional development of newly qualified nurses and a modified action research approach was used. Data were collected by using a variety of methods which included self-completion questionnaires, semi-structured interviews and observation. Whilst specific educational needs and professional development of the newly qualified nurses were clearly identified within the schemes, it was evident from the findings that other more experienced nurses also had a need for continuing education and support. The conclusion drawn from this evaluation project also suggests that commitment to continuing education of nurses should be a shared responsibility between individual nurses and the organisation. Presumably this shared responsibility refers to the provision of opportunities by the organisation to facilitate continuing education for nurses.

The UKCC makes it clear that individual nurses are accountable for their practice, the improvement of their professional knowledge and competence and above all taking responsibility for their own learning needs (UKCC 1990, 1992). On the other hand, Hogston (1995:587) argued that “by making CPE a mandatory requirement the UKCC is placing the matter firmly onto the political agenda, ensuring that nurses’ CPE needs are not neglected by managers”.

Although the emphasis of these two arguments appear somewhat different, they nevertheless reflect a shared responsibility as suggested by Lathlean et al. (1986). Conversely, it is the responsibility of nurses to take every opportunity of CPE which is made available to them by their managers who in turn should show commitment to the continuing professional learning needs of the nurses.

Another survey funded by the DHSS in 1984, focused on the CPE opportunities available for qualified nursing staff in all clinical specialities in
England and Wales (Rogers and Lawrence 1987). It also addressed issues of identification of needs for CPE as well as nurses' perception of and participation and non-participation in CPE. The study consisted of self-completed questionnaires to gain information about the opportunities for CPE and in-depth interviews to explore the nurses' attitudes to CPE. The findings indicated a discrepancy between the expressed commitment to CPE and the extent to which that commitment was demonstrated in practice. Many of the nurses interviewed were motivated to get involved in CPE but it appeared that there was a lack of interest and support from their senior colleagues.

The literature reviewed indicated that other studies had also explored qualified nurses' participation or non-participation in CPE. In an American survey of 1,700 nurses, O'Connor (1982) found that participation was influenced by reasons related to improving professional knowledge and skills and seeking professional advancement. Evidence of compliance with authority was not surprisingly one of the identified dimensions underlying nurses' reasons for participation in CPE since requirement for CPE was already mandatory in the USA. Nonetheless, it is encouraging to note that this reason was not as strong a motivator as the search for knowledge. Houle (1980) explained this situation by claiming that some people are clearly orientated towards learning. In another American study, Urbano et al (1988) found that nurses who participated in mandatory CPE demonstrated similar patterns of motivational orientations to those who participate in educational activities on a voluntary basis. Apparently, these nurses were motivated primarily by a desire for professional advancement and competency. On the other hand, the authors also suggested that, as a result of mandatory requirement, a large number of relevant, professional educational opportunities were made available for participation in CPE. Nonetheless, these findings are encouraging for British nurses at a time of the implementation of mandatory CPE.
Further research evidence in the 1990s also demonstrated a similar focus in the studies conducted on CPE. For instance, Nugent (1990) explored the extent of nurses' awareness of the need for continuing education among a group of 100 qualified nurses in one Health Authority. The findings from the analysis of the questionnaires showed that these nurses highly valued CPE as a means to increase their competencies as professionals. Hogston (1995) addressed the impact of perceived CPE on the quality of nursing care. Eighteen registered nurses participated in this qualitative study which came to the conclusion that CPE risks being dictated by the needs of managers due to financial restrictions. It is thus argued by Hogston (1995) that professional development may depend on individual nurses' ability to gain financial support to attend courses. It would appear that there is a dissonance between the requirements of the profession and the demands and expectations of service managers which does not seem conducive to the CPE of nurses.

Nolan et al's (1995) evaluation of the Welsh National Board's Framework of continuing education for nurses involving a sample of 1255 respondents, showed that, although the need for CPE had a high profile among the nurses studied, financial considerations were also a major concern. There is also evidence from the findings that while a large number of these nurses were funding their own CPE they did not necessarily see this as a reasonable expectation. Nolan et al (1995) concluded that some form of joint responsibility would be the only way that CPE can be made available to a larger number of practitioners.

From the literature reviewed it is evident that the issue of funding is not a new phenomena. A number of other studies had identified lack of financial support as a hindering factor in the CPE of nurses. These are often expressed indirectly in terms of poor staffing levels, low priority given to CPE by managers, lack of funds, time, difficulty or inability to be released from the wards, workload pressures and limited CPE opportunities (O'Kell 1986,
Lathlean et al 1986, Rogers and Lawrence 1987, Mackereth 1989, Chiarella 1990, Nugent 1990). Barriball and While (1996), who studied the level of participation in CPE among both qualified and unqualified practitioners, also found that poor funding was a barrier to CPE. They therefore argued that while it might be reasonable to expect qualified nurses to demonstrate some level of personal commitment to their personal and professional development it might be unrealistic to expect similar commitment and personal burden from enrolled nurses, and those working part-time or on night duty. There is also evidence from these studies that commitment and collaboration from both the service and individual nurses is crucial in the development of a realistic CPE system as mandated by PREP. However, in the Nursing Times (1995) guide to PREP it seems that employers do not have a legal obligation to provide or finance CPE for nurses.

It thus became clear that despite the substantial number of related studies on the CPE of nurses, they have largely focused on the outcomes of CPE. Little attention had been paid to the process of continued professional learning of nurses once they qualified, in terms of how nurses plan, organise and continue to learn in their professional career. Moreover, none of these studies were exclusively targeted towards P2K nurses although in Nolan et al's (1995) study there was one newly qualified nurse who had undertaken the P2K course.

### 2.2.1 P2K Nurses and CPE: A review of related literature

A review of published research findings within the context of P2K between 1990 and mid-1994 (Elkan and Robinson 1995) identified nine studies which were commissioned and funded by the Department of Health. These evaluative studies highlight the difficulties and successes during the early stages of Project 2000's implementation. Much of this research concentrated on the first thirteen colleges which had been commissioned to implement the
reformed nursing programme based on the P2K principles.

Additionally, published studies from other colleges of nursing, which addressed the supervision of P2K students in the clinical setting (Twinn and Davies 1996), P2K students’ perceptions of their pre-registration education programme (Parker and Carlisle 1996) and the P2K course as a new and innovative nursing course (Holmes 1996), also appear to have adopted an evaluative stance.

Whilst various studies documenting P2K draw attention to the effect of the new course, little has been reported so far about the outcomes for the nurses themselves. However, Jasper (1996) studied the experiences of eight staff nurses during their first post-qualification year. These diplomates undertook their P2K nursing course in one of the demonstration colleges of nursing. A phenomenological approach was used in this qualitative study and data were collected by focus group interviews. It is not clear in the report at what stage of the registered practice the interviews took place and the number of interviews which were conducted. The main findings address minimal discussion of CPE in the five main themes which emerged from the analysis of the data. Nonetheless, there was some evidence that CPE had been discussed in one of the themes which describes the nurses’ perceived difference between the qualification of traditional nurses and their own. It was reported that these diplomates were able to see beyond their pre-registration course and had embarked on further studies. Thus in Jasper’s (1996) study, CPE was addressed within a formal, academic context and was expressed in terms of courses undertaken.

Another study, commissioned by the English National Board, and undertaken to examine the impact of P2K on the perception of the philosophy and practice of nursing, also addressed some issues about the diplomates’ CPE (Macleod Clark et al 1997). Eight cohorts of P2K students were involved in
this large scale three year study. A range of data collection methods was used to obtain information from participants in two case-study centres in the North and South of England. A qualitative approach was primarily employed as well as some quantitative methods in the analysis of the questionnaire data. Seventy-eight newly qualified diplomates responded to the questionnaire and a sample of twenty contributed to in-depth interviews of up to eleven months in registered practice. Focus groups interviews were also undertaken with groups of teachers, practitioners and nurse managers to elicit their perceptions of the diplomates as professional practitioners. It is not made clear in the report whether those involved in the group interviews were directly involved with the diplomates who participated in the study.

It was reported from the main findings of these diplomates' interviews that there appears to have been a commitment to CPE in their first year of registered practice which seemed to have emerged within the context of academic and professional development. In this study, these newly qualified nurses perceived nursing as a professional occupation and recognized the need to remain updated and to continue to learn for the benefit of their patients. However, the nature of this continuity to learn was not clearly discussed nor the manner in which these diplomates would update, except that they did not perceive their pre-registration education programme as an entity in its own right and they were eager to progress from their diploma to degree level education. It should be recognized here that CPE was not the focus of this study.

Unlike other studies, such as Rogers and Lawrence (1987), this study's findings showed that managers and other nurses had also recognized and acknowledged that these diplomates were committed to "lifelong learning"and were seen as change agents in the practice of nursing. But similar to previous studies of non-P2K nurses, as stated above, they too had identified lack of funding and study days as barriers to CPE. This clearly indicates
that, despite such a recognition of CPE by managers, resource implications remain a problem.

It is evident from the literature reviewed on the CPE of nurses that what seemed to be absent from all this work was a conceptualization of the dynamic nature of the nurses' continuing professional learning. An exploration of how nurses' learning experiences and orientations may change over time once qualified or according to different levels of learning they experienced seemed to be also lacking. Thus the area of interest for this study was to focus on the process by which the P2K diplomates conceptualize and engage in their professional learning activities during the first two years of their registered practice. It was felt appropriate to explore this by using a qualitative research approach.

2.3 Continuing Professional Education of nurses: a theoretical review of the literature

This second part of the literature review helped to refine and re-define the emerging research questions and related tentative propositions by embedding those questions in larger empirical traditions. The flow from concepts to tentative propositions helped to focus the research questions. This was the part of the literature review which provided some direction to the research on a continuous basis during data collection and analysis as well as the explanation, interpretation and discussion of the findings. Hence, relevant theoretical literature was explored to address issues around the development of professional learning in nursing and the impact of the P2K course that affected those nurses who were being educated in a different way.
2.3.1 **Defining Nursing: Some theoretical and philosophical perspectives**

A search of what the literature had to say about nursing was felt appropriate when it became evident during the data collection that the participants' responses were clearly embedded in nursing which they perceived to be at the centre of their professional learning during their registered practice. Nursing was expressed with a lot of emphasis on clinical practice and patient care which the participants in this study linked with nursing as a profession. It is within these dimensions that the concept of nursing is being defined here, that is, as in clinical patient care in the profession of nursing.

In the search for a definition of nursing as a concept, it was evident that there was no one sentence answer to the pertinent question of: What is nursing? It was also evident that nursing is a concept that had undergone a succession of change and modification according to the era it was being defined, the environment where it was being defined and to social values that prevailed at the time as well as the purpose it serves at a given time. Nonetheless, nursing is still a much debated concept. Thus, from an historical perspective, it was felt appropriate to start by examining Florence Nightingale's writings and her notion of nursing in nineteenth century England.

2.3.1.1 **Florence Nightingale's concept of nursing**

From Nightingale's (1859) earliest writings, "Notes on Nursing: What it is and what it is not", she seemed rather hesitant in defining nursing when she stated: "I use the word nursing for want of a better", in her opening remarks. This statement was appropriate at the time it was written since she viewed nursing in a both general health and specific nursing context. In the preface of this book, she also argued that "every woman is a nurse". In her general health view, nursing was generally carried out by women without any formal
training and who, she believed, did not know how to look after their family's health. She clarified this meaning of a nurse as a woman within a family who has "personal charge of the health of others". Within a specific nursing context Nightingale (1882b:334) referred to the practice of "nursing proper" as what was done by those women who were formally trained.

She also believed that the purpose of nursing was "to put the patient in the best condition for nature to act upon him" (Nightingale 1859:75). She made it clear that although "it has been limited to signify little more than the administration of medicines and the application of poultices", she asserted that "it ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of proper diet" (Nightingale 1859:6). It is thus explicit in her writings that individuals and their environments are both at the centre of nursing. She strongly believed that "nature alone cures" and that "nothing but (the nurse's) observation and experience will teach (them) the ways to maintain or bring back the state of health" (Nightingale 1859:74). She therefore clearly inferred that nursing involved both health and illness.

Nightingale's perception of nursing in her writings seems to have stood the test of time. Her views and ideas have stimulated a number of debates and have been explored as they relate to contemporary nursing over the years. Skeet (1980) reviewed Nightingale's thirteen hints to nursing, which at the time pointed to the main aspects of nursing care, and applied them to the science and art of twentieth century nursing. There are also further examples of Nightingale's conceptual framework of nursing which other writers have used to demonstrate its relevance to modern nursing practice, for instance Dennis and Prescott (1985) and Henry et al (1990).

However, critiques of Nightingale's writings point out that her definition of
nursing did not change much even with the introduction of the concept of health nursing (general nursing) which was an innovation at the time. Van der Peet (1995:39) argued that:

"as a matter of fact, there was no change of heart at all as the concept of health nursing exemplified the same sanitary approach as "Notes on Nursing" which had been written some 34 years earlier, except for the introduction of the professional or trained nurse as a health-missioner".

Further critiques refer to Nightingale's conceptualization of nursing which is argued to be based on her personal religious outlook on life as stated by Van der Peet (1995:78): "For her, nursing was the art and science of applying sanitary principles, discovered by means of statistics and manifesting God's law". This may be inferred as a subjective interpretation based on sanitary implications as well as religious assumptions (Welch 1986). Consequently, it is argued that Nightingale should not be seen as the founder of modern nursing. In any case, models of nursing normally offer the subjective view or views of those who construct them and are based on particular learning perspectives and experiences.

Although Van der Peet (1995:82) concluded that "as nursing builds a sound base of theory and practice, it has largely out-lived the obsolete bases of Nightingale's model of nursing", he does nonetheless recognize aspects of the Nightingale's legacy which still have relevance to modern nursing. However, it is evident that Nightingale's legacy continues to be a subject of much debate. Wheeler (1999:10) suggests that "it was time for the Florence Nightingale's myth to be debunked" and insists that the impact and interpretation of her legacy has held nursing back too long, on the grounds of "churning out robotic acolytes from her school of nursing".
2.3.1.2 Beyond Nightingale’s concept of nursing

According to Kuhn (1970), any scientific discipline adopts its own methods to address common issues or problems in the development of its particular concepts and theories. The term ‘paradigm’ has been used to describe such a perspective. There have been several attempts to identify the paradigms which inform the discipline of nursing. Marks-Maran and Rose (1997:154) succinctly explained that “paradigms are simply different ways of looking at the same thing”. However, the most commonly used “metaparadigm”, which represents a global perspective of nursing consisting of four essential concepts within nursing, is the one proposed by Fawcett (1984, 1989). She accordingly claimed that the nursing metaparadigm is made up of the person, the environment, health and nursing as its key concepts. Whilst Fawcett’s aspects of her metaparadigm for nursing have been criticized and a whole range of other concepts have been proposed and used by other nurse theorists, such as Kim (1987) and Ramos (1987) to delineate nursing, her four concepts seem to have been increasingly accepted as central to the domain of nursing.

A further review of the literature which seeks to define nursing reveals that various conceptual frameworks, models and theories of nursing take into consideration the nature of the person, their environment and health and nursing. These are defined in the conceptualization of nursing and put forward to give directions to the manner in which nursing should be interpreted with regard to its goals, its activities and its own view of the person. For instance, Peplau’s (1952) theory of interpersonal relations in nursing, Orem’s (1956) self-care deficit theory, Henderson’s (1960) and Roper’s (1976) activities of daily living, Orlando’s (1961) theory of the nursing process, Levine’s (1973) conservation model for nursing practice, Roy’s (1984) adaptation model, Neuman’s (1989) systems model, and Rogers’ (1990) science of unitary human beings.
A comparative review of these nursing theories and conceptual frameworks classified them as developmental, interactional and systems models (Riehl and Roy 1974, Fitzpatrick and Whall 1989, Fawcett 1989). Thus, they offer a perspective for nursing by identifying the focus, goal and boundaries of nursing depending upon the philosophical viewpoints of their writers. Kikuchi and Simmons (1994:18) argued that:

"much of what has been referred to as a conceptual model is, in fact, a philosophy - that is, a set of beliefs about what the basic entities of nursing are, how these entities are known, and what values should guide the discipline".

Nursing has also been defined within the confines of the concept of 'caring' as a means to understand the elements of nursing (Leininger 1988c, Watson 1988). Ideologies promoted by nursing leaders and writers as mentioned above suggest that nursing involves caring for people rather than curing diseases and pathology which are seen to be more the concern of medicine. In his attempt to identify the fundamental difference between nursing and medicine, Graham (1996) argued that diseases can also be the concern of nursing but he views nursing as being more holistic and humanistic, whereas medicine with its positivistic tradition is often more reductionist in nature. Roach (1992:41), who also used a comparative interprofessional stance, proposed that "nursing does not differ from other helping professions in that it cares, but it differs in the manner in which it cares, within prescribed roles, using a discrete body of knowledge and skill". This conceptualization of caring sometimes takes the form of adaptation nursing which is "dealing with the way that people respond to illness and to disruptions in their state of health" (Rambo 1984:41).

Additionally, Leininger (1988c) did not believe that nursing should be included in the metaparadigm of nursing as advocated by Fawcett (1984). She suggested that the concept of care should be included instead since she believed that care is the central and unifying focus of nursing firmly placed in
a transcultural context. She also viewed nursing as involving both humanistic and scientific caring (Leininger 1988d). Similarly, Watson (1988) perceived nursing as a human science within its distinctive transpersonal caring role which stresses a commitment to a holistic, humanistic nursing practice. She also argued that “nursing, as a word, is a philosophical concept that holds various meanings for people” (Watson 1988:53) and as such she viewed human care and caring as the moral ideal of nursing.

Sceptics of the nature of contemporary nursing, often known as ‘new nursing’ which according to the writings of Salvage (1992) refers to the development of nursing as part of the new professional reform movement, view the definition of nursing differently:

“It seems that nursing is now defined in terms of academic ability in such topics as sociology and research methods, what part of the patient you specialise in and what junior doctor tasks you can take on. The high flyers are making nursing, as perceived by both patients and others, unrecognisable” (Glover 1999:31).

Such an argument is based on anecdotes. Salvage (1999:22) wittingly addressed this kind of attitudes and their detrimental effects to nursing itself by pointing out the paradoxical situation of these nurses who she stated “simultaneously display an inferiority complex about their own supposed ignorance and a superiority complex about their practical skills”. Such attitudes could be due to the shift of nurse education from focusing on didactic imparting of information to that of the learner’s self-development which is required for them to continue learning and grow as a person.

Thus, nursing seems to be far from achieving congruence with the various philosophical positions which can be found within it. The literature suggests a lack of definitional clarity, dichotomies and dualistic thinking such as science or art, holistic or particular, practice or theory. Consequently, Rose
and Marks-Marxan (1997) proposed a new paradigm for nursing which moves away from viewing nursing in a dualistic, conflicting manner. They therefore argued that nursing should be reconstructed so that the connection between the opposites are not in conflict but "made of the same substance, joined together by an energy we call nursing" (Rose and Marks-Marxan 1997:162). They further demonstrated how nursing concepts could be interpreted from an 'opposite' to a 'connection' mode by giving some examples in a table which illustrates the concepts and connections of their new paradigm.

It is also evident from the literature that nursing has a dynamic interpretation which is also influenced by a range of external factors such as advanced technologies, socio-economy, and politics. In fact, Roper (1994a & b) argues that her beliefs about what constitutes nursing are not static as demonstrated by her four editions of her writings on the principles of nursing and three editions on the elements of nursing within fifteen years. However, what seems to be evident in this search for a definition of nursing is the plurality of conceptualizations of nursing whereby the basic assumptions and beliefs used to identify and define the nature of nursing are conceived in different ways.

2.3.2 The socialization of the nurse into the professional role

The concept of socialization originates from three different traditions - anthropology, psychology and sociology. Despite the different focus, theoretical and methodological perspectives adopted by each of these traditions, in their conceptualization of socialization, they have all attempted to describe some aspects of how the person develops within a given social and cultural environment. Thus, there is no single theory of socialization. Various theoretical perspectives give the concept of socialization different connotations. However, socialization is viewed as an interactional process in which individual and societal perspectives are interrelated in the acquisition of
those types of social learning which are required for the performance of a socially acceptable role (Clausen 1968, Inkeles 1968).

One of the objectives of nurse education is the socialization of nurses into their professional role. Hence, this review of the literature examines the nature of socialization from a role theory perspective which provides a mechanism for viewing socialization as a continuous and cumulative process. Role theorists have primarily focused upon adult socialization for marital, parental and occupational roles. Brim (1966:3) defined socialization from a role perspective by stating that it is "the process of learning by which persons acquire the knowledge, skills and dispositions" that enable them to participate as more or less effective members of their groups and society to which they belong. Thus, by definition socialization entails the learning of social roles and implies what is learnt is according to the role demands and expectations of a given social structure which occurs within an interactional context.

2.3.2.1 Role socialization in nursing

The body of knowledge that has focused upon the process of socialization has been role theory. It consists of two major complementary theoretical perspectives, the symbolic interaction and social structural, also known as functional, role theory. Both perspectives use the term 'role' as a basic concept but differ in their level and unit of analysis, research and theory development strategies (Hardy and Hardy 1988). Roles and role performance have been studied in the behavioural sciences from both of these perspectives.

George Mead (1934), a social philosopher and physiological psychologist is considered the originator of symbolic interaction. Mead's main interest was in the development of the human mind, the social self and the structure of society which he proposed are interdependent and emerge during the
processes of interaction. Mead argued that there is no separate self and that self only exists relative to others. The primary focus of symbolic interaction is on the self in interaction with others which involves meaning, interpretation and dynamic processes developed by individuals. Thus, the symbolic interactionist interpretation of roles and role behaviour focuses on individuals interpretations of their actions in the process of interaction (Conway 1988). In a nursing context, this process would involve individual nurses interpretation and discovery of the meaning of their role expectations and the socialization process would consist of constant modifications of their roles as situations change.

In contrast, the structural-functional perspectives, of which Parsons (1951) and Merton (1968) are major theoretical contributors, focus on society, social systems and the social structure. Social structures are seen to shape and, to a large extent, determine individual behaviour rather than the individual in relation to the environment. As a result, in the structural-functional view of society, roles are viewed as sets of behavioural expectations associated with given positions in the social structure. Thus, in nursing, the role socialization would consists of individual nurses being involved in the process of adopting and internalizing the role expectations which already exist in the system.

Neither the structuralist/functionalist nor the symbolic interactionist perspectives of role theory alone is sufficient to account for the complexity of human behaviour. However, various writings indicate that the symbolic interactionist approach to the study of human behaviour clearly has taken precedence over structural theory in the continuing attempts to explain human behaviour (Handel 1979, Stryker 1980). The humanistic perspectives of symbolic interaction together with its basic assumption of the integrity of person and environment and the meaning of events are all relevant and of particular interest to nursing. Symbolic interaction theory combines physiological, psychological and sociological aspects in its core concepts.

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Concepts such as socialization, the self, role identity, status passage are used extensively in the nursing literature. Nurse scientists have found the symbolic interaction methods useful in developing a knowledge base.

Nonetheless, Hardy and Hardy (1988) argued that Mead's notion of the self in relation to others makes it possible to connect symbolic interaction to the structural role model. Hardy and Conway (1988) suggested that role theorists are increasingly combining the symbolic interaction perspective with the structural-functional perspective of role theory to provide a theoretical knowledge base for a more in-depth analysis of phenomena. The two perspectives can therefore provide complementary insights, explanations and strategies for the study of role and role behaviour in nursing.

2.3.2.2 Professional socialization of the nurse

Professional socialization is described as the process whereby the knowledge, skills, attitudes, norms and values which characterize a profession are gradually assimilated by practitioners. The processes by which a person becomes professional are similar regardless of the specific profession. Lum (1988) argued that a profession requires not only formal education but also an informal, internalized system of standards that guide the practice of the professional role. Hence, the socialization process involves taking a heterogeneous group of students and changing them into a more homogeneous group with respect to the knowledge, skills, attitudes, values and behaviours that they will acquire as a result of socialization. Nonetheless, while the necessary knowledge which is acquired for achieving a professional status varies, the process is common for all professions.

Different theoretical perspectives give rise to different views to what it means to become a professional. The functionalist position emphasises the socialization of professional 'trainees'. According to this model, socialization
consists of transmitting a professional culture to students who are eager to learn it through role relationships with the professional teachers from whom they learn expectations of professional role. The emphasis is therefore on socialization by professional education into a professional role. Simpson (1979), who undertook a study of socialization from student to nurse, argued that such a functionalist approach fails to consider whether what students learn formally persists into their working as professionals. Thus, interactionists believe that the search for criteria of 'profession' is quite misconceived. Profession is regarded by them as a 'lay' term which some occupations claim under certain conditions.

In line with their interests in day-to-day survival during professional socialization, interactionists Becker et al (1961) and Oleson and Whittaker's (1968), in their classic studies of medical students and nursing students respectively, focused on what happens to students and not on the professional role. Oleson and Whittaker did not consider it useful to take the view that a professional is produced during professional education. They argue that it is not until the individual actually occupies the status that they can learn appropriate behaviour and that the organization of the environment after leaving professional education influences performance. Thus, while student nurses learn attitudes as well as skills and knowledge during their professional education, these are not regarded as major influencing factors on the behaviour of practitioners.

An essential feature of socialization is continuity and in this case, the continuity of behaviour between the status of student and that of professional. The functionalists do not see this as problematic since the student acquires professional culture through the educational process and so membership is assured by the acquisition of appropriate norms, values and attitudes as well as knowledge and skills. The interactionists, on the other hand, make no such assumption since behaviour in unknown future situations depends on
the interaction between the individual and what they will meet in a particular situation. Therefore, the student nurse who moves into the new status of professionally qualified nurse will behave and respond to the behaviour of others according to the way they and others perceive their roles at that time.

Merton (1957) used the term anticipatory socialization to describe elements of a role which are learnt prior to the time a person occupies a given position. This premature role learning involves the process of taking on the acceptable behaviours, attitudes, beliefs, norms and values relevant to the particular work group to which the individual wishes to belong. The process of becoming a registered nurse has been the focus of many studies of nurses (Oleson and Whittaker 1968, Conway 1983, Melia 1987, Bradby 1990a & b, Wilson and Startup 1991). Korte and Sylvester (1982) argued that anticipatory socialization is often discussed but less often demonstrated. However, in nursing, anticipatory socialization occurs when the student learns the role values compatible with the role of a practicing professional nurse. This learning process usually takes place under the supervision of a mentor during nursing practice experiences. Mentorship is seen as the strategy used to promote anticipatory socialization to the professional nurse role. Teaching staff also play a fundamental role in shaping nurses' understanding of the professional role in the classroom preparation for their clinical experience. Socialization into the professional role may therefore be either facilitated or hindered depending on the extent of congruity between the role expectations of these 'agents' of socialization (Lum 1988), such as mentors and teaching staff, and those of the students.

Studies in nursing have shown that there is a lack of unified professional role model (Gott 1982, Melia 1987, Wilson and Startup 1991) which is often due to the conflicting values and philosophies between theory and practice, education and reality of nursing practice. In their comparative study of the professional socialization process of student nurses in three nurse education
centres, Wilson and Startup (1991) interviewed and observed the students as well as the teaching staff and charge nurses responsible for their education. From the analysis of their data they concluded that student nurses do not undergo a homogeneous and integrated professional socialization process. Such dichotomy in values and philosophy, and incongruity between the nurse role concept and the reality of the role, raises issues about whether nursing students’ learning experiences actually promote anticipatory socialization to their professional role.

Melia (1987) emphasised that students are socialised throughout their experiences of working as nurses. She found, in her qualitative study of forty student nurses, that this placed great emphasis on getting the work done, whatever it might be. Indeed the importance attached to getting through the work is not only a major feature for nursing students. As Clarke (1978:79) noted: "a good nurse becomes someone who knows the ropes and pulls her weight". For nursing students, however, "learning the ropes", occurred in the clinical settings where the major teachers were not professional nurses but nursing assistants. This paucity of contact with qualified nurses meant that, whilst students may acquire a certain degree of skill and proficiency in accomplishing tasks, they were unable to develop any model of nursing beyond this or to prepare for the role of staff nurse. Runciman (1982) observed the same phenomena in the transition from staff nurse to charge nurse when, although these nurses had been aware of the status, the duties and responsibilities of the role were poorly understood.

These studies are important for nursing as they have implications for continuing education and socialization for roles which follow after initial professional education. Kramer (1974) coined the term 'reality shock' to describe the powerful experience of nurses discovering that their initial education is in conflict with the values of the world of work. This applies to the newly qualified staff nurse but later in career development there are also
other important features of transition which occur during the professional life of the nurse, for instance, when a nurse moves from one role to another, either moving from hospital to working in other settings or moving from one step to the next up the career ladder. Yet there are few studies of socialization of nurses beyond their formal, initial basic education. Studies of nursing students do not seem to consider development of the professional role during the initial formal education but the students' survival during socialization.

It is evident, from the discussion so far, that the socialization that takes place during nurses' pre-registration years of education plays an important part in the development of their professional role identity. Furthermore, the process of socialization does not end upon qualification and, regardless of the outcome of the initial socialization, it continues throughout the nurse's professional life. Values, norms and role-specific behaviours to which the nursing students have been exposed during their pre-registration years become internalized when they begin their professional career.

2.3.2.3 Learning of professional role

Role has been consistently difficult to define due to its multi-dimensional nature. A variety of perspectives has been adopted in relationship to roles, role performance and role socialization. Conway (1988) identified two major perspectives, the structuralist/fuctionalist and interactionist approach as discussed in section 2.3.2.1 of this chapter. Hurley-Wilson (1988) acknowledged the legitimacy of both approaches. Both the learning and shaping of roles are embedded in the process of professional socialization. Hinshaw (1988) suggested that the individual is an active participant in the socialization process and the learning of roles involves the acquisition of knowledge and skills as well as the internalization and shaping of the values and attitudes so as to fulfill a specific role within a particular social structure.
This active participative view is consistent with the interactionist and integrated perspectives of roles and role performance. The manner in which professional role is learnt is further explored in the following two sections. It is discussed within the context of the social learning processes and the contributing factors which may affect nurses' motivation to learn their professional role.

2.3.2.3.1 Social learning processes

Social learning is implicit in the role theorists' orientation since it derives from the assumption that socialization occurs through interactional processes rather than the learning processes it achieves. The interactionists role theorists also recognize the conscious as well as the unconscious nature of learning processes in socialization.

Bandura (1977) proposed a social-learning theory of 'identificatory processes' which suggests that the basic learning process underlying identification is observational learning. In Bandura's theory he used the concepts of "identification, imitation and observational learning interchangeably to refer to behavioural modification resulting from exposure to modelling stimuli" (Bandura 1969b:219). Thus, the social learning perspective deriving from Bandura's work emphasises the acquisition or internalization of values and motives through modelling, direct reinforcement and disciplinary techniques of rewards and punishment. Whilst modelling might have been appealing to the role learning of nurses, it is limited since it portrays an apprenticeship model of education which nurses no longer subscribe to in view of the reformed nurse education, Project 2000, which is built upon a firm theoretical base (UKCC 1986, Robinson 1991, Jowett et al 1994).

On the other hand, the cognitive-developmental perspectives offered in the studies of Piaget (1948) and Kohlberg (1969) also point to the acquisition of
values through successive stages, whereas Freud's psycho-analytical perspective suggests that the mechanisms of defensive identification are the underlying factors in the development of an inner conscience (Hoffman 1979). In contrast, Mead's role theorists propose the development of the self as the main outcome of socialization, which makes internal or self-regulation of behaviour possible. In their view, they consider this self-regulation to develop as a result of interaction with significant others who represent role models with a certain amount of authority and able to apply relevant sanctions to encourage the internalization of appropriate values and norms (Brim 1966, Elkin 1976, Elkin and Handel 1984). Thus, from this role theorist perspective, individuals have more controls over their own social behaviour in the development of the self. This view is more in keeping with the contemporary view of learning in nursing which emphasizes both personal and professional development and encourages nurses' control over and responsibility for their own professional learning.

2.3.2.3.2 Motivation to learn

Both the roles of internal and external sanctions are emphasized in the interactional processes through which socialization occurs. The two major motivational forces enhancing the learning of role expectations and role behaviours are the reward and punishment imposed by significant others and the internalization of attitudes and values (Brim 1966, Kerckhoff 1972, Elkin and Handel 1984). The concept of internalization is referred to as the adoption of social norms or roles as one's own (Aronfreed 1969). Although there is some agreement on the sociological and psychological perspectives of the effectiveness of internal and external sanctions on the role learning and role enactment, Goslin (1969) found that the views of the learner lead to somewhat different interpretations of the function of reward in relation to the socialization process.
The sociologist views reward and punishment as means to provide the learner with feedback which allows for conscious evaluation of the adequacy of role performance and behaviour is modified accordingly (Goslin 1969). This conscious evaluation of role performance is akin to the nursing practice of clinical supervision (Barber and Norman 1987, Butterworth and Faugier 1992) and reflection-on-practice as advocated by Schön (1983) whereby nurses' modification of behaviour occurs as a result of feedback. In contrast to the sociologist, the psychologist appears to place greater emphasis upon the effects of reward and punishment in facilitating desired behavioural responses as a result of operant conditioning (Skinner 1938) and upon the process through which external reward and punishment become internalized over time (Hurley-Wilson 1988). This psychological behaviourist approach has increasingly become controversial in healthcare practice. Punishment fails to give a choice among alternatives and may lead to dislike or fear of the punishing person and of the situation in which the punishment occurred leading to an even less desirable behaviour than the original one.

Although psychologists have provided experimental evidence that extremely strong negative sanctions result in acquiring response dispositions that are accompanied by high performance motivation and high resistance to extinction, there is, however, evidence that shows a decrease of individual's motivation to perform as a result of very strong punishment (Parke 1970). Furthermore, it is worth noting that the earlier studies on operant conditioning were carried out on animals. In Skinnerian experiments, rats and pigeons were the favoured subjects. Thus, the same laws of learning as applied to all species and situations could be questioned in this instance. Additionally, human behaviour cannot be understood by considering only external or environmental factors. Cognitive psychologists, such as Piaget (1952), have argued that motivation is intrinsic to human learning and that humans have an innate inclination to learn about their world. Thus, learning naturally incorporates motivation whereby human beings act upon the environment.
Motivation is a complex phenomenon. It is the product of a variety of factors and it is not built out of simple behavioural associations. For instance, the type of organizational control (Ouchi and Johnson 1978), individual ability (Locke et al 1978), self-esteem and reward contingencies (Terborg et al 1980) as well as feedback on performance from others (Hom et al 1982) are all considered as contributive motivational factors. Motivation has been defined in a variety of ways. It can be seen as the driving force which enables the individual to take action towards a particular goal or goals.

Campbell et al (1970) categorized the orientation of motivation theories as content and process. Content theories are those which focus on the environmental factors that sustain or extinguish individuals' behaviour whereas the process theories are those that explain the 'how' of behaviour (Conway 1988). Maslow's (1954) pioneering work on the theory of motivation, which expands on the understanding of the forces that prompt individuals to behave the way they do, provides the basis for most of the theories of motivation. Maslow identified an hierarchy of five basic needs which individuals attempt to satisfy: physical needs; safety; love; esteem and self actualization. According to this theory, the hierarchical order of these needs is not constant and it suggests that once the lower-order needs have been met, one attempts the ones in the higher order. Thus, Maslow's theory of motivation could be seen clearly to fit into the category of content oriented theory.

Herzberg's (1966) theory of motivation is one of those which draws on Maslow's hierarchy of needs. Herzberg distinguished between those taken-for-granted aspects of work and the recognition ones which he calls 'hygiene' and 'motivators' factors respectively. According to this theory, the hygiene factors are not the ones likely to stimulate improvement in work performance.
A significant difference between this conceptualization of motivation and that of Maslow's is that Herzberg only considers the higher-order needs to act as motivators whereas Maslow stipulates that any unfulfilled needs can be a motivator (Gibson et al 1973).

Thus, work satisfaction does not only derive from anticipated payment, such as a salary, but the extent of individuals' self-gratification seems also to be an influencing, motivational factor in determining whether they are likely to conform to the values, norms and behavioural expectations of their work situation. These intrinsic factors of motivation have implications in the exploration and analysis of nurses's socialization and learning of their professional role. For instance, nurses' self-satisfaction with the amount of responsibilities, extent of personal achievement and challenges of their job can all be seen as motivating factors in respect of adhering to the expectations of their role performance.

2.3.2.4 Role transition and professional socialization in nursing

Role transition occurs as an individual moves from one major position to another and it is viewed as a social process that brings one's self-perception and behaviour in line with the role expectations of the new social position (Hardy and Hardy 1988). This process, which usually involves stages of progress over a period of time, promotes changes in the development of social identity, self-concept, values and role behaviours. Nicholson (1990) focused on two main outcome dimensions in his theory of work-role transitions. He proposed personal change which involves alterations in self-identity to accommodate the demands of new roles, and role development which consists of those behaviours enacted to reshape role and context so that they fit better in a given environment of socialization. Nicholson's work provides theoretical frameworks of work-role transitions which help in understanding what happens to people who experience job mobility and
transitions. The needs and motives of people entering into transitions and how the characteristics of the roles into which people move differ from roles previously occupied are taken into consideration. Such theoretical insights into the dynamics of role transition perspectives can thus be viewed as part of personal and professional development in terms of nurses' adjustment to change during their professional socialization process.

Glaser and Strauss (1971) suggested that the process of socialization is one of the many transitions from one social status to another, which they refer to as status passages, and includes the anticipations and anxieties experienced prior to the event. When considering the nature of transition in respect of the status passages, Arnold (1990) argued that planning for, and institutional interventions in, the transition can have beneficial effect over the outcomes of the transition itself. Conversely, the manner by which the nurse has been prepared for, and their experiences of professional socialization in, the role transition contribute to the adjustment to the nursing role. Nicholson (1990) further proposed role requirements and individual personality characteristics, such as the desire for control and desire for feedback, as influential factors in the adjustment to a new role.

The conceptualization of professional socialization clearly brings this process into the domain of role theory in terms of role transition. Evidence from analysis of professional socialization shows that symbolic interaction has been used to describe the process whereas structural/functional role theory provides the direction, constraints and outcomes expected from the process. For instance, Oleson and Whittaker's (1968) study on professional socialization into nursing was undertaken from a symbolic interaction perspective and Simpson's (1979) longitudinal study "From student to nurse" drew upon structural role theory.

Professional socialization has many of the characteristics of role transition.
Oleson and Whittaker (1968) and Glaser and Strauss (1971) maintained that role transition is a prolonged process in which the social environment is influential in bringing about changes in the self-concept.

Hence, professional education, whether it is in nursing or medicine, is designed to shape attitudes, values, self-identity, role skills, role knowledge and role behaviour.

2.3.3 Teaching and learning in the education of nurses

It is suggested in the pre-P2K nurse education literature that the socialization process in the nursing environment does not develop nurses to become self-directing practitioners (Mauksch 1972) and that the traditional education system does not foster the qualities of independence (Diers 1972) which would facilitate on-going learning. Burnard (1984) argued that this traditional education system is an inappropriate teaching strategy for a caring profession. Rosendahl (1974) maintained that in order for nursing to become a profession, its educational programmes must initiate continuous learning using a non-traditional approach. In order to achieve this, she therefore proposed 'andragogy' which she considered to be an adult teaching approach for nurses.

Debates around adult learning are of obvious concern to nursing since all nursing learners are adults. Knowles (1968) originally introduced 'andragogy' in the literature to describe an emerging approach to adult learning. He further defined it as "the art and science of helping adults learn" (Knowles 1980:43) and the general purpose is to assist adults to achieve their full potential. This suggests that the teaching of adults is viewed as the facilitation of learning which is referred to as the 'education of equals'. Jarvis (1986) stated that this type of education involves the learner taking an active part in directing, managing and being responsible for their own learning. It is
thus a process that takes the learner's growth and development into consideration. Knowles (1984) differentiated andragogy from pedagogy which he claimed involves the art and science of teaching children to learn. Pedagogy implies that learning is within a system of 'education from above' whereby the child adopts a passive role and is fitted within the system.

Thus 'education of equals' could be seen as empowering learners which could be interpreted as having the power to control their own learning, growth and development. In nursing this might be somewhat difficult, because of the external factors, such as the UKCC Code of Professional Conduct, which monitor professional standards and the ENB which control the requirements for the education of nurses. Consequently, within such a context, the andrological approach of 'education of equals' gives way to 'education from above'.

Nonetheless, the facilitation of an adult approach to learning has brought a humanistic perspective to the nature of education. Facilitation of learning by teachers becomes more prominent in the education of nurses. It helps the learners to enhance and fulfil their own expectations of their roles. This was largely influenced by Carl Rogers' (1961) work which focused essentially on an adult person-centred approach to teaching. This approach seems to be one of the favoured type of teaching found acceptable in the nursing curricula and has brought change in nurse education (Jarvis 1986, Burnard 1991). Teaching or facilitating nurses to learn more effectively by being self-directed learners, based on the 'education of equals', although not always possible for reasons quoted above, has been recognised by nurse educationalists as a means to foster commitment to continued professional learning. Thus adult-centred learning has obvious similarities with the humanistic approach to education.

Historically, the behaviourist approach has been the accepted basis for
nursing education. Adherence to such an approach can still be found through learning outcomes in nursing curricula which in turn are informed by the requirements of relevant validating bodies. Thus, such behaviourist approach reflects this notion of ‘education from above’ and learning is achieved through learning outcomes. Conversely, behaviourists would advocate that learners follow prescribed curricula with measurable outcomes as prescribed by validators of nurse education such as UKCC and National Boards. Behaviourism which emphasises stimuli and response considers that human behaviour is determined by conditioning rather than thoughts or feelings (Quinn 1988). In contrast, a humanist perspective would view education as aiming to benefit individual nurses who may consider education for its own or their own sake and not necessarily for the benefit of patient care.

Humanist ideologies and educational theories as advocated by key contributors such as Dewey (1938), Rogers (1961), Knowles (1968) and Freire (1972) emphasise intrinsic rather than extrinsic values. Humanist education aims at enabling learners to express their needs and interests for their personal and professional development. Humanists insist that the educational process should address the affective as well as the cognitive dimensions of nursing. Affective education stresses non-intellectual aspects of learning such as emotions and feelings (Cox 1987). This notion of a more holistic approach to education and learning as advocated by humanists therefore rejects both the behaviourist and cognitive positions. The behaviourist stance does not take into account the learners, awareness and interpretative faculties and the cognitive position does not address the affective dimension of learning. The social perspective of the educational process is also challenged on the basis that individualistic values of the learner are replaced by institutional structures such as a college of nursing. Hence, there is a tendency for the learner to depend on institutions to meet their learning needs which leads to a lack of control over one’s own learning.
However, individualism of the humanistic perspective is not always possible to achieve. For instance, in a college of nursing, structural constraints cannot fully permit self-directed learning and student centredness.

Furthermore, embedded within this humanistic and andragogical approach to nurse education is the encouragement to use learners' past and present experiences in teaching activities. Thus, Kolb's (1984) experiential approach to learning has contributed to change in the nursing curricula. This learning approach is mainly derived from Dewey's (1938) progressive educational philosophy, Lewin's (1951) view of social psychology which suggests that all actions are influenced by the environment in which they take place, and Piaget's (1971) developmental and cognitive theory. This model of the learning process therefore involves a holistic, integrative process which combines an individual's experience, perception, cognition and behaviour.

From the literature reviewed, it seems that each of the educational ideologies and theories has something beneficial to offer in the education of nurses. Both pre- and post-registration nurse education aim to produce practising nurses and improved practice, and thus, some behavioural (psychomotor) development is inevitable. Moreover, external factors such as student numbers and motivation, subject matter and teaching style have to be taken into consideration, depending upon individual student, teacher and institutional needs. Thus, an eclectic approach is called for whereby different educational and learning needs are met by using different approaches to suit individual learning situations. This does not preclude teachers from facilitating individual responsibility for learning.

### 2.3.3.1 Self-directed learning in nursing

Adult learning-andragogy generates self-directing and self-initiating learning behaviour and a readiness to learn when the learner perceives a need (Knowles 1984, Richardson 1988). Mezirow (1985) asserted that self-
directed learning is the goal of andragogy which he viewed as the prevailing philosophy of adult education. Such an approach not only encourages nurses to think for themselves but it also stimulates and facilitates the management of their personal learning. Olson and Kartha (1983) also believed that nurses should be self-directed learners as this fosters the characteristics of a professional nurse. Bruner (1966) had a similar view of adult education and suggested that learners should be made self-sufficient. Sweeney (1986) added that the androgogical approach combines self-directed learning and learner-centred learning. Additionally, Murdoch and Davies (1994:4) suggested that the basic philosophy of self-directed learning is that "learning does not equate with teaching" which implies that individuals do not only learn by being taught but "they also learn by discovering for themselves".

Knowles (1975:18) also defined self-directed learning as "a process in which individual learners take the initiative with or without the help of others", in identifying their learning needs and resources for learning. Such learners are able to choose and implement appropriate learning strategies and evaluate the outcomes. Thus, this process infers a sense of personal responsibility, active participation and commitment to learning which currently underpins the whole ethos of continuing professional education in nursing. In fact, many authors have advocated that promoting self-directed learning in an educational programme prepares individuals for life-long learning, for example Faure (1972), Gibbons et al (1980), Mezirow (1985), Jarvis (1987, 1992), Murdoch and Davies (1994).

Self-directed learning is also central to the Project 2000 pre-registration nursing course curriculum which seeks to promote the characteristics of an adult learner in the nurse and Schoen (1979) suggested that these are achieved when the nurse displays initiative, self-direction, an inquiring mind and thinks critically. Subsequently, the ENB (1986:3.4, 3.5) course
development guidelines state, among other aims of P2K programmes, that the practice-based curriculum should:

"provide opportunities for students to develop their intellectual abilities, self-awareness and self-direction" so that students "acquire the ability at registration to take responsibility for their own continued professional development".

Additionally, in their regulations and guidelines for the approval of institutions and course, the ENB (1990) has placed greater emphasis on nurses' individual accountability for professional practice and their responsibility for their learning which they viewed as on-going. Hence, these aims became embedded in all nursing curricula, in the UK, which developed within the framework of assisting nurses to develop self-directedness in their learning so that they are able to take responsibility for their own CPE. These aims also indicate the profession's attempt to develop a nursing culture which recognizes the need for CPE and its relevance from the onset of professional education during the initial socialization process.

2.3.4 Professional learning in nursing practice

Nursing, like many other professions such as medicine, law and accountancy, has several different perspectives on the acquisition and the maintenance of professional knowledge. Greater emphasis is increasingly being attributed to valuing professional knowledge and identifying the necessity to communicate how nursing practice reinforces and reflects the acquired professional knowledge. Fish et al (1991) maintained that the processes of learning and acquiring knowledge through nursing practice are still not well understood. Professionals in nursing have different opinions about how to categorise themselves but Schön (1987) and Palmer et al (1994) perceived it as having different kinds of skills and knowledge required for competent practice. Boud et al (1985) argued that competency not only involves taking action in practice but learning from practice through reflection which is further discussed in
Section 2.3.4.2 of this chapter.

By contrast, James (1993), who is an advocate of collaborative practice in nursing as a means of determining professional knowledge, argued that professional learning is often unpredictable, individualistic, idiosyncratic, complex and not always obviously sequential. Collaborative practice involves working with others with similar beliefs, values and goals in order to enhance healthcare provision. Consequently, it can be argued that any model of learning can be seen as only a conjecture of what goes on in the complex process of professional learning in the practice of nursing.

Nonetheless, the ENB (1986) provided guidelines to P2K curriculum planners which recommended that a range of teaching and learning strategies should be utilised to assist students to take personal responsibility for their learning as well as encouraging the development of critical enquiry and an analytical approach to the practice of nursing. These guidelines reflect the kind of learning found in critical thinking and reflective practice as described by Schöen (1983, 1987) whose work has been influential in the development of nursing curricula. He suggested that reflection has to occur in order to foster critical thinking skills which he viewed as an essential component of professional practice. This viewpoint is supported by Brookfield (1987) who stated that critical thinking involves a reflective dimension and that reflective learning is closely related to critical thinking. In fact, some theorists believe that critical thinking is a cognitive as well as an affective process which is embedded in learning through reflection (Jones and Brown 1993). Section 2.3.3 of this chapter discusses the affective aspect of learning further.

2.3.4.1 Critical thinking in nursing

Baker (1996) found that numerous authors have proposed definitions for critical thinking in relation to their disciplines. Watson and Glaser (1964),
who were among the earlier authors of critical thinking, viewed it as constituting knowledge, skills and attitudes which is a rather vague interpretation and does not clearly address the nature of the concept. These authors, nevertheless, developed a useful critical appraisal tool. This tool attempts to measure the kind of skills during the process of reflection such as identification, interpretation and evaluation of the significance of personal experiences and there is evidence of such a tool being used by researchers of critical thinking in nursing. For instance Pless and Clayton (1993) used a similar tool to study critical thinking in nursing and Hartley and Aukamp (1994) explored the critical ability of both nurse educators and that of student nurses.

In their writings on “becoming critical”, Carr and Kemmis (1995) distinguish between critical theory and Haberman’s (1974) theory of critical social science. Critical theory, which aims to reassess the relationship between theory and practice can be interpreted in various ways. It is viewed here as the product of a process of critique carried out by an individual or a group concerned to expose contradictions in the rationale for their actions. This involves subjective interpretation of one’s actions and does not necessarily imply changing practice. Hence the notion of critical social science which contains theoretical insights related to practice was developed by Habermas to overcome this limitation. The process is seen as a form of self-disciplined reflection. However, the main criticism of Habermans’ work was that it does not concretely exemplify his theory but merely discusses its possibility within a practical situation. Carr and Kemmis (1995:144) therefore argued that the relationship between theory and practice cannot merely be one of “prescribing practice on the basis of theory” which they viewed as a transformation of consciousness with limited application to practice.

A further search for a definition of critical thinking as alluded to by the ENB (1986) revealed that it has been described as “the skill and propensity to engage in an activity with reflective scepticism” (McPeck 1981:81), and Ennis
(1987:10) viewed it as "reasonable thinking that is focused on deciding what to believe or do". Other authors refer to the characteristics of critical thinking which include being inquisitive, open-minded, flexible, diligent and self-confident in one's ability to reason (Pless and Clayton 1993).

In the nursing literature on critical thinking, reflective learning has been addressed to some extent. Atkins and Murphy (1993) argued that, as a result of this notion of learning through reflection, nurses are able to critically evaluate their performance and will be able to enhance or change their practice in the future. However, it is evident from the literature that the concept of critical thinking in nursing is not clearly defined and is much debated. Thus, in relation to nurse education, McPeck (1981,1990) maintained that the concept of critical thinking is so vague that it cannot be taught. On the other hand, although Fisher (1995) argued that critical thinking is a skill which can be learned and taught, the manner in which it can be learnt and the necessary conditions required for such learning to take place are not very clear.

2.3.4.2 Learning through reflection

Reflection means different things to different authors on the subject. Although, Schön (1987) and Mezirow (1990) argued that the definition of reflection lacks clarity and tends to cause confusion in its interpretation, there is evidence from the literature reviewed that the concept of reflection has been addressed by many authors. Boud et al (1985) refer to reflection as a generic term whilst others generally infer that reflection is a retrospective, subjective and cognitive process focused on action (Habermas 1974, Van Manen 1977, Clarke 1986, Jarvis 1992).

However, within a learning context, Boyd and Fales (1983) described reflective learning as a process whereby an individual responds to a lived
experience and cognitively reviews and explores the experience in such a way as to create and clarify its meaning in terms of the self. They stated that this process in turn leads to increased self-awareness, increased sensitivity to the environment and a change in conceptual perspective. This working definition suggests that it is a process of thinking about and exploring an issue of concern, which is triggered by an experience.

Schön (1987) seems to be the only one to identify a non-traditional interpretation of reflection (reflection-in-action) which involves learning occurring in practice as well as the process of looking back on one's practice (reflection-on-action) which largely indicates when learning through reflection occurs. Schön (1983) identified three stages in the process of reflection which he argued are contributive to learning: conscious reflection; critical analysis and action. The first stage is triggered by an awareness of uncomfortable thoughts or feelings of uncertainty, the second stage involves a critical analysis of the situation which demands the examination of feelings and knowledge and the last stage entails the development of a new perspective of the situation. Boyd and Fales' (1983) work also identified levels of the process of reflective learning which to some extent appear to be an extension of Schön's three stages of reflection. It is evident that both sets of the learning process through reflection involve levels of cognitive and affective activities which are integrated and cyclical in nature.

Reid (1993) offered an interpretation of reflection which was felt relevant here to the traditional learning in nursing practice. It is defined as a process of reviewing an experience of practice in order to describe, analyse, evaluate and inform learning about practice. Individuals need to do and feel the experience before they can understand what they are doing, what Schön (1987) referred to as the professional artistry of practice.
2.3.4.3 Reflective practice in nursing

By virtue of the nature of reflection and reflective learning in practice, as implied here, facilitation of reflective practice is crucial for continued professional education in creating a balance between practice and knowledge as well as in the acquisition of professional expertise or artistry. Nevertheless, it appears that there is a need to understand the definition and interpretation of what constitutes reflective practice among nurse practitioners (Jarvis 1992) in order to understand the nature of reflection in nursing. James and Clarke (1994) suggested that in order to conceptualise reflective practice to assist nurses to become reflective practitioners, there is a need to consider both the processes and the content of reflection. Jarvis (1992) argued that thoughtful practice is often mistaken for reflective practice. He clarified this by stating that reflective practice is more than just thoughtful practice and that it is the process of turning thoughtful practice into a learning situation. He therefore suggested that, by seeking to problematise situations of professional performance from which learning can take place, practitioners would be able to continue to learn, grow and develop in and through their practice. While it is undoubtedly worthwhile for the nurse to spend time reflecting on aspects of their practice, it needs to be recognised here that the nature of the experience could dictate whether the nurse wishes to learn from it or not. The nurse might choose to suppress or ignore unpleasant and painful experiences. It can therefore be argued that nurses may decide to remain in a thoughtful mode of practice for aspects of their practice and be selective in their process of reflective practice.

Richardson and Maltby's (1995) study on the extent and level of reflection achieved by student nurses used a combination of reflective diaries and focus group interviews. Although they claimed that the theoretical basis of their study is based on Schön's work on reflection-in-action, it clearly demonstrates reflection-on-action and in their report of the findings they do not specify the
type of reflection achieved by the participants. Baker (1996) also reported his findings of a study of student nurses’ reflective learning whereby a reflective journal was used. This account does not however fully reflect reflection-in-action since the students reflected retrospectively on activities experienced during or in response to their clinical practice. It thus appears that the research methods used to study reflective practice do not adequately demonstrate nurse practitioners’ reflection-in-action. On the other hand, it can be argued here that reflection-on-action, as a type of retrospective reflection, could also involve reflection on the reflection-in-action which would influence the nurse’s decision about the care given.

However, Powell (1989) used interviews and observation to examine how nurses learn from practice and develop the skills of reflective practice in an attempt to ascertain whether reflection-in-action is present in nurses daily work. The problem with these methods is that potentially nurses who are possibly able to reflect-in-action may be unable to verbalise the knowledge behind their actions which they have intuitively brought to their performance. In her study of the nature of professional expertise among nurses, Benner (1984) identified expert nurses who, due to their extensive experience, have an intuitive grasp of each clinical situation. Benner and Tanner (1987) refer to intuition as understanding without a rationale for one’s action. Polanyi (1964) had also recognised such an issue among professionals and has called this “tacit knowledge”. Schön (1987) did recognise the implications of intuitive knowledge but he appears less certain in his writings about how reflection-in-action is acquired. He does, however, admit that reflection-in-action is a process that can take place without individuals being able to state explicitly what is being done. This suggests that the use of reflective diaries, together with interviews and observations of a participative nature, might be more appropriate methods of data collection when studying reflection-in-action.
Despite the difficulty of evaluating reflection empirically, reflective learning which involves the ability for the nurse to think critically about their practice is supported by both the ENB (1991) and the UKCC (1986, 1990) in their respective recommendations in the implementation of P2K and a framework for CPE. It is thus recognised by professional nursing bodies that reflection in nursing is likely to play an important part in learning and in the development of nursing knowledge from clinical experience. Additionally, this also demonstrates the important role that learning through professional practice plays in preparing competent practitioners. Reflective practice has therefore become widely adopted as the philosophical framework informing curriculum development.

2.3.4.4 CPE: implications of reflective learning and critical thinking in nursing

From the literature reviewed, it is evident that, despite the dearth of empirical research about the effectiveness of reflective practice approach in nurse education and the extent to which it occurs (Jarvis 1992, Palmer et al 1994, Reid 1993), reflection as an on-going learning strategy which enables nurses to enhance their professional practice is considered to be a positive and necessary attribute in CPE. Atkins and Murphy (1994) explain that, since reflection-on-action occurs after the experience, it contributes to the continuing development of skills, knowledge and future practice. On the other hand, Schön (1987) reiterated that it is reflection-in-action which is the important source of knowledge for professional artistry and asserted that awareness of this kind of reflection should become an explicit part of continuing education, though he does not clearly explain how this is done and how reflection-in-action can be measured. Furthermore, none of the discussion seems to emphasise the importance of the nurses' attitude within reflective practice which is also a crucial aspect of professional development in nursing.

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Additionally, Boyd and Fales (1983) argued that part of the uniqueness of reflective learning lies in the fact that it has the potential for generating new knowledge from clinical practice, whereas application of content knowledge does not have such a continuous function. Similarly, Schön (1983, 1987) promoted his model of reflective professional practice which assumes that knowing is derived from the actions of professionals as opposed to the application of scientific theory and technique to practice which he describes as the model of technical rationality. Technical rationality focuses on systematic problem solving as opposed to problem setting which Greenwood (1993) argued cannot be resolved by the techniques derived from science.

Furthermore, reflective learning which entails the development of critical thinking skills is also considered useful for nurses in their on-going acquisition of professional knowledge. Baker (1996:19) claimed that the 'ability to critique one’s clinical practice is a skill which must be acquired if nursing students are to continue to learn and develop as practitioners after they have graduated'. He also argued that the reflective learning process not only improves critical thinking skills but also contributes to growth of self-awareness, self-actualisation (Maslow 1979) and the development of new and/or additional knowledge from practice experience.

However, in the midst of the debate about the relevance and benefits of reflective practice in nursing, little attention seems to have been paid to ways of developing skills for reflection which may enable nurses to learn more effectively from their practice settings and/or what they have learnt in practice. Atkins and Murphy (1993) proposed self-awareness, description, critical analysis, synthesis and evaluation as skills required to engage in reflection, whereas James and Clarke (1994) insisted that the skills required for reflective practice remain unclear.

In studies focusing on the development of professional expertise in clinical
nursing practice, it has become increasingly evident that much knowledge can be gained within nursing practice itself (Benner 1984; Brykczynski 1989). Thus, from this exploration of professional practice in nursing which demonstrates an integration of reflection and critical thinking it is evident that these learning strategies have the potential to influence the continued personal and professional learning of individual nurses. As Carr and Kemmis' (1986) work within education had suggested, it can be concluded that nurses develop and maintain their competencies through critical reflection on their clinical experiences. Hence, by virtue of its nature, critical reflection offers a questioning and personal practice-based learning approach which can enable nurses to respond to the challenge of their practice and provide them with a means of continued professional learning in order to enhance their professional expertise. The review of the literature also suggests that the whole concept of reflection and the pursuit of the critical reflective practitioner has become influential in the contemporary education of nurses.

### 2.3.5 Conclusion

Since the research focused on an aspect of learning within a reformed nurse education, previous literature and theory seemed inadequate for constructing a particular theoretical framework for the study. Hence, no single thread of theoretical or empirical literature is reflected in the entirety of the research at the outset of the study. As this review of the literature illustrates, an integration of literature was used instead to help shape the research focus. Illuminating constructs from various disciplines were searched widely, instead of narrowly constricting the study to focus on only one theoretical framework.

As a result of such integrative literature reviews, relevant literature about CPD and CPE were discussed followed by theoretical perspectives pertinent to concepts and theories emerging from the data. Although, during the
planning stage of the research, the conceptualization of the study was somewhat influenced by the researcher’s personal background knowledge of nurse education, a review of such literature allowed for the growth of relevant research perspectives. Consequently, the review of literature developed on a continuous basis throughout the duration of the study.
CHAPTER THREE: RESEARCH DESIGN AND METHOD

3.1 Introduction

The purpose of this chapter is to describe the research design and the methodological considerations. The chapter therefore gives a detailed account of the "trail" that was followed for the study. Five main sections can be identified within the chapter. It begins with an examination of the principles and theoretical perspectives underpinning the research design and approach followed by the research questions which provide a basic foundation within the established parameters of the study. The strategies used for collecting the data are discussed in the second section and these include the sources and nature of the data. An account of the research sequence is then given and this addresses the procedures that were followed and their relevant issues. The fourth section considers ethical issues related to this study and an appraisal of the methodological rigour of the research. The last section discusses the way the data were organized for analysis and the procedures developed for the analysis of the data.

3.2 The research design: principles and theoretical perspectives

Within the field of nursing research, there are numerous studies that have demonstrated the various methodological approaches of inquiry which nurses have used to answer pertinent nursing research questions. The principles and theoretical perspectives underlying nursing research can be traced from two basic orientations which are broadly described as quantitative and qualitative methodologies or philosophical approaches. Conflict and tension between these two orientations have existed for a long time and their respective use and value have been much debated among different schools of social science and in nursing's search for a disciplined knowledge base (Duffy 1985, Cushing 1994). However, each of these paradigms are based upon certain basic assumptions which distinguish one from the other. The
quantitative methodologies derive from a positivistic philosophy (Popper 1959) which is described as a hypothetico-deductive model of science. This model of science, which is borrowed from the biological sciences, is based on a belief in universal laws and insistence on objectivity and neutrality (Thompson 1995) so that personal biases can be avoided. Positivists follow the natural science paradigm in which theories and hypotheses are tested. A hypothesis is formulated with an expected outcome which is then tested. The main aim of this form of inquiry is to test theory in search for cause and effect and Duffy (1985) claims that this type of research seeks causal relationships or links between events. It focuses on explanation, prediction and control. Consequently, this positivist stance is developed from a theory and the concepts which are established before the study begins. It does not address the subjective experiences and interpretations of the subjects involved in any depth, nor the context of the research.

On the other hand, the qualitative methodologies stem from a philosophy within the social and behavioural human sciences particularly history and anthropology (primarily inductive in nature). This model (socio-anthropological) seeks to describe and understand the meaning of individuals' experiences or particular events within their natural settings. It supports the assumption that behaviour can only be understood in the context in which it occurs, and hence it is known as naturalistic inquiry (Lincoln and Guba 1985, Erlandson et al 1993). Guba (1979:274) defined naturalistic inquiry as a "kind of inquiry in which the investigator is open to all elements of the situation and is willing to receive any information from it". The naturalistic paradigm therefore focuses on the lived experience and the interpretations and meaning which people attach to it, adopting a holistic person-centred, humanistic perspective. There is no initial hypothesis. Concepts and/or theories are developed directly from the data. Leininger (1992:409) succinctly alludes to the strength of this kind of inquiry as "grasping the totality of institutions, human environments and life contexts, beliefs and values".
As the focus of this study centred on the professional learning of a group of P2K nurses within the context of their continuing professional development a qualitative methodology was considered appropriate. The intention was to understand how these diplomates chose, planned and organized their professional learning, the types of plan and guiding steps they used and the manner in which the strategies for continued professional learning are developed and enhanced from the earlier stage of qualification. The study further intended to establish the extent to which these nurses' notion of professional learning was reflected in their pattern of learning during their first two years of registered practice. The research strategy used and the research design that best addressed the study objectives was therefore influenced by the purpose of this study, which emphasises an understanding of professional learning. Consideration about the level of knowledge that has been developed in the area of the research interest was also a contributive factor.

It was evident from the literature search, at the inception of the study, that very little was known about P2K nurses since at the time of the study there was only one other cohort of nurses who had qualified through a P2K programme. Also, other studies of P2K did not address the professional learning of P2K diplomates. Morse (1991:147) advocated the use of a naturalistic inquiry when "the research context is poorly understood, the boundaries of the domain are ill defined and the nature of the problem murky". De Poy & Gitlin (1993:26) also recommended the use of a naturalistic inquiry "when little to nothing is understood about a phenomenon", because this type of research can reveal processes that go beyond surface appearances. They go on to suggest that predicting designs are better suited to a well-developed body of knowledge but, in any case, the design should also be combined with the researcher's purpose of inquiry and their view of reality.

Thus, the design of this study is based on the belief that knowledge is socially
constructed and the assumption that, in order to understand the professional learning constructs of these diplomates, their views had to be sought about how they perceived their experiences of professional learning and the meanings they attached to them. This qualitative inquiry did not have predetermined outcomes but focused on the actual impact of the P2K course and the professional learning process over a period of time. No attempt was made to manipulate, control or eliminate situational variables and the data included whatever emerged as important to the understanding of professional learning. Qualitative inquiry design cannot be completely specified in advance of fieldwork. While the design of this study specified an initial focus on professional learning of a group of diplomates, interviews with initial questions and areas to be explored were planned. The naturalistic and inductive nature of the inquiry made it both impossible and inappropriate to specify operational definitions of variables or concepts and to state testable hypotheses. Patton (1990) supports this viewpoint and argues that a qualitative design unfolds as fieldwork unfolds and the design is partially emergent as the study occurs. Additionally, the flexibility of this research design stemmed from the open-ended nature of qualitative inquiry as well as pragmatic considerations during the planning stage of the study.

Having established the epistemological assumptions of the study, the design clearly indicated a case study approach since the intention in the research was to focus on a specific group of nurses' real-life events with common experiences. Some authors (e.g. Platt 1988; Patton 1990) suggest that the depth and details of qualitative research methodologies typically derive from case studies which are holistic and contextual. One of the commonly quoted writers on case study research is Yin (1989) who acknowledged the relevance of case study design to qualitative research. It is evident from the literature that different authors have their own definitions and ideas about the nature of the case study but they also agree on many issues such as the holistic and meaningful characteristics of real-life events.
Merriam (1988:9) defined a case study as "an examination of a specific phenomenon such as a program, an event, a person, a process, an institution or a social group". On the other hand Yin (1989:23) offered a more technical definition by stating that "a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomena are not clearly evident and in which multiple sources of evidence are used". This perspective captures the breadth and purpose of a case study.

Further considerations of the research design were addressed. As previously discussed, the study aimed to focus on capturing the process of learning, documenting any variations and exploring the professional learning experiences of a group of P2K diplomates. Thus a longitudinal naturalistic inquiry was felt to be particularly appropriate for the conduct of this study since exploring a process requires description over a period of time. The experience of a process varies for different people; a process is not static and the participants' perceptions of their experience of professional learning were a key process consideration.

A qualitative longitudinal study involves the use of interviews and/or observations of individuals with the goal of studying the process and causes of inter-individual change (Clinton et al 1986). Thus research of this nature requires the same group of nurses to be studied over a period of time so that a full picture of the developmental dynamics can be captured. The longitudinal features of a study thus permit such exploration to take place, unlike the pre- and post-tests and cross-sectional designs. These may be useful for studying many problems of professional change but they imply a linear continuum with no explanation of what happens along the way. Although a longitudinal study overcomes the limitations of a cross-sectional one, in studying individual developmental change, it creates problems such as attrition from the sample. This is addressed later in this chapter (see Section 3.9.5).
In this research, the design reflects a longitudinal, qualitative case study of a small group of nurses. De Poy and Gitlin (1993:156) suggested that a case study is ideal for describing a small group of individuals "over time in their contemporary contexts without sacrificing the complexity of human experiences".

### 3.3 Research approach: principles and theoretical perspectives

The qualitative approach to research is not exclusive in the same sense as, for instance, experimentation and surveys. It is more like an "umbrella of activities" (Schatzman & Strauss 73:14) beneath which a range of techniques may be used for gaining the desired information. The term qualitative research is not used very precisely and it conveys different meanings to different people. This has caused considerable confusion and it can often be a misleading label (Sandelowski 1986, Jacob 1988). The fundamental factor seems to be that different authors have focused on different features of qualitative research.

Thorne (1991) maintained that there are a number of possible philosophical perspectives which drive naturalistic inquiry but, despite some broad similarities, each of these perspectives represents a distinct approach to all components of the qualitative research process. However, this research does not adhere rigidly to one specific approach. Indeed, qualitative researchers such as Atkinson (1995) and Sandelowski (1994) warn about restrictive and prescriptive approaches and their exclusivity, whilst mindful of "methodological anarchy" and "sloppy mishmash" (Morse 1989:4). Holloway and Wheeler (1996) also alluded to "method slurring", the way in which a single approach is described superficially, but they also argued that methodological processes and strategies evolve over time and involve breaking the rules and guidelines of specific approaches. Thus, based on the philosophical positions of this study, it was felt that an eclectic approach to data collection and analysis would provide more flexibility which would
allow the study the possibility to go beyond descriptions of the participants' subjective experiences through to the level of theoretical explanations.

In this study, the exploration, description and interpretation of the meanings the nurses used to conceptualize their professional learning experience reflects an understanding of a selected aspect of their culture in its broadest sense. Elements of ethnography can be found in the study since it seeks to describe and analyse part of a nursing culture which is unique to this group of P2K nurses. From a phenomenological line of inquiry this study uncovered the meaning of professional learning through the description of those experiences as they were "lived" by the diplomates themselves during the first two years of their registered practice.

Principles of grounded theory (Glaser and Strauss 1967), which derives from symbolic interactionism (Mead 1934), guided the data collection and analysis of the data to some extent. Data analysis and data collection were undertaken in sequence with preliminary inductive analysis (Patton 1990) of the data informing subsequent data collection. The inductive process used involved conceptualizing the patterns, themes and categories of analysis which emerged from the data to develop theoretical ideas. However, the grounded theory approach emphasises the study of interactional processes within a group of individuals, which was not the focus of this study. In other words, the study did not particularly focus on theorising and shared meanings in interaction. However, although from the above discussion this study contains some similarities with the three research approaches, it is evident that there are also some differences in the focus of these approaches and that of the study.

3.4 The use of theory in the research

Schatzman & Strauss (1973) argued that the qualitative researcher should be at liberty to think of any or all pertinent theories and assumptions about their
subject matter and thereby free themselves from substantive orthodoxy. What the researcher does need, they add, is some theoretical perspective or framework for gaining conceptual entry into their subject matter and for raising relevant questions quickly. De Poy & Gitlin (1993) also believed that all research begins from a particular framework which is normally based on assumptions of human experiences and their reality. Similar to other authors of qualitative research, such as Goetz & LeCompte (1984) and Patton (1990), they maintained that in the naturalistic paradigm a theoretical framework is not substantive or content specific.

Thus, in this study, a framework of the key areas to be studied was designed to form the basis of the data (see Figure 3.1 p.81). The framework reflects the researcher's assumptions of connections which might exist within the professional learning of P2K nurses. These were identified prior to the initial stage of data collection. These were then "bracketed" and only used in the data analysis if they emerged from the data. The concept of "bracketing" (Oiler 1981) refers to the suspension of prior attitudes, beliefs and suppositions of the research setting. Gregory (1994) argued that it is impossible to suspend such knowledge from the research and suggests that a preferred way of working is for the researcher to be aware of and use such knowledge constructively.

Thematic conceptual frameworks were subsequently constructed from the findings of each set of data analysis. These frameworks provided structure to the data collection and guided the type of questions which were asked in subsequent interviews. The purpose was not to fit the data into the frameworks by subjecting the emergent concepts to predefined measures but to allow the meaning of the diplomates' learning experiences and activities within their settings to emerge naturally. The identification, development and application of concepts, constructs and propositions and their connections therefore facilitated the interpretation of those data so as to make logical descriptions of the events, interactions and activities as they were
Figure 3.1: Framework of key areas to be studied.

This framework is a graphical explanation of the main factors that were to be studied and the presumed connection among them. This was done at the planning stage of the study. Continuing professional learning was considered to be a very broad area of study and such a framework helped to define the key areas.
experienced by these diplomates.

Goetz & LeCompte (1984) also advocated that theoretical models or perspectives, which they described as loosely interrelated sets of assumptions, concepts and propositions are more pertinent to naturalistic inquiry. They further argued that applications of grand theory which emphasise the discovery of universal laws of human behaviour and beliefs are inappropriate in qualitative research. Hence, the emphasis of this study was more to do with the exploration of the participants' perspectives which constituted their view of their world of professional learning and the constructs were developed from data which focused on a small group of people.

In this study, during the course of data collection and analysis the links between many of the concepts and constructs which emerged were found to have an impact on the diplomates' professional learning during the various stages of transitions they experienced. Therefore, substantive theories such as role theory, theory of transitions and socialization were used where appropriate to explore, explain and make sense of the data collected about the participants' experiences during their early and ensuing stage of adjustment on the wards, as staff nurses. Theories were thus used as an explanatory device and provided boundaries in the inquiry.

Moreover, it was appropriate to use theories when the complexity of the research increased and the focus was on discovering specific patterns and relationships among constructs. De Poy & Gitlin (1993) confirmed that the use of a theory occurs primarily within an inductive process that moves from shared experience to higher levels of abstraction. The focus is on understanding complexity and generating concepts, constructs, relationships and propositions which these authors view as the four basic components of a theory. Thus, these components provided this study with the meaning of multiple subjective understandings of these P2K diplomates and, in such a process, the required knowledge emerged from the participants themselves.
In this sense, naturalistic design is tied inextricably to theory and Burgess (1982) insisted that it is the integrating and interpretive functions of the theory that make the study comprehensible.

On the other hand, Patton (1990:90), while attempting not to appear heretical, argued that there is no universal standard which can be applied to choose from different theoretical frameworks and that in real-world practice, "methods can be separated from the epistemology out of which they have emerged". He further argued that the methods of qualitative inquiry now stand on their own as reasonable ways to find out what is happening in specific human settings. This view is reflected in this study whereby neither the data collection nor the analysis of the data were influenced by specific, predetermined theories beyond the assumptions specified in the framework as illustrated in Figure 3.1. Applying such theories rigidly would have masked the realities of these nurses' experiences of their professional learning and would have also prevented the research evolving in the way it did, as new insights and meanings were gained during the course of the study. Moreover, Hammersley et al (1985) asserted that the pursuit of theory tends to imply a causal explanation of social processes which does not make allowance for the creativity aspect of social behaviour. Additionally, since the qualitative approach proposes that the participants' accounts stem from their own perspectives, these should therefore form the fundamental basis of any explanation of their behaviour.

3.5 Research questions

The aim of this study was to understand the perspectives of a selected group of nurses by exploring their experiences of professional learning. It was therefore aimed at discovering the processes through which these diplomates learned professionally as they progressed through the first two years of their career. An appropriate method of inquiry for this particular research had to be sought so that information about the professional learning development of
these P2K nurses could be elicited and best understood once qualified. Hence the following three research questions were asked initially to represent the broad research area from which the study was developed:

♦ To what extent does the P2K course equip nurses for continued professional learning?
♦ To what extent did the nurse educators contribute to the post-registration learning of these P2K diplomates?
♦ What are the diplomates' perceptions of professional learning during the first two years of registered practice?

These questions defined the topic of interest at the initial stage of the study. Goetz & LeCompte (1984) maintained that research questions vary in scope, abstractness and precision, depending upon the purpose of the study and the level of theory that informs it. In qualitative research the formulation of questions and problems can be complicated because of the variety of ways initial objectives may be extended, modified or redefined by such factors as participant selection difficulties, change in context over time and emergent analytic categories.

Thus two further research questions were considered appropriate as a point of focus for the research:

• How do P2K nurses choose to plan and organise their professional learning during their registered practice?
• How does the P2K nurses' conceptualisation of professional learning reflect in their registered practice?

These basic questions were asked in order to explore the diplomates' perceptions and developmental processes of professional learning and to determine to what extent they were committed to continued professional learning. These five research questions clearly required that a long range
view was taken and also incorporated the transition whereby diplomates moved from student status to registered practising nurses. The diplomates were therefore followed over a two year period. The research was thus designed to examine the diplomates’ acquisition of professional learning as they progressed through their post-registration learning in their world of work.

The design and approach of this research can be viewed from what Jacob (1988) referred to as an exploration of the unknown whereby information from the participants was required before formulating specific research questions. Consequently, further research questions were generated throughout the study to assist in the on-going data collection and analysis and were found helpful in allowing the study to evolve within the parameters of the research area. The subsequent research questions which were formulated during the course of the study were based on new issues that emerged within the study itself and as such were placed within their relevant context. Chapter Four offers details of these subsequent questions.

3.6 Selection of participants

The study focused on a small group of P2K nurses and those lecturers most closely related to them. The sample of students was selected from one cohort of thirty-eight student nurses from the Adult and seven from Mental Health branch programme six months prior to qualification as registered nurses. Twelve nurses from Adult and four from the Mental Health Branch were selected from thirty potential participants who expressed willingness to participate in the study. Of these, twelve were females and four males. The sample of educators consisted of two team leaders and four lecturers; two were males and four females.

This sample aimed to represent a specific group of nurses and their educators who have been involved in one diploma course within one College of Nursing. Since the primary goal of this study was to understand the
participants' experience of professional learning in context, the sampling method did not seek to obtain a representative sample. The aim was to illuminate the meaning and the process of post-registration professional learning of a small group of P2K nurses, and thus to be in a position to theoretically generalise rather than to statistically generalise.

The sampling strategy used in the study was a judgemental technique also known as opportunistic sampling (Fettermann 1989 and Honigmann 1982). According to Fettermann, judgemental sampling is the most commonly used technique in naturalistic research. He describes it as the technique which relies on the researcher's judgement to select the most appropriate members of a subculture, based on the research question. Nonetheless, Robertson and Boyle (1984) argued that representatives of the sample may cause concerns because even a whole community may not accurately reflect cultural practices or beliefs of other communities in a region.

On the other hand, Honigmann (1982) asserted that naturalistic methods of sampling are logical as long as the fieldworker expects mainly to use their data not to answer questions such as 'how much' and 'how often' but to solve qualitative problems. Thus a judgemental sampling was appropriate for this study which set out to discover what happened to P2K diplomates once they qualified and the significance of what occurred during their professional learning and the links between these occurrences. According to Honigmann (1982) this kind of sampling is appropriate for the researcher who is primarily engaged in searching for patterns that occur and recur within a group.

Sampling criteria were adopted for the selection of the nurses who participated in this study. They consisted of nurses who once qualified would:

1. Find employment within three months. This was necessary due to the time constraint of the study.
2. Be likely to stay in the U.K. or Europe during two post-qualification years. The mobility of the nurses was an important consideration because of the researcher's limited financial resources. It was also anticipated that the data collected from these nurses over a minimum period of two years would be at their place of employment.

3. Be willing to participate and be interviewed at least every six months during the data collection period. A minimum of two years was considered necessary in order to gain an understanding of occurrences of professional learning in a meaningful manner.

4. Commit themselves to a long term study. Commitment to longitudinal studies is crucial in order to minimize attrition rate.

This process reinforces Honigmann's (1982) argument of judgemental sampling which seeks to meet specific criteria and he also maintained that this approach is most likely to be successful when it is informed by expert knowledge of the subject area to be studied. In this study, prior knowledge of the students was used to draw an appropriate sample which reflects the selected cohort of P2K nurses. Nevertheless, Honigmann proposes to ignore such strict usage of the concept and process of sampling.

A judgemental/opportunistic sampling strategy was also used in the selection of the lecturers. The two team leaders and four lecturers who volunteered to be interviewed were from various subject teaching teams. They had knowledge of all the subjects which were taught both in the Common Foundation Programme as well as the Adult and Mental Health Branch programmes. They had also been involved in the planning of the participants' curriculum, its development and evaluation.
3.7 Gaining access

The recruitment of participants for the study commenced at the College of Nursing in June 1993, six months prior to the end of the students’ nursing course. It can be argued that the success of a study depends on gaining access to the site of study. This study was conducted on two specific sites. Data were initially collected in a College of Nursing and then at the participants' respective work places where a rich mix of many of the processes, people, programmes interactions and structures were present.

Fetterman (1989) suggested that being recommended and introduced by someone in authority helps to strengthen the fieldworker's capacity to work in a community. He claimed that this improves the quality of the data. Appropriate entry was thus sought through formal and informal “gatekeepers” of the College. In research gatekeepers are described as “those who control access to data and to human subjects” (Homan 1991:82). Access to the identified study population was gained by an informal discussion about the research project with the Principal and the Vice-Principal of the College, followed by the submission of a copy of the research proposal attached to a formal letter of request stating the purpose of the study in order to satisfy the protocol of the College. The Vice-Principal then gave written permission for the study to be carried out and for the students from Adult and Mental Health Branch programmes to be invited to participate accordingly.

Arrangements had then to be made with respective Team Leaders so that the students could be met informally in class. The aim of this meeting was primarily to discuss the research proposal and the purpose of the study with a view to recruiting suitable participants.

Hornsby-Smith (1993) recommended that time must be spent forging links with the community, exploring how the proposed research can be mutually and reciprocally advantageous to both the researcher and the participants.
During this initial discussion, issues of the rights of individual participant were addressed. It was made clear that participation was entirely voluntary, that all personal details would be treated with absolute confidentiality and that anonymity would be maintained. The long-term commitment to the study was emphasized but the participants were assured that, once committed to the study, they would be able to opt out whenever they wished without being disadvantaged in any way. It was felt important to make contact with potential participants in this manner and for the researcher to be open, honest and reassuring at this critical time of the study.

Cassell (1988) described a two stage process of accessing groups: “getting in” when attempting physical access and “getting on” when attempting to gain social access. This distinction between physical and social access was relevant at this stage of the study. After careful negotiation of access to the students, credibility was felt to have been enhanced by the fact that the researcher taught this cohort of students throughout their course and was therefore perceived herself as having an “insider” status which seemed to have facilitated unconditional access. However, this apparent open access became rather closed and some students reacted differently from the already established student-teacher relationship. This occurrence supports Hornsby-Smith’s (1993:59) argument that “erection of barriers” may be due to what the students perceived as “external threats from intruders”, thus causing problem with social access. Hornsby-Smith, suggested the need to provide appropriate reassurance to defensive groups even in situations of physical open access, before social access can be achieved. At this point, despite the intimate knowledge of the setting, the students and their environment, it was felt necessary to devise appropriate strategies to deal with this situation.

The role of the lecturer-researcher had to be considered. The students perception of this role was explored in order to elicit trust, co-operation, openness and acceptance of these potential participants, since the formation of participant-researcher relationships was crucial. The activities that the
researcher's role involved were also discussed and the manner in which participants could help in the research made explicit. Then, an outline of the methods which would be used to collect data for the study, the frequency and duration of involvement as well as other issues which were of interest to the students, such as the funding of the research, the university involved and the selection criteria were discussed. It was felt necessary only to give a broad outline of the study during this recruiting stage.

In exchange for participation in the study, career advice and guidance if and when required, general update of the College events and the profession, interim report and/or reporting back useful information of the research study and help with work in further studies were offered. Besides developing roles that ease access and facilitate receptivity of environment and participants Marshall and Rossmann (1989) suggested that researchers who conduct qualitative studies should offer rewards or benefits of some sort to motivate participants' co-operation. Furthermore, the nurses gave their time to be interviewed and had to adjust their routines to help the collection of data for this study. However, this reciprocity fitted within the constraints of the research and personal ethics as well as within the boundaries of the researcher's role maintenance.

A form was sent to each of the 45 students seen a week after the initial discussion, when they were asked to indicate whether they were willing to participate in the study or not. Thirty students expressed their wish to be considered for the study. The sixteen participants who met the criteria specified in Section 6 were then asked to sign a letter of informed consent on college headed note paper, to convey the research genuineness and legitimacy. The letter informed and reminded the participants, in broad outline, about the nature of the study of professional learning of P2K nurses, indicating that four to six monthly interviews would be held over a period of two years when a tape recorder would be used to collect data. Anonymity and confidentiality were assured and they were encouraged to contact the
researcher personally if they had any queries or worries about participation in the study. This was done prior to arranging a mutually agreed time for the first interview in December 1993/January 1994.

3.8 Data collection: methods and issues

While direct observation is at the heart of qualitative research, the interview can be used to obtain data which conveys meaning from participants within a specific context. Thus, the main method used in this study to gather data about the P2K diplomates' experiences and perceptions of their professional learning, within a particular context, was in-depth, open-ended interviews and group interviews. Relevant fieldnotes of the groups and individual interviews complemented by documentary evidence were also useful data. Section 3.8.1 will deal with one-to-one interviews and in Section 3.8.2 the documents will be discussed.

Schatzman & Strauss (1973) considered the interview to be a special mode of inquiry which is particularly suited to the study of human beings and necessary where the actions of people are either unfamiliar or very complex. The nurses in this study needed to describe their experiences of professional learning once they qualified and, therefore, interviews were considered important to gain the required information.

Given the nature of the research topic, the possibility of direct participation or observation of the research setting for any length of time seemed unproductive. Direct observation was not possible in order to find out from the diplomates the necessary information about their professional learning during the first two years of registered practice. For instance, these nurses' feelings, thoughts and intentions, their behaviour that occurred at some previous point in time, the ways they organized their professional world of learning once qualified and the meaning they attached to what went on in their world were not amenable to observation.
Additionally, an attempt was made to use personal reflective diaries to supplement data collection and for the participants to keep an account of the sequence of events because of the time lapse in between the interviews. Despite numerous reminders, only two participants returned their account of their professional learning experiences during the two years of the study. When this situation was investigated, it seemed that some of them simply forgot to make the required entries in their diaries and others stated that they did not feel it was important enough since they were being interviewed regularly. It was thus felt that these two diaries were not sufficient to reflect the experiences of all the participants studied.

3.8.1 *In-depth open-ended interviews: principles and application*

In-depth, open-ended interviews were the main way in which data were collected. The purpose of open-ended interviewing was to gain access to the nurses' perspectives by allowing and facilitating them to express their understanding of professional learning in their own words over a period of time. Qualitative interviewing methods are appropriate for "capturing developmental dynamics" (Patton 1990:114), that is, gaining an understanding of the developmental processes in a specific context. The quality of the data collected during an interview is essentially dependent on the interviewer (Hammersley & Atkinson 1986; Patton 1990). Ways to enhance the collection of high-quality data from these newly qualified P2K nurses had, therefore, to be carefully considered.

Among a range of different kinds of interviews Patton (1990) used the term "general interview guide approach" which he described as one of the three basic approaches to collecting qualitative data. The other two approaches are the informal conversational interview and the standardized open-ended interview. A general interview guide was thus designed during the planning of the research study. This approach involved writing down a synopsis of relevant issues to be explored with each participant before interviewing
begins. These issues were used as a general guide and the exact wording of the questions to obtain responses about those issues was not determined in advance.

3.8.1.1 Rationale for choice of interview approach

The general interview guide approach was favoured for this research study, as there was only one interviewer involved, whilst, if there were other interviewers involved in conducting the interviews, a more structured interview would have to be used instead so as to maintain consistency in the interviewing approach. Although, Patton (1990) defended the usefulness of an informal conversational interview when data collection is not dependent on a single interview, he also suggested that interview questions change over time. As this study demonstrates, each new interview was built on those already completed which enabled elaboration from previous information and clarification from previous participants. Hence there is much flexibility in the sequencing of the general interview approach.

In this study, the interview guide approach allowed for issues from which particular subject area were explored, probed and clarified. Although the questions were worded spontaneously and a conversational style was established, the focus was maintained on a particular, predermined topic and key issues. Another advantage of this approach was that it was also useful in conducting the group interviews which were carried out during the exploratory stage of this study. Thus, those initial interviews were kept focused while the participants' perspectives and experiences were allowed to emerge.

3.8.1.2 Participant-researcher relationship: rapport and neutrality

It can be argued that the validity and quality of qualitative interviewing depend upon the effective establishment of a particular kind of social relationship
between the interviewer and the participant (Ackroyd and Hughes 1983). It was important to be aware of strategies for establishing and maintaining this relationship, especially during the first stage of contact, because the participants were free to refuse to give an interview or to break off at any moment. Thus, at the outset of the study, the co-operation of the participants was ensured in order to establish a suitable relationship with them. Trust, honesty, reassurance and the extent of participation were communicated so that interest and motivation were maintained in the continuance of the interview.

Patton (1990:317) viewed “rapport” as a “stance vis-à-vis the person being interviewed” and “neutrality” as a “stance vis-à-vis the content of what that person says”. Watson et al (1991) reported that during the initial period of their interviews, relationships between interviewers and participants were cordial and information orientated. However, as time went by in their longitudinal study, and the participants lives began to fall apart, it became increasingly difficult for them to remain neutral, although they were unable to intervene in participants' lives or to advocate on their behalf. Similarly, in this study, the participants being interviewed started off by being enthusiastic about entering the world of nursing for which they had waited three years but, as time went by, and they encountered difficulties, the “reality shock” was in evidence. It felt at times that they were relieved to be given the opportunities to discuss those problems with an outsider who was willing to listen and empathize with what they were experiencing.

It is also suggested that when establishing rapport with the person being interviewed, it should be done by maintaining neutrality, meaning that the interviewer cannot be seen to be shocked, angered, embarrassed or saddened (Treece & Treece 1986, Patton 1990). This does not however mean that the interviewer does not care or respect what the person being interviewed is willing to share with the interviewer. In some research, studies such as this one, it is difficult to see how this position of neutrality, value-free
and uninvolved role could either be adopted or maintained. For instance, when information appeared contradictory, certain issues had to be challenged to validate the responses or at times when some of the nurses were experiencing difficulties at work such as alienation and lack of recognition from others on the ward. Cornwell (1984) argued that the researcher who does not admit to investing something of themselves is dishonest. Thus, during the two years of data collection and regular contacts with these participants it was evident that bonds of empathy and concern had gradually developed. Watson et al (1991), during their longitudinal study, realized that the abstract notion of remaining completely uninvolved is neither possible nor desirable.

Oakley (1981) felt that the traditional techniques of neutrality were basically methods of manipulating people and calculatedly treating them as objects to obtain what is wanted from them. She found that when she interviewed her participants, she did not feel able to use purely exploitative techniques as a source of collecting data nor could she interview the same women over many months and remain detached. Oakley therefore suggested that finding out about people was more effective when the interview was relatively intimate and non-hierarchical.

Other feminist researchers such as Finch (1984) and Scott (1985) also became increasingly concerned about the potentially exploitative nature of their activities in relation to those being interviewed. Finch noted that she left interviews with the feeling that her interviewees needed to know how to protect themselves from people like herself. Accordingly, there were instances in this research when personal comments were made about preceptors and ward managers, specific examples that the participants gave to justify their responses which could not be used and when three participants in particular overtly expressed their distress, considerations other than the research had to be given primacy. Thus, from these arguments, it can be inferred that it could be difficult for the research, especially the qualitative
inquiry approach, to be independent of the researcher.

Throughout this study, the participants were made aware that their knowledge, experiences, feelings and attitudes were important and a non-judgemental attitude was also adopted about the information gained from them. The way this was achieved was to constantly remind the participants that there were no right or wrong answers to questions about their experiences of professional learning and whatever they felt was important at the time of the interview was considered valuable information for the study.

However, Hammersley and Atkinson (1986) drew attention to problems of "over-rapport" whilst many researchers have expressed concern about becoming too involved with their participants (Adler et al, 1986; Goetz & LeCompte, 1984 and Miller, 1952). Adler et al (1986) believed that to become too close or overly empathetic would be to risk completely accepting uncritically the perspectives of the participants. This situation would obviously depend on the skills of the researcher.

3.8.1.3 Social and cultural factors influencing qualitative interviewing

Benney and Hughes (1966) referred to the norm of "equality" which should govern interviewer-participant relations. On the other hand, Ackroyd and Hughes (1983) suggested that the convention of equality by which the interviewer should try to minimize any inequalities arising from age, gender, race and ethnicity, social class and status and religion is not always easy to meet. Nevertheless, it was useful to know how these social characteristics might affect responses from members of the researched population. It is, then, essential that the researcher reflects on the nature of researcher-participant relationship and the factors which may be important in that relationship.

However, during the process of this study, status seemed to be the main
socio-cultural factor that became evident, particularly during the initial stage of the researcher-participant encounter. A feasible explanation for this could be because the participants had to adjust to the researcher's different role during the study. Prior to the study the researcher was one of their nursing educators. Consequently they could have perceived this new role as having a higher status than theirs since traditionally in nursing a nurse researcher is seen as having an hierarchically higher status.

Nevertheless, it is not self-evident that the establishment of a warm and trusting relationship and researcher's awareness of social and cultural factors will always get the participant to tell the truth. It is known that people can and do lie and among other things, say things intended to maximise their self-esteem or try to avoid offending others. It seems reasonable to argue that it may, sometimes, result in the participant avoiding potential controversy, offering blandness and deceptions instead, designed to maintain conviviality (Cicourel 1964). All of these and other factors which can lead to bias in the information gathered had to be considered. Since the aim of the interviews was to obtain useful and meaningful information from the participants' learning experience, clearly, to be of any use for this research study, all the information gathered had to be as accurate as possible without claiming to seek an ultimate truth.

3.8.1.4 Dealing with interview discrepancies

It is also a fact of life that people often have not done what they report they have done or do what they say they will do. Mehan and Wood (1983:49), who described the purpose of the interview as the capturing of "lived experiences outside the interview", argued that as the interview situation is a portion of time from one reality that is separated from the lived reality, even when the interviewer and participant share the same reality in the sense of class, background, language or age, distortion is inevitable. In view of these arguments, practical strategies had to be addressed in order to enhance the
quality of the data collected from the nurses in this study.

In order to deal with discrepancies, Watson et al (1991) designed their research instruments so that the questions which participants might be reluctant to answer truthfully were asked several times over the course of the interview but were worded in a different way each time. They argued that, in a longitudinal study, it is extremely difficult for participants to remember distortions and omissions over a period of time. Thus, in this longitudinal study, the participants were asked to be specific in their answers and to give concrete examples of what they were describing, for instance when they stated what professional learning they were undertaking and how they were doing it, from one interview to another. Alternatively, they were also asked to repeat themselves to clarify unclear answers and when inconsistencies were detected, the participants were reminded of a previous answer as suggested by Watson et al (1991).

3.8.1.5 "Listening beyond"

It is by no means self-evident that good rapport between interviewer and participants results in more valid data. Cicourel's (1964) detailed study of interviewing shows how it is taken for granted that interpersonal knowledge is used by interviewers in order to get the work done. In other words, a great deal of interpretive work is necessary on the part of both the interviewer and the participant in order to generate appropriate responses as was the case in this study as discussed above, since the interpersonal tactics necessary in any social encounter are varied. In conducting these interviews it was obviously necessary to retain a critical awareness of what was being said and to be ready to explore some issues in greater depth which Measor (1985:63) referred to as "listening beyond" and which Hammersley and Atkinson (1986) described as active listening.

This sensitivity to "listening beyond" had to be employed especially
throughout all the interviews. Even when what was said was highly relevant, at times the information given was insufficiently detailed or concrete and some clarification was necessary so that ambiguity could be avoided. Thus, listening actively when the participants were talking was crucial as they were the people with the necessary information to answer the research questions and information about "their" world of professional learning. Listening actively and carefully helped to maintain control of the interviews and to direct them, so as to collect the kind of data required for this study.

3.8.1.6 Tape recorded interviews

As Shipman (1988) suggested, a tape recorder was used as a way in which the participants could talk freely about the subject under study. In addition to increasing the accuracy of the data collection, it enabled all attention to be given to the participants and facilitated the process of writing down fieldnotes during the interviews. This approach demonstrates Measor's (1985) concept of "listening beyond". A tape recorder was seen by Patton (1990) as part of the indispensable equipment of researchers using qualitative methods for data collection. The interactive nature of in-depth interviewing, he argued, can be seriously affected by the attempt to take verbatim notes during the interview, the pace of the interview for instance can become non-conversational. However, the use of the tape recorder did not eliminate the need to take notes. To supplement tape recorded interviews, Devault (1990) suggested keeping notes which reflect the researcher's own reactions to situations and to the fieldwork as it progresses. Very often during the interviews, how things were said and what was left unsaid was considered as important as what the participants had said.

3.8.1.7 "Saying good-bye"

Ackroyd and Hughes (1983) described the final stage of interviewing when the interview itself is complete and it is time for the interviewer to disengage
from the scene. They pointed out that this disengagement can often be harder than anticipated especially if the relationship has been a rewarding one for the participant. Accordingly, disengagement had to be handled delicately because it was felt necessary to seek permission from the participants to contact them at a later date to confirm any details and interpretation of the data with them. Patton (1990) maintained that the period after an interview is critical to the rigour and validity of qualitative inquiry. He suggested that even if the tape recorder had functioned properly during the interview, the interviewer should go over the interview notes to make sure they make sense, to query areas of ambiguity and uncertainty and to review the quality of information gathered from participants in terms of whether the interviewer really found out what s/he wanted to find out. These were particularly important in this longitudinal study as the interval between one interview and another was as long as six months. The period after an interview was thus a crucial time for reflection and elaboration. It was a time for quality control, to ascertain that the data obtained were useful, reliable and valid. To have bypassed this time of reflection was to seriously undermine the rigour of the qualitative method (Patton 1990) used in this study.

With regard to the person-centred approach to this study, the participants were reminded of the imminent end of the series of the interviews well before the actual last set of interviews. This was done in preparation to the “saying good-bye” stage of the study. Eventually, at the last interviews, it was felt important to allow the participants to express their feelings and thoughts about their two year involvement in this study. They generally felt that they had enjoyed participating in a study which had helped their personal and professional growth. However, mutual sadness was particularly evident at the realisation that there was actually a five year involvement from the time these nurses commenced their nursing course. Similarly, Watson et al (1991) reported sadness as the interviewing part of the study drew to a close and the necessity to end the friendships that they had established with their participants over time and they admitted that it was sad to say good-bye. But
it seems that few studies mention this acknowledgement of sadness as part of the research experience, which indicates that this may not be recognized as important enough to report.

3.8.1.8 Evaluation of interviewing as a method of data collection

Unlike quantitative research, naturalistic research needs to emphasise the methods used because there is no established traditional way of organizing and reporting the study. Although, as discussed in this chapter, the interviews depended upon particular social and cultural conventions prevalent in some kinds of social system, the general principle of this study's data collection had to be evaluated in terms of the conditions that prevailed as well as in terms of its methodological adequacy. As such, there does not seem to be any single way of interviewing, no correct format that is appropriate for all situations and no single way of wording questions that will always work. The particular situation within which the study took place, the needs of the respective interviews and the individual style used all came together to create a unique situation for each interview. This, in fact, can be argued to have been the challenge of qualitative interviewing.

The in-depth interviews used in this study opened up what was inside these participants with regard to their experiences of their individual professional learning during the first two years from the time of qualification and it is that what makes the qualitative inquiry more intrusive and involve greater reactivity than quantitative approaches. In a longitudinal study this can be more pronounced as the researcher is involved with the participants over a period of time, thus developing a much closer rapport due to the long term commitment of both the researcher and the participants, as evident in this study. It was crucial to select which interviewing style and which questioning format would be suitable for a particular participant. It was also important to establish an interview climate that facilitated and generated open, valid responses. As Patton (1990) purported, when the interview does not go well,
it is the responsibility of the interviewer, not the fault of the participant.

3.8.2 Documents

It was felt necessary to examine and explore the participants' education in the context of the curriculum model, which was used to prepare them for their career in nursing, in order to fully understand the nature of their course and its influence on the diplomates' professional learning during their registered practice. Three sections of the curriculum, namely, the Common Foundation Programme, the Adult and the Mental Health branch programmes were therefore examined. These supporting data sources helped to make some aspects of the nurses' professional learning more understandable and they provided data which could not be observed or described during the interviews (Schatzman & Strauss 1973).

Thus, educational documents and records used in this study, such as the course curriculum and timetables, were examined to further identify important issues and to check the accuracy of some aspects of issues raised in the interviews. They were also used to increase knowledge and understanding about the programme. Furthermore Documents provided the study with valuable information and stimulus for generating questions that were essentially pursued through interviewing.

A careful scrutiny of these documents also provided a behind-the-scenes look at the course content as well as leads from which interview questions could be asked. This educational documentary evidence might not have made sense without the interviews. However, taken together, the two sources of data enabled a fuller picture of the nature of the course and its contents. Working back and forth with the interview responses and the documents also helped clarification of issues raised. They thus provided a better understanding of the meaning of the professional learning process that the diplomates had experienced when they undertook the P2K course.
Moreover, an examination of these documents was useful in the discussion of the context within which the study took place. They contained useful information such as a description of the educational institution involved, the course philosophy, the manner in which the P2K course was interpreted and organised at the time of the study, teaching and learning strategies used and the course contents. Thus, this information provided an insight into the nature of the course for the college of nursing involved in the study. They were also found helpful in furthering understanding of the professional learning of the diplomates.

3.9 Research sequence: procedures and issues

Figure 3.2 (see p.105) is a diagrammatical illustration of the sequence of the interviews which were carried out for the study. The sequence was as follows:

- A large group discussion with all students from the Adult and Mental Health branch programmes took place in June 1993, six months prior the end of the course. The research proposal, aim and purpose of the study were discussed with a view to recruit suitable participants.

- In September 1993, three students (two from Adult & one Mental Health) volunteered to participate in the exploratory study. This was the preliminary preparation for the fieldwork. The aim was to develop an interview guide for the main study as well as to provide insights and to raise an awareness about procedural matters of the interview process.

- At the time of qualification, four small group interviews were conducted in December 1993 and January 1994. There were four students per group: one Mental Health & three Adult groups. The aim was to explore the participants' perceptions, their experience of and views about professional learning in nursing. This helped the construction of the individual
interviews' topic guide.

- In May, June and July 1994, six months post-qualification, the individual interviews of the dipomates commenced. Sixteen nurses were interviewed: twelve Adult & four Mental Health.

- The lecturers' individual interviews were undertaken during August and September 1994. Two team leaders and four lecturers agreed to be interviewed.

- In November and December 1994 and January 1995, fourteen of the dipomates agreed to be interviewed, one year after they had qualified: ten Adult and four Mental Health nurses.

- In May, June and July 1995, 18 months post-qualification, there were thirteen participants who were individually interviewed: nine Adult & four Mental Health nurses.

The last set of individual interviews took place in November and December 1995 and January 1996 when the dipomates were two years into their registered practice. Twelve participants were interviewed: eight Adult & four Mental Health nurses.

3.9.1 Preliminary exploratory work

In preparation for the first set of interviews, exploratory work was done in order to develop an interview guide which was to be the main tool for the collection of data. Three individual (one-to-one) interviews and four group interviews were conducted for this purpose. The interviews provided insights and raised awareness about procedural matters of the interview process, alteration to the topics as well as addition of issues which were of particular
Figure 3.2: Data collection: Sequence of interviews.

Exploratory Work

Six Months

1 Year

18 Months

2 Years

Post Registration

Sept: 93
Jan: 94
Dec: 93
May/June/July 94

Nov/Dec 94
Jan: 95
May/June/July 95

Nov/Dec 95
Jan: 96

Individual Preliminary Interviews

Group Interviews

First

Lecturers Interviews
August / September 1994

Second Individual Interviews

Third

Forth
concern to the topics and research questions but which were not thought of and omitted. This study's group interviews of the P2K nurses were used in combination with the three sets of individual in-depth interviews as a preliminary approach in preparation for specific issues addressed in individual interviews. The goal was to get closer to the understanding of the participants' professional learning development by finding out about their experiences and perspectives from which their views, feelings and attitudes would emerge.

These interviews were, therefore, carried out to gather information about the professional learning of P2K nurses and at this stage they were found useful to lay a foundation for three of the research objectives as stated in the introductory section (p2, objectives 1, 3 and 4). In a sense, the exploratory work helped to conceptualize the main aims of the study and made preliminary preparation for the fieldwork. Consequently, some of the key features which needed to be pursued were identified. A descriptive framework (Figure 3.3, p.107) was thus designed specifying the nature of data sources, key issues to be explored and anticipated themes based on the study's areas of focus. Additionally, such exploratory work also helped the researcher to gain some practice in interviewing.

3.9.2 One-to-one exploratory interviews

Exploratory work commenced in September 1993. It involved individual taped recorded interviews with three students (two Adult and one Mental Health) from the same cohort of students as those of the main study since they were comparable with the selected sample in their knowledge and way of thinking in respect of the course of study. Those three students did not wish to participate in the main study but volunteered to be interviewed for the pilot study. They, nevertheless, fulfilled the criteria which were set out for the selection of participants in the main study.
Figure 3.3: DESCRIPTIVE FRAMEWORK OF KEY AREAS TO BE STUDIED AND ANTICIPATED THEMES

This Framework was designed after exploratory work, and specifies who and what would and would not be studied. It indicates key issues to be explored and anticipated themes based on the study’s areas of focus.
An explanation of the aim of the study was given and they were asked to give
critical feedback on the interviews. After each interview, the students were
asked to comment on what was being asked of them, the management and
procedure of the whole interview, any relevant points they felt would be useful
in refining the research tool and anything they did not understand.

A very broad topic guide with a few questions was used, addressing issues about:

* the nature of the course;
* views on the course philosophy and course content;
* learning and teaching styles and
* preparation for the future.

The duration of the interview was also noted as well as the effectiveness of
using a tape recorder during the interviews. Oppenheim (1992) suggested
that exploratory interviews should always be tape recorded and listened to
afterwards and that from these interviews a rough shape of the enquiry
should emerge. These in-depth interviews lasted between one to one and a
half hours. As a result, a list of issues for the interview guide was compiled
for its application in fieldwork.

3.9.3 Small group exploratory interviews at time of qualification

In qualitative research, group interviews can be used as a method of data
collection for studying ideas in the context of a group. They are useful to
facilitate exploration of topics and as an interview technique (Morgan 1988).
Their strengths clearly lie in the ability to observe interaction on the topic
which leads to a greater emphasis on participants' points of view. It was
within this context that the group interviews were conducted in this study.

It was useful to consider the two methods of interviewing because of the
potential effects of group interviewing as opposed to individual interviews. Groups may inhibit discussion for some participants on some topics whilst others might be more honest with their peers. In order to overcome this problem some questions and issues were repeated in the individual interviews of the main study. This was done for the purpose of cross-validation of the data being collected which was useful to ascertain whether individual responses were subjected to group influence or pressure.

Morgan (1988) argued that the single most important way in which group interviews can contribute to a study built around individual interviews is in devising the interview strategies. Thus, four small group exploratory interviews were conducted, one month prior to the completion of the participants' nursing course, with one interview for each group of four students. Consequently, the results of these groups formed the basis for the creation of a more organized interview guide for subsequent individual interviews which were the primary means of data collection. This was found useful since both the subject area and the study population, in terms of P2K nurses' perspectives, have not been extensively studied in the past. The aim was to bring a number of different perspectives in context and the emphasis was to ascertain how the participants perceived their professional world of learning collectively. Attention was paid to what aspects the participants found interesting and what they found important which provided some insights into their thought processes and values.

A mixture of informal conversational interview approach and the interview guide approach (Patton 1990) was used to conduct focus group interviews, when the nurses were about to complete their three year nursing course. These interviews involved mostly unstructured interviews lasting on average one and a half hours. Although Oppenheim (1992) strongly suggests the use of a tape recorder for exploratory interviews, two of the four groups were apprehensive to have their group interviews tape recorded. So, it was decided to keep verbatim and field notes for all the group interviews. Despite
the participants' apprehension about the use of a tape recorder to collect the data at this stage of the study, they all consented to have one used for their individual, subsequent interviews. Additionally, upon the participants' requests it was felt that it was preferable to allow the participants to form their own group. This was necessary to facilitate active participation and free discussion on the topic of interest and its relevant issues.

The optimal size of a group differs from one literature source to another, depending on the year of publication (e.g. Merton et al. 1956; Morgan 1988) and the recommended number ranges from six to twelve. However, Morgan suggested that four is the smallest size for a group interview and that the more homogeneous the groups are, in terms of background and role-based perspectives, the fewer one needs. This was evident in this study and it ensured adequate participation and involvement from all the participants. The decision of a smaller size also helped the observations of participants' reactions and taking down of fieldnotes. Furthermore, at that stage of the study consideration about the data analysis suggested that it would be easier to manage the data from a smaller group than a larger one.

3.9.4 Individual interviews

The individual interviews of the main study were carried out six months after the participants were qualified. The rationale for commencing the interviews six months post qualification followed by six monthly intervals was to give the participants an opportunity to reflect on the impact of the course and have a clearer perception of their process of professional learning. A total of fifty-five in-depth individual interviews of the participants took place over a period of two years each lasting between one to one and a half hours. Figure 3.4 overleaf illustrates an overview of the data sources and sample sizes. Additionally, there were a further six individual interviews from the lecturers involved with the education of these nurses so as to gain a deeper insight and
Figure 3.4: OVERVIEW OF DATA SOURCES AND SAMPLES

Main Data Sources

Diploma Nurses n=16

Adult (n=12)
Mental Health (n=4)

Team Leaders (n=2)

Adult (n=1)
Mental Health
CFP (n=1)

Lecturers (n=4)

CFP (n=1)
M/H (n=1)
Adult (n=2)

Supporting Data Sources

Course Documents

Curriculum

CFP
M/H
Adult

Timetables

Interviews
4 Diplomates' groups
55 Individual Diplomates
6 Individual Lecturers

Key
CFP = Common Foundation Programme
MH = Mental Health
wider perspectives of the nurses' professional learning. Furthermore, it was felt appropriate to seek the lecturers' views since they were all in contact and to some extent involved with the diplomates through their clinical liaison role.

Before and at the end of each interview the participants were asked whether they were still interested in participating in the study. Four of the sixteen participants chose to discontinue and did not complete all the four interviews.

3.9.5 Fieldnotes

Fieldnotes are usually associated with data collected from participant observation but in this study they supplemented the interviews which were the main form of data collection. Since all the individual interviews were tape-recorded, non-verbal communication and any other observable details could not be captured on an audio cassette. These observations were thus recorded in fieldnotes and consisted of making brief notes of salient points during the collection of data. They were also used to identify ideas on relationships within the data which provided a cross check for later on in the analysis stage.

In their discussion on fieldnotes, Field and Morse (1985:79) drew on the work of Bogdan and Biklen (1982) who defined fieldnotes as "a written account of the things the researcher hears, sees, experiences and thinks in the course of collecting or reflecting on data in a qualitative study". During the course of an interview, the researcher may become aware of subjective biases and unsubstantiated hunches relating to the setting or the phenomena. Although Field and Morse (1985) suggest recording these impressions in a separate diary in order to separate subjective from objective records, it was felt best to record both in the same diary for continuity and it was more practical for cross checking with other data.
3.9.5.1 Content of the fieldnotes

Fieldnotes were descriptive, concrete, detailed accounts and objective records of any occurrences in the setting where data were collected through watching and listening which Patton (1990) views as an on-going, crucial part of the data that is being collected. In this study they took the form of self instruction, reminders about specific events and notes about personal reactions (including the participants') and reflections. They also constituted a written record of the development of the interviews and ideas which were felt useful in subsequent interviews.

Thus the data collected from the fieldnotes of this study included: a brief description of the physical setting where respective interviews took place; non-verbal cues such as eye-contact; facial expression and gestures; physical appearance if felt meaningful at the time for instance, make-up, type of dress; any behaviour that might have affected the interview; actions and conversations that might have caused a reaction or change of behaviour and areas that needed clarification later or cross checking with other participants. Fielding (1993) suggested that feelings and reactions should be recorded at the time they are experienced. He also argues that doing fieldwork does have emotional costs and one needs data on one's attitude in order to document one's evolving relationship to others in the setting.

In the group interviews, in addition to descriptive accounts of the setting, key words, phrases and/or direct quotations from individual participants, had to be recorded as well because a tape recorder was not used for any of these interviews. However, Fielding (1993) argued that while recording speeds things up, it has the disadvantage of leading to a less reflective approach during interviews. A diagramatic representation of each of these four interviews and a systematic way of recording was also found useful later in the data analysis.
For each interview session the place where the interview took place, the date and time of the interview were recorded. These records were useful in obtaining a greater insight into the context of the participants' professional learning experience which interviews alone might not have revealed. They also added meaningful understanding to the data collected. These were cross-referenced with the interviews and acted as an aide-memoire in keeping track of the data and locating related interviews.

Fieldnotes were a useful way of reflecting on each of the interviews. They helped to identify and control interviewer bias and to reflect on the connections between the processes, sequences and elements of interaction with the participants (Wilson 1993). Fieldnotes were also found useful to reflect on the personal meaning and significance of what had been discussed in the various sets of interviews.

3.9.5.2 Analysis of the fieldnotes

Different analytic uses are made of fieldnotes. It is suggested (Fielding 1993, Wilson 1993) that such data should be collected systematically in order to maximise the elements of description. Field and Morse (1985) stated that after fieldnotes are recorded they become the basis for analytical memos. These authors suggested that fieldnotes should stay at the lowest level of inference and contain as little interpretation as possible. They nonetheless also suggested that any abstractions and analytical ideas should be recorded separately or in a distinct column in the margin of the page. This study's fieldnotes were generally descriptive. They were then analyzed alongside the primary data to validate and cross-check findings if and when felt necessary. Data from fieldnotes were found useful in this research when there were apparent instances of participants' and researcher burnout.

Participants' burnout was experienced on two occasions when during the interviews the participants appeared to have very little to tell the researcher.
On another occasion, when one of the participants informed the researcher at the time of making an appointment that she did not have very much to report and wondered whether it was worth her while to give an interview. Watson et al (1991) came across similar situations and as a result they devised some "sympathy evoking" strategies which involved sending copies of the articles they had published about their research findings from the study together with a letter that implored the participants' help, stating that their data would be incomplete if they did not hear from them. This method proved to be successful for them whilst for this study such drastic measures were not necessary, and it was felt that a gentle persuasion which reinforced the valuable contribution of the data to the research study was sufficient.

Although the attrition rate for each interview was relatively low (see Section 3.9.4), further anticipated attrition evoked a sense of failure, helplessness and a temporary decreased interest in the study. Cooperation and support from the supervisor, peers and the participants themselves helped to resolve this problem. Watson et al (1991) maintained that in any longitudinal study there is always the possibility of researcher and/or participants' burnout and suggested that this should be taken into consideration during the data collection and analysis.

3.10 Research contact and attrition

Since the sample of this study consisted of newly qualified registered nurses who are known to often be very mobile especially during the early stage of their careers (Robinson and Marsland 1994), it was felt that the issue of attrition was crucial especially during the design stage of the study. Thus, decisions about practical strategies in order to minimize attrition rate of the diplomates had to be considered and applied as much as possible. The need to explore factors which might influence retention in this longitudinal study were also addressed.
3.10.1 Access and maintaining participants' contact

Killien and Newton (1990) found that respect for participants' time helps to maximize retention. In this study, when data collection appointments were arranged, allowance was made for a lot of flexibility. Interviewing times were arranged at the participants' own convenience and included evenings, weekends and at night. Waiting time was also kept to a minimum so as to convey a positive regard for each of the participants and an appreciation of their extensive time and effort which were required in this study.

Although it was relatively easy to find diplomats who were willing to submit to the initial interview, there was no guarantee that all of them would maintain their interest throughout the two years of the study. Every effort to maintain contact with the participants in between the series of interviews was made. This was done with sensitivity because the participants might have felt under pressure and contact took the form of personal interest in the individual's well being and/or of greetings, for instance at birthdays and Christmas. Telephone contact in between interviews can alert the researcher of any change in the participants; Killien and Newton (1990) claimed that this was an additional component of successful retention.

Watson et al (1991) found that, as time goes on, more difficulties can be encountered with participation especially when participants are no longer involved in a given system such as the educational system which applied to this group of nurses. Hence, an open invitation to contact the researcher by letter or telephone with any questions, suggestions and concerns about the progress of the study or any status change was also encouraged. This system proved useful mainly when there was a last minute change in interview times.
3.10.2 Systematic follow-up

It is essential that a longitudinal study should be able to locate individual participants when they are required for data collection (Killien and Newton 1990). Therefore, methods of "tracking" participants had to be carefully considered especially since the ability to maintain contact with them throughout the follow-up interviews could have been difficult in view of the known mobility of newly qualified nurses. Furthermore, the completion of the study depended on this.

Hence, the follow-up tracking information during the initial interviews included a current address and telephone number which was checked and updated at each set of interviews and each participant was given a self-addressed, change of address card. In anticipation that this address might become outdated within the following six months, two back-up addresses and telephone numbers of family members or friends, who were unlikely to move away during the two years of data collection were also recorded so that letters or messages could be passed on, if and when necessary. One of these two addresses and telephone numbers was from a next of kin. This method proved successful when two of the participants had left the area without notification. In many studies, failure to trace is associated with high geographical mobility (Goldstein 1979). Asking all the participants at each interview their plans for the following six months also helped in raising awareness of their whereabouts.

However, it was evident in this study that, despite successfully tracing the participants, in between the interviews, there was still a failure to make contact with two of them. Goldstein (1979) suggested trying at least three times to obtain a satisfactory response rate but, as the above account indicates, it is not always possible to adhere to such strict guidelines. Each case was assessed on an individual basis. Furthermore, due to the responsibility to maintain participants' confidentiality the researcher had to be
careful how and who to contact when attempting to trace a participant and it was not felt correct to divulge the reasons for seeking the participant. As far as this set of participants was concerned, it was not appropriate to let the ward managers know the nature of the contact because of the difficulties that some of them were experiencing and had discussed during the interviews. An account of the study's attrition history can be found in Appendix B.

3.10.3 Pragmatic philosophy

Whilst encountering some of the problems of participants' attrition in this longitudinal study it was to some extent guided by what Killien and Newton (1990) coined "pragmatic philosophy" which suggests that to have had some data was better than none at all. They reported that this is one of the factors which contributed to the successful retention of the participants in their own study. Similarly, in this study two of the participants participated in only one individual interview and two others did not take part in the complete set of data collection. Nonetheless, the data that were collected from these four nurses was found to be valuable and contributed to meeting the goals of the study.

3.11 Ethical issues

When the pragmatic aspect of qualitative research methods for this study was being considered, ethical issues relating to the study and ethical implications which might arise from the research had to be identified and justified since it involves humans as the subject of research. In this research, ethics refers to "the standards established within the profession for the conduct of its members" (Homan 1991:1). The first guidelines related to research ethics in nursing were published in 1977 by the Royal College of Nursing (RCN) of the United Kingdom and updated in 1993 and then more recently in 1998. These guidelines are necessary because they clarify the conditions under which nursing research is acceptable. Hence, all nurses engaged in
research with human participants are required to abide by these guidelines and they are considered to have legal as well as moral responsibilities for those who are involved in their study.

The guidelines on research ethics in nursing relate to issues which nurses undertaking research need to consider and these include: the rights of participants; the obligations and responsibilities of the researcher, and considerations of the setting in which research is carried out. The protection of the research participants is the RCN's (1998) main concern. Thus for those nurses who undertake research three main areas are addressed: the integrity of the researcher; the researcher's responsibility to the participants and relations with sponsors, employers and colleagues. A summary of the ethical issues from the RCN's guidelines which were particularly applicable to this study can be found in Appendix C.

In order to apply the RCN's (1998) guidelines adequately, a framework which is commonly used in healthcare settings was identified and adopted for this research. It is based on the principle-based approach (Beauchamp and Childress 1994, Edwards 1996) which is relevant to nursing research and refers to four ethical principles. These are:

a) beneficence;
b) non-maleficence;
c) respect for autonomy and confidentiality and
d) justice.

In this research the last three principles are the ones which were mostly relevant and have been applied accordingly.

3.11.1 Beneficence

The principle of beneficence refers to the act of doing good through research. In nursing this principle is normally applied to research findings for the
enhancement of patient care. This research does not directly relate to changes in nursing practice and was carried out as part of an educational programme. It is therefore suggested (RCN 1998) that in such an instance, it is the improved intellectual development of the nurse researcher that can indirectly be applied in practice. Furthermore, it can be argued that the findings from this research of the continued professional learning of nurses have implications for their professional development which involves keeping up to date with nursing knowledge and skills for the benefit of patients.

3.11.2 Non-maleficence

Non-maleficence requires the research to avoid doing harm. An ethical argument pertaining to this study was whilst it may appear evident that the participant must be protected from physical harm, this may not be as apparent in nursing education research as, for example, in experimental studies involving humans. However, in this study, it was felt necessary to consider the psychological and emotional harm that could be caused by the researcher's activities which is not always easy to anticipate. Even just one insensitive question could have caused distress to participants.

In this study, potential areas of ignorance in the nurse about their work may be found during the collection of data and it would be harmful to leave any participant with the newly discovered feeling that s/he ought to know more than s/he does. It was therefore decided prior to collecting data, that information which the participants become aware they are lacking could legitimately be dealt with during and/or at the end of the research activities without affecting the data. This decision was based on the experience gained with one of the participants during the exploratory work. This particular participant had to be reassured during and at the end of the interview about an increasing tendency of self-criticism, introspection and self-doubt which emerged unexpectedly during data collection. These kind of feelings may eventually have a psychological effect on participants' self-
concepts in relation to their professional development. On the other hand, one could argue that this incidence could act as a motivator for further learning.

Another unanticipated effect of the series of interviews was that it made the participants reflect on what they had done in respect of their professional learning up to the time of each of the four interviews. The consequences of such reflection had to be taken into consideration. Such an activity may not be positive for all the participants and could have a somewhat detrimental effect in the realization that they had not done as much as they felt they should have done. Some of the participants may feel guilty, be worried and anxious about under-achieving. On one occasion one of the participants had commented:

"It's like an appraisal really. Thinking, oh dear, perhaps I should have done more courses, I should have learnt more. All this could be threatening".

Although this particular participant did not appear overtly distressed, this statement typifies the kind of psychological consequences that reflection could have on participants in research. However, in this instance the situation was further explored and dealt with at the end of the interview. It was felt immoral to have interviewed this nurse and then leave her in emotional distress without adequate support. Hence, it was ensured that participants received any necessary debriefing in the form of active intervention before they left the research setting. Follow-up contact was also made about the participant's well-being and to ensure that she was functioning within the limits of her abilities with regard to her professional learning.

3.11.3 Respect for autonomy and confidentiality

Respect for autonomy refers to allowing individuals to make free choices about making decisions to participate in the research. This principle is
central to informed consent in research which is considered to be one of the means by which participants' rights are protected (Seibold et al. 1994). Steps were thus taken to safeguard the autonomy of the study's participants. No coercion was used to persuade the nurses and the educators to take part in the research and those who agreed had the right to withdraw at any point during the study. This issue has been discussed in details elsewhere in this chapter (see Section 6 and 7).

Confidentiality is seen as part of autonomy in research. It is concerned with the participants' right to control access to information about themselves. Thus participants' control over self-disclosure was an important consideration for this research and involved the assurance of anonymity and confidentiality. The privacy of the participants was ensured during every set of interviews and they were given the choice of venue on each occasion. Confidentiality and anonymity had to be addressed since repeated contacts at the workplace increased the possibility that participation became known to others. This was resolved by asking the participants to state when and where they preferred to be contacted and whether others were aware of their participation in the study. Each situation was dealt with on an individual basis and a record kept accordingly. Other examples of the manner in which anonymity and confidentiality were offered to the participants of this study and how it was maintained can be found in Sections 7 and 9.5.3 respectively.

However, related ethical issues were identified after conducting the first interviews with regard to participants' personal revelations. It was evident that due to the researcher being known to the participants there was a tendency to express highly personal aspects of their professional as well as private lives. In fact examples of such data also appear in subsequent interviews (see Section 3.8.1.3). These had to be handled with sensitivity with the assurance of confidentiality being maintained at all times. These data was not included in the transcription for analysis but notes were made of their occurrences so that the remaining data could be understood in its
context.

3.11.4 Justice

In research justice is about fairness. This principle was applied by ensuring that the participants were not expected to neglect their nursing activities and responsibilities on the wards in favour of research participation. Examples of this occurred on three occasions during data collection. The interviews were arranged to take place on the wards where two of the participants were on night duty and the other was working on a Sunday afternoon. These times were chosen because the participants considered them to be appropriate for their interviews. However, on these occasions the interviews were cancelled without hesitation because the nurses were called out due to untoward incidences arising on the wards. Clinical duties were therefore given primacy and the participants treated fairly.

3.12 Methodological rigour of the study

Methodological rigour of a study is usually assessed through the reliability and validity strategies which are commonly used for quantitative research. However, Guba and Lincoln (1988:103) contended that although criteria derived from quantitative research can be applied to qualitative research, some “re-interpretation” of these criteria was required in order “to better fit the assumptions of the naturalistic paradigm”. Consequently, they proposed analogous terms for the four factors, normally used to evaluate the rigour of research studies, which they believe are more appropriate to the naturalistic paradigm: credibility for truth value; fittingness for applicability; auditability for consistency and confirmability for neutrality. The methodological rigour of this study was sought within this framework as well as by references to the work of other qualitative researchers such as LeCompte and Goetz (1982), Field and Morse (1985), Sandelowski (1986), Leininger (1985, 1987), Marshall and Rossman (1989), Miles and Huberman (1994) and Morse.
(1994) who have based their arguments along similar lines.

3.12.1 Credibility/truth value

Guba and Lincoln (1988) suggested that, in a qualitative inquiry, "truth value" can be accomplished by assessing the credibility of its findings with the various sources from which the data was drawn rather than by the internal validity as in quantitative research. Field and Morse (1985:139) referred to validity in qualitative research as "the extent to which the research findings represent reality" which they considered an essential criterion of the research design. Hence, a qualitative study is considered credible when it accurately describes and interprets the participants' individual experiences in a meaningful way, as they are lived and perceived in natural settings, rather than the verification of 'a priori' conceptions of those experiences in a contrived setting (LeCompte and Goetz 1982; Sandelowski 1986).

Consequently, in this study, a summary of each interview was prepared for the participants to verify the accuracy of their own data so that their experiences of professional learning could be described and interpreted in a meaningful manner. Any dubious data were checked with other data for clarification to establish whether an event was unique to only one or a few particular participants or whether others had similar experiences. For instance, when some of the participants talked about self-directedness in practice and when it became apparent for some of them that learning was grade related, these were checked for universal evidence. Then, prior to the end of data analysis the interpretation of the study findings were discussed with four of the participants to check the credibility of the analysis and whether the participants' experiences of professional learning were reflected in the findings. This use of participants to review the analysis ensured that the data were viewed in a consistent manner thus confirming the interpretations of participants' meanings to the events described.
Moreover, besides this participant review findings, LeCompte and Goetz (1982); Field and Morse (1985); Miles and Huberman (1994) suggested two other specific strategies that could be used to reduce threats to "internal reliability" which in this qualitative study refers to credibility: low inference descriptors and peer examination. Low inference descriptors are described as verbatim accounts of data provided by participants to the researcher. The use of a tape recorder for the individual interviews enhanced the accuracy and appropriateness of the verbatim which were used to substantiate the categories in the analysis of the data. Peer examination was achieved by eliciting colleagues' help in examining the transcripts to see if they could identify the same categories and structures, within the data, as the researcher. Discussion of the findings with fellow colleagues also led to peer review.

Additionally, Miles and Huberman (1994) believed that a study is more likely to be credible when the meanings emerging from the data have been tested for their "plausibility" and their "sturdiness" which infers the validity of the data collected. This belief is also shared by several other authors, for instance Guba (1981), Lofland & Lofland (1984) and Denzin (1978). They all considered this data testing process as an important source of verification and they maintained that findings should be checked with the participants not only during analysis but also at various stages of the data collection. In this study, the participants tended to give personal examples to support their claims of professional learning to demonstrate that they did what they said they did. When examples were not forthcoming they were asked to think of recent situations or events to justify their statements.

The claim of qualitative research to high validity derives from the way data collection and analysis are selected (Denzin 1978). Thus another factor of the method design which could be considered to have contributed to the validity of this study is the tape recorded in-depth interview data which were collected over a two year period. LeCompte and Goetz (1982) argued that
collecting data for long periods provides opportunities for continual data analysis and comparison to refine constructs and to ensure the match between scientific categories and participant realities.

Finally, in the pursuit of this study's credibility, triangulation as defined by Denzin (1978) was used to collect the data. Guba and Lincoln (1988) recommended the use of triangulation because it makes data and findings credible. Thus, multiple sources of information were sought and provided a comprehensive perspective of the research questions. By using a combination of in-depth interviews, fieldnotes and educational documents, different data sources were used to validate and cross-check findings. Moreover, since each of the type and source of the data collected had their strengths and limitations, using a combination of data types increased validity as the strengths of one approach compensated for the limitations of the other approach (Marshall and Rossman 1989; Fielding 1993).

3.12.2 Fittingness/applicability

Guba and Lincoln (1988) suggested that, in qualitative research, "fittingness" is more appropriate than the concept of "applicability" which refers to external validity in quantitative research. External validity consists of the generalizability of findings and representativeness of participants. Thus, a study is considered to meet the criterion of fittingness when its findings can fit into contexts outside the study situation and when its findings are viewed as meaningful by similar individuals and applicable in terms of their own experiences. In addition, Sandelowski (1986) suggested that fittingness occurs when the findings of the study fit the data from which they are derived.

However, Guba and Lincoln (1988) argued that generalizibility of findings can only be obtained in similarly controlled situations and that replication can be a problem in circumstances of rapid change whereby different conclusions can be derived from a similar situation at different times. As an alternative,
they suggested that it should be up to each audience of qualitative research to ascertain the applicability of the findings according to the meanings which apply to them. This study supports this argument since generalizability was not the purpose of the study but to elicit meanings in a context-related situation. The findings can thus be considered for generalization within the population of diplomates (from one college of nursing) from which the sample was derived or other similar situations which share similar conditions.

Guba and Lincoln (1988) also asserted that what is needed in qualitative inquiry are thick description and working hypotheses. The latter are described as propositions emerging from a particular investigation and are regarded as context related which Field and Morse (1985) referred as reality-based theories.

They, therefore, suggested that qualitative inquirers should think in terms of working hypotheses and of testing the degree of fit between the context in which the working hypotheses were generated and the context in which they are to be applied. In this study discussion on emerging propositions can be found in Section 3.14.4 of this chapter whilst thick description is evident in the descriptive interpretations which resulted from the data analysis and the rich data base produced, in order to understand the professional learning of P2K nurses, as discussed in chapters 5, 6 and 7.

Furthermore, in keeping with the principles of naturalistic inquiry, representativeness in this study was focused more on the data than the participants or the setting. The nature and the participants' experiences of professional learning were thus considered in relation to a particular group of P2K nurses.

3.12.3 Auditability/consistency

Guba and Lincoln (1988) propose that "auditability" is a more appropriate
concept to address the issue of consistency in qualitative studies. In quantitative research consistency refers to the reliability of a test or a procedure which aims at repeatability which determines the generalizability of a study. Reliability is described as a constituent element of validity which “measures the extent to which random variation may have influenced stability and consistency of the results” (Field and Morse 1985:139). These authors therefore reject the concept of “reliability” as it is used in quantitative studies. In contrast, qualitative research emphasizes “the uniqueness of human situations” occurring in natural settings and “the importance of experiences” where repetition is not sought (Sandelowski 1986:33). LeCompte and Goetz (1982) also maintained that unique situations cannot be reconstructed precisely and produce identical results because human behaviour is never static and argue that a study cannot be exactly replicated regardless of the methods and designs employed.

Hence, a study and its findings are viewed as being auditable when another researcher is able to follow the “decision or audit trail” (Guba and Lincoln 1988:122) of the researcher so that comparable conclusions could be achieved, given the same data, the researcher’s perspective and similar situation. Consequently, this study was written with a view to allow sufficient detailed information so that the “audit trail” is adequately maintained. Care was taken to carefully record and report the progressive stages of the study, all the decisions made on the data (Kirk and Miller 1986) upon which the study was based, together with the justifications of those decisions. It can thus be argued that, as a result, this study could be replicated in the broad sense of its methodology, despite not necessarily generating the same data (Reason and Rowan 1981). Sandelowski (1986) insisted that auditability, which is primarily demonstrated in the research report, is specifically achieved by a clear description, explanation and justification of all the stages of the research process.

However, Patton (1990) argued that there are no straightforward tests for
validity and reliability in qualitative studies and there are no simple formulas or clear-cut rules about how to do a credible, high-quality analysis. He stated that a qualitative researcher returns to the data over and over again to see whether the data, constructs, categories, explanations and interpretations make sense and whether they really reflect the nature of the phenomena. In effect, all of the procedures for validating and verifying data collection and data analysis discussed were aimed at reducing misinterpretations introduced by the researcher's biases. However, Patton (1990) indicated that the issue of validity remains particularly difficult for qualitative researchers because, on the one hand, the principles of qualitative procedures are aimed at substantiating the validity of the data and yet, on the other hand, the data inevitably represent perspectives rather than absolute truth.

3.12.4 Confirmability/neutrality

Confirmability is one of the four criterion of qualitative rigour purported by Guba and Lincoln (1988) rather than neutrality. Within quantitative research neutrality means that the research components are free from bias in order to achieve objectivity, once validity and reliability are established (Sandelowski 1986). In a qualitative study, confirmability is said to be achieved when credibility, fittingness and auditability have been established. Guba and Lincoln (1988) argued that in any inquiry, the objectivity of the data is of critical concern because the data should be factual and confirmable. However, Sandelowski (1986) believed that the findings of any study are as much a reflection of the inquirer as of the phenomenon being studied. She clarified this argument from the perspective of qualitative inquiry by stating that the very nature of the naturalistic inquiry values subjectivity because of the involvement of the inquirer with their participants and the meanings participants give to and derive from their personal experiences. However, in this study an attempt of neutral stance was maintained during data collection as discussed earlier in
this chapter (see Section 3.8.1.2) as well as when analysing the data so that the participants' own perceptions and experiences of professional learning could be captured. Moreover, it is evident from the discussion in this section that credibility, fittingness and auditability had been established in this study.

A common concern of qualitative research is that the researcher is the sole instrument which could result in researcher bias. However, Bogdan and Taylor (1975) argued that bias is present in all other methods by the very nature of choosing a method and participant. In this research specific strategies were used to address the issue of researcher bias in an attempt to increase the confirmability of the data collected. Fieldnotes which helped to reflect on personal experiences during the study were found useful in identifying and recognizing any factors that could have led to researcher bias.

The use of a tape recorder for all individual interviews also increased the confirmability of the data collected as well as being aware of Oiler's (1981) concept of "bracketing" which involved putting aside what was already known about the participants and their course, having previously been one of their lecturers. LeCompte and Goetz (1982) indicated that the more familiar the researcher is with the language of the participants the greater the accuracy of the interpretations. However, the participants were encouraged to define their own perceptions of different concepts in relation to professional learning such as professional development, self-directed learning and preceptorship so that they reflected their own perspectives and not those of the researcher.

3.13 Organization of the data

Raw data were the group interviews' verbatim accounts, direct tape recordings of individual interviews and field notes. These were processed before analysis commenced. The organization of the data began when the interview tapes had been transcribed and the fieldnotes written up soon after each set of data was collected, so that recall of the chain of events was not
Recalling and writing up verbatim accounts for the group interviews posed more of a problem than anticipated because of the participants' reluctance to have these interviews tape recorded. On the other hand, they did not object to note-taking during the interview and repeating certain responses which were required, to be noted word for word. Consequently, interviews lasted much longer than the anticipated hour to an hour and a half.

Thus, fieldnotes for these group interviews were restricted to specific issues of interest which were dictated by the purpose of the study. These were complemented with short direct quotations and significant non-verbal data, such as facial expressions and explanatory gestures. Non-verbal data were considered important because at the time of analysis they helped to understand further the context of the ongoing data being collected and what went on during the interviews. Nevertheless, the knowledge of 'speed writing' skill, which is an adapted version of 'shorthand', was an asset here because a lot of the rich data would have otherwise been lost. Moreover, these group interviews had to be written up almost immediately because reading back speed writing notes can become meaningless, if left for too long.

3.13.2 Transcribing individual interviews and fieldnotes

The tape for each interview was replayed and listened to carefully for both the content and the tone of the responses and notes were written down describing the interview context. This procedure allowed for familiarization with the data which was the first major task prior to the analysis of the interview data (Field & Morse, 1985).

The tapes were transcribed word for word. A system of notations was
adopted. Various notations consisting of personally constructed symbols, such as dots and dashes, were made on the transcripts to denote pauses, unfinished sentences, laughter, expletives and inflectives. Margins on each side of the transcripts were used for coding categories on one side and fieldnotes on the other. Following each transcription, the tape was re-played to check for its accuracy and margin notes inserted as appropriate. Care was taken to indicate any emotionally laden phrases or sentences, inflections e.g any changes in the intonation of the voice, significant pauses and anything else that could indicate that any of the issues raised or being discussed was important. This proved to be useful during the analysis process later.

Raw, descriptive and concrete field notes were reviewed and written up in detail accordingly. Write-ups of fieldnotes during the interviews allowed for insertion of some of the missing contents, remembered post-interviews, which were not in the notes. Personal thoughtful impressions, reflections and feelings as well as reactions arising from and captured during data collection were also recorded. Such additions were marked so that researcher bias was not introduced.

After each wave of data collection, transcription and field notes write-ups, three copies of all data collected were made as recommended in various literature (Field & Morse, 1985; Patton, 1990; Fielding, 1993; Miles & Huberman, 1994). All original copies were kept separately in a safe place to guard against any onoward happenings, such as loss. The others were used as working copies during analysis with one set always kept complete. Each set of transcripts was sequentially numbered and labelled, then arranged chronologically, in a systematic order.

3.13.3 Coding method

Coding is an important and iterative exercise in the organization of data for
analysis, to label and retrieve meaningful data in transcribed texts, relating to a particular pattern, theme, research question or construct. Since it is a form of early and continuing analysis, it can be considered as part of the cyclical analytic process together with data collection, transcription and field notes, helping to discover underlying meanings in the text.

In this study, codes which are also referred to as 'labels' or 'tags', were used to organize relevant segments of the data by assigning meaning to the descriptive or inferential information compiled during the study. These codes, of varying sizes, were attached to words, sentences, phrases or whole paragraphs and a coding system was devised in order to organize, identify and retrieve them later on. Thus unique numerical codes were attached to each data segment, for instance 101.2 means data segment number 101 from interview number two. Additionally, an index of all data segments as well as one for each participant was kept so that a numerical code could be traced back not only to its actual occurrence but also to the participant. Thus, in this instance a glance at the participants' data segment index revealed that Teresa was the participant who offered the information in data segment 101.2. This method was therefore found extremely useful in keeping the data in their respective context throughout the analysis. All coding was done manually.

3.13.4 Data filing system

The setting up of a data filing system was also done by hand. A personal filing system was devised so that every required data segment for each category could be easily and quickly retrieved during analysis. Every significant data segment, consisting of phrases and quotes from the transcribed text was either copied onto small cards or larger data segments cut from transcripts and pasted onto cards for manual sorting. Each card, which provides actual instances of the category, had a number corresponding to the unique "pin" number from the transcripts and the category label it belonged to, was also inserted. The cards were then sorted into piles and
placed under the appropriate category. Whilst this process created categories and differentiation, it also gave an idea of the frequencies of each category.

When categories were revised, for instance, when creating sub-categories because of too many or too few data segments for the same category or new ones had been identified, the data cards were re-examined and placed in the appropriate category envelope. Data labels were altered, the old category crossed off the card and the new category label inserted as a reminder of its prior location.

Data appearing in more than one category was indicated at the bottom of the data card and cross-referencing was done using data card number and category number. When data pieces which belonged to more than one category had to be re-written, this filing system proved to be worthwhile because it helped to become further immersed in the data and it also ensured maintenance of the data in its appropriate context.

3.14 The process of analysing the data

A variety of analytic frameworks were considered but most seemed not entirely applicable to the eclectic approach used in this research. For instance Lofland & Lofland (1984) discussed the development of units of analysis and the physical and mechanical procedures that can stimulate analysis during period of data collection Goetz & Lecompte (1984) identified different types of qualitative analysis such as typological analysis and constant comparison with an emphasis on ethnography and Leininger (1985) identified different kinds of analysis such as thematic, componential and semiotic.

On the other hand, Miles & Huberman's (1984, 1994) work offers a pragmatic, flexible approach to qualitative data analysis. This was felt to have merits. It
suggests a three-stage cyclical process: the systematic process of reducing the data from the interview transcriptions; the organization of condensed data and the presentation of narrative text supported by extracts from the data, along with the use of visual data matrices which allow for drawing conclusions and verification. Similarly, Wolcott's (1994) three main steps in the analytic approach were relevant: description of the data including the participants verbatim; the systematic identification of relationships among key concepts and interpretation which is making sense of the data in their contexts. Some of Patton's (1990) and Field and Morse's (1985) suggestions of qualitative data analysis were also used.

In order to address the purpose of this study, general principles for analyzing the data collected were applied based on the work cited above rather than following rigid procedures or a set of instructions. Thus a process of analysis was devised to analyse the data collected for this study at various intervals over the two year period.

The analytic sequence which consists of two parts was followed as shown in Figure 3.5 (p.136) and 3.6 (p.137). Part one describes the procedures used to generate descriptive categories from the data (Figure 3.5) and part two the development of meanings to the data (Figure 3.6). Thus, two levels of analysis were undertaken in the study. The first level analysis consisted of making sense of the data and the second level involved linking and interrelating the different parts of the analysis. The meanings and contexts of the data were maintained by constantly referring back to the completed transcripts and other base data. Data collection and analysis ran concurrently and the final stage of analysis was the period when previously developed concepts were brought together.

3.14.1 Generation of categories and sub-categories

Data transcripts were scanned line by line and, with the use of highlighter.
Figure 3.5 THE ANALYTIC SEQUENCE FLOW CHART 1

Generation of Categories & Sub-Categories.

1. Scan transcripts line by line & highlight potentially important data segments.

2. Review transcripts and
   - Look for recurring data patterns
   - Insert appropriate descriptive pattern label/code

3. Assign ID number (Numerical codes) to each data segment.

4. Copy data segments on index cards or cut larger data segments and paste on cards, inserting ID number from transcripts.

5. Group cards with similar patterns together.

6. Attach meaningful category labels to each pile of cards (apply key phrases/terms used by participants wherever possible).

7. Check data segments within each category with original transcripts.

8. Review categories & note:
   - Meaningful organisation of data groupings
   - Quantity of data segments within each category
   - Incidence of overlapping data

9. Validate categorisation method with independent researcher/participants.

10. Place each pile of cards in large envelopes, clearly labelled with appropriate categories and their sub-categories.

If too many or too few data
   - Remove & review with pattern labels &/or other categories.
   - Repeat steps 6, 7, & 8 to create sub-categories &/or new categories.
Development of meanings to the data

- Develop propositions to reflect findings & check against themes.
- Formulate research questions to guide further data collection & analysis.
- Establish possible relationships & construct thematic conceptual framework.
- Summarise accounts (use matrix to illustrate).
- Identify key concepts within categories & search for themes.
- Describe participants’ accounts & link with supporting verbatim examples.
- Organize major categories & sub-categories in a meaningful sequence.
pen, key words and potentially important phrases or sentences were marked. The transcripts were then reviewed and carefully examined for recurring data patterns. Summarizing notations and comments such as "attitudes of traditional nurses", "effects of the course", "effect of classroom theoretical knowledge" were placed in the margin.

Although all the data collected were considered potentially important, some was considered to be irrelevant within the context of the study. Field & Morse (1985) referred to these unusable segments of data as 'dross' and Miles & Huberman (1994) argued that it is not the words themselves that matters but their meanings within their appropriate contexts. They also identified three types of category labels which were used in this study: descriptive which entail little interpretation, followed by pattern and interpretive labels which are more inferential and explanatory and these were used when patterns became clearer. Categorisation of data therefore took place at different levels and different times during analysis, with the descriptive ones first followed by the inferential and interpretive ones later. An example is illustrated in Figure 3.7 (p.139) when the participants were talking about the aim and philosophy of P2K course:

The cards with similar data patterns were grouped together and category labels that best described them were attached to each group. These emerging categories consisted of both "indigenous" and "sensitising" concepts (Patton 1990). Indigenous concepts were key phrases and terms used by the participants themselves during the interviews which described the data segments within the categories, for instance "self-directed learning", "support". Whilst the sensitizing concepts were developed constructs which were generated from the sets of transcribed data in order to give some direction to the analysis and a general frame of reference e.g. "practical knowledge", "coping strategies". These broader categories were thus generated inductively from the participants' responses and embedded in the data representing them.
Figure 3.7: Illustration of the three types of category labels used in this study.

Participants’ verbatim

- “For nurses to have a better insight in what they are doing and to rationalizes their care. Nurses won’t be doing things just because it’s always been done that way”.

- “It makes nurses more aware of what they are doing, more aware of themselves and encourage them to have enquiring minds, more research minded, to know what and why they are doing something rather than being task orientated”.

- “The course gives nursing a higher status, educationally”.

- “Our (P2K) course is now recognised by higher education (institutions)”.

- “The course is at diploma level, unlike the other nurses who only had a certificate”.

Descriptive category

- Informed nursing practice.

Pattern category

- Clinical effects of P2K course.

Interpretive category

- The diplomates’ perception of P2K course effects on nursing.

Higher educational status.

Professional effects of P2K course.
All the data segments within their respective categories were checked against the original transcripts to ascertain the contexts within which they belonged. The categories were then reviewed and when there were overlapping data or a large discrepancy in the quantity of data segments within categories, the data cards were taken out of their original categories and each reviewed with further annotated pattern codes. This process of careful scanning and re-aggregation of data segments helped to formulate new categories and sub-categories which were components of major categories. Thus, these descriptive categories and their sub-categories provided a framework for the participants' accounts of their professional learning experiences as discussed in chapters five, six and seven.

In order to help reliability and clarity of definition, a validity check of the identified categories was done with the help of another researcher who worked separately on some of the uncoded copies of transcripts to confirm the appropriateness of the emerging categories. The category that best described the segments of data and the data which best fitted the category were used accordingly. Category checks were also undertaken alone by revisiting uncoded copies of transcripts intermittently; they were recoded and compared with previously assigned categories and adjustment was made accordingly. Cross-referencing of the categories was found useful to make corrections for conceptual bias. This process had to be as precise as possible. As the study proceeded the categories improved and became more focused on emerging patterns and themes which best answered the research questions and conveyed a sense of understanding.

3.14.2 Development of meanings to the data

The systematic process of generating and creating categories and sub-categories was the first step in making sense of the data. The process of finding relationships within the data followed what Ely et al (1991) described as the process of category development. This results in the identification of
concepts and formulation of themes. The aim of this second level analysis (Flow chart 2 - Figure 3.6, p.137) was to establish key concepts in a systematic way and to make sense out of the group of nurses' multiple perspectives of their professional learning. Thus the categories and their subcategories were organized in a meaningful sequence in order to convey a sense of understanding of the data.

At this point of the analysis once all the categories and data segments were bound together, a description of the participants' accounts began and were linked with relevant verbatim examples from a cross-section of the participants. This process helped to illuminate and support the analysis provided in the narrative form. Descriptive matrices were also developed when felt appropriate for a visual representation of the results of the analysis. These are specifically designed tables consisting of rows of major categories and columns of participants' verbatim and/or summarized narrative texts which are illustrated in Chapter 4.

The next analytic step was to search for relationships among categories and to detect the underlying meaning in categories and their components beyond what was immediately visible as well as to recognize what was important and significant in the data.

Hence, analytic summary tables were created to represent and facilitate further analysis. At this stage of analysis these helped to further reduce the bulk of the data within their original contexts and also provided an additional source of focus in identifying key concepts and searching for themes. The entries in the summary tables consisted of brief paraphrased data and/or short direct quotes from the participants' responses which were verified to ensure that they reflected the data in their respective contexts. The summarizing data segments tables were then scanned and annotated with key concepts emerging from recurring patterns within the summarized data. This led to the development of themes which linked the data in and across
The themes were derived from emerging patterns of the participants' own accounts of their experiences. Conceptual frameworks were then constructed to illustrate the relationship between key concepts and recurrent themes deriving from the analysis. Tentative propositions which indicated potential relationships within the data were then developed and were checked against the emerging themes. They provided an explanation of the findings and reflected a comprehensive perspective on the range and types of conceptual insights and theoretical ideas which emerged from the data.

The final phase of data analysis was undertaken when significant concepts had been well established and refined, and emergent themes and theoretical ideas identified. The process then became one of ordering the results of all the data for the final report to illustrate a total picture of the nurses' experiences of professional learning.

Thus, once the organization of data and description of the participants' experience of professional learning had been completed, the data analysis process moved to the theoretical interpretation of the findings. Significance and meanings were attached to findings and explanations were offered in an attempt to present an illuminating holistic picture of the study and an understanding of the fundamental nature of continued professional learning of these nurses. The significance of the data did not lie in the individual segments of data or individual participants but rather in the collective pieces of data in order to create a meaningful picture of their professional learning. Hence, during the data analysis process it was necessary to remember that the goal of the study was to seek meaning and pattern of the participants' professional learning experiences rather than to measure the degree or rate of occurrences on anyone piece of data.
3.15 Conclusion

This chapter provided a discussion of the principles and theoretical perspectives underpinning the research and the methodological perspectives pertinent to the study. It highlighted decisions made about the strategic methodological choices used for the research and their appropriateness within a wide range of possibilities. The last section of the chapter discussed the process used to analyse the data and chapter four will illustrate the way in which the process of analysis was applied in the management of the data collected for this study.
CHAPTER 4: DEVELOPMENT OF THEMATIC CONCEPTUAL FRAMEWORK

4.1 Introduction

The purpose of this chapter is to illustrate the way in which the procedures followed to analyse the data, as discussed in chapter three, were applied chronologically in this study. The data analysis comprised three stages. The first two stages involved the group interviews followed by all the diplomats' and lecturers' individual interviews. The data from these sets of interviews were analysed separately. Once the recurrent themes had been identified, and the key emerging concepts were established, the last stage consisted of making sense of the large amount of information in their contexts, as Wolcott (1994) suggested. This was done by integrating the first two stages of the data analysis, since at this point of the analysis, it was felt necessary to gain an understanding of the overall picture of the diplomats' professional learning over the period of two years.

4.2 Data analysis 1

The group interviews were the first set of data to be analysed. This was analysed in great depth because its main purpose was exploratory and it was intended to guide the individual interviews. All the data collected were considered to be important during this initial analysis. Thus, the procedures for this analysis of the data were broader in comparison with the analysis of the individual interviews which were more focused and in greater depth.

Broad categories were generated from the data following the analytic sequence (see Figure 3.5 - Flow chart 1) as discussed in chapter three. These categories contained the course process, its content and the learning outcomes. All the data segments within the categories were checked.
alongside the actual data transcriptions and they seemed to describe the
category labels with reasonable accuracy. Three descriptive matrices (Miles
and Huberman, 1994) were then developed, incorporating all relevant data
segments within the four groups interview transcripts, and they were linked
with their emerging categories as appropriate for ease of data analysis.
Tables 4.1, 4.2 and 4.3 (pages 147-154) are the descriptive matrices which
contained first level descriptive data across all the cases.

These categories were classified according to the three areas of interests
during the group interviews: the participants' experience of the P2K course;
their views and perceptions of professional development and their feelings
and thoughts at the end of the P2K course. On close examination of these
three areas of focus, it became obvious that both the participants' feelings
and thoughts at the end of the course, and views and perceptions of
professional development, reflected the participants' experience of the P2K
course. They were, nevertheless, kept separate because of the apparent
distinguishing features of each of them.

The three matrices were then scanned and reviewed, in order to ensure
completeness of the available data and to see whether they fitted the
categories. Annotations in the margins were also attached during the
reviewing process. In this search for descriptive meaning and conceptual
understanding of the data within identified categories, care was taken not to
lose sight of "professional learning" which was the area of focus in the study.
It was also important to ensure that the learning experience of these
participants was viewed within the context of the learning environment of
nursing.

Moreover, a reduction of the bulk of the data of these three descriptive
matrices into a manageable set was essential at this stage. The data set
was thus divided further into ways which could best describe those
GROUP INTERVIEW: DESCRIPTIVE MATRIX - Table 4.1
AN OVERVIEW OF THE PARTICIPANTS' EXPERIENCE OF PROJECT 2000 COURSE
AT THE TIME OF QUALIFICATION

CATEGORIES

<table>
<thead>
<tr>
<th>Clinical staff attitude</th>
<th>'Things are getting better (in clinical areas), I think. I have met staff nurses who are doing degrees and are into research as well.'</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>'It took clinical staff a long time to know us.'</td>
</tr>
<tr>
<td></td>
<td>'We were seen as different on the wards and they (clinical staff) behaved differently towards us.'</td>
</tr>
<tr>
<td></td>
<td>'I was lucky, only sister knew that I was a P2K student, in my last placement. So the others were really nice to me.'</td>
</tr>
<tr>
<td></td>
<td>'The staff on the wards used to talk about these P2K students don't know anything.'</td>
</tr>
<tr>
<td></td>
<td>'We were always known as P2K students.' 'I suppose, now it will be P2K staff nurses. Personally, I don't like that (being called P2K) at all. It puts my back up.'</td>
</tr>
<tr>
<td></td>
<td>'In the branch, the staff realized we can do more than they thought.'</td>
</tr>
<tr>
<td></td>
<td>'It was bad enough when we were students.'</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attitude towards P2K course</th>
<th>'Interpersonal skills were useful and relevant in clinical setting.'</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>'Learning in branch was better, did what chose to do (nursing).'</td>
</tr>
<tr>
<td></td>
<td>'It (the course) was good; very good.'</td>
</tr>
<tr>
<td></td>
<td>'I was rather disillusioned about P2K, especially the CFP. It didn't feel like nursing, at all.'</td>
</tr>
<tr>
<td></td>
<td>'All these core subjects, social policy, sociology, psychology and so on, meant little to us. I often wondered, what I was doing here.'</td>
</tr>
<tr>
<td></td>
<td>'I didn't like the &quot;ologies at first (CFP) and felt they were irrelevant at the time.'</td>
</tr>
<tr>
<td></td>
<td>'I certainly started to learn nursing in the branch, CFP did not make sense to me.'</td>
</tr>
</tbody>
</table>
| Understanding of course philosophy | Course prepared ‘to find things out for ourselves and learned in small groups right from the beginning’.
| 'Being able to put a point of view forward.' ‘To be independent.’
| ‘Making nurses more accountable and professional,’ ‘Being recognized by others as professionals.’
| P2K increases student and nursing status and ‘provides knowledge of academic subjects, professional knowledge.’
| ‘To assess and plan care holistically.’ P2K prepares for ‘holistic patient care.’
| Course is about ‘Teaching of holistic care. Looking at all aspects of a patient, a person.’
| ‘Knowing why we do what we do.’
| ‘We were forever being told about (responsibility & accountability) especially during the branch programme.’ |
| Practical knowledge | P2K course ‘should have been extended for a further three to six months to allow us to practice nursing skills.’
| Limited experience on clinical placements.
| ‘Yeah, skill-wise, I don't feel good about. I keep on thinking, I need to know this, to learn that.’
| ‘Feel ‘scary’ in relation to staff nurse role: ‘being a staff nurse and not having enough skills.’
| ‘It was good to feel I was able to communicate with patients. I used interpersonal skills all the time’ in clinical areas.
| ‘It’s the more technical things, I feel I ought to know about.’ |
| Self-directed learning | ‘From what I understood it was going to be a DIY course and it was.’
| ‘I was motivated and I looked at more things than what was expected.’ ‘A sort of adult learning approach.’
| With regard to the DIY course, ‘I don’t feel so threatened, now.’ |
Table 4.1 - (Continued)

Group 4 acknowledged how all the assignments they had to do helped 'to find things out' for themselves, 'to search for information and come up with answers.'
'At least we know where and how to get hold of information if we need it.'

<table>
<thead>
<tr>
<th>Coping strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 4 felt somewhat apprehensive 'to challenge others who have more skills' than them, they have to depend on others (traditional nurses) to learn 'their new role, new skills.'</td>
</tr>
<tr>
<td>'I wanted to pass my practical assessment, so there was no point in confronting staff on the wards to tell them what they were saying about P2K students was not true' (P2K students didn't know anything).</td>
</tr>
<tr>
<td>'We are not what they thought we'd be (useless).'.</td>
</tr>
<tr>
<td>'All I need to do now is to work hard towards being on the same level as them (traditional nurses) skill-wise.'</td>
</tr>
<tr>
<td>The 'knowing where and how to' access information seems to be the 'biggest asset.'</td>
</tr>
<tr>
<td>Taking acquired academic knowledge from classroom to practice.</td>
</tr>
<tr>
<td>'I'm sure, we'll survive'</td>
</tr>
<tr>
<td>Studying together, sharing knowledge and learning from each other.</td>
</tr>
<tr>
<td>Need 'to show them' (non-P2K nurses); having to prove themselves on the wards. ‘We have to work harder to prove them wrong.’</td>
</tr>
<tr>
<td>Challenging routines, rituals, how? 'I don't know. I guess by being assertive and put forward sound knowledge, using research findings.'</td>
</tr>
</tbody>
</table>
Table 4.2 GROUP INTERVIEW: DESCRIPTIVE MATRIX
PARTICIPANTS’ VIEWS AND PERCEPTIONS OF PROFESSIONAL DEVELOPMENT

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions of professional development</td>
<td>Professional development means ‘doing courses and updating as much as possible’. Group 4 viewed prof. develop. as being part of nursing, ‘that’s what it’s all about.’ ‘(Professional development is) needed for nursing to go forward.’ Professional development means further studies. ‘Courses to help in staff nurse role.’ Group 1 viewed professional development as their responsibility when qualified. ‘Tutors are not there (in the clinical areas) to help you, to support you.’ ‘Out there you are on your own.’ Group 4 felt responsible to fund for own courses. Group 2 perceived professional development mainly in relation to further studies, degrees except no.8 ‘I won’t throw (the textbooks) away. ‘Will need ‘more and more’ textbooks according to needs later on. No mention of informal way of professional development except no. 12 ‘I would subscribe to nursing journals to keep up with developments in the area of nursing, I’ll end up in.’ ‘I can go on studying at a much higher level.’ ‘Learning has not stopped, (the end of course is) only the tip of the iceberg.’ ‘I need to learn a lot more.’ ‘The course is only a basis to practice, after that it’s up to us to build on it.’ ‘If a nurse does not continue to improve her practice, her skills and knowledge, she might as well give up.’ ‘What we’ve learnt to-day, will soon be out of date.’ ‘Things changes so quickly (in nursing), new research, new technology...’ ‘It’s impossible to stop learning.’ Group 3 demonstrated commitment to prof. develop. only when lack of skills was discussed. ‘We need to master our skills, to learn them quickly and all the time.’ ‘We will be compelled to update our skills with new technology.’</td>
</tr>
</tbody>
</table>
Table 4.2 - (continued)

New technology discussed, 'new types of patients, a lot more nursing research.'
'The end (of the course) for (lecturers) is only a beginning for us.'
'For me it will certainly be the case (for continuous learning), I want to work in coronary care.'
No. 11 implied course prepared them for professional development 'we had sessions in our last unit telling us about what was available to us when we qualify, other courses and that sort of thing.'
Group 3 discussed how they were taught to always search for, up to date research to apply to practice.'
Group 4 discussed how throughout the course, they've been told by lecturers about, 'where' their P2k dip. could take them in their career; courses of higher level etc.
Group 4 felt that they 'now, would continue on finding out' (as a result of self-directed classroom teaching).
<table>
<thead>
<tr>
<th>Categories</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New staff nurse role</td>
<td>Fears about lack of skills (others see them as ‘useless’). Others (traditional nurses) expect more from us. ‘Scary’ because ‘(non-P2K) nurses, students and patients would expect us to know a lot more than we do.’ ‘Different responsibility’ i.e. for patient care and accountable for own actions. ‘Tutors are not there to help you out.’ Group 1 felt apprehensive about (pending) new role. Having to prove themselves on the ward ‘being P2K’ and may not be readily accepted on the ward. Group 2 expressed no great concern re: transition to new role. Feeling ambivalent about course ending ‘when we started and everything was new, we made friends then after CFP we had to go to our own branch and now, we don’t know where we’ll all end up’; ‘it’s going to be hard to start again, I’ve made good friends and I shall miss them.’ Group 3 couldn’t ‘wait to put into practice what’ they’ve ‘learnt’ whilst being student nurses. Although expressed feeling of sadness re: end of course but ‘can’t wait to get on the ward and do proper nursing.’</td>
</tr>
</tbody>
</table>
Traditional terms of practising nursing skills and managing wards.

Nurses' Given the chance, we'll be just as good as the traditional certificated nurses on the wards.

'When we do something we know why.' Of the traditional nurses: although they seem confident
'their knowledge is very shallow no sound knowledge, not research minded at all.'
Table 4.3 - (Continued)

For the traditional nurses ‘it's all a matter of routine’; ‘they don't seem to know why they do things the way they do.’

Were made aware by lecturers the value of Diploma in Higher Education.

‘We are in a better position than (traditional nurses) to do a degree’ and ‘I can go on studying at a much higher level.’

‘The sound knowledge we have will take us forward.’

‘Yes, but we have more knowledge than traditional nurses.’

‘At the end of the day, we are all going to be staff nurses.’

Less clinical experience during P2K course.

<table>
<thead>
<tr>
<th>Practical knowledge</th>
<th>‘I've learnt things in class but we had very little time to practice them.’</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>‘Being in a student nurse role and not have enough skills.’</td>
</tr>
<tr>
<td></td>
<td>‘I only wished we had more practical experience.’</td>
</tr>
<tr>
<td></td>
<td>‘I’m not afraid of communicating with patients, it’s the more demanding things, technical skills, I feel I ought to know about, (especially as a staff nurse).’</td>
</tr>
</tbody>
</table>
participants' experience of the course and bring these broad, identified concepts and categories more in focus. Hence, it became apparent that some of the categories contained a lot of data segments, for example "participants' perception of professional development", whereas "support" had comparatively few data segments. Additionally, there were data segments which were found to describe two or three categories, for instance "attitudes towards P2K course"; "practical knowledge" and "theoretical knowledge". These overlapping data segments were therefore carefully re-examined and reviewed within the contexts of the original transcripts and further descriptive pattern labels were inserted alongside them. This process allowed for new categories to be formulated and sub-categories to be created from the eleven major categories. Subsequently all the data were re-grouped and organized with either original category labels or with newly created labels and sub-categories.

At this point of the data analysis, these three descriptive matrices indicated the possibility of creating typologies which Patton (1990) described as 'classification systems made up of categories'. It was felt that a classification system could link the process of learning during the nurses' experience of the course to the learning outcomes at the end of the course. This decision seemed appropriate here for making sense of the data since the reported accounts of the participants' experience of P2K at the time of the interviews were all obtained at the end of the course and they contained the process of learning, the course content and the learning outcomes of the course.

It was appropriate to examine the effects of the nurses' learning experiences of the P2K course. The participants indicated that their learning took place in two different types of settings, in the classroom and in clinical areas by which they meant hospital wards or departments, or in the community, although these were not specifically differentiated. Then, a typology of five different types of learning outcomes which can be applicable to both settings.
was identified from the data. Consequently, the participants' learning process here was viewed in terms of the change that occurred in knowledge, skills, attitude, behaviour and feelings of this group of nurses. At this stage, although this newly created classification of the categories did not entirely put the data in an appropriate context, it seemed to offer a much fuller picture of the course experience by looking at the cognitive, behavioural and affective aspects of learning.

Nevertheless, this analytic step started with the design of two process-outcomes matrices (Miles & Huberman 1994), which were found to be helpful in re-organizing the data in a systematic and appropriate manner. Table 4.4 describes the participants' outcomes of learning experience in the classroom and Table 4.5 describes those emerging in clinical settings. The entries are brief summarized phrases and/or direct quotes of participants responses, transcribed from the descriptive matrices, that were felt to best describe specific learning experiences which originally emerged from the interview transcripts. The original numerical codes were retained and found useful at this stage. They acted as "retrieval tags" which were used to retrieve segments of data from their original source. The cell entries were verified for the completeness of the set of categories which appeared to make sense in relation to the available data.

At this stage of the analysis, it was appropriate to find out what the data revealed when the two settings of classroom and clinical learning are examined together in an attempt to create the overall picture of the learning experience for this group of nurses. In order to facilitate this process of understanding and making sense of the data (see Figure 3.6, Chapter 3) in a meaningful, coherent manner, the two process-outcomes matrices were combined then refined. This procedure involved developing descriptive and pattern categories, as illustrated in Figure 3.7, Chapter 3, so that the data can be further condensed and begin to become more conceptually ordered whilst
Table 4.4: PROCESS - OUTCOMES MATRIX OF THE PARTICIPANTS' LEARNING EXPERIENCE OF THE PROJECT 2000 COURSE IN THE CLASSROOM

<table>
<thead>
<tr>
<th>Aspects of Learning</th>
<th>Learning Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td></td>
</tr>
<tr>
<td>→ Holistic care (course philosophy). Rationale for care (‘knowing why’).</td>
<td></td>
</tr>
<tr>
<td>→ Professionalism of nursing; advancement of nursing (progression).</td>
<td></td>
</tr>
<tr>
<td>→ Nursing is a continuous learning process.</td>
<td></td>
</tr>
<tr>
<td>→ Self-directed learning (assignments, self/peer assessment).</td>
<td></td>
</tr>
<tr>
<td>→ Learnt about: accountability (‘for ever told about this’); responsibility; academic status of P2K (more academic opportunities).</td>
<td></td>
</tr>
<tr>
<td>→ Acquired sound knowledge to base practice.</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
</tr>
<tr>
<td>→ ‘Able to put a viewpoint forward.’</td>
<td></td>
</tr>
<tr>
<td>→ Self-directed learning approach: find out for self; where &amp; how to get information; looked at more things than what was expected.</td>
<td></td>
</tr>
<tr>
<td>→ Able to search for literature.</td>
<td></td>
</tr>
<tr>
<td>→ Basic nursing skills: course only a basis for practice.</td>
<td></td>
</tr>
<tr>
<td>→ Interpersonal skills; communication skills.</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.4 - (Continued)

| Attitude                           | Positive towards course. |
|                                   | Nursing skills relevant in branch; core subjects irrelevant to nursing (especially in CFP). |
|                                   | Course made sense in branch, started to learn nursing in branch. |
|                                   | ‘The end (of the course) for you (lecturers) is only a beginning for us’; ‘what we’ve learnt to-day will soon be out of date.’ |
|                                   | Academic status influenced by lecturers/curricula. |
|                                   | Initially sceptical about course: ‘new to all’; ‘not properly tested’; did in 18 months what others (traditional nurses) did in three years. |

| Behaviour                         | Adult learning approach; had ‘to find things out’ for self ‘and come up with answers’; independent learner ‘would continue to be inquisitive and carry on finding out’; shared learning (group work)/co-operation. |
|                                   | Responsible for learning (influence of lecturers/curricula). |
|                                   | Peer support. |

| Feelings                          | Positive: Excited about starting nursing career: this is what chose to do; ‘can’t wait to get on the ward and do proper nursing’; autonomous/independence; committed to and responsible for continuing learning; supported by lecturers; confident in knowledge (theoretical knowledge and IPS); solidarity and mutual support (sharing of knowledge, learning together & from each other). |
|                                   | Negative: Sadness/sense of loss (end of CFP then branch); fear of non-acceptance from traditional nurses; apprehension re: readiness to practice. |
Table 4.5: PROCESS - OUTCOMES MATRIX OF THE PARTICIPANTS’ LEARNING EXPERIENCE OF A PROJECT 2000 COURSE IN CLINICAL SETTINGS

<table>
<thead>
<tr>
<th>Aspects of Learning</th>
<th>Learning Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td>Need to hang on to theoretical knowledge.</td>
</tr>
<tr>
<td></td>
<td>Need for further learning (due to lack of practical skills/limited clinical experience).</td>
</tr>
<tr>
<td></td>
<td>Rapid change in nursing skills (dynamic learning process of nursing).</td>
</tr>
<tr>
<td></td>
<td>Course only a basic foundation for practice.</td>
</tr>
<tr>
<td></td>
<td>Insight/awareness of accountability and responsibility.</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td>Identification of skill strength (able to use IPS, communication skills).</td>
</tr>
<tr>
<td></td>
<td>Self-awareness of skill limitations; little time to practice; lack of practical skills: ‘Being a staff nurse and not having enough skills.’ ‘Need more technical skills.’ ‘Skill-wise, I don’t feel good about.</td>
</tr>
<tr>
<td><strong>Attitude</strong></td>
<td>Staff: Labelling by staff; perceived alienation of traditional nurses, ‘seen as different, useless’; too much knowledge and too little skills; better in branch.</td>
</tr>
<tr>
<td></td>
<td>Participants: ‘All in the same boat’; need to work hard to progress; ‘it’s impossible to stop learning’; ‘would continue to find out’; self-belief (not useless, has academic status and theoretical knowledge).</td>
</tr>
</tbody>
</table>
Table 4.5 - (Continued)

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>In the past (as students on clinical placements): non-challenging; non-confronting; ‘trade-off’ of knowledge for skills; use of strengths (IPS, communication); alienation of traditional nurses.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The future (as staff nurses): need to prove self-worth; perceived high expectations of others; responsible for patient care and accountable for own actions; commitment to professional learning; need to prove occupational identity (to be on same level as traditional nurses); assertive to challenge nursing practice; take theoretical knowledge to practice.</td>
</tr>
<tr>
<td>Feelings</td>
<td>Positive: Hopeful; optimistic; responsible and accountable for nursing actions; ready to practice.</td>
</tr>
<tr>
<td></td>
<td>Negative: Lack of self-worth (skill-wise); lack of identity; fear of non-acceptance(by traditional nurses).</td>
</tr>
</tbody>
</table>
continuing to reduce the bulk of the data within their original contexts.

Table 4.6 illustrates the design and development of a content-analytic summary table, as suggested by Miles and Huberman (1994), which is partially descriptive and conceptual. This summary table thus facilitated further analysis of the participants' learning experience as a whole. They were compared and contrasted, then checked and evidence confirmed from their original source by retracing the steps backwards through the matrices.

In order to explore the interaction between the diplomates' learning experience in the classroom and in clinical settings, a cognitive map was developed in an attempt to further clarify the meaning of the data and to give some direction to the data collection of individual interviews of both the diplomates and the lecturers for the next stage of analysis. Figure 4.1 displays a learning experience of a P2K course in the classroom and clinical settings. This cognitive map is displayed in an interactive manner and represents an evolved version of the initial descriptive framework (see Figure 3.3 in Chapter 3) which initially guided the data collection. The display was then scanned to examine and confirm the interconnection and relationship of its components.

Having explored and discovered some relationships among the key concepts, generated from the data, the major emerging themes were then transcribed onto a thematic-conceptual matrix so that they were easily understood. Table 4.7 thus represents a conceptualization of a P2K course learning experience. Together with the cognitive map this matrix helped to develop tentative propositions and subsequently research questions were formulated for the analysis of ensuing data.

However, having established a baseline of the nurses' notion and construction of professional learning as a result of their experience on the P2K course, the
### TABLE 4.6: CONTENT - ANALYTIC SUMMARY TABLE: OF THE PARTICIPANTS' LEARNING EXPERIENCE ON THE PROJECT 2000 COURSE IN THE CLASSROOM AND CLINICAL SETTINGS

<table>
<thead>
<tr>
<th>Aspects of Learning</th>
<th>CLASSROOM LEARNING EXPERIENCE</th>
<th>CLINICAL LEARNING EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>- Rationale for holistic care based on theoretical knowledge.</td>
<td>- Importance of theoretical knowledge to base nursing practice.</td>
</tr>
<tr>
<td></td>
<td>- Professionalism in nursing achieved by continuous learning and progression.</td>
<td>- Need for further learning (rapid change in nursing; lack of skills; a dynamic learning process of nursing; course only a foundation).</td>
</tr>
<tr>
<td></td>
<td>- Course facilitated self-directed learning.</td>
<td>- Awareness of / insight in accountability &amp; responsibility.</td>
</tr>
<tr>
<td></td>
<td>- Importance of accountability and responsibility.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Academic status provides more opportunities for further learning.</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td>- How to articulate care holistically.</td>
<td>- Limited clinical skills; lack of practical skills.</td>
</tr>
<tr>
<td></td>
<td>- Interpersonal skills.</td>
<td>- Able to use communication/interpersonal skills.</td>
</tr>
<tr>
<td></td>
<td>- Self-directed learning skill (group &amp; individual).</td>
<td>- Self-directedness not evident in clinical practice.</td>
</tr>
<tr>
<td>Attitude</td>
<td>- Positive attitude in branch.</td>
<td>- Perceived alienation of traditional nurses.</td>
</tr>
<tr>
<td></td>
<td>- Irrelevance of CFP and sceptical about P2K course.</td>
<td>- Labelling &amp; alienation motivate anticipated skill progression and further learning.</td>
</tr>
<tr>
<td></td>
<td>- Motivated towards further professional learning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Course encourages positive regard towards academic status.</td>
<td></td>
</tr>
<tr>
<td>Behaviour</td>
<td>-Application of adult learning approach: self-directedness/independence; responsibility; shared learning/group cohesion &amp; solidarity; peer support &amp; co-operation.</td>
<td>-As students: non-confrontative approach to deal with skills deficits. -Strategic plans identified to cope with new staff nurse role. -Approaches based on various ways to tackle problem of alienation, building on already acquired strategies.</td>
</tr>
<tr>
<td>Feelings</td>
<td>-Positive: eager to start practising; confidence in acquired theoretical knowledge. -Negative: Uncertainty about nursing practice.</td>
<td>-Positive: optimism &amp; hope; caring role/duty to care -Negative: Powerless; vulnerability; inadequacy; no control over practice; lack of belongingness; non-acceptance from others (traditional nurses).</td>
</tr>
</tbody>
</table>
Figure 4.1: COGNITIVE MAP OF A P2K LEARNING EXPERIENCE IN THE CLASSROOM & CLINICAL SETTINGS

Legend:
- **CPL** = Continued professional learning.
- Arrows denote actual and/or potential relationships/influences.
- **→** short term potential relationship
- **—** Long term potential relationship
- **One way actual relationship**
- **Reciprocal actual relationship**

NB: It was not the intention of this thesis to measure the extent and depth of the relationships.
<table>
<thead>
<tr>
<th>Learning Experience</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Attitude</th>
<th>Behaviour</th>
<th>Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASSROOM</td>
<td>Theoretically-based Nursing Knowledge</td>
<td>Self-Directedness</td>
<td>Consensus of Values</td>
<td>Mutual Support</td>
<td>Readiness vs Practice vs Apprehension</td>
</tr>
<tr>
<td>CLINICAL</td>
<td>Dynamic Learning Process</td>
<td>Skills Deficit</td>
<td>Conflict of Interest</td>
<td>Coping Strategies</td>
<td>Readiness vs Practice vs Apprehension</td>
</tr>
</tbody>
</table>
key question at this point of the analysis was:

How does professional learning manifest itself once these P2K nurses are actually working as staff nurses in clinical settings over the two years of data collection for the study?

4.3 Data analysis 2

A "cross-case analytic" approach, adapted from Yin (1984), Patton (1990) and Miles & Huberman (1994), was developed to analyse the participants' and lecturers' individual interviews. Although the analyses were focused across all the cases, some references were made to individual cases when it was felt necessary to illustrate a particular characteristic or attribute, for instance the difference between a younger participant and a older one. In some instances, it was difficult to portray an individual's special feature in a way that would preserve the participant's anonymity and confidentiality at all times. The diplomates' nursing speciality is an example of such an instance, whereby having only four out of sixteen in Mental Health increased the chances of these being identified. Thus, differentiating between the nursing specialities was found to be appropriate throughout the study only when it was absolutely relevant. However, the coding system adopted allowed for individual participant data set to be retrieved from its original source. This system of retrieval was maintained throughout the analysis and data was analysed accordingly, within its relevant contexts.

All the individual interviews were analysed sequentially, as described in Chapter three, to generate categories and sub-categories and develop meanings to the data collected. Summary tables of findings derived from the data of individual interviews, of which, Table 4.8 is an example, were designed. These tables contain all the relevant condensed data which
Table 4.8: DATA REDUCTION OF THE DIPLOMATES’ FIRST INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS

EFFECTS OF P2K COURSE ON CLINICAL PRACTICE:

P2K nurses perceived themselves to be functioning at a higher level of nursing than traditional nurses, being able to provide theoretically-based nursing care. P2K nurses considered themselves to be professional, autonomous, accountable and informed practitioners. Abilities to question and reflect on nursing practice is identified as a skill learnt on the course. There were conflicting views with regard to the extent the course had prepared P2K nurses to practice nursing, essentially to undertake a staff nurse role. The main issue was the lack of clinical skills due to limited clinical experience gained as student nurses. This caused difficulties for these nurses during their initial post registration months. They felt alienated and labelled by the traditional nurses. Nevertheless, the role was embraced pro-actively and the nurses confidence gradually increased. Peer support was demonstrated, similar to the kind experienced during the course and minimal clinical support from preceptors was identified.

SELF-DIRECTEDNESS OF LEARNING:

P2K course influenced self-directed learning in clinical practice. This approach to learning was found beneficial in the practice of nursing. Learning needs were identified independently. Self-directed learning meant ‘going and finding out for self’, as learnt in the classroom. Several factors influencing P2K nurses to be self-directed were identified: lack of time to ask other nurses on the wards; P2K nurses' knowledge was better than the traditional nurses; self-motivation, being inquisitive and questioning own practice; the wish to look beyond what was being told by others; the need to check information because of previous conflicting messages from traditional nurses and feeling responsible for the quantity and quality of own learning.
Table 4.8 - (Continued)

METHODS OF LEARNING IN CLINICAL SETTINGS

A wide range of informal learning methods were used and a lot of these reflected those experienced in the classroom. The emphasis of these learning activities were on clinical skills and involvement of the patient. Whereas, the more formal methods were the ones related to clinical practice but involved attendance on short or long term courses. Learning by teaching was another area discussed and was perceived as part of continuous informal learning strategy. Learning through the preceptorship system was not fully established and learning within this system depended on accessibility and approachability of the preceptors; staffing level; preceptors' attitude towards them, interests and willingness in teaching and understanding of their learning needs. Learning took the form of gaining knowledge and skills on whatever was available to them.

FURTHER LEARNING:

Further learning was perceived here as any learning, initiated by self or others, that was beyond what was expected of the staff nurse's role. It was described as a dynamic learning process which was perceived as being the nature of nursing, for personal and professional development. Factors influencing further learning were: self-directed learning process; recognition of skills deficit; personal achievement; career progression; academic status; professional behaviour learnt from the course; sense of responsibility and commitment to professional learning; the provision of better care for their patients and meeting the needs of their employers (the NHS Hospital Trusts).
consist of a combination of descriptive and conceptually derived data. Then thematic-conceptual frameworks, as Table 4.9 illustrates, were constructed to facilitate understanding of the data. Key emerging concepts and themes were identified and their relationships were ascertained to explain meaning of data. These tables are from the diplomates' data of their first set of individual interviews. The remainder of all the summary tables and thematic-conceptual frameworks constructed from the diplomates and lecturers' individual interviews can be found in Appendix D.

The analysis focused on the contents of the data set and do not relate to the specific case from which they came. The intention here was for the analysis to be more conceptual in nature and to elicit main trends across the participants' experiences of professional learning. Tables 4.10 further illustrates the analytic process from category development to conceptualization of the diplomates' professional learning. This table was constructed from the diplomates' summary of data findings of their last interviews.

The overall aim of this set of analyses was primarily to explore and describe the nature of experiences of professional learning across the participants over a period of two years. The lecturer's contribution to the post-registration professional learning of these P2K nurses was also explored. Analysis of these data was considered important since it was evident that the teaching and learning process was informed by the reformed P2K curriculum. This was followed by explanations of the possible reasons for the occurrences of professional learning derived from the data within the diplomates respective environment of registered practice. The major recurrent themes which emerged from the analysis of individual interviews reflected the issues of interests that were discussed in an attempt to answer the research questions formulated at the end of the interviews and those based on the aim and objectives of the study.
Table 4.9: A THEMATIC CONCEPTUAL FRAMEWORK OF THE PROJECT 2000 DIPLOMATES' NOTIONS OF PROFESSIONAL LEARNING

<table>
<thead>
<tr>
<th>Learning experiences</th>
<th>Notion of Professional Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-directedness</td>
<td>'Going and finding out for self'.</td>
</tr>
<tr>
<td>Learning methods</td>
<td>Self-initiated informal learning strategies</td>
</tr>
<tr>
<td>Further learning</td>
<td>Dynamic learning process</td>
</tr>
<tr>
<td>Effects of P2K on clinical practice</td>
<td>Theoretically-based practice</td>
</tr>
<tr>
<td></td>
<td>Conflict of interests</td>
</tr>
<tr>
<td></td>
<td>Skills deficit</td>
</tr>
<tr>
<td>Attitudes of traditional nurses</td>
<td>Alienation (due to lack of P2K knowledge)</td>
</tr>
</tbody>
</table>
### Table 4.10: AN ANALYTICAL PROCESS OF THE PROJECT 2000 DIPLOMATES' PROFESSIONAL LEARNING: FROM CATEGORY DEVELOPMENT TO CONCEPTUALISATION

<table>
<thead>
<tr>
<th>Major Categories</th>
<th>Recurrent Patterns</th>
<th>Emerging Themes</th>
<th>Emerging Concepts/Constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of Professional Development</td>
<td>1. Initially, emphasis on clinical skills followed by specialist technical and managerial skills</td>
<td>1. Development of knowledge and attitudes at different level and stage of career</td>
<td>1. Ongoing learning process (from general to specific in-depth skills)</td>
</tr>
<tr>
<td></td>
<td>1. Learning 'all the time' for self</td>
<td>1. Self expectations</td>
<td>1. Self directed learning</td>
</tr>
<tr>
<td></td>
<td>2. Learning according to grade and speciality</td>
<td>2. Organisational expectations</td>
<td>2. 'Other' directed learning</td>
</tr>
<tr>
<td></td>
<td>3. Dynamic nature of nursing and nursing code of professional conduct</td>
<td>3. Professional expectations</td>
<td>3. On-going learning process</td>
</tr>
</tbody>
</table>
4.4 Data analysis 3

The last stage of the data analysis involved the development of conceptual meanings from the data in order to gain a comprehensive understanding and theoretical perspective of the overall picture of the diplomates' professional learning during their first two years of registered practice. The organization for this final analysis was thus drawn from the questions generated and clarified during the conceptual phase of the study when analytic insights and interpretation emerged during the successive data collection and analysis.

This stage of analysis was carried out by a careful examination and integration of all the thematic conceptual frameworks designed during data collection and analysis. Recurrent themes across all the thematic-conceptual frameworks were identified. Consequently, the diplomates' developmental process of professional learning was constructed based on the conceptualization of the identified stages of their learning during the first two years of registered practice derived from the recurrent themes. Thus, Table 4.11 illustrates the developmental process of the diplomates professional learning.

An explanatory stage was also developed from the findings which addressed a theoretical perspective of the diplomates' professional learning. This was informed by relevant theories within which the research findings could be located. Chapter eight discusses this in more detail.

4.5 Conclusion

This chapter demonstrated the data analysis process adopted for the study in practice supported by illustrations from relevant tables and matrices. The procedures followed the analytic sequence of Flow charts 1 & 2 in Chapter three which were found to be adequate and appropriate in addressing the
Table 4.11: A DEVELOPMENTAL PROCESS OF PROJECT 2000 DIPLOMATES’ PROFESSIONAL LEARNING

<table>
<thead>
<tr>
<th>Stages of Learning</th>
<th>Rationale for Professional Learning Emerging from the Themes</th>
<th>Conceptualisation of the Affective Aspects of Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Inaugural' Professional Learning</td>
<td>Self-directed identification of learning needs</td>
<td>Vulnerability</td>
</tr>
<tr>
<td></td>
<td>Responsibility to address skills deficits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expectations of staff nurse role</td>
<td>Apprehension</td>
</tr>
<tr>
<td></td>
<td>Preceptorship system</td>
<td></td>
</tr>
<tr>
<td>Indiscriminate Learning</td>
<td>Need to justify staff nurse role</td>
<td>Inadequacy</td>
</tr>
<tr>
<td></td>
<td>Learnt whatever was available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proof of safe practice</td>
<td></td>
</tr>
<tr>
<td>Role-directed Learning</td>
<td>Taking charge of patient group</td>
<td>Insecurity</td>
</tr>
<tr>
<td></td>
<td>Need to acquire management skills</td>
<td></td>
</tr>
<tr>
<td>Change of Learning Emphasis</td>
<td>Increased responsibility</td>
<td>Increased confidence, Hope and optimism</td>
</tr>
<tr>
<td></td>
<td>In charge of whole ward</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In need of higher level skills: technical and specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflection on practice</td>
<td></td>
</tr>
<tr>
<td>At a 'Cross Road' Learning (End of Year One)</td>
<td>Review of professional development</td>
<td>Uncertainty of career path</td>
</tr>
<tr>
<td></td>
<td>In search for career-orientated progression and higher nursing grade</td>
<td></td>
</tr>
</tbody>
</table>
| 'Saturation point' Learning | Review of professional learning  
|                           | Monotony and repetitiveness of skills  
|                           | In search for skills-orientated progression;  
|                           | change of speciality and patient / client environment | Boredom |

| Discriminate Learning | Need for specific, focused grade and speciality-related learning  
|                       | Mentoring and preceptoring others | Increased confidence |

| Continued Professional Learning (End of Year Two) | Need to continue to learn and update  
|                                                   | to move forward and meet employers' needs  
|                                                   | Has reached required level of expertise  
|                                                   | Has learned how to learn | Security and adjustment | Positive self-concept |
research problem. Chapters five, six and seven will follow by offering a
discussion of a full descriptive account of the main findings which derived
from the development of the thematic conceptual frameworks discussed in
this chapter.
CHAPTER 5: THE EXPERIENCE OF BEING ON A P2K COURSE

5.1 Introduction

This chapter describes the experiences of a group of nurses who undertook a Project 2000 course which was implemented in January 1991 in a College of Nursing in the U.K. It focuses on the nurses' reflections of their experiences of the course which took place in the classroom and in clinical settings. It also includes their understanding of the course philosophy, their feelings and thoughts about the course prior to their staff nurse qualification and registration in Mental Health or Adult nursing. Additionally, their views and perception of professional development at the time of the interviews were explored.

An account of these different perspectives provided a platform from which the overall experience of the course reflected these nurses' attitudes towards the course and also an overview of the behavioural and attitudinal changes which occurred during the three years of preparation to become a staff nurse. This experience was specific to this group of nurses. The intention here is to present those experiences of a P2K course as perceived by the participants themselves. This was felt appropriate in order to address the first research question: to what extent does the P2K course equip nurses for continued professional learning?

5.2 The meaning of the P2K course philosophy

When the participants were asked to discuss their understanding of the philosophy underpinning P2K course they mainly talked about aspects of nursing care and nursing as a profession. They claimed that the course equips the nurse with theoretical knowledge which provides a rationale for the
delivery of holistic care in an autonomous, accountable and professional manner. They also referred to self-directed learning as well as the higher academic and professional status of nursing. Some of the key issues emerging from these nurses' understanding of the course philosophy were then explored and their views about the effects of this philosophy on nursing practice.

The notion of professional accountability which was identified as underpinning the course philosophy was further explored. The meaning of this notion was explained in relation to increasing the professionalism of nursing. As June, one of the participants stated:

"The course philosophy is about making nurses more accountable and making nursing more professional, therefore increasing student nurses and nursing's professional and academic status".

For participants the theoretical knowledge underpinning the course philosophy seemed to take the form of caring for patients holistically and provided a rationale for nursing interventions on which they based their practice. It was thus acknowledged that the course taught them "to assess and plan patient care holistically".

When the participants were asked what holistic care meant to them, they referred to the care of the whole person. They reiterated that it was the physical, psychological, social and spiritual aspects of a patient when planning and implementing nursing care. This showed the way these nurses' views of core subjects had changed during their respective branch programmes as opposed to during the Common Foundation Programme (CFP) when they found that the core subjects, such as biology, psychology, social policy and sociology, were irrelevant to nursing. (This is discussed later Section 3 in this chapter).
A rationale for their nursing actions seemed to be also embedded within this holistic care. As John explained:

"(Holistic care) means looking at all aspects of a patient, a person and knowing why we do what we do".

5.2.1 P2K nurses versus traditional nurses

The effects of the P2K philosophy were also discussed by asking the participants to compare themselves with traditional nurses with regard to nursing care approach and academic status. The P2K approach to caring for the patient was seen as different from that adopted by traditional nurses they had met in clinical areas. The participants considered informed, holistic care to be a progressive approach to nursing care because besides looking at all aspects of a patient they also linked this type of care to the application of research findings and nursing knowledge. On the other hand, they found that the traditional nurses did not seem to apply research-based knowledge in their practice of nursing nor to have a rationale for their care. As Joe had observed during his various clinical placements:

"Although the (traditional nurses) seem more confident their (theoretical) knowledge is shallow. They have no sound knowledge, not research minded at all. For them it's all a matter of routine and they don't seem to know why they do things the way they do".

This progressive, reformed approach of learning to nurse and the acquisition of nursing knowledge were considered to be linked to the professionalism of nursing. The participants' arguments were that their knowledge of academic subjects led to professional knowledge in terms of being recognized as professionals. Hence, they maintained that their academic status provided them with more opportunities for further and higher education in nursing or otherwise, than the traditional nurses:

"We are in a better position than the traditional nurses to do a degree. I can go on studying at a much higher level".
It appeared that the lecturers also instigated this attitude of higher academic status, in an attempt to develop these nurses' awareness of professional development. Upon further exploration, this was confirmed when it was stated that:

"We were also made aware (by the lecturers) of the value of our Diploma in Higher Education in nursing studies and how far we could go with it".

5.3 Learning in the classroom

The participants reported that the teaching and learning of theoretical knowledge largely took place in the classroom. For these nurses classroom instructions consisted of thirty-four out of sixty-eight weeks in the CFP and twenty-two out of sixty-seven weeks in their branch programme. This was confirmed in an examination of the College course document (1990,1:27). Each college week comprised a minimum of twenty hours of taught sessions and fifteen hours of self-directed study.

The participants felt rather skeptical about the P2K course at first because it was a new course which they said had not been tested properly. (They were the first cohort of students to be on the P2K course at the college of nursing where they studied). They reported that during the CFP they had difficulties in settling into the course. They felt that the theoretical aspects of the course were irrelevant to nursing and were somewhat disenchanted about P2K. They further reported that they could not understand the meaning and relevance of the "core subjects" such as psychology, sociology, social policy, philosophy and biology to nursing. As Angie stated:

"I was rather disillusioned about P2K, especially the CFP, it didn't feel like nursing at all. All these core subjects, social policy, sociology, psychology and so on meant little to us. I often wondered what I was doing here".

However, these nurses' reactions towards the course content in their branch programmes were more positive. This coincided with the time when the
course started to make sense to them, in terms of the nature of nursing as advocated by the P2K curriculum. They emphasized that their learning became more relevant then. This was confirmed by Claire:

“I certainly started to learn nursing in the branch. CFP did not make sense to me”.

It was thus evident that it was only towards the end of the course that most of them could really appreciate the relevance of the core subjects to nursing. This relevance of core subjects and importance of the branch programme seemed to have been because the emphasis during that time was on their chosen speciality i.e. Adult or Mental Health nursing. Furthermore, the mental health nurses indicated that they had some choice of what they felt they needed to learn and that some of their sessions were student-directed. They explained that they were given the opportunity to select topics which met their learning needs and they were able to relate them to their clinical experiences. They then prepared those topics and presented them to their peers in a seminar session in class. This student-directed learning was also evident in the mental health branch time-table. Apparently, the ability to organize this kind of time-table was easier and more practical in this branch of nursing because of the group size; twelve students in mental health branch whilst the adult branch had forty-five students. This was an explanation gained during an informal discussion with other lecturers and was later confirmed by the lecturers who were interviewed in the study.

However, apart from this student-directed approach, the learning experience in the classroom followed a similar format in both of the branches in which the participants were involved.

5.3.1 Shared learning

It was evident that small group work and shared, collaborative learning were
paramount and were encouraged throughout the course:

"Right from the beginning, we were always split into small groups and presented our work to each other".

It was suggested in the course document (1990,1:38) that "P2K has the potential to form a cohesive nursing profession" and the course was "planned to allow this cohesiveness to be achieved both in the CFP and the branch programmes". The promotion of shared learning, particularly during the branch programmes, was clearly recommended.

Both the adult and the mental health branch groups of nurses recognized the value of this approach. Although some felt a little uncomfortable about it, they gradually got used to such classroom learning activity and they eventually enjoyed actively participating:

"Presenting work to others in class was a bit nervy, but we soon got used to it".

"(Presenting work to others) became fun really. I like to talk, to be active in a learning environment".

5.3.2 Learning to be responsible and accountable

The curriculum design and teaching style seemed to have also influenced the participants to be responsible for their learning and taught them appropriate study skills so that they could be independent and build on the P2K course once they were qualified. The participants were aware of this and it was recognized that the course was only a basis to practice. Besides being responsible for their learning, the participants were also taught to be responsible for patient care and accountable for their own nursing actions:

"We were forever being told about (responsibility and accountability) especially during the branch programme".

Thus, responsibility and accountability were two concepts which were acquired in the classroom with a view to being transferred to clinical settings.
To some extent these concepts were influenced by the lecturers who saw them as important aspects of adult learning which would contribute to these nurses' clinical practice. This supports the teaching/learning strategies in the course document, which clearly stated that "the responsibility for learning rests with each student" (p38).

5.3.3 Self-directed learning

Additionally, the participants reported that learning in the classroom also entailed finding out information for themselves. This kind of learning strategy was referred by some of them as a "do-it-yourself" (DIY) approach which was viewed as a kind of adult learning approach. They said that the aim for such an approach was to prepare them to become independent learners but one of the mature participants pointed out that some of them coped better than others. Younger participants also had problems:

"This self-directed learning was new to me. It took me a while getting used to it. I was always expecting the teacher to teach me everything. Now, I'm o.k. about it".

Nevertheless, the self-directed approach to learning was welcomed by a number of the participants and was seen as a way of increasing their self confidence. As Maureen explained:

"Because of this DIY course, I don't feel so threatened now".

Additionally, one of the group discussed how this style of learning was also initiated by all the assignments they had to do during the course which required them "to find things out" for themselves. A self-directed approach to learning was identified to have both short-term and long-term effects. The short-term effect referred to the way this approach had helped the participants during their three year nursing course under the guidance and encouragement of the academic staff. They saw it as a challenge and they were motivated to learn more than what was expected of them. On the
other hand, the long-term effect of self-directed learning referred to its relevance after they qualified. One of the groups expanded on this meaning and explained that self-directed learning as a strategy would help them to become resourceful and to continue to be questioning and searching for additional information. Sinead pointed out:

"I would continue to be inquisitive and carry on finding out. At least we know where and how to get hold of information if we need it".

This clearly reflects the philosophy of the P2K curriculum which stated that "a major feature of the course is the development of learning skills to help the newly qualified practitioner continue to learn throughout their nursing career (Course document 1990, 1:11). It therefore has implications for continuing learning here, in terms of these nurses developing commitment to continued professional learning. It was evident that, despite being at the end of the course, these nurses felt that their learning would continue. As Teresa stated succinctly:

"The end for you lecturers is only a beginning for us".

5.4 Learning in clinical settings

The participants learning in clinical settings entailed the practical knowledge gained during their various clinical placements, which meant the learning of nursing skills. During these group interviews it was noted that the questions about practical knowledge generated more reactions than questions on any other aspect of the course. The participants' responses to this aspect of their learning typically addressed two major issues: the need to base the practice of nursing on theoretical knowledge and the lack of nursing skills at the end of their course. These were broadly explored and discussed in the four group interviews.

It was acknowledged by the participants that the course prepared them with a sound knowledge to base for their nursing practice. They therefore
recognized the need to take their theoretical knowledge to clinical settings and apply it in their nursing practice. This was not only because it would provide them with a rationale for their nursing care as previously discussed, but it would also help them to progress in their nursing career:

"The sound knowledge we have will take us forward".

5.4.1 Lack of nursing skills

The realization of a lack of nursing skills seemed to be a major concern for these participants. They expressed this in a variety of ways. For instance, Joe and Sinead stated respectively:

"I only wished we had more practical experience".

"Yes, skill-wise, I don't feel good about. I keep on thinking, I need to know this, to learn that. It's like an obsession at times".

Upon exploring their lack of skills, the participants identified some of the key factors which they felt contributed to their nursing skills deficits at the end of their course. The main factor which they identified was the limited time they spent on their clinical placements during the course. Hence, there was a lack of opportunities for these nurses to learn, practice and master those skills which were either learnt in the classroom or demonstrated in clinical areas. Adam argued:

"I've learnt things in class but we had very little time to practise them on the wards. The P2K course should have been extended for a further three to four months period to allow us to practice nursing skills".

It was also felt that they missed out on opportunities to practice because of the lack of knowledge and understanding about the P2K course philosophy and content among non-P2K nurses. According to the participants most of their clinical experiences were spent observing other nurses rather than participating in the delivery of nursing care. They felt that their supernumary student status was misinterpreted by their mentors who were all traditional
nurses. They also described their CFP mentors to be less committed to teaching them. As Liz noted:

"Our supernumary status was not well received by staff on the wards. They thought we were only there to observe, not doing. It took them a long time to get to know us".

However, one of the group in particular felt that their clinical experiences improved during the later part of the branch programme when they were given more responsibility on the wards and the staff began to realize that the participants were more capable than they thought. It was also suggested that by the time they were nearing the end of the course, they noticed that clinical staff were updating themselves professionally and the issue of lack of knowledge about the P2K course was also being addressed. This group of nurses, nevertheless, thought that at the end of their course they became of interest to traditional nurses:

"Everyone on the service side is just waiting to see what sort of nurses, we will turn out to be".

5.4.2 Labelling of P2K nurses

Another issue of concern which the participants felt impeded their clinical learning to some extent, was their experience of being labelled by traditional nurses during their clinical placements. Many of them talked about the negative attitude of traditional nurses towards P2K nurses: For example:

"We were seen as different on the wards and the (traditional) nurses behaved differently towards us".

"Staff on the wards used to talk about us and they would say that these P2K nurses don't know anything".

"We were always known as P2K students, not just student nurses. I suppose now it would be P2K staff nurses".

This had infuriated some of the participants. As Anne stated angrily:

"Personally, I don't like being called a P2K student at all, it puts my back up".
But other participants reacted differently and seemed to have been more tolerant about being labelled. For one, the main concern at the time was about being successful in the practical assessment. She did not feel that it was appropriate to confront the nurses on the wards since they were the very same nurses who would have to sign her practice documents. She said:

"Of course, I wanted to pass my practical assessment, so there was no point in confronting the staff on the wards and telling them that what they were saying about P2K students (that they didn't know anything) was not true".

It was interesting to note that another participant escaped being labelled because during his last clinical placement the staff did not realize he was a P2K student, except for the ward manager who happened to be his mentor. Thus, there was evidence that P2K students were treated differently as this particular student. Adam, confirmed:

"I was very lucky in my last placement, only sister knew that I was a P2K student, so others were really nice towards me".

5.4.3 Coping with being labelled

At this stage of the interviews it was felt appropriate to further explore these participants' views about being labelled, since this issue seemed to be important to them. Thus the intention here was to ascertain the way these nurses felt about with being labelled and whether they had any planned coping strategies for when they started working as staff nurses alongside traditional nurses with negative attitudes.

Challenging the clinical staff who have more skills than them was found to be undesirable and imprudent. The participants' apprehension was justified within the context of their pending staff nurse role when they felt that they would have to depend on these nurses to learn their new staff nurse role and more importantly the practical skills. They, therefore, expressed a certain amount of self-belief, hope and optimism:

"I'm sure we'll survive but we have to work harder to prove them"
wrong and we need to show them that we are not what they thought we’ll be”.

Thus, they felt that it was in their best interest as staff nurses to react proactively because of this underlying fear of rejection and not being readily accepted by non-P2K nurses on the wards where they would be working. The ways in which the participants planned to achieve this was further discussed. They maintained that they would use what they felt they were “good” at and felt comfortable with. This included the use of communication skills, “trading-off” (exchanging) their theoretical knowledge with traditional nurses for clinical skills, applying knowledge to clinical practice in an informed manner, using research findings, and by challenging routines and rituals by being assertive and putting forward sound knowledge. They thus relied heavily on their theoretical knowledge. The application of self-directed learning was also evident here:

“At least, we know where and how to get hold of information if we need it”.

The ‘knowing where and how’ seemed to be one of the biggest assets for them. In addition to this, they also mentioned the sharing of knowledge among themselves and peer support, which is discussed elsewhere in this chapter (Section 5.2), as well as the feeling of solidarity fostered in the classroom. Thus, the negative attitude of clinical staff generated further planned coping strategies built largely on those already acquired or learnt from their student nurses’ days.

5.5 The anticipation of becoming a staff nurse

Despite the participants’ apparent confidence in their readiness to practice which was largely due to their acquired theoretical knowledge and its value to their nursing practice, they expressed some apprehension about their pending staff nurses’ role. They indicated a sense of vulnerability because of
the expectations of traditional nurses, their lack of clinical nursing skills and having to prove themselves on the wards as P2K staff nurses. As Anne said:

"(Traditional nurses), students and patients will expect us to know a lot more than we do".

The pending staff nurse role was also described as "scary" because they felt they did not have enough nursing skills. When these diplomates were student nurses there had been negative attitudes expressed towards them. Thus, in the interviews there were statements which indicated that they were anticipating the same negative attitudes as staff nurses. They felt apprehensive about these attitudes from other nurses as Liz recalled:

"It was bad enough when we were students".

The transition from student nurse to staff nurse also evoked sad feelings and a sense of loss among the focus groups. They made reference to the transition they experienced within the course, when they moved from the CFP to their respective branch programmes and at the time of these interviews they were just a few weeks from yet another transition which explains their feelings of sadness. Angie confirmed this:

"When we started and everything was new, we made friends, then after CFP, we had to go to our branch and now, we don't know where we'll end up'.

However, this could suggest that the solidarity perpetuated in the classroom could be responsible for the emerging sadness, the sense of loss and vulnerability at the end of the course.

Although these feelings were expressed, the participants felt relieved that they would soon be practising nurses. There was also some trepidation at the thought that they would be "doing nursing" which was what they felt they had been studying for during the three year of the course. Statements; such as: "I can't wait to get on the ward and do proper nursing" exemplify such feelings.
5.5.1 Planned coping strategies for the staff nurse role

It became more evident that the lack of skills were of major concern for these nurses when the pending staff nurse role was being discussed. Nonetheless, they identified interpersonal skills which involved communication skills as one set of skills which they had acquired in class and were able to apply adequately in their practice. Hence, they felt that using the skills they were comfortable with, as was the case earlier on in their course, would help them cope during the initial months working as staff nurses. They stated that they would then learn other skills which they felt they needed to know and those specifically required of their job as staff nurses. Sarah’s views were shared by others:

“It is good to feel I am able to communicate with patients. I use interpersonal skills all the time on the wards. I’m not afraid of that, I know I shall be alright with this one, it’s the more demanding things, the more technical things, I feel, I ought to know about, especially as a staff nurse”.

Additionally, it was interesting to note how some of the participants talked about the manner in which they intended to use their academic knowledge the way they had used it as student nurses when they “traded it off” with clinical staff for clinical, practical knowledge which they felt was lacking. By this, they meant that, for instance, they would share materials such as literature that they may have on a certain topic of interest with clinical staff, usually those who were undertaking post registration courses and in exchange they noticed that they were given extra help with practical skills. Learning opportunities were also more readily available to them on the wards.

5.5.2 Peer support

It was also evident during the discussion that group work, shared learning and self-directed learning in the classroom engendered and fostered co-operation,
mutual/peer support and solidarity among these participants. Thus, in view of their past negative experiences on the wards as student nurses, they felt that peer support, which had been nurtured in the classroom, would be essential to 'survive' in their new staff nurses' roles. They expressed this by the need of support from each other. Some recalled their experiences of valuable support from their peers throughout the course. As Jeanne stated:

“If it wasn't for my friends on the course with me, I would have left and done something else”.

Hence, they said that they hoped to keep in touch with each other and sustain this mutual, peer support which they had found beneficial in the past. As David commented:

“We must continue to support each other. I hope we'll continue to keep in touch and help each other whenever we can”.

5.6 The need for further and professional learning

The participants emphasised their lack of clinical skills throughout all of these group interviews. Consequently, they recognized the need to learn further skills in the near future, as newly qualified staff nurses, because of the skills deficit they had identified earlier in the interview, which was causing them a lot of concern for their pending staff nurses' role. They felt that their main goal, at this stage of just being a few weeks away from their nursing qualification, was to initially learn and gain all those extra clinical skills so that they could have a sense of occupational identity with the traditional nurses. This was how two of them, Adam and Liz, expressed their thoughts:

“All I need to do now is to learn and work hard towards being at the same level as the traditional nurses, skill-wise”.

“We need to master our skills, to learn them quickly and all the time really”.

5.6.1 Continuous learning process

This notion of 'learning, all the time' was explored further within the context of
the participants' perception of professional development in nursing. At this point of the interviews, it was felt necessary to ask the nurses to clarify their understanding of further learning and professional learning. For these participants, further learning implied an immediate type of learning with short term aims. By contrast, professional learning was considered to be a cyclical type of learning which consisted of both short and long term aims of professional development. These explanations seemed to be influenced by their views about the nature of nursing.

Two of the groups expressed their views about the nature of nursing as a continuous process of learning. They talked about the continuous learning of new nursing skills and knowledge as well as updating those already acquired skills. Jeanne clarified this further by stating that:

“If a nurse does not continue to improve her practice, her skills and knowledge, she might as well give up. In nursing we can't stop learning and updating”.

As far as this group of nurses was concerned learning had not stopped for them despite reaching the end of their three year nursing course. This was exemplified by the following comments:

“The end of this course is only the tip of the iceberg”.

“It's impossible to stop learning but I know of some non-P2K nurses who have, it's very sad for nursing”.

“What we've learnt to-day will be soon out of date. Things change so quickly, there is new research, new technology etc”.

New technology was also discussed by others in relation to new types of patients. Further, it was acknowledged that a lot more nursing research was available. Those who intended to work in specialist areas were particularly anticipating a continuous updating of skills:

“For me, (continuous updating of skills) will certainly be the case because I want to work in coronary care”.

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In this study, in order to address the research problem, the issue of professional learning was explored within the context of the professional development of nurses. Thus the notion of professional learning emerged from the participants’ need to continuously keep updated and learn about their nursing skills and knowledge and the dynamic nature of nursing.

However, it was evident that even at this stage of these interviews, which took place shortly prior to these nurses being qualified and before the UKCC’s mandatory requirement of post-registration education and practice, participants had begun to demonstrate a commitment to their professional learning which they conceived to be continuous. This commitment was also translated in their responsibility for their own learning and accountability to patient care and for their own actions from the time they were qualified. David pointed out:

"Out there, you are on your own".

The course was very much viewed as only a basis to practice; after that it was up to them to build on what they had learnt. These nurses therefore believed that once qualified they were responsible for their own professional development and were prepared to fund their courses and other learning activities. An examination of the course document (1990, 1:14) confirms these nurses’ view of professional learning and it is evident that one of the aims of the P2K course was:

"To foster a commitment to continued personal and professional development".

5.6.2 Perception of professional development

Although these participants felt that professional learning was fundamental to professional development, when they were asked about their views of professional development, all but two tended to discuss it within the context of course attendance, study days and reading for a degree. The two
participants talked about more informal ways of developing professionally such as reading nursing literature and textbooks:

"I would subscribe to nursing journals to keep up with developments in the area of nursing I'll end up in".

"I won't throw (my textbooks) away. I'll need more and more textbooks according to my future (learning) needs".

Upon further exploration of their views about professional development, they reported that it was formally introduced to them in class, in their last unit of study. They were told about career pathways, availability of nursing courses, degree courses and so on. One of the group of participants discussed how they were also taught to always search for up-to-date research findings to apply to their practice. They all found these sessions interesting and relevant to their nursing career.

"In our last unit, we were told about what was available for us when we qualify, other courses and that sort of thing".

It could thus be concluded that the participants' accounts of the way they were prepared for their professional development reflected their perception of professional learning.

5.7 Conclusion

This chapter clearly identified the participants' perspectives of their experiences of being on a P2K course which prepared them for their staff nurse role. In their reflection of their experiences on the course, both in the classroom and in various clinical settings, the participants' meaning and the effects of the P2K course philosophy provided a basis from which pertinent issues emerged. The key issues, which the nurses felt were important to them at the time were identified as: their approach to nursing care; the learning process which took place, both in the classroom and in clinical
settings; their readiness to practice and their need for further and professional learning. These participants largely addressed these issues by comparing the P2K course with that of the traditional nursing course.
CHAPTER 6  THE EXPERIENCE OF A P2K COURSE FROM THE LECTURERS' PERSPECTIVE

6.1 Introduction

Having examined the diplomates' experiences of being on a P2K course in chapter 5, this chapter examines the lecturers' perspectives within the context of their own experiences of teaching these nurses on the course. This provided further insight into the diplomates' professional learning. The aim of interviewing six of the lecturers who taught the participants in this study was to ascertain the extent to which their roles as educators had contributed to the post-registration learning of these nurses. The chapter therefore addresses four broad issues:

♦ the lecturers' perceptions of the P2K course;
♦ their perceptions of the outcomes of the P2K course;
♦ their perceptions of professional development and
♦ the strategies they used for the promotion of professional learning of nurses.

Thus these issues address the second research question asked at the initial stage of the study as discussed in chapter 3, section 3.5: to what extent did the nurse educators contribute to the post registration learning of these P2K diplomates? These issues also addressed a further question which was based largely on insights gained during the group interviews and the first set of the nurses' individual interviews. This was: to what extent do the lecturers' perceptions and conceptions of professional learning reflect those of the P2K nurses?

6.2 Perception of P2K course

All the lecturers discussed their perceptions of the P2K course in terms of the way its underpinning philosophy aimed to prepare the nurse to care for their...
patients. They, therefore, gave various explanations which reflected their understanding of what the course aimed to achieve in relation to the changing nature of nurse education and the manner in which P2K nurses would care for their patients. They implied that P2K was aimed at giving the nurse a greater depth and a broader insight into the whole of nursing rather than looking at part of the work, thus preparing the nurse for the future changes in society and nursing. A holistic approach to nursing was also alluded to which seemed to engender a knowledge-based practice, taking into account psychological, sociological, physiological and ethical issues.

The lecturers also believed that the increased knowledge would take the nurses to the level of a knowledgeable practitioner who would be able to analyse, evaluate and challenge nursing practice in an informed rather than a ritualistic manner. They considered that the course aimed to equip the nurse to analyse nursing situations in more depth rather than to just take them for granted. As two of the lecturers further explained:

"The whole course was designed to produce a registered practitioner who is accountable and responsible, who is safe and who will be able to respond in a changing climate within the NHS (National Health Service). These nurses will therefore be able to account for their actions when they qualify, they will be responsible and understand all the implications of their practice".

"I think the philosophy from which we'd worked was to prepare a student who is able to deliver care in an informed way; to make informed decisions about care and to be able to articulate their own reasons for decision making. I think it's also giving them theory as well as practice".

As far as the changing nature of nurse education was concerned, one of the explanations which echoed the lecturers' understanding was:

"My understanding was that we would not have to get nurses to do two qualifications but one formal qualification which allows them the ability to work in all settings, specialized in one particular area and at the same time prepare them for the demands of nursing in the year 2000 and beyond".
These lecturers felt that as a result of this change to nurse education, the patient should get a better service by being cared for by nurses who would deliver safe, up-to-date knowledge-base nursing care. However, when they were discussing the aim and the underpinning philosophy of the course it became apparent that they were also addressing the implications of its aim at different stages of the course implementation. This was thus explored because it was felt that these issues seemed important to the lecturers.

6.2.1 Transitionary stages of the course

The lecturers were asked to discuss what they meant by the different stages of the course implementation. Consequently, they clearly identified four transitionary stages of the course through which the nurses gained their learning experiences. The meaning of each of them was discussed accordingly.

One of the main problems identified at the beginning of the course implementation was that a lot of the diploma nurses came in with very different viewpoints of nurse education from what the philosophy advocated. The lecturers stated that, at this stage, the students did not expect the course to be so academically orientated. This had caused some problems and difficulties during this initial period of the course. The students were said to have experienced a lot of frustration at college and were longing to be in clinical settings where they could practice nursing. That frustration was expressed to lecturers through formal evaluation and interaction with the students at the time. The students also felt that they were learning many things in this early part of the course which they considered were totally unnecessary. This was how one of the lecturers described this initial transitionary period:

"These students had a certain view of the nurse, perhaps more than the actual course. Their view of the nurse was that you come in, you have some theoretical input and you get out (on the
wards) and you give hands-on care. With this cohort (of nurses), a lot of the problems and frustration that they experienced stemmed from the idea that they had to sit in a classroom, especially during the first eighteen months. They just wanted to get out onto the wards and give hands-on care, they wanted to learn about diseases, for example, and not normal biology or normal psychology. They had a different mental set, in a way, and that created a lot of frustration”.

Following that difficult and frustrating start, the lecturers reported that the students found the transition from the CFP to the branch programme quite difficult initially. This difficulty was mostly found on the wards where the students felt they did not have the skills to practice, they felt insecure and very vulnerable as well as coming to terms with the application of theory to practice. The students considered that what they had learnt so far did not relate to nursing and that they had not had enough clinical experience.

However, a stage was identified when the students became more aware of the meaning of what the course aimed to achieve. There was a consensus of opinion among the lecturers that this happened about half way through their branch programme which meant about nine months before the completion of the course. That was when they were able to apply what they had learnt in CFP to practice. This sequence was described by Paul, one of the adult branch team leader’s:

“It was only when it came really to unit seven that they were beginning to feel confident in their practice and could start assimilating some of their knowledge to clinical practice. Then, once they went to unit eight they were geared up, looking towards the end of the course and they felt a lot more comfortable about what they were doing but then they started getting anxious about becoming a staff nurse”.

The last transitionary stage was the passage from student nurse to staff nurse. The lecturers felt that this transition was a particularly difficult one for this cohort of nurses because that had just completed a new, academic type of nursing curriculum and that the traditional nurses were somewhat defensive towards them because they realized that these newly trained
nurses had more propositional knowledge than them. The traditional curriculum did not cover the academic subjects in great depth. Nevertheless, having met some of these P2K nurses on the wards, they reported that these diplomates had acknowledged a better understanding of the course philosophy. One of them, Pam, noted:

"Only last week, I spent a lot of time with some of these nurses. They are now qualified staff nurses from that (first) student group and they were reflecting on their last few months in practice after qualification and how, retrospectively, the things they've done on the course have prepared them for that particular role. They can now see what the course was trying to achieve".

6.3 Outcomes of the P2K course

The lecturers' views about the outcomes of the P2K course emerged from their perception of its effects on the diplomates' clinical practice. The sources of their arguments stemmed from the reorganization of NHS hospitals; the continuous course evaluation outcomes; clinical staff and students' feedback to the course management committee; feedback from traditional nurses and ward managers; their own observation of the nurses in clinical practice and personal interactions with P2K nurses on the wards.

6.3.1 Conflict of interests

For these lecturers, one of the main concern about the reformed nurse education was that soon after the implementation of P2K curriculum, the service and support systems within the NHS were reorganized, with some hospitals beginning to gain Trust status. This meant that the Trusts became managers and providers of healthcare services for their users and their philosophy did not seem to be in line with the philosophy of nursing education. In other words, what the P2K course aimed to achieve in the education of nurses was in conflict with the demands of the hospital Trusts for their service users. Whilst P2K aimed to provide a knowledgeable nurse
practitioner who was orientated to all aspects of care because of the current economic climate and hospital cut-backs, the Trusts, on the other hand, were working towards the acquisition of cheaper skill-based nurses which could be found among healthcare assistants. It was, therefore, evident that the P2K was not entirely meeting the needs and demands of hospital Trusts at that time. The CFP team leader explained how the underlying philosophy of P2K did not match the requirement of the Trusts:

"In essence (the course philosophy) doesn't seem to be working that way because (P2K nurses) are expensive to train and in the present economic climate, with the Trusts coming about, these people are expensive. So these managers of support systems don't want high powered, highly intellectual, knowledgeable nurses; they want more doers, nurses with a lot of basic skills".

6.3.2 P2K nurses' skills deficits

Consequently, the P2K curriculum had to be adapted as time went on because it was felt that the students were not given enough clinical experience to practice their skills on the wards in the same way as traditional nurses. The lecturers recognized that these nurses were somewhat deficient as far as their skills were concerned and that more time ought to be invested in clinical settings in order to meet the Trusts' needs at the time. They also reported that towards the end of the course some of these students had identified their weaknesses and were very angry because there was not enough focus on nursing skills. That was a great concern for these diplomates; they did not feel clinically competent in managing a group of patients and other nurses. Thus, attempts were made to redress this deficit of skills. As Sharon explained:

"We used to run extra sessions for them, we adapted the curriculum as we went along and we put in more skills to make them feel more comfortable. We did things like, we adapted the conceptual approach to actual patient care instead of looking at concepts in general which were in the curriculum. We actually began to focus on patients' problems and broke it down to the students' level of understanding".
6.3.3 P2K nurses’ clinical performance

However, despite the identification of skills deficits among these P2K nurses, observation of some of these same nurses on the wards and feedback from different sources in their place of work revealed a more positive picture than anticipated by both educators and hospital Trusts' staff. The lecturers found that these nurses were feeling a little uneasy about their clinical skills but they felt that they had the theoretical knowledge and it was only when they had begun to actually work as staff nurses that they realized how much they had learnt on the course. Furthermore, it was evident that other staff on the wards had also been able to appreciate the kind of contribution these nurses could make in caring for patients.

The lecturers also reported that, initially, the traditional nurses on the wards compared themselves with these new type of nurses and although they felt that the P2K nurses were less skilled, they were more questioning and appeared to be more stimulated to learn further and give care. This comparison between the two types of nurses was observed to be decreasing and the traditional nurses were less defensive because they were getting used to P2K nurses and there seemed to be a better understanding of the way that these nurses were being educated. It was further reported that these newly qualified nurses were looking at nursing care more critically and were able to reflect on their clinical performance. This was one of the observations which the Mental Health/CFP team leader mentioned:

"The feedback we were getting in the course management curriculum committee was that, at that particular time, people were not quite sure why the students were taught all those things but now looking back on it they are appreciating it more. The dependency on mentors and preceptors on the wards was gradually being taken away and these nurses are hopefully now working independently as competent practitioners".

Similarly, one of the lecturers stated the following in respect of the positive outcome of the course for these P2K nurses' clinical performance:
"One of the managers was saying how well these staff nurses were functioning. They are not afraid to come forward and express their ideas in a professional manner. They have very good interpersonal skills, they are questioning and they are also willing to learn. She was very positive about (these nurses) and several members of staff and managers have said this, they are quite positive about the product of the course, although initially they weren't sure whether these nurses were suitable candidates for their wards".

6.4 Perception of professional development

The lecturers' perception of professional development was expressed in terms of their understanding of its meaning and how they felt they had prepared their students for their professional learning in the future. The process through which these nurses would develop professionally during their registered practice was also identified during their discussions of professional development.

6.4.1 Process of professional development

The lecturers perceived the professional development of nurses as a continuous cycle which evolved through a dynamic reflective process of individual clinical practice. Sara further explained the meaning of this viewpoint:

"Professional development is technically a continuous circle. You achieve something, you evaluate how that has changed you and your performance. You then move on by identifying your next need and how you're going to meet that need; what you need to do and then you search for something that would help you meet that need and you move on to start again because knowledge and skills in nursing don't stand still, they move all the time".

The lecturers were then asked how they felt that these nurses developed professionally, during the three years at college, based on their views of the on-going process of professional development. It was evident that the process of professional development was seen very much as part of the
These lecturers felt that they facilitated the evolvement of the students' personal and professional development throughout the course both in the classroom and in clinical practice. Students' development was closely monitored and students were made aware of their progress. A lot of emphasis was placed on their professional role as well as the profession's expectations of individual nurse responsibilities with regard to professional development:

"The planning initially was very much focused on them, examining their own bias and beliefs and looking at their professional role as well as the professional regulations in relation to practice, considering any regulations that are laid upon the practice of nursing. So, it's very much looking at them and the way they were developing throughout the course".

The lecturers were then asked how they felt those nurses in the study had developed professionally when they qualified. They described what they had observed when they had been in contact and interacted with some of these nurses on the ward. It was felt that these nurses had the necessary personal resources to guide and help them to develop professionally. Sharon observed:

"I think they developed quite quickly from what I've seen of them and I've met quite a lot of them on the wards. They have actually developed very, very quickly, they know where to go, what to do, who to contact and how to get on this course, that course and basically how to develop professionally".

6.4.2 Preparation for professional development

The preparation for professional development was addressed when the lecturers were asked about the ways they prepared the student nurses for their future in nursing. They felt that professional development was gradually introduced throughout the course. Although not explicitly discussed, it was seen as one of the functions of being a qualified nurse and seemed to have been discussed particularly when the issue of the nurse's duty of care was being addressed.
Therefore, the lecturers felt that in class they did raise these nurses' awareness in respect of their professional development. They stated that they talked to the students about the nursing professional code of conduct and within that, particular duties and obligations that the code imposes on nurses were also discussed. They also talked to the students about the nurses' commitment and responsibilities as part of a profession, using the code as a framework to foster the idea of professionalism and pointing out that, although the nurse is expected to work within their code of professional conduct, it only serves as a guideline.

Furthermore, in class, guidance was given as to how to be responsible for their own professional development and what this entailed. The purpose of development at this stage was seen as making them resourceful and trying to get them to reflect on themselves and to give them some insight into their weaknesses. This the lecturers felt would help them to look at areas for development as they went through the course:

"(The P2K nurses were prepared for their professional development in the future) basically by teaching them where they can get resource material from, how to use the library, how to construct an argument, present a case, behave at an interview, how to actually teach people which will all be part of their developmental process in the future. Whichever area they want to develop, they can always build on what they've done and at least they've got stepping stones to climb higher."

The lecturers also commented that the students themselves did not really start thinking about their professional development until about six months before the completion of their course. This was when more structured sessions were organized during their last unit of study whereby specific issues, mainly relating to the staff nurse role, were addressed. For instance, sessions on being a staff nurse - the responsibility that the role entails; being responsible and being professional; looking for jobs; career advice and the availability of post-registration courses as well as, apart from the development
of knowledge and skills, how to develop coping strategies to deal with the changing nursing climate.

However, professional development did not seem to have always been addressed in the classroom. Some of the lecturers felt that professional development was mostly dealt with on a one-to-one basis at tutorials since they viewed it as an individual and personal activity which allowed for professional growth and development. They talked of various methods adopted, the most common being the use of reflective journals and learning contracts. As Kate said:

"I suppose we mostly look at professional development on a one to one basis in personal tutorials. In any case that's something I look at with my personal students, looking at the ways they develop and how they develop professionally. I encourage them to keep their reflective journal and we draw a learning contract if we feel it's necessary. But I can't really say that's something I very often address in class".

Although the students did not like keeping their reflective journals one team leader, Chris, stated that the feedback to the course management and curriculum team was very positive and that the benefits of keeping a journal were highlighted by those students at the end of their course:

"They reported back to the course management team that when they looked back on their (reflective) journal they could see how they were changing. At first it was a matter of why do we need to keep this journal but afterwards they felt that it was nice to look back and realize how naïve they were and that gradually they were able to deal with very sensitive issues. It was only when they were qualified that they began to appreciate many of the things they thought were a waste of time, but it came much later on".

6.5. Promotion of professional learning

However, it was evident from further analysis of the lecturers' interview data that there were other contributive factors which might have influenced the professional development of these nurses. The lecturers maintained
that focusing on the students' responsibility for their own learning and the teaching strategies used in the classroom and in clinical practice contributed to the nurses' professional learning as staff nurses.

The aim of exploring the emerging teaching strategies was to ascertain the extent to which they influenced the nurses' professional learning in the future. The teaching strategies which the lecturers felt contributed to the professional development of these nurses were discussed in relation to the subjects they taught in the classroom as well as their contacts with the participants in clinical settings during the course and during registered practice. The lecturers' involvement in the planning and the development of the curriculum were also seen as contributive factors.

6.5.1 Facilitating individual learning needs

The lecturers felt that within the curriculum framework, there was a degree of autonomy given to students. Some of the sessions on the time-tables were opened for negotiation with the students. However, the lecturers acknowledged that, at the beginning, the students did not seem familiar with reflecting back on their practice in order to identify their individual learning needs. They needed a lot of guidance until later on, especially in the branch programme, when they were more able to identify their learning needs individually. It was thus evident that there was some flexibility in the curriculum which was reflected in the time-tables:

“There was a lot of flexibility in the time-tables. If the students felt they needed a session on something, they identified that as a learning need and we were able to negotiate extra hours or fit it in one way or another”.

Furthermore, the lecturers had stated that, especially in the branch programme, the students themselves had requested more free study time, over and above the fifteen hours allocated for self-directed study, because they felt that they did not have enough reading time to supplement the
sessions done in the classroom. Thus, guided study time with negotiated learning outcomes and worksheets was given in order to allow the students to take responsibility for their own learning and to meet their individual learning needs. The students also had a choice of topics for some of the seminar sessions such as philosophy, ethics and nursing studies.

It was evident from an examination of the course document that this collaborative learning approach was to be encouraged and it is stated:

"The lecturer is seen as working in partnership with the student facilitating learning and offering support. It is believed that (partnership) is necessary in order to promote an educational environment conducive to learning, support, experimentation, discussion and reflection. This involves respect for individual students, support for the idea of co-operation and collaboration and autonomy" (Course Document 1990, 1:13).

6.5.2 Students’ responsibility for their learning

It was evident that, from the beginning of the course, a lot of emphasis was placed on individual students’ responsibility for their learning with back up tutorial support. Hence, the lecturers were asked to explain what they meant by giving the students’ responsibility for their learning and how they achieved this. They reported that they tried to engender situations where the students could take responsibility for their learning. This was done directly by having sessions on professional responsibility which were incorporated in the teaching of professional practice and how to become a responsible practitioner and indirectly by the lecturers acting as role models to the students. Sharon explained how this was done in the classroom:

“Well, they had sessions on professional responsibility. I suppose, we talk about it in theory and we engender responsibility partly by our own attitudes as teachers. For students to become responsible, they must see that we also are responsible for our actions and that we value that. For example, in my teaching there is the responsibility to turn up, to contribute to group work, those sort of issues. They can also do things like contacting us for appointments; we wouldn’t chase them up for their assignments,
they have to take responsibility to come to us, completing their work on time”.

It was also acknowledged that it was hard for some of the students to accept responsibility for their learning because they have to do quite a lot of it for themselves and this could involve highlighting their own deficits and their weaknesses. One way of addressing this difficulty was to get the students to work in small groups. The lecturers facilitated this by setting specific tasks, giving them guidelines which enabled them to work in the right direction for the right information, thus giving the responsibility to the group to learn from each other.

Although, the responsibility for learning seemed to be more focused on the classroom, the students also had some learning responsibilities in clinical settings. For instance, they had specific learning outcomes to achieve when on clinical placements. They were, therefore, responsible for ensuring that their clinical competencies were assessed and that they undertook any other learning activities required of them for each unit of study.

6.5.3 Promoting self-directedness of learning

However, the analysis of the data clearly indicated that whilst the lecturers emphasized the reflecting skills, the theory-practice link, shared learning and mentors preparation, the two team leaders, on the other hand, seemed to focus on the adult education approach to the teaching of these students. They reiterated that the curriculum was designed with adult education in mind and, as far as the teaching was concerned, they thought that the onus was put on the students with various designated resource persons to support them. What they also meant by that was that the students had lecturers as facilitators of learning and were expected to initiate and pursue some of their own learning. The aim was also for the students to become resourceful, critical and independent learners. They felt that this approach would help the
students in their professional development when they qualified as staff nurses. One team leader discussed this approach by stating:

"With the diploma course, what we've actually done, yes we've tried to develop the adult education approach. We've given the students work which they could actually explore in libraries and develop their own opinions and viewpoints to a situation rather than taking what they are told in class for granted. We also encourage and motivate them to read as widely as possible. The course also demands that they actually do in-depth analysis of nursing situations to show critical thinking rather than just looking at pure mechanistic aspects of treatment and care, based on bodily dysfunction".

It was evident that the course curriculum supported this approach of learning nursing studies which were to be applied in clinical practice through the development of critical thinking:

"It is important that the knowledge base is demonstrated within practice and that a critical approach is taken by the student to patient care" (Course document 1990, 1:65).

6.5.4 Reflecting clinical practice in the classroom

One of the aims of the course was to develop reflective practitioners. One of the ways the lecturers attempted to achieve this was to encourage students to reflect on their clinical practice in class. The lecturers reported that to develop this skill in students proved difficult initially, especially when they had to examine and justify their views by giving a rationale for their arguments which formed part of their basis for nursing practice. This was how Pam described the way the students were helped to reflect on their clinical practice in the classroom:

"With this particular group of students we've used critical incident analysis or reflection, especially when they have been exposed to the clinical areas. We asked them to bring back clinical case studies of particular situations, it may be a positive resolitional incident or it could be negative, so they are encouraged to bring back both situations. I think reflection is a difficult skill to develop in class but it's part of the learning process".
The lecturers further explained that what they were trying to achieve there was to engender in the students the way to look at nursing practice, that they needed to question and that the onus was on the students to make informed decisions about nursing care. The lecturers were also trying to demonstrate how a given theory was implemented in practice. The process by which the students were initially prepared to reflect on their practice in class was to get them to look at and clarify their own beliefs and values and to consider those of the patients. Students were also asked to think about the kinds of options which were available in relation to decision making and then to articulate the reason for one option of care to have been chosen instead of another. It was evident that the students at the time could not see the immediate benefit of this type of learning activity which was a regular feature of the time-table on their return from clinical placements:

"We allowed time when they came back from clinical areas to discuss what they'd learnt. This worked out very well because they were allowed time to reflect, to share a lot of their anxieties and concerns about decisions which had been made about patients care on the wards. It was very hard at the beginning but later on they appreciated the value of why we were actually doing it".

It became very clear that the lecturers were also attempting to address the link between theory and practice. Besides getting students to bring back incidents or real work situations in class they were also sent to the wards to gather information about something learnt in class. Thus the linking of theory and practice had a two-way process:

"We would do something in class. For example bodily fluids and fluid balance charts, then we'd asked them to go out on their clinical areas to find out what was happening in practice, when we've given them the theory".

Hence, this process enabled the students to reflect on theory, learnt in the classroom, in clinical practice which as a result would enable them to apply knowledge-based practice in the future. This was seen as a continuous process and it was felt that it would also form the basis for the development of nursing practice in the future in keeping with the underpinning
philosophy of the P2K course.

6.5.5 Teaching-learning continuum in clinical practice

Although every effort was made to prepare the staff on the wards, especially those who were going to be mentoring these students, about what the course intended to do, it was evident from the lecturers' accounts of teaching/learning strategies, that the traditional nurses were not fully aware of the ways the P2K students were being taught in the classroom. Before the implementation of the course a lot of time was spent preparing the service staff. The lecturers reported that they went on the wards and all relevant clinical areas where the new curriculum was to be implemented. They addressed issues such as the course content, the continuous assessment document, the students' responsibilities and the role of the mentor. The staff, especially the potential mentors, did not seem to have been involved in the planning of the curriculum in any great depth. The lecturers recognized their omission of not discussing teaching/learning strategies with the staff on the wards. Paul confirmed this by stating:

"I think basically we told them about the content (of the course), we told them about the philosophy of the course, we gave them handouts about criteria they needed to meet to become mentors. But with regards to what we would actually teach and how we would teach it, we didn't explain that sort of issue at all and they didn't ask".

Consequently, it was difficult for the mentors to fully meet the students' needs in clinical practice together with a lack of continuity with the teaching/learning approach in the classroom. Furthermore, if the aim was to influence future learning in practice, this gap between classroom and clinical teaching/learning and lack of mentors' awareness could have some implications for the professional development of nurses in the future.
6.6 Conclusion

The lecturers' perspectives of their experiences of the P2K course was highlighted in this chapter. Issues about P2K nurses' professional learning emerged within a teaching and learning context, from the lecturers' perception and conception of the P2K course. These issues provided added insights into the P2K nurses' professional learning, both in the classroom and in clinical settings, and the extent of the lecturers' contribution to the post-registration learning of these diplomates.
CHAPTER 7: THE EXPERIENCES OF THE P2K DIPLOMATES' POST-QUALIFICATION LEARNING

7.1 Introduction

Participants' experiences of being on a P2K course as described in Chapter five and the lecturers' perspectives of the P2K course as described in Chapter Six is followed by accounts of the post-qualification learning experiences of the same group of P2K diplomates in this chapter. It is presented in two parts. Each part examines an individual year of these diplomates' professional learning during their first two years of post-qualification registered practice. The participants were interviewed twice during each of the years.

THE FIRST YEAR OF THE DIPLOMATES' PROFESSIONAL LEARNING

The first set of interviews which took place six months after qualification was considered appropriate in this study so that the participants would be in a better position to reflect and give an account of the extent to which, they thought, the course had equipped them to practice nursing within the context of professional learning. Furthermore, getting the participants to reflect on the possible effects of their course helped them and the researcher to put their process of post-qualification learning in perspective from the inception of their learning experiences as staff nurses. This provided a baseline so as to note any changes in the participants' viewpoints and attitudes during the study.

Thus, the four key questions which were addressed after the group interviews analysis were:

* How do diploma nurses construct their notions of professional learning during registered practice?

* What factors contribute to the process of these nurses' professional learning?
How do the diploma nurses' notions of professional learning affect their professional development status?

In what ways are the nurses' attitudes and behaviour reflected in their conceptions and constructions of professional learning?

7.2 Effects of P2K course on post-qualification practice

At the first post-registration interviews, the participants were individually asked to discuss the underpinning philosophy of their nursing course in order not only to establish their understanding of it but more importantly the extent to which it was reflected in their clinical practice. An analysis of their varied responses revealed nine factors which appeared to be related to their learning experience of nursing and their perception of their clinical practice after six months of registered practice. The factors identified also reflected their understanding of the way the course aimed to prepare them and what it meant to them. These responses were similar to those discussed in their group interviews. Thus, these factors were:

1. Higher educational status for nurses
2. Increased professionalization of nursing
3. Increased awareness of research based practice
4. Upgrading of nursing care
5. Increased theoretical-based nursing practice
6. Rationalization of nursing care (knowing why)
7. Informed practice (knowing what and questioning)
8. Holistic approach to care

It was evident that these interrelating factors consisted of both clinical and professional effects (Table 7.1) which had had an impact on their learning of nursing practice and nursing as a profession. Central to their perceptions of
Table 7.1: ANALYTIC DATA SUMMARY OF P2K COURSE EFFECTS ON NURSING

<table>
<thead>
<tr>
<th>CLINICAL EFFECTS</th>
<th>Increased awareness of research-based practice: “To make us more aware of research based practice when planning patient care within our speciality”.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upgrading of nursing care: “A way forward for the future and the upgrading of nursing standards”.</td>
</tr>
<tr>
<td></td>
<td>Increased theoretical nursing practice: “To give nurses a more theoretical base in their practice”.</td>
</tr>
<tr>
<td></td>
<td>Rationalization of nursing care and informed practice: “For nurses to have a better insight in what they are doing and to rationalize their care. They won't be doing things just because it's always been done that way”. “To make nurses more aware of what they are doing, more aware of themselves and to encourage them to have more inquiring minds, more research minded, to know what and why they are doing something, rather than being task orientated”</td>
</tr>
<tr>
<td></td>
<td>Holistic approach to care: “Using certain specific core themes, such as physiology, psychology, social policy, sociology, nursing studies and integrate them so that you have a greater understanding of patients' needs”.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROFESSIONAL EFFECTS</th>
<th>Higher educational status: “To give nursing a higher status, educationally”.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Increased professionalization of nursing: “To enable us to become more professionals as nurses”.</td>
</tr>
<tr>
<td></td>
<td>Autonomous, independent practitioner: “To make nurses more autonomous practitioners which I found, in practice, has made me”.</td>
</tr>
</tbody>
</table>
clinical practice and nursing, the participants indicated an upgrading of their nursing care and that of their nursing status compared to traditional nurses. Liz's response was a good example of the relationship of the course to clinical practice and nursing:

"(P2K course philosophy was) about increasing our knowledge of nursing and to give nursing a higher status educationally. Even as we've been through the course in recent months at diploma level, most of us realize that degree level nursing will be very much the thing of the future".

Thus, according to these nurses' accounts of the course philosophy, in practice a research and theoretically based practice enables the P2K nurse to rationalize nursing care ('knowing why they do what they do') and provide an informed ('knowing what they are doing'), holistic approach to nursing care, taking all aspects (i.e. physical, psychological and sociological) of the person into consideration. Professionally, they considered that the P2K course provided a nursing status which was achieved by a higher academic level of education and the educational approach used produced an autonomous, independent practitioner, thus making nursing more 'professional'.

However, as reported in Chapter five (section 5.3), some of the participants failed to recognize the nature and purpose of the course, especially the CFP, but they felt that 'things got better' in the branch aspect of the programme. Nevertheless, once qualified, although they experienced some difficulty in settling in, their confidence in their knowledge-based approach helped them to cope in their role and they were able to appreciate the relevance of the course content to their nursing practice:

"Once you get on the wards and start practicing, then you know, why you do it all. Now I find all these ('ologies') so useful in my nursing practice".

"The knowledge of physiology has been a marvellous tool on the ward which some of the other nurses (traditional nurses) don't have. Some do, some don't and it gives you a greater base to present your argument or your understanding of the patient. To be research minded does help as well".

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These nurses further argued that their approach to care, resulting from the way they have been taught, was much more flexible and broader than that of their colleagues. They felt that the diploma level nursing course had changed their perceptions of the nature of nursing and had given them a better framework for their practice to work at a higher level of nursing care. They considered themselves different from the traditional nurses because of their ability to see patients' problems in more depth. June gave an example of how she felt P2K had influenced her clinical practice:

"I think the course has actually changed my outlook on nursing. I wasn't quite sure of what nursing was really about anyway, but it covered issues that I never dreamt were involved in nursing. I'm more aware now of issues from the core subjects we've covered and it has changed me. I'm different, I think I'm more aware of what I say, of what I think of different things on the ward. I can look at nursing from different perspectives and not as narrow minded. For example looking at different aspects of patient care; holistic patient care, looking at social aspects, how social policies affect patients' care, it's so broad and vast."

The knowledge-base of these nurses was also reflected in their approach to nursing care, in terms of providing individualized, holistic care for their patients. This was seen as a different way of learning to nurse patients efficiently and safely:

(P2K) "course adopts a different attitude, you deal with people and the fact that individuals differ, you need different approaches and it's not one rule all the time. So you learn to be a lot more flexible in your approach."

"You are able to make a reasoned judgement, using different perspectives."

"The holistic approach (to nursing care) is that, you don't look at someone just physically, you look at the whole person. This provides better nursing care and it's safer for the patient."

Consequently, the participants believed that they were able to provide a higher level of nursing care than the traditional nurses. They also argued that they were able to rationalize their practice from the theoretical knowledge they gained on the course. They demonstrated this aspect by reporting
examples of involvement in their clinical areas:

"We are working to a higher standard. We've got a sound basis to have a viewpoint, to actually contribute to discussing patient's care. We are able to put forward a scientific viewpoint. In my own experience, I think that I am able to achieve that. I am able to do that and learning to do it more each day but the course has certainly given me the basics to feel that I could argue a case on behalf of the patient".

"We are, actually, able to articulate a point, backed up by scientific information that should do more for nursing as a profession than anything else, really".

Thus, from the statements above, it appears that the initiation of professional behaviour originates from the participants' learning experience on the course, which they perceived as part of the process of learning to nurse. Sarah explained this:

"(The course) makes you more aware of how to develop, how to behave, how to act, what is professionalism itself, how to communicate with people. I think this course has centred a lot on communication as well and on how to speak to patients and other people professionally".

Embedded within that aspect of being professional, which they linked with their theoretical background, is that the course encouraged them to become autonomous practitioners; accountable nurses who are able to take more responsibility to improve patient care. Being an autonomous practitioner was described as the ability to work independently in making decision about patient care. Tommy described the way he felt autonomous in various aspects of nursing care:

"The way it is for me is, I don't have to rely so much on the Multidisciplinary team (MDT). Whereas, some of my colleagues who have not been on the P2K course, they are very closetted and narrow in what they know, they rely very heavily on the MDT input".

Other participants confirmed how the course enabled them to ask questions and to be questioning in their practice:

"The course is more academically-based, it has made the nurse more questioning, nurses are taught to question, to be more critical
thinkers, to question decisions, make suggestions and to play a
greater or fuller part within the MDT”.

"(The course) made me question a lot about patient care. Why are
we doing that? What's that for?"

This process of questioning led the participants to reflect on their practice
which was also viewed as one of the participants' learning strategies, discussed later (section 7.3) in this chapter:

"I'm reflective all the time, I brought this with me to the ward'.

"I think, you don't actually teach reflective practice. I think the
continuous self-assessment and evaluation on the course taught
us that and you learn to develop that skill as you go along”.

7.2.1 Extent of preparation for clinical practice

The participants were asked how they felt the course had prepared them for
their clinical practice (Their concern about their lack of skills and uncertainty
about their practice were explored during the first interviews because these
were issues which emerged from the group interviews which took place a few
weeks before they completed the course). Some participants felt that the
course prepared them adequately, others thought that it did it to some extent
and the rest felt that it did not prepare them at all due to skills deficits.

Those who felt that they were adequately prepared thought that they gained
knowledge to deal with different aspects of nursing practice. They acquired
relevant skills that enabled them to think about what they were doing; about
issues that they were unaware of and how to apply theoretical knowledge to
their practice of nursing. They also talked about how the course prepared
them to adopt an holistic approach in their nursing care; making them self-
directed, autonomous and enabling them to make decisions about patient
care. For these nurses, their lack of nursing skills did not seem to be a
problem. As two of them indicated:

“Yes, absolutely, bearing in mind that we were the first group
to have come through the course. A criticism that always came
to me, was that we got no practical training, which to me is rubbish, because it's mere procedures that you pick up, as you go along and you learn them very quickly”.

"Yes, the course did equip me to practice, I'm doing it now. I feel confident, I know everyday I learn something new, nobody knows everything”.  

Although some of the participants felt that they were given the required knowledge to perform their general nursing duties, they considered that as far as the practice of clinical skills was concerned, these lacked depth. The clinical experience they had was not long enough for them compared to traditional nurses. They suggested that the course should have given them an extra six months of clinical practice. Sarah and Teresa stated:

"Like to-day for instance, I had a teaching session on the ward (actual session mentioned here) which was excellent. I feel that we went through the same thing on the course but not in detail as that nurse did. You could tell that she has had a lot of practice, she gained the knowledge by practicing on the ward while we didn't get the chance to do that".

"I think the course does prepare nurses in so far as they are going to be more accountable. Although the skill part of it is not sufficient to prepare them for working immediately, the skills-based practice does get better after six months or so, working as a staff nurse”.

Thus, they felt hopeful because with their background knowledge they were able to catch up with their skills deficit quite quickly. However, their preparation to meet the needs of the wards was another factor which these nurses felt was lacking. They found it difficult at times to cope with the demands of the wards because of the emphasis on skills-based practice rather than theoretical-based knowledge. Donna and Jeanne expressed this viewpoint by stating:

"I think we have been pointed in the right direction as far as the patients are concerned but I wish that the course fitted more with the economic climate because as I have been told on the ward, education is going one way and what they want on the wards is more skills, they don't want this wider approach (to nursing care)”.  

"Although the course tried to prepare us for a future in nursing, I don't think it actually prepared us for the situation that nursing is
in at the moment. The actual reality of nursing is that very often there isn’t the time or the staff available for you to practice what you’ve been learning during the course. I think the course prepared nurses for an ideal job and we have come out here and brought those ideals and our knowledge and we are trying our best to get them into the situation as it is. I don’t think that’s easy”.

Those nurses who did not feel that they were prepared to practice also talked about their feelings of not being equipped to do “real nursing”. This group of participants were somewhat disappointed that they had had to learn a lot of their clinical skills when they were already qualified. They blamed the course structure which included a lot more theory without giving much thought to the application of theoretical knowledge to practice. This was the way Anne expressed her negative feelings about her preparation to the practice of nursing:

“No, I didn’t feel at all equipped (to practice). I’m afraid, I hate to say but I’ve been totally misled and a lot of the time I’ve been very disheartened (about P2K) and often wished that I did the traditional course but having said that, I made the best of the situation and got on with it really. I’ve learnt a lot (on the ward) but as I said, a lot of (the practical knowledge) hasn’t been from the college, it’s been from other sources and myself”.

However, personal growth was an area the participants unanimously identified as contributing to their preparation for clinical practice. They talked about an increase of self-confidence, being able to confidently articulate nursing issues, and self-awareness of their strengths and limitations of their competencies on the ward. They attributed all these to their academic knowledge gained on the course:

“(The course) has given me a lot of confidence academically, because I’ve learnt that it’s all right to question and it’s alright to say you don’t know. I’ve gained enough confidence on the course. I’ve grown as a person anyway”.

“The course has made me more self-aware than I was at one stage. It has made me look at where I feel I could work well in my practice, my qualities, where they all fit in”.

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7.3 Learning to cope with being a newly qualified staff nurse

For these participants, being a newly qualified staff nurse entailed learning to cope with different aspects of the role, which they had to face in various situations. Their main concerns about their role seemed to have been their fight for their identity as staff nurses, to be recognized as valuable members of their teams in their attempt to make a significant and meaningful contribution to nursing care. They reported the difficulties they experienced, which they felt were due to undertaking the P2K course.

One of the contributing factor that they felt caused some hindrance during the initial stage of the coping process was their lack of managerial experience. Teresa explained how her lack of management skills affected her performance as a newly qualified staff nurse:

"I felt that when I became a staff nurse, I didn't have enough practice because we only really had the last placement in which to do (management). I felt a lack of experience about making decisions, being confident about those decisions and negotiating with the multi-disciplinary team. I haven't had a lot of practice at those sort of things".

They also realized that they lacked clinical experience during the early months of registered practice. They coped with this deficit by applying and building on the knowledge and basic skills acquired during the course. The participants lack of skills represented, mainly, some of the procedures and skills relating to specialist skills that they came across when they became staff nurses. They did not have the opportunity to gain those specialist experiences when they were student nurses due to the limited time they spent on clinical placements. They, nevertheless, admitted that they had some useful skills which they found helpful in their practice:

"I might not have had all the necessary skills, as the course was designed in that way, but obviously we had lots of other skills that we gained on the course, such as interpersonal skills and such things".

Thus, for these nurses, coping as staff nurses meant having to learn those skills which they were lacking, in order to catch up with the traditional nurses
on the wards. Some of them felt that the basic knowledge gained from the course helped them to learn those skills quickly, whilst others felt that it took them a little longer. However, they believed that despite the fact that they might not all develop the same way or at the same rate, once they had acquired those skills required in their practice, they were as good as the traditional nurses with whom they worked. From their observations and discussions with the traditional nurses, they maintained that it took the traditional nurses a lot longer to gain similar kind of knowledge to theirs:

"You pick up those skills very quickly anyway and I do feel the course did give us the basic grounding to work on, it does help you in that way".

"Obviously, it could take the P2K nurses a little longer to catch up with the practical side of things, once they qualify. It took me a little time, but, I would say that, now, I'm no worse than a traditionally trained nurse".

The participants' grasp of the basic, managerial concept of nursing care seemed to be one of the reasons for some of these nurses to claim that they were able to learn the required skills for their practice rather quickly.

Furthermore, by the end of their first post-qualification year the participants had deduced that the basic concept of nursing was always the same, as long as the patient's safety was maintained and they were able to recognize the limitations of their knowledge and skills. Tommy summarized this viewpoint as follows:

"I think the basics are all the same. If you observe the patient and you know when to call a doctor, get the team to work with you, I think it all works out the same at the end of the day, it's for the patients' safety. You cover yourself well, making sure you go by the ground rules really; also knowing that you'll never get to know everything that there is to know in nursing".

Once they have understood and clarified the meaning of nursing practice it was apparent that their confidence had increased accordingly.

They described themselves as being less unsure and less vulnerable in their
staff nurses' role and also in what was expected and required of them. They became aware of the 'rights and wrongs' of the job and were able to manage a ward at a level that they felt confident:

"I think, it's the basic things, that you've learnt and know now, that can make you feel more relaxed. I go through the day and I don't worry about a drug round, I just get on and do it. I don't worry about how I can send a patient home, I just organize it, the basic concepts are there, my management has improved an awful lot".

Previously, this participant, Sinead, had described the experience quite differently, indicating a shift in confidence:

"It was a nightmare even doing a drug round or be handed the keys and told that you were in charge; that's when you worry and think everything wrong is going to happen, it was nerve wracking".

Similar feelings were expressed in relation to decision making experiences especially when they were in sole charge of the ward. Claire described her experience which reflected the extent of her vulnerability when she was left in charge of the ward on her own:

"I felt quite vulnerable especially when I was left in charge on my own because I didn't know what I was doing most of the time. Most of the time, I was making decisions which I thought were making sense, but whether they were right or not, I didn't know and at the end of the day I was responsible for them".

Thus, at the time of these interviews, the participants clearly recalled their feelings of anxiety, inadequacy and apprehension when they initially started to work as staff nurses. However, they reported that they felt confident enough about their academic status but they had pre-conceived ideas about their limited clinical abilities, which were perpetuated to some extent by their previous negative experiences as student nurses. On the other hand, this helped them faced their role in a more positive and pro-active manner, in terms of their willingness to learn the skills they felt they were lacking:

"I felt very inadequate to start with. I felt quite insecure, quite nervous about the whole thing but I realize that we were all in the same boat, really".

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“I remember situations on the ward when I felt really self-conscious, really nervous but you can actually feel comfortable in a staff nurse role by just doing it to the best of your ability; proving to yourself and to others that you have the skills to contribute to patient care and learning the ropes as you go along, really.”

7.3.1 Factors influencing the staff nurse adjustment process

Adjustment to the staff nurse role was a gradual process for all the participants, in spite of some being given the responsibility of taking charge of the ward sooner than others. During their initial period of registered practice, the participants had another staff nurse working alongside them and, as stated earlier in this chapter, it was when they were left in sole charge of the ward that they found it hard to learn to cope.

The hardest of all the influencing factors during the staff nurse adjustment process, with regard to their learning of the staff nurse role, seemed to be the conflict of interest which existed between them and the other staff on the ward. These diplomates went on the wards with their own perception of professional learning and ideas of nursing care which did not entirely match those of the traditional nurses. They learned to apply theoretical/research based practice from the course, whilst the ward routines were not in line with the theory they had learnt on the course. They, thus, reported the difficulties of entering a ward culture which was already well established and in many instances the staff were somewhat resistant to any new ideas brought into the wards by them. Teresa gave one of the reasons for this:

(The traditional nurses) are a very tight knit team, things get done but you are not quite sure what is going on and who is doing what and who is who and the rest of it. They have set ways of doing things, some which I thought were very good and some which I didn’t agree with. So, making the adjustment was more difficult than I anticipated”.

Some of the participants also found that it was quite difficult to question the staff on the wards and that questioning nursing practice was not always
welcomed. They felt that, at that time, they had to depend on others to help them cope but at times it was as if they were on their own. Thus, following set routines in the way things were done on the wards caused some problems for them, initially. It was evident that such problems were being experienced in both the adult and mental health nursing, as two of them from each of these nursing specialities stated:

"I think there are still ward routines and every ward has their set routines in what they do and they were not going to listen to us. What is laid down by the top person on that ward goes and a lot of nurses have to follow that".

"(The nurses on the wards) have a real problem with questioning because they are quite institutionalized. Whoever is in charge, whatever they say goes. They do things because that's the way they've always done them".

However, the participants addressed this by gradually working out various strategies to cope with their difficult situations and relying on the knowledge and skills they felt sure about. They, then, began to make suggestions by taking risks, being non-confrontative and asserting themselves. By that time, some of them had been given specific responsibilities such as becoming a wound care resource nurse for the ward or a key worker for a group of patients and they had had a lot more opportunities to take charge of the ward on their own. This was also when they felt that they were more accepted by some of the staff on the wards and the doctors as well:

"I think, because I'm the pressure care and wound care resource nurse, I suppose, I tend to say that this dressing is better than that dressing or, 'can we try this or I've read about this, could we try this'?"

"If there was something that cropped up on the ward, you wouldn't just take it that, that was the necessary thing to do, you'd say research has shown that... whatever".

The participants identified the resources which they used to help them learn to cope, especially when dealing with difficult and new situations or when they were not sure what they should be doing, during their adjustment period.
They found asking questions and having discussions with the ward manager, other staff nurses and the doctors helpful. They also referred to written resources kept on the wards that they could use to gain answers to their problems.

7.3.2 Diplomates' meaning of nursing practice

However, the participants' approach to nursing care seemed to continuously create a conflict with some of the traditional nurses on the wards as discussed in the previous section. The main frustration for these nurses was that, whilst some of the traditional nurses were quite open to suggestions and flexible in their attitudes, there were still others who were quite rigid in the way they approached nursing care. They, nevertheless, felt that the possible reason for such attitudes could be that the traditional nurses were not trained to question their practice as they did on the P2K course. Joe explained this:

“If you are just doing something like regurgitating an action, when changes come it's difficult for you to change because you're doing something that somebody has taught you to do without questioning anything. It wasn't like that for us”.

They, therefore, realized that their style of nursing care was influenced by the way they were taught at college, but this in turn caused problems on the wards when they had to learn from those who did not share a similar nursing ethos:

“I think doing things like sociology, psychology, research, and other subjects, it meant, you go on the wards with a much broader outlook, with an open mind. I think for me anyway, I'm much more likely to challenge what's being done”.

7.3.2.1 Application of theoretically-based knowledge

Thus, challenging practice was found to be another way these diplomates further perceived their practice of nursing. This was, essentially, done by continuously questioning their own practice and that of others (nurses, doctors, physiotherapists and other health care practitioners). When
they were asked what they meant by 'questioning', they, unanimously, described a practice which consisted of understanding and applying theoretically-based knowledge underpinning patient care and not carrying out a procedure blindly. In fact, they were all adamant that they would not do something without a sound rationale or that they did not understand. This approach was seen as the basic principle in the practice of nursing. When they were in doubt they would check with other nurses or relevant health care professionals and if they were not satisfied they would go out and find out for themselves. Joe confirmed this and explained his nursing approach:

"My way of doing anything (in nursing) is by understanding what I'm doing. I don't do anything without giving the reasons. If I do something I give reasons or I explain. So, it's more or less, actually, finding the source of knowledge; where does that comes from. You need to know what you are doing. You don't do it because everybody does it, definitely not; it's because you can work it out in your head".

However, they reported that some of the traditional nurses were also beginning to question and develop their practice. This was particularly evident in the second individual interviews. They welcomed this initiative since they felt it was an essential part of clinical development and professional learning. Liz noted:

"I use to think that the traditional nurses didn't question enough, they took things as they've always done, they just accepted it. I don't think that's entirely the case these days, some of them are into developing themselves, they know they have to learn to do it that way".

7.3.2.2 Reflective practice

It was evident that the process of questioning nursing care enabled these nurses to be reflective in the way they learned to practice. They recognized that, as student nurses, they they did not have the opportunity to always apply knowledge to practice. However, when they qualified they were able to reflect on the knowledge they had acquired during their nursing course and were able to apply it to practice. Hence, reflective learning was expressed by
self-assessment of their own performance and critical evaluation of nursing practice; continually questioning whether the nursing procedures that were being carried out were correct, up to date, theoretically based or just done as a matter of the ward routine. Claire's response exemplifies this reflective learning approach to nursing practice:

"Although something looks alright, you start questioning it and sometimes you find that there's no conceptual framework, no theoretical base, it's not sound, nobody knows where it comes from, somebody has designed (a nursing framework) but it hasn't contributed to the nursing knowledge, to the theoretical framework underpinning patient care or whatever".

From the above discussion, it was evident that the participants continued to learn by applying theoretically based knowledge to their practice of nursing. Consequently, when they were asked to explain what made them reflect on their practice the way they did, besides the fact that this was one of the ways they approached learning during the P2K Course, they identified safe nursing practice and their responsibility and accountability for patient care as contributory factors. They also mentioned that these factors were influenced by their awareness of the importance of adhering to the UKCC professional code of professional conduct for nurses, their hospital Trusts' policies and the patients' charter.

7.3.2.3 Safe nursing practice

The participants perceived patients' safety as an important aspect of nursing and this was, therefore, incorporated in their professional learning. Their conception of safe nursing practice was to ensure the application of theoretically based practice. They demonstrated this by the way they checked their practice when they were in doubt and by continuously evaluating it:

"(Checking practice is) very much a safety thing. If you feel it's not right, if you are not sure of something and you do not tell somebody, that's dangerous because letting something go unnoticed, it's not safe for the patient and you can be found
out very easily. You need to query whether it's safe or not”.

"We are quite open about our capabilities and I wouldn't go around pretending that I knew something that I don't. To be quite honest, nowadays, you just can't afford to make any mistakes”.

7.3.2.4 Responsibility and accountability

Two other important aspects of nursing, which these nurses linked with the safety of their practice, were being responsible and accountable for patients' care. Responsibility and accountability were demonstrated by their tendency to refuse to carry out procedures that they felt were not safe because they were aware of the consequences for patient care. Hence, they were learning to do things correctly by checking and ensuring the safety of their patient care. Sarah asserted:

“I wouldn't just copy someone, no, because at the end of the day, it's your PIN number that's on the line. You've got to protect yourself and protect your patients. I hope I don't come across something like that (having to copy someone without questioning) anyway. In any case I'll stop and check first’.

7.3.3 Relationship with other nurses on the wards

As in the previous interviews relationships with traditional nurses was an issue. The negative attitudes of a lot of the traditional nurses caused interpersonal relationship problems during these nurses' initial registered practice. They felt these affected their learning and their working relationships on the wards. This group of nurses resented the label of P2K and wanted to be recognized and treated as the other staff nurses on the wards. Angie reported angrily:

"There were always some jokes about us, P2K staff nurses and whatever. We would be introduced that way, not just as staff nurses. It was more of a joke really, but you always have to face such attitudes".
The participants, also, thought that they had proved to the other nurses that they were capable of learning what was expected of them in order to function at the required level. Moreover, they felt that they had performed better than the traditional nurses had anticipated. David and Sarah described the effect of their performance on the wards respectively:

"I think I have opened their eyes as to what P2K is really about. It's not about walking around behind a nurse all day, everyday, not knowing anything, not doing anything. I think, in that sense, I've made them more aware and they do ask me questions about the course, the sort of things I did or they would say what they did during their training and would compare it with mine".

"I think at the beginning they didn't know how to take us really but I know certainly the sister there and other nurses have said that we are doing so well. Sometimes, I think it can be quite patronizing but on the whole it's quite nice to hear that really. I think we are equal to them now but it takes a little time".

However, the relationship with the other nurses on the wards was said to be better and the participants' learning enhanced when the ward manager or staff nurse was young, not long qualified, open minded, had some knowledge about the P2K course, showed interest in what they were doing and was open to suggestions. Thus the quality of relationship with others on the wards depended on certain identified personal attributes. Sinead clarified this when she stated:

"I learnt a lot from this particular staff nurse. She was similar to myself in the sense that she was young, she'd only been qualified two years before me. She was very open minded, she accepted your viewpoints and ideas. She would always give you the chance to do what you felt was right".

7.3.4 Coping with the attitudes of traditional nurses

Similar to findings in previous interviews, the participants felt that the course had not adequately prepared them to meet their employers' (the NHS Trusts') needs. Teresa explained the extent of this conflict:

"Service is still seeing things differently from education. Service is still looking for a skill-based nurse, whilst the
college has taught us to be questioning and to have a good theoretical base. When you get into clinical areas, they are not interested in the theory, as long as the work gets done and what they look for is skills. There is still a gap or a negative link between service and education. What we've been learning is not always known on the wards, there doesn't seem to be a lot of knowledge about the course theoretical content on the ward”.

Consequently, these diplomates were met with a certain amount of estrangement from some of the staff on the wards. They felt that this attitude affected their learning process, to some extent:

“There was almost a conspiracy, which sounds absolutely horrid, that prevented us from doing anything practical except commodes and bedpans. You can't get the clinical practice just doing that!”

“The difficulty was coming into the clinical area with people who were very negative about P2K. They just felt it was a complete shamble and a waste of time because, I suppose, they felt threatened by it or whatever, that made it even harder for us”.

In order to address this negative attitude of the traditional nurses, the participants proposed more staff education about P2K:

“Perhaps, if people were able to be more informed, they would be less threatened and more supportive. The more information people have, the less threatened they should feel”.

Although, they felt that they were treated differently and not approved of by the traditional nurses, they thought that by the end of their six months there was not much difference between them and other newly qualified nurses they had come across on the wards. Nevertheless, they felt that they had coped quite well:

“I've been conditioned to think that I'd been missing on drugs, on nursing procedures and all that we didn't get as P2K students but, low and behold, traditional nurses’ input on the ward, those who are at the same level as myself, is the same as mine or perhaps less. To me that dispels that myth. There is good and bad in all. I didn't look at the course as having great deficits, nothing is perfect”.

“If everybody who had done nursing before is against P2K course, you ask yourself, what is the value of this nursing course. At one time I was more or less listening to these people and then I have
come to realize that it doesn't make any difference. Now that I'm on the ward performing, I feel there's no difference between a P2K and a traditional nurse”. 

Angie explained how she felt they had coped with this conflicting situation with traditional nurses in a proactive manner:

“After a while on the ward you settle in, you become more prepared and you make yourself settle in faster because there is this barrier after being a P2K student. That what makes you want to know even more than the traditional staff nurses and you have to prove yourself even more”.

7.3.4.1 Peer support

In view of the difficulties experienced on the wards with the traditional nurses' negative attitude, especially during the initial stage of being staff nurses, the issue of support was addressed here. It was apparent that clinical support was mainly available among the participants themselves to supplement their own individual learning. The emphasis was on peer support, in terms of shared learning and sharing of information with each other outside work. Anne explained the extent of their peer support which they had identified:

“We sort of help each other out quite a lot when it comes to learning new things. We have been a good support for each other in that respect. We all had a certain amount of things to learn. We would help each other and we have learnt a lot from each other”.

Apart from this participant-initiated peer support, the other type of clinical support was from the preceptorship system which will be discussed in Section 7.4.3.2.

7.4 Methods of professional learning

The participants were asked about professional learning throughout all the interviews; what it meant to them and how they went about it. They identified a range of learning methods that they had experienced. The way they
perceived this process of learning was by continuously building on what they had already learnt and what they still needed to learn to meet the requirements of their jobs.

Thus learning needs were mostly identified informally and spontaneously, except for one participant who said that she had had an “Individual Performance Review” (IPR) with her team leader, whereby she had identified and formally recorded her learning needs for the following two years. However, the identification of learning needs was seen as an ongoing activity which these nurses had to do regularly from the time they were on the P2K course. There was no actual written format such as a learning agreement. It was left up to individuals to identify what they needed to learn during the course of their work. Explanations of how this was done were given. For example, June and Joe stated:

“Even though, I didn’t actually say that these are my learning needs and I didn’t write them down, this is what I need to learn but it is always at the back of my mind, it is an ongoing thing as a staff nurse”.

“Only what (learning needs) I identified for myself and that would be, like, if something happened on the ward and I realized that I didn’t know how I would deal with that, then I’d know what I needed to learn. So, I’d ask someone on the ward and find out that way or whatever, there isn’t any formal teaching as such”.

7.4.1 Learning process

All the participants reiterated that they had not finished learning and emphasized that learning is an ongoing process in nursing, whether one is a newly qualified staff nurse or not. They also suggested that in order to continue in the practice of nursing, one has to be learning all the time. For them, having a basic nursing qualification to practice was not enough. They felt that nurses need not do academic courses to keep up to date with their practice and that there are other learning activities that they could engage in. They also considered that failure to update nursing knowledge and skills
could lead to unsafe practice. They therefore perceived professional learning as a dynamic process and that it was important for learning to be valued by all nurses because of the rapid changes in nursing. Additionally, they emphasized the responsibility of individual nurses in their professional development:

“I’ve not finished learning, learning is an on-going process for me. What I have finished is the P2K course. This was a first step, then I started again. Learning is a life long process. There is a lot of things to learn in nursing, you can go on and on, there’s no end to it”.

“I will never finish learning, I mean, you learn different things everyday in nursing. It has just started for me. Everything is changing, new research is coming out, you can’t stagnate, you have got to continuously learn. These days to advance yourself, you’ve got to be responsible for it. It’s all about the autonomy of the nurse and professional development of the nurse. That’s what takes you forward, you can’t stay in one place and stagnate”.

It was apparent that these nurses recognized the importance of the on-going, cyclical learning process which is involved in nursing. They all implied that the outcome of a professional qualification was not sufficient in the development of a competent nurse. This is an example of how John described his professional learning:

“I view learning not just gaining an end product, gaining qualifications. (Professional) learning has to do with developing yourself and learning how to learn in many different ways”.

7.4.2 Learning strategies

Thus, at this point in the research, it was felt appropriate to explore the methods by which the participants were learning in their respective clinical areas. Accounts of a variety of learning methods that the participants had experienced so far were reported as either a series of learning actions taken, or series of learning events that they felt helped them to learn in their clinical settings, from the time they qualified.
A content analysis of the large number of data segments attached to this category, particularly during the first individual interviews, showed that learning methods used were largely at an informal level, on the wards especially at the time of the first set of post-qualification interviews (Appendix E). The informal learning activities and learning methods used were mostly initiated by the participants themselves. The few learning methods which were either mandatory or initiated by others e.g. ward managers, according to the demands of the wards, were done both formally and informally. Thus, the nurses' professional learning consisted of both formal and informal strategies.

7.4.2.1 Informal learning activities

Informal learning strategies were those which the participants learnt as they 'went along' whilst working on the wards. June confirmed this explanation when she stated:

You learn what you see as well, which is probably informal. I mean as you go along you see things you don't understand or you don't know how to deal with".

When the participants were asked about their professional learning activities on the wards, at the second set of interviews which took place at the end of their post-qualification year, no formal ward teaching was reported. Thus, the main types of learning strategies and source of knowledge which these nurses identified at that time were:

1. Listening, observing and questioning others. Information was sought from their more experienced or specialist, nursing colleagues, doctors, pharmacists, social workers and any other health care professionals involved at the time.

2. 'Doing', which meant practicing their skills on actual patients.

3. Reading and referring to textbooks, journals, either on the wards, from personal collection or borrowed from the library or colleagues.

4. Referring to ward resource files, policy/procedure manuals and clinically based booklets.
5. Visiting the library to either borrow books or using the CD-ROM to do a computer literature search on a given topic or subject area they knew very little about or to find updated literature.

6. Attending specialist interest group meetings/discussions e.g cardiac, wound care and sharing updated literature.

7. Mentoring and teaching student nurses on the wards. Some were also involved in preparing and/or updating teaching packages for students nurses.

It was evident, from the accounts of learning activities in which these diplomates had participated in their first year, that they had used a wide range of informal learning methods for the various learning activities on the wards. Some of these methods seem to have been brought in from the classroom, for instance "group/shared learning"; "looking up and finding out for self" and this need for wanting to check information out for themselves, not relying too much on others and actually not taking for granted what being taught by others. The participants, therefore, assumed responsibility for the quantity and quality of their learning as well as being motivated to learn further, independently, and in a self-directed manner.

The participants' learning activities were very much patient centred, learning through caring for patients, and there was a definite emphasis on the learning of clinical nursing skills. They found that their course was more knowledge-based with minimal practice of nursing skills. As Maureen said:

"I think you can learn all the theory behind the practice throughout the course but once you qualify and you are on the ward, that's when you really start to learn nursing. I have a lot of knowledge but skills are by no means up to what I think I should be. I'm not being assessed for my learning or anything now but I think there is so much to learn".

However, their accounts of learning at this stage of their nursing practice also demonstrate their use of interpersonal/communication skills which were embedded in their mode of learning e.g. questioning, listening, observing. "Reflecting on their practice" and "teaching of others" were also two other
methods which they had previously experienced in classroom learning and they were able to actively use these approaches in clinical settings.

Sharing of clinical information on the wards was another method which the participants identified as informal learning. They did this by taking relevant, updated literature on the wards and sharing the information with others either by discussions or making the information available to others. This exchange of information seemed to have mainly a positive effect between them and the traditional nurses especially when the latter were in need of academic material. Consequently, this seemed to have also contributed to the improvement in their relationship with the traditional nurses:

"A lot of the traditional nurses on the ward will actually come to me when they are doing (English National Board) courses. They'll ask for our essays and how to reference and things like that, which they've never done before. We get on fine with traditional nurses now, really well".

"(A staff nurse) used to ask me questions and I tried to tell her what I remembered from college. I learnt a lot from that particular staff nurse".

On the other hand, sharing of information and knowledge had a less positive effect in other instances, whereby some of the traditional nurses were less interested in updated literature. Anne observed:

"I often bring articles to the ward and put them on the notice board for people to read, some of (the traditional nurses) would update themselves and others, I suppose, are stuck in a rut, they have been on the job for so long and they are not going to change their ways, they probably think that the research thing is a load of rubbish, you know, but some of them are quite interested in the research-based stuff".

7.4.2.2 Formal learning activities

By contrast, formal strategies were described as some of the formal sources of learning which included short courses and study days. These were clinically relevant to their individual nursing specialities and organized by the
hospitals where they worked e.g. staff nurse development, venous-puncture, mentorship and teaching and assessing courses. Although, these courses were mandatory and were largely suggested by the ward managers or team leaders, some of the participants already knew about them from the nursing college or from other colleagues. In many instances, these nurses had to ask to go on some of these courses and because of the great demand, they had to assert themselves when they felt ready to attend them:

"I knew this (staff development) course was about and there is quite a lot of competition to get on it and I really had to push to get on it".

"On the ward they might suggest that you do (a mandatory course) but I'd asked to do it anyway, so I don't know whether they would have asked me to go on it at this stage. I think not, I think you need to ask for the courses when you feel ready really, even though we are meant to be doing them at some stage or another".

However, those clinically-based, nursing related courses and study days which were normally undertaken by newly qualified staff nurses were considered essential because the diplomates felt that they helped them meet the basic requirements of their role, according to the nursing speciality and types of patient group they were involved with. At this stage of the interviews, not all of the participants had had the opportunity to attend the relevant study days and short courses because of their varying length of practice since qualification. Nevertheless, the ones which they mentioned, covered three main areas of their practice:

1. Specific nursing procedural techniques e.g. blood glucose monitoring.
2. Staff nurse development course e.g. mentorship of student nurses.
3. Computerized nursing documentation.

The learning methods which the participants said they used were attendance on study days and courses. These seemed to be the favoured methods of professional learning which was also reflected in their learning plans for the following two years whereby planned formal courses were included in all of their strategies. The most popular of these were management courses and
specific specialist nursing courses. Eleven different courses were quoted, including wound care, urology, coronary care, oncology and counselling. However, some of them did not feel it necessary to go on a course to manage a ward or a group of patients and considered that it was a skill which could be learnt during the course of their work. Teresa confirmed this viewpoint by stating:

"Managerially, I think there is still a bit of deficit, but I don't think that's a huge problem, to be honest. I think, you can learn to manage a ward, a group of patients. You need help to learn to manage but you can't really learn that until you are in different ward situations".

The three other types of courses were those to do with teaching and assessing of nurses, application of research to clinical practice and health related degree courses.

7.4.3 Other learning methods

Other learning methods which these nurses had identified and explored were as a result of their experiences of mentorship/preceptorship system and their involvement in teaching student nurses.

7.4.3.1 Learning through mentorship/preceptorship system

At this stage of the interviews the terms mentorship and preceptorship were used interchangeably. Preceptorship was a fairly new system in the clinical supervision of nurses in the U.K. Normally, mentorship applies to the supervision of student nurses, whilst preceptorship occurs when newly qualified nurses are being supervised. However, for the majority of these participants, this system had not been implemented in their area of work, hence the tendency to use the term "mentor" rather than "preceptor".

Two out of the thirteen participants interviewed reported that they did not go
through such a programme at all and thought that the main reason for this was because of a shortage of qualified nurses on their wards. These wards were also undergoing a lot of changes at the time. The way these two nurses coped with this was by approaching experienced staff nurses with whom they were working. Adam confirmed this:

“When I started on the ward, I never had a mentor, I was just left alone. I picked up bits and pieces here and there, by asking whoever I happen to be working with”.

All the other participants reported that they had had one or two named preceptors at some stage during the initial six months of working as staff nurses. These nurses’ experiences of being preceptored varied to some extent but most of them had positive experiences and were able to develop a good working relationship with their preceptors which helped their learning.

Four of the participants found that their preceptors did not really know what preceptorship entailed. They had not formally attended a session on it nor had they received any hospital Trust’s guidelines on how preceptorship should be carried out. Thus, initially the preceptors did not know what these nurses were meant to be learning and they had to work with the participants, in a collaborative manner, since none of them had previous experience of preceptoring newly qualified nurses. Sinead recalled her experience of being preceptored:

“She wasn’t very aware of the role of a preceptor, initially. We did look into some literature, there were some articles we found on preceptorship and we didn’t really know how to approach it. We used to discuss it between the two of us, there was nobody else being preceptored on the ward and I was the first person to have to be preceptored and nobody had the experience”.

However, it appears that guidelines were issued towards the latter part of their preceptorship. The participants’ account of preceptorship conveyed an informal approach throughout, except for one who reported to have had ‘three informal interviews’ with her preceptor and had signed a form at the end of six
months. Otherwise, for all the others, there were no specific times set aside to discuss the preceptee's progress and feedback seemed to have been given on an ad hoc basis:

"Every so often, maybe at the end of a shift, (the preceptor) would call me in the office and ask if I had any problems or if something in particular happened that day, something major. She'll ask how I felt about that or whether I thought I'd coped well or whatever".

"(Preceptorship) was not structured in a written form, but there were certain things that I had to learn to do on my own, for example, (the preceptor would) tell me (that) I have to learn this and that. So it was very informal really".

It was evident that once there were some guidelines, an attempt was made to follow them and the preceptorship improved. However, one of the main problems encountered in meeting the requirements of the guidelines was that the participants found it difficult to work on the same shift as their preceptors. As a result, they could not identify with one preceptor and had to involve all the other experienced staff nurses on the ward, in their preceptorship. Donna described this problem of meeting the requirements of the preceptorship guidelines by stating:

"My preceptor and I rarely worked together. So, although, I had her as a preceptor, I used everybody else on the ward. You couldn't follow the guidelines completely, they asked us to make appointments to update regularly, but that wasn't possible. I mean, besides the different shifts, it could be also so hectic on the ward. We never seemed to be able to make the appointments, it was just a matter of taking the opportunities as they arose".

Preceptors, clearly, had a role to play in clinical learning for these newly qualified nurses although not all of them seemed to have been allocated specific preceptors at the time of the first interviews. Thus, for most of them, as discussed earlier in this section, supervision was done informally. None of the participants actually mentioned being formally prepared by a preceptor during the initial stage of their staff nurse role.
Hence, there was a variation in the mentors' involvement in the participants' clinical settings. Some of them gave comprehensive accounts of their mentors' involvement, whilst others felt that they had to initiate the involvement of mentors in a haphazard manner. Those who had to elicit their preceptors' involvement felt that they had to do this because "the mentors did not understand enough about the P2K course" and their needs as newly qualified nurses. David and Jeanne described their contrasting experiences:

"(The preceptor) will give me feedback, I'll ask for feedback, normally at the end of each shift. I'll just reflect on what I've done during the shift".

"There again everybody's experience is individual. By and large and certainly, for example on the ward, you learn who to go to and who is not perhaps so supportive or able to fulfill that role (of preceptorship). You work that out for yourself".

On the whole, preceptors were perceived as being valuable people to learn clinical skills from, but this did not always happen. It was apparent that these nurses learnt a lot from their preceptors when they were accessible, willing to teach and seen as approachable. Anne explained her experience of working with preceptors:

"When (the preceptors) have the time and they are interested, I learn a lot from them and the teaching sessions on the ward. It isn't always the case that they are interested or have the time to teach (newly qualified nurses)".

The way that learning took place with preceptors varied but it seemed that teaching was on an ad hoc basis with minimal structure and most of the time at the request of the nurses themselves. When discussing their experience of preceptorship, the participants tended to talk in terms of "help" received, usually from an "approachable" preceptor, with certain tasks or procedures from which they learnt. Very few of them mentioned the teaching which took place in relation to their identified learning needs. The reason for this could be because most of them reported that they did not always learn or seek help from their designated preceptor. These are some examples of how the diplomates experienced learning through the preceptorship system:
“Mentors have given me food for thought, to go away and things up”.

“The (preceptor) I have, at the moment, is excellent. She is really very good and she takes interest in what I'm doing and what I need to do or what I need to learn, although I don't always work with her. When I do, she's been a great help and she has taught me quite a lot and I've learnt a lot, without doubt’.

“Preceptorship helps me with decision making and management. I do make use of (preceptors) when appropriate, those who are more approachable”.

There was thus evidence that the nurses were also selective about their use of preceptors; they only used the ones who they felt were “approachable” and were willing to share their practical knowledge with them. In the participants' views, preceptors were only good at teaching them practical skills because they considered themselves to have a higher academic status in terms of knowledge-based nursing care. As Claire, one of the participants explained:

“If it was anything theoretical then I would look it up for myself because normally my knowledge is better than (the preceptors), so they would not be able to help me”.

Thus, overall, despite some of them having different preceptors, preceptorship seemed to have worked quite well for these newly qualified nurses. They also recognized the extent to which they could learn from the preceptorship system but staffing levels, interest of the preceptor in them and an understanding of P2K nurses dictated how much learning took place. The various methods they used to learn, under such a system, were also indicated.

Although they all welcomed the idea of being preceptored during the initial months of registered practice, some of them felt that they were given very little responsibility during that time. They were not very happy being supervised all the time, especially towards the end of their preceptorship when they felt that they could have learnt a lot more about the practice of managing a ward. Sarah explained this situation:
“You are under somebody's wing all the time. They manage the ward, you leave them to manage and you go out (on the ward) just doing bits and pieces”.

From these diplomates’ accounts of their preceptorship experiences, developing clinical support was an important contributive factor to their professional learning. Self-initiated clinical assistance was sought on the wards from nursing, medical and other health care professionals such as pharmacists. As Liz said:

“It was up to me to go to (one of the healthcare professionals) if I had a problem, if I didn't understand something or a procedure, I would ask someone to help me”.

7.4.3.2 Clinical support

Despite the various sources of support used on the wards these nurses maintained that they, nevertheless, tended to support each other as discussed in the previous section of this chapter (Section 7.3.4.1). They felt more comfortable discussing clinical or managerial matters with their peers, those who were on the same course as themselves. Peer support took place mostly outside work. Now and again, a small group of them would get together to discuss their problems, difficulties, fears and worries. They felt that they were able to empathize with each other and that it took place in a supportive, non-threatening environment. These peer support meetings were very often used to reflect on their practice. They would discuss a day's work, talk about any problems and difficulties, or share new experiences they had encountered on the wards. They found this to be a useful way of learning and updating each other and it was something that was encouraged when they were student nurses. There also seemed to be an element of pastoral care embedded in this mutual understanding, which was being provided in their self-help, support groups. They found this approach to be a useful way to learn unconditionally. Liz and David described the way they learned through their peer support group which was still taking place at the end of their first post-qualification year:
"I still carry on with that (peer support), you know, visiting friends (those from the same nursing cohort), talking about things that had happened on the ward. The others know where I'm coming from and what I'm talking about. We talk about our fears, anxieties together, things that had happened and laugh them off, scream, cry together. Sometimes, when I don't know how to do such and such, we'll discuss it, get out our books and find out. So, that's the way we do it, really and it's a good learning process".

"Very often when we sit down and talk about our day's work, you hear something that you haven't met before and you question it, it does help".

Hence, from these nurses' accounts a recurrent theme which emerged was the significance of clinical support either from others on the wards or essentially from their peers outside work. Additionally, part of the learning process which took place within the clinical support was the development and maintenance of interpersonal relationships which was also considered to be important.

7.4.3.3 Learning by teaching

One of the ways that the participants identified clinical learning was by teaching others on the ward. They viewed clinical teaching as part of their continuous learning; a way of linking theory and practice in an informed manner, keeping up to date with nursing practice and making them aware of their own practice:

"What I find is not only learning when nursing patients; you are also learning all the time by teaching because when you are teaching you are self-aware and sometimes you get stuck and you go back to it and develop some more skills and re-do it better next time".

"When you are teaching others, they ask questions and it makes you think, you are actually making those links between theory and practice, it's not mechanical, not routine, you are thinking it through".
Some of these nurses were also actively involved in mentoring student nurses, once they had completed their own preceptorship and had begun to develop their own approach to teaching. They also recognized that teaching style was important in motivating students to learn on the ward:

"I take interest in the students' views and their thoughts, in what they want to learn and not teaching because I have to get it done, to have their assessment documents signed off".

"I think if someone comes prepared and engages the audience or if they have anecdotes they can use to bring the teaching alive, then it becomes stimulating and people are willing to learn".

Thus, their teaching styles reflected the way they had learnt from the course and found beneficial. The participants' also implied a self-directed approach to the students' learning and tended to encourage participation in discussions as well as questioning:

"I always feel that I have to do some work for myself. I expect others, students to do the same (being self-directed, independent) then you are sure of the quality of your teaching and learning".

"My preferred teaching style is to get up and do it yourself, but I give some guidance and make sure that the students are getting the right information".

7.4.4 Self-initiated learning

From the participants' accounts of their professional learning at this stage of their career, it was evident that they continued to make decisions about their learning (what and when to learn) by identifying their learning needs and initiating their sources of knowledge within the wards or outside work. Nevertheless, instead of asking someone, they claimed that very often they would look up information for themselves. Self-directedness was still very much in evidence. Sinead and June gave examples of their self-initiated learning:

"If you want to look up things, (the library) really helps you to learn things, to find out for yourselves, which is good".

"It isn't a case of what I learn on the ward or what I don't. I think,
it's more about what to do and what to learn if something came up on the ward. We can go and look up for ourselves what we want to find out, what we intend to learn and develop our (professional) learning that way and bring it back on the ward”.

Clinical supervision, which was organized both formally and informally, essentially in mental health nursing, was another self-initiated strategy used for professional learning. These seemed to have been mostly self-initiated as and when required during their practice of nursing. As two of the mental health nurses indicated:

“I have to use a lot of my own initiative for a lot of the time. It is just doing what I think is right. You get supervision, so I use the supervision for the clinical work”.

“I was also given a supervisor just in case I'm stuck with things like counselling and also because I have a few of my own patients, I'm like a key worker. So, when I need supervision, I refer to my supervisor”.

Furthermore, whilst most of the short courses and study days were mandatory and were attended as a requirement of their jobs, there was an incidence of one participant who attended a study day, which she self-funded, on her day off. She felt that she was interested in it and it would be useful in her practice. She therefore made the necessary arrangements to attend it without being prompted by anyone.

However when the diplomates’ self-initiated learning activities were further explored, this was expressed in the way they were taught in class and numerous references were made to the process of 'going and finding out for oneself'. Their explanations for this process remained consistent and examples were given both from the classroom and clinical settings. It was evident from the analysis of the data that these nurses believed that self-directed learning is an adult approach to learning which takes place in any learning environment, such as in their case, the classroom and/or in clinical settings.
An examination of the P2K course curriculum revealed a philosophy of "andragogical" approach to learning, whereby "the students are seen as" adults "progressing along a continuum from dependence to independence". Additionally, the course aimed "not only to prepare students to become competent nurses but to become self-directed learners" (Course document, 1990, 1: 13; Students' course handbook 1991:9). Thus, according to the same document and the students' handbook, it is evident that this notion of andragogical approach to learning emphasises a "process (of learning) which promotes independent learning" (Ibid, 40,9).

It is also clearly stated in the course document (1990: 38) within the course teaching/learning strategies, that "a proportion of the student learning will be self-directed" and "the responsibility for learning rests with each student". This meant that out of a thirty-five hour week, the students were "expected to do fifteen hours of private study each week" (Student handbook : 8). Thus, self-directedness of learning was made explicit from the time the participants commenced their P2K course and was reinforced throughout the course. This was confirmed in their accounts of their understanding of self-directed learning in relation to the P2K course. Tommy and June explained:

"Self-directed learning, that's what the course was meant to be right from the very beginning. Self-directed in the sense that tutors would direct you, then you go and do it yourself. It was self-directed learning from our first day and in our course profile. I thought it was obvious, it was very clear. You will be given so many thousands hours input on certain subjects and the rest is up to you. You will be expected to do a minimum of 20 hours per week on your own".

"We've always been told that it was up to us to go away and expand on issues which we were instructed in class, so I don't think we were led astray with regard to the course, it was always something that we knew".

7.4.4.1 Understanding of post-qualification self-directed learning

It was felt appropriate at this point of the study to seek further clarification of
what self-directed learning meant to these nurses in their first year of post-qualification. It was evident that their explanations of self-directed learning conveyed a sense of individual responsibility for their learning and that they were aware that they were not going to learn everything there was to learn in the classroom. The following excerpts from June and Jeanne interviews exemplify the participants' meaning of the self-directed learning process:

"We got an introduction and guidelines from tutors but it was just a basis, a foundation and we had to go around and find out more on the topics, it wasn't given to us on a plate. We had to go away and expand, therefore, it was an individual responsibility. It's something you take with you even when you become a staff nurse".

"The information was there, for example in the college library, but it was a question of finding out for yourself. We certainly knew where to find resources from different libraries and certainly drug companies who would be hugely helpful and other specialists as well".

However, according to these nurses, self-directed learning was not only about where to find the information for themselves but also knowing how to find it. They attributed the learning of this process through the types of assignments they had to do throughout the course and the teaching styles of the lecturers:

"We were taught how to go out and get information, how to use the on-line computer, CD-ROM, where these places were and then sent out to go and find more".

"We had to find the information out for ourselves because we were given assignments to complete, which was part of our assessments and our ability to continue on the course depended on these".

Although self-directed learning was new to some of the participants, especially the more mature nurses (defined as those over 26 years old, in the course document), they felt positive about this learning approach. Donna explained:

"Before coming on this course, self-directed learning wasn't the thing about, you just sat and listened. For someone like me, (self-directed learning) has helped me to learn all along. It was certainly a good thing, it focused me on areas I have to look in, ways of learning, so I benefitted by it even it was new to me and I certainly benefit from it now".
Additionally, even though the participants saw this method of learning as very much part of the course, they felt that there was always a set amount of the course content that they had to fulfil. This restriction imposed by the curriculum prevented them studying other areas of interest that they might have had at the time. Thus, it was evident from the first set of individual interviews (six months post-qualification) that they seemed to be enjoying the freedom of choice with regard to what they were interested to learn:

"During the course, we did decide what to learn for ourselves, to a certain extent, when it came to our personal development but when it came to specific assignments that was laid down for us. But now, I'm able to spend more time doing things that I really want to do for myself".

"I know what I'm lacking in, so I just have to look them up for myself but at college we were being taught what was required from the curriculum and a little of what we wanted to learn for ourselves".

7.4.4.2 Application of self-directed learning in registered practice

The participants recognized that their experience of self-directed learning in the classroom was a way in which the course aimed to prepare them for nursing practice, in their role as staff nurses. This reflects one of the aims of the course as stated in the course document (1990, 1:14) which recommends the development of "a competent, academically and professionally autonomous practitioner". Claire described this viewpoint:

"I think the course taught us to be independent or tried to teach us to be independent in our learning because when we are qualified, we can go out and learn things and not expect to be taught".

Thus, the participants perceived the effect of a self-directed approach to learning in the classroom, which they seemed to have learned to value, as essential for their clinical professional development. Hence for these diplomates the process of self-directed learning in clinical settings started with the identification of learning needs which were based on some of those clinical skills they felt they were lacking or those they were unsure about.
They, then, took the responsibility for what they wanted to learn by 'going out and finding out' for themselves. Sarah gave an example of this process of self-directed learning and how she took responsibility for her own learning:

"Say, for example, things like drugs, when I think that I don't know enough about some of them, I would make a list of all those I should know, pertinent to the ward, get the BNF (British National Formulary) and see what they are for and then do a bit of background reading about the types of drugs, what they are, what they do and all that sort of things".

The nurses also found that this method was useful to them in their clinical practice and professional development. They were able to state how they were benefitting from being self-directed:

"I've actually learnt to be interested. I've learnt to question (on the wards), to look for information myself. So, I'm much more likely to have the confidence to go on, now that I've finished the course".

"As practitioners, we've got to be able to go out and (find out for ourselves) because if we are going to be able to take care of our career development, we really do have to be able to be self-directed".

However, they implied that embedded within the notion of self-directedness there should be a certain amount of self-motivation by which they meant a wish to find out for oneself and be in control of what is required to be learnt at a given point and time. Anne illustrated this point of view when she stated:

"I think a lot of what I learnt is because it's due to the fact that I motivated myself to learn and that I, sort of, push myself to learn. A lot of it didn't come from other sources as such. In fact, I feel I didn't really learn very much from the college and from the theoretical input that we got, it was all and still is, off my own back".

These nurses also argued that they did not wait to be taught by others on the wards because there might be personal, clinical issues which emerged in clinical situations that they felt they wanted to learn for themselves and other nurses might not have been aware of. They also wanted to look beyond what
they were told on the wards because of their previous experience of conflicting messages from traditional nurses and their belief that their knowledge was better than the other nurses on the ward.

Although they did not take what they were told for granted, they admitted to have taken advice and respected other nurses' advice as well as their experiences and knowledge. They would nevertheless check information, gained from other staff on the wards. This seemed to be the way they learned to practice:

"This (self-directed) approach to learning made me inquisitive and this is the way I now practice on the ward. I can stand back and see things as they are. I would sit and reason things out for myself. I won't just take anything that's taught to me or what's said. I would go and look for myself'.

"I just don't go by what's there in front of me. If I see something and I don't understand it, I'm more likely to go and look it up, find out as well as asking people on the ward to tell me, but that self-directed part is there now and I'll continue with that. It's alright when I find things out for myself but, you know, it's sometimes difficult to accept what other (traditional nurses) at the same level as yourself tell you".

It was evident that this self-directed approach to learning which the participants had acquired from the course enhanced their eagerness to increase their knowledge and nursing skills so that they could be more efficient in their work. As Adam and Sarah confirmed:

"The course made us more aware of the way to study, we learnt from it. You can look at different things and pick up what you want and need to learn. For me, I don't find this difficult, I like to look at things and develop my own ideas, an opinion".

"The course has taught me that there's no way you can stay in your little world, all by yourself. It has taught me, you've got to go out on the wards with a positive attitude to learning and therefore increase your knowledge, your skills, so you can be better at your work".

Thus, from these findings, it was evident that the course did have some influence on the participants' self-directedness of learning in clinical practice.
which in turn enhanced their professional learning. This was supported by Jeanne who described how she applied self-directedness in her nursing practice:

"For example, one of my patients came in with a leg ulcer; it was a long time since I've done such dressing. I wanted to check it out. So, I got in touch with the 'granuflex' rep. and the wound care specialist for the ward. I knew who to contact, I felt confident, but I needed more back up, more information. So, you know where to make your links; knowing those things; knowing who to contact; knowing where to go and get more information from specialist; resources from drug company or whatever, continuing the self-learning actually in the ward environment. It's really part of what it's about. It's also intensely satisfying when we do that, but I see it as being very much part of nursing, both intrinsic and extrinsic".

7.5 Attitudes towards professional learning

The diplomates felt that the P2K course orientated them to learn independently and to be able to meet their individual learning needs accordingly. Thus this notion of independent learning, which the participants recognized to have been borne out of the nursing course they undertook, seemed to have had an influence on the way they viewed professional learning. This was particularly evident when the participants expressed their ability to take charge of their own learning and to develop professionally as staff nurses. As June said:

"I'm still doing that, learning for myself. You don't depend on others to tell you everything. I feel it's not right, you need to find out for yourself and take the responsibility for your knowledge, the development of your skills".

The participants' experiences of working on the wards, so far, had also made them realise that they still had a lot to learn. They talked about their need to develop and update their nursing skills. They felt that the more updated skills they had, the better it was going to be for them to cope with the ongoing changes in the practice of nursing. They also believed that if nursing skills were not continuously practised, they would deteriorate or become outdated:
“Obviously, you lose your skills, your ability to update, unless you keep on doing it, practising and updating. Yes, that’s something I’ve always done, I think most of us are probably (practising and updating)”. 

“We are geared towards the future and the changes. When you continue to develop your skills, you become very adaptable to deal with whatever comes up, whichever way, research, changes in nursing and so on; just developing yourself and understanding the changes”.

7.5.1 Factors influencing professional learning

When the participants were asked about what factors they felt were contributive to their professional learning, both enhancing and hindering factors were identified. These factors related mostly to their attendance on formal courses and study days.

Enhancing factors were expressed in terms of learning opportunities, consisting of either attending relevant courses/study days or being given the opportunities to be exposed to certain clinical experience so that they could apply in practice what they had already learnt in theory. Donna argued:

"Learning is more about having the chance to experience new things on the ward. Usually, what I learn are things that I know in theory but that I'm coming across now in practice and often knowing something in theory has very little to do with the practical elements of dealing with things on the ward".

The hindering factors consisted of the lack of opportunities to attend courses and study days due to either shortage of staff on the wards; too many staff attending courses at the same time; being made aware of study days and courses at short notice or not being told of what was available for them to attend. Hence, they experienced difficulties in getting time off from work.

7.5.2 The influence of the P2K course on further learning

Various aspects of 'further learning' were reported during the interviews. Key
emerging issues which were considered important to these nurses were thus explored. Further learning, in the context of learning beyond what is expected of them in their professional development, was felt to have been primarily influenced by the P2K course. The influence was not only seen as the result of going through the process of learning on such a course and its higher academic status but, also, because of its end product i.e. "skills deficit" which the participants had identified in their accounts of their experience of the P2K course, discussed in the previous chapter. Claire and Joe explained the influence of the course on their further learning accordingly:

"I think (P2K course) is better in the preparation for professional development. I think more P2K nurses will go and do courses than the traditional nurses".

"Theoretically, we gained a lot of knowledge but in the practical skills as such, we need to develop further, much further".

7.5.3 Rationale for 'Further Learning'

Consequently, having been given the opportunity to go further in their learning and being made aware of their skills deficits as a result of the course, the diplomates demonstrated a sense of individual responsibility towards their professional learning:

"It's up to us to develop ourselves really, doing other courses, degrees and so on. We have more options to increase our status but it all depends on individual nurses".

"Beyond the preceptorship, I'll still be responsible for my decisions to learn. I expect, I'll still come across things that I probably don't know much about".

The participants offered a wide range of other reasons for their wish to learn further which was seen as part of personal and professional development.

At a personal level, they expressed satisfaction in their academic achievement, the need to learn further in order to progress in their career and the effect of P2K course on their motivation to continue their learning compared to the traditional nursing course. As Tommy and Anne said:
"The course makes you eager to go on. I have contacted a good few of my classmates and the difference between us and the other nurses on the ward is that we are not prejudiced against further education, whereas a lot of the staff on the ward can only see as far as the ENB (English National Board) certificate. They can't see beyond, a diploma, a degree as time goes on. The course made me interested, I enjoyed the achievement of doing it. If I can do that, I can go and do something else, other courses, a degree, I don't have any fear".

"(Further learning) is part of my development. As you climb up the ladder, you need to further your knowledge".

On the other hand, "further learning", for these nurses, at a professional level takes the patient into consideration, the provision of better nursing care for the patients, for the benefit of the ward and meeting the needs of the Trust (their employer) and the services to the patients by developing their practical skills. Some of them also talked about nursing as developing into a research-based profession and the need to apply up-to-date research findings in the care of the patients:

"As I go on, I would take into consideration whatever the Trust needs, where services for patients are going, so that I'm able to tailor my needs to theirs".

"I have thought about my professional development. My aim was to start on the wards and to develop from there, not academically really, I mean as in college, university. At the moment, my aim is to further develop my practical skills".

"Due to research, a lot of things have changed in nursing. A lot of things that I've learnt now might not be the same later. A lot of things might not be useful, not relevant due to more up to date research findings".

7.5.4 Commitment to further learning

The diplomates demonstrated commitment to their learning activities by discussing their willingness to finance their own courses if funding was not provided for them. Some were more spontaneous than others on this rather sensitive issue of professional development. They viewed it as beneficial
both to themselves and their patients. Although all expressed a wish to self-finance, some stated certain conditions. Nevertheless, it seems that they all had an insight into the economic climate of the NHS and that the educational budget was decreasing further:

"I would like to do a lot of study days but it's a question of money now, whether you are financed for these or whether you pay for them yourself. If it interests me, I think I would pay myself".

"I'll pay for my degree, so long as they give me an extra day off".

Furthermore, commitment was not only translated in terms of finance but also personal sacrifices, as Teresa, one of the mature nurses pointed out:

"I'll do my degree at the same cost as I did my diploma. This was a big cost for me, in terms of family life and commitment and a loss of quite a lot of parts of my life, but it becomes very important. I think it becomes slightly addictive. Yes, I'm willing to pay for my degree and any other courses if I have to".

7.6 Professional development status

It was felt appropriate at the end of these nurses' first post-qualification year to establish where the participants thought they were, in their professional development. When they were asked to reflect on their professional development so far, they described their various stages of professional development. Whilst some of them were more specific in what they had learnt and what they wanted to learn at this stage of their career, others seemed to be at a cross-road, uncertain about what they would like to do, to develop professionally:

"My goal is to stay on this ward and develop my nursing skills further, then move on to a different speciality of nursing".

"Recently, professional development has been more on my mind. I'm now a staff nurse and I've been wondering where I want to go and (asking myself) am I fulfilling my role properly or adequately?; Am I doing the right thing? Is this what I really want to do?".

"Yes, I'm definitely staying in nursing but I feel I'm at a cross road at the moment, uncertain as to which path to take".
This feeling of being at a 'cross-road' was further explored to clarify its meaning. The key factors identified were that there were a lot of changes, where they were working, which discouraged them from looking too far ahead into the future. Consequently, some of the participants found themselves in a dilemma because they had planned to apply for a higher grade at that stage of their career and were unable to do so because of the Trust's financial constraints. Those who had planned to travel and work abroad were debating whether it was the right time to do so after being qualified a year. Others had planned to attend various courses and were just deciding on the best and most appropriate ones to attend. Whilst some felt restless, wanting to move with fear of becoming stagnated like some of the traditional nurses they had observed on the wards, they also felt bored and did not find their patients challenging anymore. Sinead described this restless period:

"I mean at the moment, I'm getting itchy feet, very much so. I want to do something but it's trying to decide what I want to do. Something to do with any short courses or anything like that".

However, those who felt more settled, seemed to be taking things steadily, not wanting to overload themselves with further learning in terms of formal courses. They were also a few of those who had recently managed to get a higher grade and felt they had a lot more to learn, they were generally satisfied with their work and their professional development:

"I don't want to overload myself with what I'm learning and take on new things. Everyday, there is something that I'm asking people or I'm finding out for myself. Taking up the 'E' grade is enough for me at this minute, that's how it is at the moment but I would like to do more courses".

7.6.1 Professional development plan

The diplomats unanimously claimed to have a professional development plan which they were able to discuss in detail. Some of them had it all planned at the time of qualification and others planned their development as they went along, according to their identified learning needs. However, none
of them acknowledged having a professional development plan which was
formally recorded, except for one who recently had an IPR done. Their plans
consisted of formal, mandatory or self-selected, clinically based courses/study
days and informal learning contributing to their professional development.
The formal courses were either planning to start a health related degree; to
specialize further in their chosen nursing specialties; to attend the teaching
and assessing course for nurses; or short, clinical or management courses
with academically recognized credits. Informally, they talked about clinically-
based study days; updating of already acquired professional knowledge;
joining professional bodies/interest groups of own specialism such as child
psychiatry, coronary care and moving to another speciality or seeking a
higher nursing grade. However, they all seemed to concentrate on clinical
knowledge to meet the demands of the Trusts:

"So, what I'm doing now, even though some of my plans have
changed, I'm using it to my benefit in that, I will develop clinically,
make myself marketable".

"I'm trying to stick to in-house practical courses and try to keep
my knowledge updated that way and keep a professional profile".

7.6.2 Professional profile

Some of the participants had begun to keep a professional profile of all their
learning activities, whilst others were aware of it and intended to do so in the
very near future since all of them had been engaged in formal, academically
recognized nursing courses and had gained nursing certificates or had
received certificates of attendance for informal, in-house courses they had
attended. The format of their professional profile was either an official pack
or a self-designed portfolio or diary where a record of all learning activities was
kept by individual nurses. The idea of the profile originated from the time
they were at college, followed by suggestions made by some of the ward
managers. Anne confirmed:

"(The professional profile) was originally from the college and
then when I started here the ward sister suggested that it would
be a good idea to put a folder together with certificates and things like that. It's just for future reference, if we are going for some other jobs or whatever".

THE SECOND YEAR OF THE DIPLOMATES' PROFESSIONAL LEARNING

7.7 Introduction

When the diplomates' notions of professional learning and the way these had shaped their behaviour at different stages of their registered practice had been established, two research questions pertinent to the overall analysis of the combined individual interviews' data were further addressed:

◊ How did the diplomates' perceptions and conceptions of professional learning evolve during the two years of registered practice?

◊ Are these nurses' notions of professional learning reflected in their two years' experience of registered practice?

These questions therefore focused on the diplomates' construction and reconstruction of their notion of professional learning based on their nursing experiences at the time and the manner in which these influenced them in shaping their attitudes and behaviour towards continued professional learning.

Thus, during the diplomates' second post-qualification year, an attempt was made to ascertain the way in which these nurses' perceptions of professional development had evolved, in terms of their learning, and to establish whether their notions of professional learning related to their experience of registered practice since they qualified.

7.8 Perception of Professional Development

The participants were asked firstly to explain their understanding of professional development, in the last two individual interviews. They
expressed professional development as the development of their skills, knowledge and attitudes. They all held the view that there was both a need and a requirement for all nurses to develop personally and professionally. They also felt that it was necessary to keep on updating already acquired skills and knowledge for the benefit of the patients:

"Professional development is a never ending development. The development of skills, knowledge and attitudes. There will always be skills you've got to learn and skills you need to develop".

“I think for me, professional development is updating. It's keeping updated on your learning, new procedures and research, so that you can use them on the ward. If you keep yourself up to date, it is the patient who is going to benefit and it also raises the standards of nursing as a profession”.

As stated in previous interviews, for these nurses, professional development was regarded as individual nurses' responsibility throughout their nursing career. Consequently, seven out of the eleven nurses interviewed reiterated the on-going learning process of professional development. Thus, when asked about professional development, two of them explained:

“You can never stopped learning, however many years you've been qualified; there is always something to learn; things get outdated and you have to be learning as you go along, all the time. I just don't think that anybody knows it all (in nursing). I think that even the ward sister is still learning”.

“(Professional development) is an on-going thing which enables the nurse to reach their full potential. They have to look, to search, to go to the library and do a lot of reading”.

However, besides their acknowledgement of their responsibility to participate in various learning activities, another dimension of professional development which these nurses identified was the development of the nurses' role and the way they function within a healthcare team for the benefit of the patient. Anne explained this viewpoint:

“I don't think that professional development is all about doing courses and things like that. I think professional development
is also your development within a team; working as a patient's advocate. I think it's a lot of things to do with developing your role on the patient's behalf, it's not just doing courses and reading books, reading journals, although that's obviously a big part of it".

Furthermore, professional development also meant the learning which takes place at various strata of their career path and progression. It included the route the nurse chooses, to reach where she wants to go and the methods she uses to achieve this by continuously expanding her knowledge and skills, 'level by level', according to each nurse's needs:

"The way I view professional development is that it goes level by level, you achieve the foundation and you build on that and then you go higher and higher. You don't stay at one level. For example when I finish this part, I go on to the next one, I'll always keep on going until I reach where I want to go, what I want to achieve".

Another participant experienced achieving more than what she anticipated two years previously. This added another dimension to her perception of professional development. Donna explained how her notion had changed over the two years:

"I did think that professional development is something which is on-going but I saw it as on-going at the same level. I mean, I said that I was quite contented to just be a staff nurse but now I'm applying for an 'F' grade, which is going towards a ward manager grade. So professional development does not only mean on-going learning at the same level anymore. It does mean working towards progression as well, depending on the individual nurse's performance and confidence. So, now that I feel I can do more, I'm pushing myself more than I expected".

7.9 Diplomates' notion of professional learning: own process and experiences

Having established these diplomates' perception of professional development at this stage of their nursing career, the extent to which their notion of on-going learning relates to their own process and experience of professional development, over the period of two years, was then explored.

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7.9.1 Rationale for continued learning

When the participants were giving accounts of their various learning activities at different stages of their professional development, they were asked also to state the rationale behind their actions. They reported that besides being exposed to different nursing situations where they practised and learnt the relevant skills during the last two years, the rationale for their continued professional learning stemmed largely from three main sources. They talked about expectations of themselves, the expectations of the NHS Trusts for which they were working, including their ward managers and other staff, and the expectations of the profession.

Self expectations

They felt that there was a lot that they expected to learn continuously. Although they were at a stage when they felt that they could deal with most of their patients, they argued that knowing what to do did not mean that learning was not taking place. They confirmed that they constantly reviewed their approach to care. This was one of the reasons given for them to continue with their professional learning. Adam who shared this viewpoint stated:

"When you've gained more practical knowledge, you feel you've achieved something. You then feel you can go on and develop your skills a bit more and review them as you go along, all the time".

Thus the participants' self-expectations and the way they perceived that professional development was on-going made them realize that their clinical skills could improve, not only by gaining clinical experience but also by participating in various professional learning activities. As Teresa stated:

"I've now come to the decision that professional development would always be on-going. You are always learning and you need to continue learning. I'd say that what would make you get better and better clinically".
**Expectations of the NHS Trusts**

The NHS Trusts for which they worked expected a certain degree/level of knowledge and skills depending on the grade and speciality for which they were employed. On the wards, different skills were needed at different times. For instance being appointed a resource nurse for a given speciality meant that the nurse was expected to acquire more in-depth and up to date knowledge in that particular area, or when in sole charge of the ward they were expected to be able to manage the staff and patients within the constraints of available resources. Since the expectations of others were always a concern of theirs, they felt that they just had to carry on learning what was required of them from their employers at different stages of their career:

"You have to learn to come to terms with yourself as a staff nurse and how to deal with people, even something that you were not taught as a student, you just have to learn it. All of a sudden, one day you are expected to know how to do it and you are not given any teaching; that's why you have to push to get on with those courses to be able to keep on top of it all the time. There are certain things that you are just expected to know as a 'D'or 'E' grade, on whatever ward you are working".

**Expectations of the profession**

They all acknowledged that because of the changing nature of nursing, nurses are expected to carry on learning all the time they are practising:

"Nursing is not stagnant nowadays. Even if you wanted to be laid back and just get on with your job you can't really, you've got to continuously update yourself in respect of these changes as well as the extended role of the nurse. I also think from a professional point of view, you've got to be able to compete as well. I think that's what it's coming down to. If you just sit back, you won't get anywhere, you'd stay as you are, you won't progress. I think that coincides with professional development".

**7.9.2 Further learning**

Participants were asked about the kind of clinical learning that was taking
place on the wards in order to ascertain whether this had an effect on their professional development status after a year of registered practice. Two factors were considered to be important in their rationale for further learning at this point. Firstly, these nurses felt that they were at the stage by which they had to develop and build on those basic nursing skills they had already acquired in order to function on their respective wards. It was also acknowledged by some of them that they had to learn new skills and found that there was always something new to learn on the ward because of the different types of patients and new clinical procedures they encountered during the course of their work. Therefore, there was a need for them to learn more specialist skills at a higher level and in more depth:

“I've got the basics and I'm developing those skills, so I now need to learn the more advanced skills. You learn that by practicing and learning them on the ward; there always new patients, different procedures and that sort of thing”.

Secondly, those who were seeking a higher grade reported that they had to learn specific skills and knowledge for their career progression:

“I mean, you have to achieve certain things if you want an 'E' grade. You have to have done your I.V. administration course, you should have done your mentorship package and things like that”.

Two other rationales were given by these nurses to explain their need to learn further. These were periodical, mandatory updating of certain skills, for instance, cardiac resuscitation which requires an annual update, and the expectations of the staff on the wards as well as members of the multidisciplinary healthcare team. When they were asked to explain how the expectations of others had influenced their learning at a higher level, it was evident that there were greater demands made of them in the second year of their registered practice:

“I think, the reason why I'm (learning at a higher level) is because of a lot of people, doctors and other professionals; they come on the ward and they expect you to know a lot more now, than before. They've seen you here for quite a while, so they
look at you as somebody senior on the ward and to tell them "oh, I don't know" is not really right".

"Even the staff, the nurses who've been here a long time ask me about (nursing) care plans and that, because I can reel them off".

7.9.3 Clinical support

It was evident that during the second post-qualification year, the participants felt more accepted by the staff. They considered themselves to be part of the healthcare team and they felt that they were able to make valuable contributions on the wards where they were working which made them feel somewhat supported by other nurses. Before that time, they were seen as a different type of staff nurses with limited clinical skills and they were labelled 'Project 2000 (P2K) staff nurses'. However, this dichotomy between them and the traditional staff nurses seemed to gradually disappear:

"We are not P2K staff nurses anymore, that's forgotten, just staff nurses who function the same way as the other staff nurses on the wards. I mean, they expect the same of me as of any other staff nurse".

"There's the type of nursing which is not P2K anymore, it's just nursing, people used to say P2K nurses but that's more or less stopped now, perhaps one or two might still say it. I think, it's because they have to accept us as we are".

However, some of participants reported that the student nurses who were allocated to their wards were surprised to know that they undertook the P2K programme because of the extent of their clinical knowledge. Apparently, these student nurses came on the wards with this preconceived idea of the label attached to P2K nurses. They expected to meet P2K staff nurses with limited clinical skills and detached from clinical situations. Claire noted:

"People are quite surprised when I tell them I'm P2K. The students say "well, it's because you know what you're doing" and that I know so much. I wouldn't say that I know so much, but enough to be accepted. There is also the fact that, although I've been (a staff nurse) for well over a year, I can't say I know everything (about nursing)".
As a result of this observation from the students, and the participants' feelings of acceptance and recognition by others on the wards, these nurses were asked to explain what they thought had happened and was happening to them. They felt that there was a role change which was taking place and to some extent a role reversal due to their added knowledge and skills gained with their experiences so far, as well as a change of traditional nurses' attitudes towards them. Initially, they coped with their staff nurse role by going and asking other staff on the wards but there was evidence that, at that time, others (all grades of staff) were going to them:

"When I was first here, I used to go to other people and ask them what to do and now I find they come to me and ask me, so my role has changed really. I suppose it means I've developed and people value my opinion".

Thus, a degree of dependence of others on these nurses was evident which further explains their motivation to continue to update their skills, learn new skills and/or acquire specialist skills. Additionally, these accounts of added responsibility for others indicated that they were offering clinical support to others. They were, therefore, asked to talk about the way they themselves were supported clinically since, in previous interviews, clinical support was felt to be essential to their learning.

Despite a much improved relationship between these nurses and the traditional nurses, clinical support among peers (staff nurses) seemed to be minimal on the wards for most of them. They did, however, report that if they had problems when in charge of the ward they could approach a senior nurse and help and support were readily available then. At other times, some of them turned to their previous preceptor.

Consequently, the participants tended to maintain their link with other nurses they originally did the course (P2K) with. Thus, they continued to seek clinical support outside work as reported in previous interviews and this support network was still there for them and Anne stated:

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"I suppose I'm much friendlier with the staff now than I was six months ago but, you know, to talk about work and things like that, I prefer to stick to the people I'm close to; somebody I did the course with".

They reported that although the frequency of their meetings had been reduced because of shift work and other personal commitments, they continued to meet in small groups and felt that the support of their peers was always available when needed at other times. However, the nature of the support remained the same; they discussed various issues pertaining to their work and any problems or difficulties they had encountered. They would share any new learning experiences and generally talked about how they felt about their work, thus providing emotional support if and when required. The discussions were considered to be making a useful contribution to their clinical learning and some also felt that these periodical meetings with their peers motivated them to develop and encourage them to learn further. Angie clarified the way the support from their peers was found helpful in their learning:

“We still keep in touch. It's really helpful. So, if we felt really bad about something we would (keep in touch) or if we learnt something ourselves, we'll tell the others. If there were some new policies or procedures in the hospital we would discuss them because we might have not, all, known about them. So, we just discuss things, mull over things and how we feel about things at work and just learning from each other, really”.

7.10 Factors influencing professional learning

Besides the rationale given by the participants for their continued professional learning, factors which were felt to have influenced their learning during the two years of the study were also explored. When the participants were asked about possible factors which may have influenced their professional learning in terms of their professional development, the phrase 'get on with it' emerged on several occasions. What they meant was that there did not seem to be any pattern to their professional learning and updating. It was at the nurses'
discretion how they were to professionally develop and they were left to decide what they felt was best for them. However, despite this discretionary approach, some of them found it difficult to adopt this attitude because of a hidden agenda and mixed messages they were getting from some of the staff. As one of the participants explained:

“They just let you get on with it really, to improve yourself, to develop, but I find it's still quite difficult because it's hard for us to improve ourselves, sometimes you feel that people don't want you to, anyway. It's like you're kept down into your own role, you are just being a staff nurse and as if you don't need any managerial experience, any roles when relatives are concerned or with certain types of patients or with the doctors. You'll just be the staff nurse kept aside to do all the routines and rituals, but it just depends who are working with”.

Further exploration of this situation revealed that most of these nurses were looked upon as junior staff nurses and when working with some of the senior staff nurses it seemed that they felt they were not given the opportunities to extend their skills and knowledge above their junior staff nurses' role. They, nevertheless, admitted that they got more experience of dealing with different situations when they were in charge of a shift on their own. Thus, some of the senior nurses were failing to recognise these nurses' needs for professional development and further learning.

However, in their accounts of possible influences on professional learning, there was evidence of three clearly defined factors: personal; organisational and professional.

7.10.1 Personal factors

The personal factors consisted of the diplomates’ personal perception of professional development and lack of challenge on the wards. These diplomates’ personal perception of professional development, discussed in section 7.1 of this chapter, indicated an on-going learning process for which
they felt individually responsible. Nevertheless, there was evidence that in some cases the participants felt they had learnt all there was to learn on a particular ward. They also thought that they had reached their peak when they felt that they were not making any further progress in their development:

"Over the last few months, I've been in constant repetition of certain things. I still go out and find out why I do them, how they're done but I think that my skills have gone as far as where I think they should be".

7.10.2 Organizational factors

These factors included nursing grade; access to courses; attitude of the ward manager and the type of ward.

Nursing grade: The findings on the lack of challenge in their job led to an attempt to establish whether nursing grade had any influence on the participants' professional learning. Thus, the analysis of the data revealed that there were certain skills which were grade related. It was reported for instance that in order to be instructed about skills such as canulation and phlebotomy, a nurse needed to be at an 'E' grade and that in order to secure an 'F' grade one needed to have done the ENB 998 course which involves teaching and assessing of nurses in clinical setting. Subsequently, Claire explained how she had to go and do a course, which she was not interested in, just for the sake of seeking promotion to a higher grade:

"If you want an 'F' grade, you have to have the (ENB) 998 course behind you. I mean, I wouldn't have chosen to do the 998 if it wasn't for that because I didn't find it particularly interesting but you have to have it. So, I went off and did it".

Subsequently, higher nursing grades appeared to be a strong influencing factor for most of these nurses to continue their professional learning. Nevertheless, there was also evidence of four of the participants who were at the same nursing grade since qualification but were equally motivated to learn and they expected to further develop their skills at a higher level regardless of their grades:
"Apparently, to do the IV cannulation you need to be an 'E' grade. I did ring the college at one stage and I was told that I could perhaps do it if I could prove that I really needed it in the environment where I'm working. I had a bit of an argument with the person concerned there because I felt that I did need it because I felt I was doing the job of an 'E' grade. I didn't particularly want to move wards just for the sake of an 'E' grade."

It was thus evident that these nurses' professional learning was related to their career intentions.

**Access to courses:** Thus, the pursuit of higher level of nursing skills led to the participants seeking to gain access to relevant courses. They reported that knowing how to go about getting on courses was essential as well as selecting those courses which were related to their job and in some cases their grade. Having a clearer picture of themselves in terms of their roles, performance and skills, helped them to select courses appropriately so that they could develop further:

"I now know what is expected of me on the ward, what other skills I need for my job, where I'm at, so, I'm getting on with it. I have also a better idea of how to go about getting on courses. All these in-house courses are brilliant, you know, they are related to your job".

"I'm in a more fortunate position than I was and I'm able to do courses which are directly related to my position, to my everyday work. I have no option but to continue learning, keep up to date and come across the most up to date papers".

However, it seems that although the participants could gain access to relevant courses, they were not always able to do those they had identified as appropriate for their learning needs and they sometimes had to do courses that were available to them at the time. One of the reasons for this was often because of long waiting lists for certain courses. One of the participants found that there was a two year waiting list for the ENB 998 course in the hospital where she was working.

**Attitude of the ward manager:** Some of the nurses found that their ward
managers were very accommodating in facilitating their request to participate in
various learning activities such as attendance on courses, study days and
conferences. Others found that there was a lack of encouragement on the
part of the ward managers. They reported that they were continuously given
some sort of excuse which prevented their attendance at their selected
learning activities. They believed, therefore, that they had less opportunities
than other nurses.

Type of ward: The type of ward where the nurses were working seemed to
also be an influencing factor. It was evident that some had more
opportunities to progress than others and they felt that the nature of the ward
was responsible for this. The contributive factors which they quoted as
influencing their continued professional learning were: being given
opportunities to manage a ward and the on-going changes on the ward, such
as new procedures, techniques and types of patients being admitted. Anne,
who had to move to another speciality as part of her professional
development, explained:

"I can honestly say that since I've started on this ward some
nine months ago, I've learned something new every single day
because it's an admission ward and the nature of the ward is
such that there's always something new that you haven't come
across".

Whilst Teresa who was working in a mental health ward stated;

"Perhaps I'm very lucky in that, this ward actually moves, it isn't
stuck in tradition, it moves and because it moves, my job expands
all the time. It has done so over the last two years; so I've had to
keep up to date with what I'm asked to do, the responsibilities I'm
asked to take on".

7.10.3 Professional factors

These were expressed in relation to nursing practice. Thus the two other
important factors which were identified as having some influence on the
participants' professional learning were: coping with rituals and routines on
the wards and maintaining safe practice.

**Coping with rituals and routines on the wards:** Having to adhere to ward routines and rituals was an area which caused some concern to these participants. They all acknowledged that this occurred to varying degrees on the wards where they worked. They found it difficult to cope at times because this approach to clinical practice went against their notion of nursing and professional development, which to them meant developing by continuously challenging, questioning their practice, thus ensuring application of up-to-date knowledge and skills. Consequently, for these nurses, having to adhere to rituals was clearly considered to be a hindrance to professional development and a barrier to further learning and progression.

However, the participants felt that there was a difference between routines and rituals. According to them, routines involved various activities which took place in a specific organised sequence within the ward during the course of a day for the smooth running of the ward, for instance prescribed drugs which have to be administered at specific times. On the other hand, rituals were described as those ward activities which are carried out without any rationale to support one's actions or any explanation as to the reasons for doing them.

Furthermore, when the difference between routines and rituals was being clarified, some pointed out that for them certain skills or procedures felt like rituals because they had repeatedly done them for the last eighteen months and were able to do them without giving them much thought. Maureen confirmed:

"You get use to them, you've practiced them and you feel comfortable with them. It doesn't mean you don't know why you are doing these things but you don't have to think about why you are doing them".

Consequently, the strategies the participants used to cope with rituals which took place on the wards were explored. It was felt necessary to do so at this
point, in an attempt to understand how this behaviour compares with the participants' previous statements that they would not do anything without a rationale. This exploration of rituals was also to establish whether the coping strategies used had any effect on these nurses' professional learning. Different coping mechanisms were reported.

Having identified existing rituals, it was clearly indicated that the participants had to initially deal with them on their own. However, at the time of this set of interviews, they felt that it was becoming easier for them to address the issue of rituals on the wards because they were working with other staff nurses (mainly the P2K nurses) who shared their notions of nursing and had similar views about rituals. They also felt more confident and not as vulnerable and dependent on the traditional nurses for their clinical learning and to 'survive' within the ward culture as they did during the early months after they had qualified. Some of them, therefore, felt able to challenge ward rituals when they came across them by asking for explanations and questioning ward practices.

On the other hand, some expressed feelings of frustration when they worked with staff who had been on the same wards for many years and who refused to alter their ways "of doing things" on the basis that "they've always done them that way".

There was evidence from some of these nurses' statements that, very often, it did not make any difference when they had challenged the ward sister or the nurse in charge of the ward even though they had produced evidence of the effects and consequences of certain rituals. This led to a feeling of resignation and some also talked about suppressing their feelings of frustration as a coping strategy. Others felt that there was avoidance of confrontation because of adverse consequences such as being transferred to other wards.
It was apparent during the interviews that the participants responded with a lot hesitation, after a long pause or monosyllabically, when they were discussing the issue of confrontation. Although the adverse consequences mentioned had not happened to any of the nurses who participated in the study, two of them had already asked to be transferred to other wards instead of challenging the ward manager. This was their way of coping as a result of having to carry out ward rituals which they felt were preventing them from progressing and developing professionally.

Nevertheless, there were illustrations of ways which demonstrated that a few of these nurses were able to alter some of the wards’ rituals proactively so that practices became more informed with rationales and understanding of the care being given. However, it seemed that changes were taking place as a result of a joint effort rather than individually and if the ward manager was flexible and open to change, it was then possible to implement non-ritualistic, progressive ideas. Sinead observed:

“i think if (the ward) sister is willing to change, she is usually quite adaptable, that helps and if she passes it on and encourages people to change their ways, then it will happen”.

Maintaining safe practice: a continued learning process in clinical settings:

Whilst discussing the importance of challenging ward rituals it became apparent that the participants still held their views of safe practice which they discussed at the end of their first year of registered practice. One of the ways they had expressed this, then, was the need to check and re-check their practice to ensure the safety of their patients. This issue of ‘checking and re-checking’ was thus explored within the context of their continued clinical learning, to establish to what extent they were applying this process and their understanding of its meaning, six months hence.

When the participants were asked to comment on the purpose of this
behaviour, they still maintained that it was because of ensuring "safe practice" at a time when they felt vulnerable and lacked confidence. Although, they continued to 'check and re-check' when they were unsure about something such as a new procedure or one which was rarely done or an hospital policy, it was evident that this process of "checking and re-checking" had greatly reduced because of the experience they had gained, their increased knowledge and skills as well as their self-confidence:

"I don't check and re-check as much now, I do it in a smaller way, obviously because my confidence has increased a vast amount, but I would always confer and make sure it was right. I'm not as hesitant and not as insecure about myself, as I used to be, but I will still check certain things as I go on, yes definitely".

"As you become more familiar with the job, the checking and rechecking is not done to the same extent but it's certainly still there, I'll check things for myself or with someone else, like a colleague".

Some maintained that even though they still had the need to 'check and re-check' some aspects of their work because they had to be cautious in their practice, it was not done for the same reasons and in the same way as before. They considered this process to be important in their practice because of their professional accountability and their responsibility as staff nurses to ensure the safety of the patients in their care as well as being aware of the consequences of clinical errors. They, therefore, continued to learn to be safe practitioners. As three of the participants stated:

"I still do it. I like to know that things are done and that they've been done properly. If I'm not sure, I'll check it again because of things that have happened in the past, mistakes that have been made on the ward that I've heard of. Mistakes can be detrimental to somebody's health, you'd sit down and think that if things had been checked again they wouldn't have happened".

"Checking is something you've got to do continuously because at the end of the day it's your qualification, your job on the line".

"I think that it's very important to keep checking and rechecking, even now".

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7.11 Experience of professional learning and updating

The participants were asked to describe and discuss their own experience of professional development; the way they felt they had professionally developed since they qualified. They all recognised that they had learnt a lot of the required skills which had enabled them to function as staff nurses. As a result, they felt that their performance on the ward had much improved which had made them more confident in their role. They all reported that when they were first qualified their priority was to acquire the clinical skills which they felt were lacking at the time and that they were more concerned about proving themselves to others (traditional nurses) that they were safe practitioners. They further added that when they were in charge of the ward, they were only doing what was needed for that shift and did not look beyond. At that time they also felt pressurised about learning the role of a staff nurse as well as having to justify their position as staff nurses but they had moved on since then. Anne explained how she had developed through this shift of professional experience:

"I was really trying to prove myself, to make an impression, so I had to develop very quickly but all that has changed now. I'm more interested in what courses the Trust can send me on, we get a lot of literature; different things; new equipment; new drugs and drug trials and things like that on the ward. So, I'm really interested in that sort of things now, I mean it's really good".

"These practical skills and communication skills don't bother me anymore these days, they are second nature to me now, so I'm interested in looking ahead and go on courses. It's moving on, picking up and learning about other things, really".

It was evident that the participants felt responsible for their professional development from the time they qualified. They, thus, maintained that they did not think that their views about professional development had changed as such but it appears that there had been a change of emphasis. As Teresa further explained:
"I think I maintain the same belief about developing professionally and learning, I think what does change slightly is the emphasis. I think when you are more confident with your clinical skills then you can move forward, you can branch out and look at other things. So, I think the emphasis changes slightly as you become more confident and you take on more responsibility which demands a different type of learning".

Despite this reported change of emphasis, all of them demonstrated from an account of their learning activities that professional learning took place to some extent, formally and informally throughout the two years of this study. A formal approach to professional learning involved attending relevant short and/or long term courses and informal learning consisted of the learning which took place during the course of their work and keeping up to date by reading relevant literature from nursing journals or those displayed on notice boards at work.

However, it was also evident from these nurses' accounts of their professional learning that they differentiated between the learning of skills and that of knowledge. Skills were described as being built on basic nursing skills they had acquired as student nurses and knowledge, on the other hand, was seen as adding to what they gained on the P2K course, but both were reported to be at a higher and deeper level. Furthermore, for the four mental health nurses, learning to work within a multidisciplinary team was also seen as an important part of professional development. Their rationale for this was that there is more to nursing than just caring for the patients. When asked the meaning of this rationale they explained that holistic care involves recognising other health professionals' participation and contribution to the care of individual patients.

**7.11.1 Perception of clinical skills deficit**

When the participants were challenged about their initial perception of lack of skills, they put forward several arguments to explain this. They identified that
acknowledging their own limitations was the first step towards professional development. Unlike at the time of qualification and six months after they qualified, they all felt that they did have the basic nursing skills of how to care for their patients and they gave examples such as knowing how to wash them, dress them, communicate with them and meet their patients' basic nursing needs. The lack of skills seemed to have been linked with the participants' fear of the unknown especially initially when it was a question of being responsible for the whole ward. They also talked about the belief, among nurses, that P2K nurses came out of college as less clinically skilled than the traditional nurses. Consequently, this belief seemed to have influenced these nurses' self-concept resulting in a kind of self-fulfilling prophecy:

“Looking back now, I think (the idea of lack of skills) was just a fear of the unknown when we started because we were the first group. Nobody had confidence in us and everybody thought we didn't know anything. So, we sort of believed it ourselves for a while. Looking back now, well, I did know quite a lot but I was just a little afraid to say what I knew, I was afraid to take the chance. I never regretted doing the P2K course, it was just because it was new and people were a bit afraid of it really”.

“I think that P2K nurses may have been less skilled than the traditional nurses but it was only during the initial stage (of being a staff nurse) and probably (the skill deficit) was not as much as I thought it was at the time. I think it was because how other people perceived P2K then. They looked upon us to be less skilled and when you are very new, you pick up a lot on what other people are saying and you think it must be right because they are more experienced, so I think that was part of it”.

The participants also indicated that during the initial stage of their experiences as staff nurses they had failed to recognise the skills they had because they were more concerned with what they felt they did not know, such as the more technical, advanced skills. They were also aware of their responsibility for running a ward and being responsible for patients' care. Consequently, the managerial skills were overlooked during that initial stage when they had to catch up with the required clinical skills:
I'm beginning to get much more interested in management issues such as where do our resources come from; who makes those decisions; how do we get involved in that decision making process; how does the money get spent. I really didn't consider those things very much at the beginning because of having to concentrate on clinical skills. I got much more interested as time went on, when I realised how decision making further up affects how I can do my job".

One of the participants, Joe, explained how he felt that the skills deficit experienced during the initial stage of being a staff nurse seemed to have disappeared:

"I don't feel there's a skill deficit now because I'm involved with most things on the ward, management, clinical and everything".

7.11.2 Process of own professional development

These nurses expressed their meaning of professional development when they were asked to give an account of how they felt they had developed professionally within the two years of this study. They discussed the various stages of their individual professional development.

When they started as staff nurses, all those clinical skills they felt they needed to know as staff nurses were identified first of all. They explained that they had to consolidate their basic skills before they began to undertake and progress towards more specialised, technical skills:

"I think the basic skills needed to be a staff nurse had to be learnt and consolidated before I could start specialising and thinking about the management aspects of the ward".

They also talked about their feelings of inadequacy at this initial stage when they had to take charge of a group of patients or of the ward. Then, when they realised that they knew more than they thought and got use to their role as staff nurses, they began to engage themselves more in the management
and specialised aspects of their development. These aspects of skills development were considered to be at higher levels which brought another dimension to their professional development:

"At first you work with the team and you've got a group of patients to care for, so all you do is to concentrate on getting that done whereas now, you have a wider aspect of the ward to think about and you are functioning at a higher level, skillwise. You know how to delegate and you don't see yourself as a basic staff nurse."

Sinead described a similar pattern of professional development but identified a period of reflection and a pause described as a 'status quo' situation at the end of the first year, whereby the whole development was reconsidered before moving on. This was evident in a large number of the participants and fully discussed in the previous chapter (Section 6.6):

"At first it was a settling down period, you start to settle for about a year and then you start, not having itchy feet but you go towards a status quo, this is when you think of changing direction, doing major courses or major pieces of work. So, you go back in the swing of things, doing small courses relating to your work and you eventually learn more technical skills. Anyway, I'm starting my (ENB) 998 course soon. Learning took place throughout really and I feel I was developing all the time."

Thus, their pattern of developing and professional learning went from a more general stance when they felt they had to know everything to more specific, in-depth aspects of their work concentrating on what they felt was required of them. Teresa illustrated this by stating:

"My professional learning is much more focused than it used to be. It used to be fairly general and I used to swallow everything but now I realise you can't take it all in. You need to take in what you feel is necessary and there are certain things that you need to know in more depth than others. You realise that as you go along really."

7.11.3 Professional development through practice

The participants' professional development was an on-going learning process through their practice of nursing. They, therefore, believed that they
developed professionally during the course of their work, continuously gaining practical experience as staff nurses which they considered to be part of their learning process. They also maintained that such experience could not be gained from reading textbooks:

"I think you learn more when you are practising something than just sitting and reading a book".

"I think by dealing with your day to day work, you come to learn the skills, you do your courses and you come to grips with your skills as it were".

However, it was evident that although the emphasis was on gaining clinical skills they were also attempting to make sense of what they were learning and how they were developing professionally. Thus, fitting their skills to previously acquired knowledge and reflecting on them was considered to be important during their on-going learning process:

"I think you learn as you go on really, you are able to put all that theory behind it, into what you are doing on the wards and you are always reflecting on what you've done. It's important because you can learn a lot that way".

Moving from one nursing grade to another and from one nursing speciality to another were also considered as professional development. It was evident that they chose what they wanted to learn and how they accordingly wished to develop professionally. Claire who was doing a part-time degree course explained:

"I think I could have got away with doing absolutely nothing about my own learning since I qualified. I mean, I didn't have to go on the 998 course, I didn't have to go for the 'E' grade and do any of what I've done but I chose to do these things".

Adam, who was working part-time at the time, also reiterated that he had not stopped learning in clinical practice even though he was working as an agency nurse in order to fund his full-time degree course. Thus, regardless of their circumstances, these nurses felt that they were learning and developing professionally all the time in their clinical practice.
Significant aspects of nursing

This sub-category emerged from the participants' discussion of the way their learning needs had developed throughout their two years, experience of professional development. They addressed this when they talked about aspects of nursing they expected to learn during the course of their work once they were qualified. Three different aspects of nursing were considered as the most important to learn once they qualified. Eight of the participants identified communication, six mentioned ward management and three thought that safe nursing practice were the most important aspects they expected to learn. Six of these nurses had identified three different important aspects.

Communication: Those who identified communication as the most important aspects of nursing implied that it was to do with the confidence and effectiveness when interacting not only with patients but increasingly with other healthcare professionals and relatives, at a staff nurse level. They maintained that every aspect of nursing involves communication:

"Everything in nursing involves communicating with people around you. Nursing is not just you and the patient. Nursing is much bigger than that, it's to do with all the people around you and I don't think you can learn it properly until you are actually on the wards with them".

"Communication has to be one of the most important parts of nursing, for instance we've got physiotherapists, occupational therapists, doctors coming on the ward but we are the ones who see the patients twenty-four hour a day whilst the others, they only flit in and out to see patients. Everyone comes to the nurse. Nurses are the link between what's happening with the patient and each discipline as it were and I feel that communication is a huge part of the nurse's role".

Management: At the time of this interview, managerial skills seemed to be the focus of learning for some of the participants. They identified these learning needs as a shift from clinical nursing skills which were a priority during the earlier months of registered practice. Nursing management was
considered important because as staff nurses they were increasingly in charge of their wards which demanded an ability to deal with staff and the whole organisation of their work. They also claimed that these were aspects of nursing which they found they could not learn from textbooks and at college:

"As a staff nurse you are responsible for coping with emergency situations, you are very often in charge when those emergencies occur. That's something you need to learn at work and the whole running of the system, as it were. You can only learn these things on the ward, not from a book and certainly not at college".

"The skills in management are probably the most important (to learn on the ward) because during your training you get the skills with patients who you spend most of your time with but you don't get the management skills, not all of them, anyway".

**Safe nursing practice:** Besides viewing maintaining safe practice as one of the influencing factors on their professional learning (discussed in section 7.10.3), participants also felt that safe nursing practice was part of their staff nurses' role:

"With (nursing) management you can try things out but you can't try things out with patients (in nursing practice) because of the consequences".

One of the mental health participants also argued that ensuring patients' safety in the practice of nursing raises standards and helps in the monitoring of patient care:

"I think patient safety is very important because it raises nursing standards and it's a way of evaluating standards of care".

**7.11.5 Responsibility for and commitment to professional learning**

The diplomates acceptance of their responsibility for and commitment to their own professional development was evident. They indicated how they sought their own reading materials regardless of whether they are on a course. They tended to take it upon themselves to find out about different things they came
across during the course of their work. They also reflected on their performances and they felt that this facilitated and motivated their learning. Moreover, they looked out for relevant courses, study days and/or conferences to attend. This reflected these nurses' perceptions of professional development. One of the participants, Joe, explained:

"I remember saying that I leave my professional development to myself, I more or less do everything myself. Maintaining professional development is the development of the self. It's you who is responsible for it and unless you do it for yourself, it doesn't get done basically".

Sinead further explained the strategies she used to initiate some of her professional learning:

"It's up to me to put my name down and attend those courses, study days, conferences or whatever. In my case, the sister on the ward is very good but she doesn't initiate those things, you've got to go and look for them yourself. The study forms all come on the ward, you need to keep an eye out for them and it's better for you to initiate these things because neither the ward sister nor any one else will do it for you".

Hence, the above accounts reinforce the participants' responsibility for their professional development and this seemed to have been perpetuated by the lack of support and encouragement from others on the ward. They, nevertheless, appeared to have maintained the peer support outside work which they seemed to value. They continued to meet on a regular basis to discuss issues of concern from work which they felt helped and motivated them in keeping up with their professional learning.

Lack of formal and informal feedback on their clinical performance was also identified as another motivating factor which made them take responsibility for their professional learning. Only five of the eleven participants reported to have had individual performance reviews (IPRs). As stated in the previous chapter some of these nurses continued to maintain that the only time they got feedback on the wards was when they had done something wrong;
"I never had an IPR, the only feedback you get here is when you do something wrong. I mean I know that I'm not useless because I never get told off for doing things wrong but that's all I know".

However, those who had not had IPRs recognised the importance of such activity. They felt that it would have helped them in their professional development by getting some kind of direction and guidance from someone more experienced rather than having to rely on their judgement and their own instincts:

"Nobody says that's what you need to know, you need to learn. I went through the preceptorship (support system) but nobody really said this is what you need, this is what you're good or bad at; talked about courses, the future; asked what I'd liked to do, so on and so forth".

"I feel if we had IPRs here, it would be helpful because I don't know what I do right and what I do wrong apart from the fact that I don't get told off or anything. So, I mean, it would be good to get some sort of guidance sometimes but everything is left up to me".

7.12 Professional learning and updating strategies

When the participants were asked to describe the ways they had used to learn and update their clinical knowledge and skills, which they had described as being fundamental to professional development, they identified various strategies for different aspects of nursing. They maintained that clinical learning was taking place all the time, learning new procedures or updating those they had already learnt. The main principle of learning seemed to be what they described as 'learning as you go along', meaning 'picking up' and developing their skills, knowledge and attitude as they went along during the course of their work.

The methods they identified included:

◊ observing and practising
◊ reading textbooks and nursing journals
asking other nurses on the ward
○ doing and participating in formal and informal ward-based teaching sessions
○ sharing of up-to-date literature with other members of staff
○ keeping up with updated or new ward policies and procedures
○ watching nursing videos or television programme
○ informal discussion with other healthcare professionals and
○ attending relevant courses, study days.

Thus, for these nurses, the ongoing process of developing oneself professionally involved participation in various learning activities. They reported the learning of skills which mostly took place on the wards, attending clinically based courses relevant to their specialities, reading books and nursing journals. Knowledge was seen as being acquired by doing academic courses such as a degree. David's response provided a summary of the process of professional learning the nurses used during their second post-qualification year:

"The way I learn knowledge is by going away and doing courses. The knowledge about the patients would be by reading it up or asking people. The skills would be by being self-aware and knowing what I need to develop, what I need to practice, what I'm not good at and getting feedback from people whenever I can because they are not very good at it, whereas, attitudes would be to be aware of my attitude and again relying on feedback from others".

Liz described updating as:

"Updating is usually in terms of in-house or outside study days; reading your nursing journals and using textbooks; going to libraries looking for recent research articles and also often in a (nursing) journal section you have something equivalent to a study day where you can actually read over and answer the questions at the end of it, a sort of distance learning package. There are nursing videos and television programmes available which also help us to keep updated with our knowledge".
7.12.1 Self-directed approach to further learning and updating

From the participants' accounts of further learning and updating, it was evident that it was mostly self-initiated, in terms of taking the initiative to learn further and to keep themselves updated. Although some of the courses were a requirement of their employers, they initiated most of the courses they attended themselves. Even, when they had attended certain courses, they found that what was being taught was not enough for them, and they would normally look for more literature and tried to learn in more depth. Some of them felt that although they might be encouraged to attend a particular course, but when it came to further learning, unless they did it for themselves, there did not seem to be anyone else to encourage them to do so:

"I don't think we are encouraged to learn more on this ward, it's up to ourselves really. I mean sister doesn't object if you want to go on a particular course, she'd back you up but I think you've got to be self-directed and stand up for yourself, very much so".

"Whatever knowledge that you need to know, you identify them yourself and you do something about it. You go and find out for yourself because people don't come and tell you".

Although the identification of learning needs was mostly self-directed, some of them had the opportunity to discuss their learning needs with someone else such as the ward sister, especially when it entailed requesting time off the ward to attend a course or some other hospital Trusts' funded learning activity. Learning needs were generally, informally identified except when they had a performance review, and then the ward sister might suggest something specific according to the ward needs or the hospital policy. It, therefore, seemed that everyday, skill-based learning needs were identified by individual nurses themselves and appropriate actions taken.

7.12.2 Learning in the clinical practice setting

Having established the participants' self-directed identification of learning
needs, it was felt appropriate to further explore the learning methods they had experienced in their respective clinical settings. Four distinct forms of learning emerged: learning by practising; learning through informal teaching; learning through collaboration and learning through mentorship/preceptorship system.

Learning by practising: One of the methods which these nurses repeatedly talked about during these interviews was learning 'by doing', 'the experience of doing something', 'hands on care', by which they meant constant practice in clinical settings until they felt competent:

"So, you've done something once, you've experienced it, you remember it, then it comes again the second time, you improve on it and so on and so forth".

"You can't learn (nursing) skills overnight, they come by practising them more than one time".

Thus, they were continuously trying to learn and improve their clinical techniques which enabled them to gain further experience and develop professionally. However, for these nurses, learning skills also involved an understanding of their actions and they sought the underpinning knowledge of the skills by ensuring that they were aware of the rationale of what they were being taught. They described the process of a procedure being first explained, followed by observation of a demonstration before doing it themselves. They did not believe in learning just by imitation. When unsure they would discuss it with someone and/or read about it first. Moreover, for some of the formal skill-based courses which all of them had attended at that stage, they had to practice under supervision. They were then formally assessed and had to demonstrate that they were competent to perform the skill or procedure independently.

Learning through informal teaching: The participants found that they learnt quite a lot from informal teaching sessions on the wards. They
described various types of teaching sessions in which they have participated which they described as being informal. These could be on a 1:1 basis or within a small group which might last just a matter of minutes. Although these sessions seemed to be on an ad hoc basis they seemed to be quite a regular occurrences. The topics were largely skilled-based and specific to their respective specialities. From the participants accounts, these sessions did not seem to be always exclusively for nurses, other members of the healthcare teams were also involved, thus learning in a inter-disciplinary manner.

Learning through collaboration: Learning in collaboration with other staff on the wards and/or other healthcare disciplines was a method that all the participants had experienced and was felt to be beneficial. These took the form of discussions, presentation of papers or the sharing of a learning experience whereby every member was encouraged to contribute, informally.

Additionally, when the nurses had attended a study day or a course, they were expected to share what they had learnt with others on the wards. Teresa gave an example of this method of learning through collaboration:

"If I learn something on a study day I'll bring it back on the ward. You were obviously expected to report back anything to the ward, any new updates, any information, any handouts that were given to you, you would share these with others".

Learning through mentorship/preceptorship system: Due to the seniority of these nurses, they were at the stage when they were involved in mentoring student nurses and some of them in preceptoring newly qualified nurses.

They viewed being involved in such activities as a contributive factor towards their own professional development which they maintained involved learning and updating. Consequently, they found that they had to pass on their skills and knowledge to others, hence another reason for them to continuously
learn at a higher level and update their basic clinical skills. Conversely, they reported that this process enabled them to learn from the student nurses and other nurses. Donna explained how mentoring and preceptoring contributed to her learning:

"I don't set out to learn from (students and newly qualified nurses) but I always find I do learn from them because they would have had different experiences and when the students come with their practice documents, it sort of reminds me that I have to keep up with things. Sometimes it's like a revision for me".

7.13 Monitoring of clinical development

So far these nurses have expressed their views about their experience of professional learning which included their rationale for further learning and the influencing factors; their added responsibilities of being depended upon; the clinical support on the wards; peer support network outside work and the methods they had used in their professional learning. It was evident from their accounts of the various aspects of professional learning that these nurses were continuing to progress by: learning new skills, building on already acquired skills, updating their skills and generally performing at a higher level. However, an area of interest at this point of the study was to establish the effects of such learning activities on their clinical practice and more importantly whether the clinical development was being monitored on the wards.

The participants recognised the value of clinical monitoring and perceived this exercise as useful in their professional development particularly when planning further learning because it enabled them to identify areas for development. When the question of monitoring clinical performance was asked, some of the participants identified the ward manager as being the only person on the ward to have this responsibility for all her staff, in terms of ensuring that the staff regularly attended relevant courses and kept updated.
In some cases, a list of courses that the nurses had attended was kept by the ward manager. It was clear, at this stage, that other aspects of monitoring needed to be explored.

The recurrent theme which emerged with regard to monitoring of clinical development was that the nurses assumed they were functioning satisfactorily all the time there was a positive outcome to their actions. The following excerpts from Joe and Maureen's responses demonstrate what they meant when they were asked to indicate what made them realise that they were performing at the required standards:

"I feel confident that I have progressed within myself because I don't get any negative feedback from people, so I feel I must be doing fine".

"I suppose (that I'm doing well) because no one complains at the end of the day, really. It's just the mere fact that they ask you to be in charge of the ward and you know you must be doing well. Also, being asked why I haven't applied for the 'E' grade by the senior nurse on the ward means that I must be doing well".

However, further probing revealed four other methods which reflected ways used to monitor these nurses' clinical development on the wards: Individual Performance Review (IPR), informal feedback, self-initiated monitoring of clinical performance and reflecting on clinical practice.

7.13.1 Individual Performance Review

Nearly half (six out of thirteen interviewed) of the participants reported to have had an IPR within the first eighteen months as registered nurses. It was done either by the ward manager or their team leader after being preceptored. The review was usually done yearly except for one of the nurses who reported to have had a six monthly performance review. IPR was considered a formal way of monitoring their performance and it was the only time they felt they were being assessed. However, they also felt that
this periodical review was not adequate to continuously assess their skills. IPR was seen to be too broad. They described the process as reflecting their performance globally whereby the learning activities they had undertaken were recorded and some goals, which were largely to do with courses they intended to attend, were set from one meeting to another.

Five of the participants were waiting to be called for their reviews. The reasons given for this were because of changes that had been taken place or that the IPR system was gradually being introduced on the wards where they were working. Nevertheless, they all acknowledged that they had heard of IPR being discussed on their respective wards and that it was just a matter of being implemented. The other two participants said that they had not had a formal appraisal of their performance since they qualified and, according to them, there was no indication of one planned for in the near future.

7.13.2 Informal feedback

Feedback was considered to be important in the monitoring of clinical development and the participants felt that it was a way of knowing the extent of their performance in terms of their clinical skills and knowledge which provided a baseline from which to take appropriate actions. Getting feedback from others was also identified as a mode of learning in clinical settings.

June confirmed to have always had feedback from the ward sister and talked about its effect on clinical performance:

"I've always had feedback from sister at some stage and I do meet nurses who get no feedback and there is a difference, they are not confident about what they are doing".

All the other participants reported a lack of regular, individual, specific feedback which was essentially skill-based. Some of them found that the only time feedback was offered was when they were appraised at their IPR.
Some had experienced a collective (whole team) type of feedback at ward meetings which they felt did not meet their individual learning needs. From their experiences, it also seemed that some believed that this lack of feedback was part of the nursing culture and that the more senior one gets in nursing, the less feedback one expects to get. They also gave the impression that it was something that they had to learn to accept:

"People are not very good about giving feedback on the wards. (Nurses) here, well, everywhere in nursing, nobody tells you, you've done something really well or really bad, you just get on with that and the higher up you go, the less people tell you".

"I suppose feedback is really lacking, to be honest. I think you assume that you are doing all right and you're getting on well if nothing is said to you. I think that's how it is, really in nursing".

Furthermore, some of these nurses spoke about how they relied on their instincts and 'gut feelings' when they described how they monitored their clinical performances as a result of limited or total lack of feedback from others on the wards:

"I may get (feedback) sometimes. You get some positive comments, you know, that you're managing well, you're doing well but nothing specific, no assessment, no pattern for individual appraisal. After a while or a few months, you just get a continuous feeling of being part of the team and feeling wanted".

"You know deep down when something is right and when something is not right, so you go by your instincts and your colleagues or the outcome of whatever you've done".

Hence, the above accounts of lack of regular, individualistic and specific feedback led to another aspect of monitoring clinical development which the participants identified as self-initiated monitoring.

7.13.3 Self-initiated monitoring

The participants indicated a sense of responsibility in the monitoring of their clinical development. They again referred to 'just having to get on with it'.

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When asked to explain what it meant within that context, they described this monitoring approach of clinical development as a 'laissez-faire' culture of some of the wards, whereby these nurses were left to evaluate their clinical performances as they wished. They no longer had a preceptor, thus a lot depended on their own initiative to assess their skills and their professional development. Sinead summarised the manner in which she monitored her own clinical performance:

“I don't get any sort of criticism, assessment or appraisal of my work. So I have to depend a lot on others, my peers, asking them for feedback and just get on with it really”.

Thus, the way they coped with this lack of feedback and monitoring of clinical development was that, besides undertaking their own self-monitoring, they sought feedback from others, essentially their peers.

7.13.4 Reflecting on clinical practice

For these participants, feedback on their practice was done after a day's work, when something significant had happened on the ward or when the ward was busy and there were a lot of decisions to be made. Regular reflection on what they have done at work was also considered to be a method of professional learning for them. This process seemed to be continuous and was found to be helpful in individual clinical development. As Sinead said:

“I think (reflection) helps you look back and see what you've done for the day. I don't think you can move on unless you reflect on what you do, all the time”.

Reflecting on practice was carried out individually, with another person or in small groups at work or outside work, among peers. It was considered very much part of their clinical learning and particularly essential to look back at their overall performance, establishing the extent of their professional development. However, reflecting on their practice seemed to be part of their
job and a natural process regardless of the fact that they were more confident as a result of having gained more clinical experiences and some of them working at a higher nursing grade. Sarah illustrated this natural process of reflecting on their practice by pointing out:

"Despite the fact that you're an 'E' grade and you feel more confident in yourself, you still reflect. Have I done this right and are there any other ways of doing that and so on".

Thus, for these nurses the process of reflecting on their practice clearly involved self-evaluation of their clinical performance, continuously questioning their performance, being inquisitive and seeking alternative solutions to problems so that when similar performances were repeated they were better informed and would improve on their skills each time. They recognised the benefits of the reflective approach and viewed them as part of their nursing practice as well as the learning process:

"It's good to reflect on what you do at work, especially when you come across a new situation because if it happens a next time you know what to do, you've made note of it. It's to do with the learning process really".

"In some situations, you don't always know if you are doing something correctly, it's only by reflecting that, often, you realise where you've made the mistakes because when you are in the middle of the situation you don't often pick up the mistakes you made and it's through looking back on the whole experience that you learn".

The nurses were therefore suggesting that reflecting was not only a way of monitoring their performance but also a way of learning from past experiences. Hence, Donna described how looking back on one's practice becomes a useful learning tool:

"It's not until afterwards you sit down and think about a situation on the ward and look back on it that you learn. You reflect on what you did and you can almost draw out your own guidelines for what you need to do next time. You can't always predict what you're going to do in every situation but you almost have a plan of action for next time, based on what you did last time, but an improved version of it".

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Another way of reflecting on clinical practice, identified by the mental health nurses, was during their clinical supervision whereby reflection was done in a formal manner by giving a rationale for one's actions and interventions and by reviewing in details one's performance with another person, who is usually someone outside the ward team. Individual strengths and areas for development also emerged during such sessions and the nurses felt they continuously learned from these.

7.14 Professional development status

The professional development status, which was explored during the second year of registered practice, consisted of the stage of learning the participants felt they had reached. They reported that they were at a stage when they considered their clinical expertise was at the same level as that of the traditional nurses of similar grades and that they were 'part of the team' and described themselves as being 'one of them'. Angie confirmed this:

"If it was comparing ourselves with other nurses who qualified at the same time, I would say that we are on par with them, with the clinical knowledge and skills".

Although these nurses felt positive about their stage of professional development and reported that their increased knowledge and experience have enabled them to function more confidently on the ward and that they were able to make decisions independently, they still felt that they needed to update their clinical skills and knowledge. As David stated:

"So I'll be going on those study days, just to update myself, really. I feel I'm at a stage when I really need to start updating so that I don't forget really. Otherwise I still read a lot".

This feeling of the need to update and to move forward in their learning was further expressed in various ways. Only a few of them felt quite settled and contented with their jobs, others appear to be going through a period of unrest with their professional learning. They expressed feelings of reaching
'saturation point', therefore finding their work getting 'monotonous and mundane', not challenging enough and not professionally progressing. These feelings not only came from those who were at the same grade since qualification and still at a 'cross-road' as discussed in section 7.6, but also those who were at a higher grade and had remained on the same ward. To them, a higher grade did not make any difference in relation to learning because they were 'acting up' in the grade before they were officially promoted. Thus, they felt that a change of ward or speciality would have been more beneficial and motivating for them:

"Although I'm continuously learning but there's nothing new really. I feel this is the end of the line now, as far as this ward is concerned anyway. Professionally, I'm not learning, not continuing on from where I was really, I'm just at a standstill.

"It's not challenging anymore, there isn't much to learn anymore and I feel I have learnt it all, I mean, on this ward".

Consequently, those nurses who felt that they had reached a stage where there was not much new learning to achieve on their particular ward were planning to move elsewhere which they hoped would keep them motivated in their learning. They felt they had to be challenged in different learning environments:

"I feel I have had enough of this ward, I've learnt as much as I can learn in this speciality, I need to move on. So I think it's stemming from within myself actually, just wanting to move in a different direction and learn something totally new".

"I feel I have to be challenged by something, that's probably why I'm taking this direction now, in moving in a different area. It will be a new challenge, I'm going to be learning so many new things gain".

7.14.1 Professional learning opportunities

In view of the participants stated notion of professional development which they maintained consisted of continued learning, it was felt appropriate, at this stage of the study, to ascertain what learning opportunities were available for
them. Lack of opportunities to develop professionally was a key factor which the participants had identified as having an effect on their continued learning. These were expressed in terms of the difficulties they experienced with regard to attending relevant clinically-based courses. Several reasons were reported to describe the lack of learning opportunities and the way it affected them. They claimed that shortage of staff on the wards and/or because of other nurses who were already studying prevented them to take time off to attend courses, unless they were prepared to give up their 'days off' work.

Furthermore, even when these nurses were willing to pay for the courses themselves it was not always possible to attend for the reasons stated above. Thus, very often in order to attend a course they had to be self-paying plus give up their days off:

"It's really hard, because to get on any course it's a question of time and money. Sister decides which ones we need to go on, really".

"So, for us to go on other courses, we have to do them off our own back; if we are prepared to study on our days off and pay for it ourselves".

This clearly confirmed that the ward manager had a lot of control over course attendance. They found that the longer one worked on a particular ward or the higher the grade, the better were the chances of attending courses, which were linked to the individual learning needs. Another reason which was also identified for the lack of opportunities, was that the nurses were not being informed of the availability of courses and study days.

However, when they were asked about the types of learning activities (more specifically courses and study days) which they had attended since the last interviews, they all reported on clinically based, mandatory courses which focused on their practice specialities. They all had therefore continuously attended work-related short and/or long-term courses. Two of them were on a degree course, one full-time and the other part-time and another one was
awaiting to start her degree course. Some had attended in-house study days; nursing and health care conferences and workshops and the frequency of attendance of these learning activities varied.

7.14.2 Current grade

During the initial post-qualification-registration months, all the participants started their nursing career as a 'D' grade the lowest of a staff nurse scale. At the time of the last set of interviews, all except four of these nurses had moved on to one grade higher and two from mental health were seeking an 'F' grade which was equivalent to a deputy ward manager grade. These two nurses felt that they had learnt as much as they could at their existing grade (E grade). Another one of the nurses was also in the process of applying for an 'E' grade. These three nurses expressed a sense of achievement in their professional development because they felt that they were achieving more than they had anticipated.

7.14.3 Increased confidence

A recurrent theme which emerged in the analysis of this set of data segments was that all the participants reported a high degree of confidence which they felt was due to their increased clinical experiences that they had had since they qualified. What these nurses meant by 'increased confidence' and the way this had manifested itself was thus explored. They explained this by comparing how they felt that their confidence had increased from the time they qualified. It was evident that their skills deficit had been addressed by the further practical knowledge they had gained in all aspects of nursing throughout the two years. The increased clinical knowledge and experience had also made them feel more settled in their staff nurses' role and they were able to deal better with different situations on their respective wards. This was how three of them reflected on their increased confidence which had gradually been developed:
"I suppose when I started, everything was new, we just didn't get enough practical skills and now that doesn't bother me, I feel confident, I feel competent and I would try anything new and things seem to be second nature".

"I'm much more confident, I know my job, I feel I know my job quite well, I have confidence in dealing with patients, relatives, doctors, emergency situations, crises and how to handle different situations, whereas eighteen months ago I perhaps would not have had that confidence to speak of, but now, yes definitely a hell of a lot more confident".

"I suppose although I'm new where I'm working now, overall I think I've got a lot more confidence in my abilities, my skills, that's the difference, I'm much more confident. I can communicate much better with people in the MDT, I can put my point across better, I know from my experience, I know more about any area of nursing really".

This increase of confidence seemed to have also made them feel capable to do as much as traditional nurses and they were able to take on more responsibility on their respective wards. Moreover, some of them expressed the feeling of confidence which had made them feel more relaxed and less frightened about everyday nursing duties such as the handover of a shift and dealing with other healthcare professionals. They also felt that they were more able to act as mentors to student nurses and they were equipped to preceptor newly qualified nurses.

7.15 Future professional development plans

Having established the extent of these diplomates' professional development and how far they had reached in their learning, it was felt appropriate to find out about their future professional development plans. They were all specific about their intentions for the future and some expressed an ongoing plan which demonstrated their commitment to their continued professional learning, thus upholding their conception of on-going professional development. Joe, who was still consolidating his clinical skills, specified his professional development plans by stating:
"My next move will be an 'E' grade obviously, hopefully after that, in one or two years time, I'll go further on for an 'F' grade and carry on studying. So, by the time I'm an 'F' grade, I want to go through management. For the time being I'll just concentrate on the clinical practice and use my own skills, keep on updating them and learning new ones as I go along".

There was evidence from the data that all the participants expected to continue to learn on the wards and to carry on with their professional development by learning more advanced and specialist skills. This was reflected in their accounts of their future development plans which consisted of specific, specialists areas of nursing such as bereavement counselling, palliative care and intensive care. It was further evident that they all felt ready to function at a much higher level regardless of their nursing grades, whether they were working full-time or part-time and whether they were doing a degree or not.

It was, therefore, evident that these nurses were functioning at a higher level of professional development to what they were two years previously. As Sharon succinctly stated:

"I'm now looking for things at a much higher level to what I used to".

An analysis of the data also showed that by the end of these interviews seven out of the eleven participants talked about doing a degree as a priority in their plan for professional development and three of them were starting the year of these interviews. A further two had applied to work abroad.

Finally, besides IPR, discussed earlier in this chapter (section 7.13.1), the way they reported that they monitored their professional development and what they had learnt was by either keeping a diary which they referred as a 'professional profile' or a portfolio which some of them had been given by their employers. They found that keeping a record of their learning activities, helped them to reflect on what they have achieved and to identify their learning needs, thus enabling them to continue further in their professional
learning.

7.16 Conclusion

This two-part chapter discussed the individual years of the P2K nurses' professional learning during their first two years of registered practice. Issues which had emerged from the previous two chapters on the participants' and lecturers' perspectives of the P2K course were compared and contrasted within a professional learning context. Key aspects of the P2K nurses' notion of professional learning are reflected in the various stages of professional learning as they experienced them during the course of the study.
CHAPTER EIGHT: DISCUSSION OF FINDINGS

8.1 Introduction

This chapter focuses on the discussion of the findings presented in chapters five, six and seven. The discussion was informed and guided by the insights extrapolated from the study findings and their respective thematic conceptual frameworks. A theoretical perspective is offered which helps to illuminate the models discussed in Chapter four, Figure 4.12 and Figure 8.1 (p.308). These were drawn from the findings emerging from data of varied sources: primarily the diplomates' group and individual interviews and the lecturers' individual interviews. The relevant supporting data from the examination of course documents including the students' course handbook were also found to be useful.

The chapter is presented in two parts. Part one is the discussion of the experiences of the P2K course from the diplomates' perspectives and those of their lecturers within the context of learning and teaching. In part two, the diplomates' own experiences of professional learning during their first two years of registered practice when the study was conducted are discussed. This decision was based on the assumption that pre-registration education is related to the post-registration professional development of nurses. Thus any knowledge, skills and attitude acquired during the P2K course would have some influence on the post-qualification professional learning of these diplomates. Lathlean et al (1986:84) also pointed out, in their report on the evaluation of three post-registration development schemes for newly qualified nurses, that "basic training and continuing professional development are interdependent". Furthermore, the course documents' findings clearly highlight an underpinning philosophy in which P2K views learning in nursing "as continuing beyond the end of the course" (Course document 1990, 1:13) in its aim to prepare professionally competent, credible nurses for their roles.
Figure 8.1: **P2K DIPLOMATES PROFESSIONAL LEARNING TRANSITION CYCLES**

**P**
- Caring for patient
- Doing practical nursing.

**S**
- Realisation of course relevance to clinical practice. Positive self-concept.

**E**
- Perception of nursing vs academic nature of P2K, confusion and frustration.

**A**
- Meeting educational and clinical expectations. Vulnerability and insecurity.

**Pre-registration learning.**

**Key:**
- **P** = Preparation: Expectations and motives up to point of change.
- **E** = Encounter: Sense making of new situation.
- **A** = Adjustment: Accommodation period, role development & relationship building.
- **S** = Stabilization: Relating and performing, commitment.

**1st Year of Professional Learning**

**P**
- Personal & professional expectations of staff nurse role.
- Apprehension & vulnerability

**S**
- Further learning, skill progression and valuable contribution to care

**E**
- Justification of staff nurse identity.
- Hope and optimism.

**A**
- Pre-registration learning.

**2nd Year of Professional Learning**

**P**
- Reconsideration of professional developments, moving to higher grade and different speciality

**S**
- Fitting personal learning to nursing culture.
- Resourceful and security.

**E**
- Conflicts of learning expectations. Feelings of discomfort.

**A**
- Self initiated role evolution. Responsible and in control of learning. Self directed.

**Legend:** Direction of transition cycle indicating continuous movements.
as staff nurses.

8.2 The diplomates' and lecturers' perspectives of P2K course: learning and teaching experiences

Key issues which emerged from recurrent themes of the findings were identified. These were considered to be significant to the continued professional learning of this group of P2K diplomates' and from their lecturers' perspectives of teaching on the course as well as having a clinical link in practice settings. These key findings largely address the extent to which the P2K course equipped these nurses for their continued professional learning and the extent of the lecturers' contribution to the post-registration learning of P2K nurses, which are the first two of the objectives identified for the study.

8.2.1 Perception of nursing as a dynamic learning process

The diplomates' commitment to continued professional learning emerged from an apparent change in their perception of nursing by the end of the course. They perceived nursing, at that time, as a dynamic learning process that goes beyond the end of the pre-registration course because of new technology, rapid changes in nursing practice and an increasing amount of nursing knowledge through research. A need to continuously pursue professional learning was thus evident from these nurses' philosophy of nursing as a profession. This need clearly reflects Roper's (1994b) beliefs about the non-static nature of nursing. It is also consistent with previous research findings which showed that orientations to nursing are not stable, fixed entities but vary according to the knowledge and experiences of nursing and continue to change once the student nurse has qualified (Brotherton 1988). The lecturers shared similar views about this perception of the professional development of nurses and this was also in keeping with the P2K course philosophy which was designed "to enable the qualified nurse to continue to develop personally and professionally" (Course Documents 1990,
This would suggest that these diplomates' notion of professional learning derived from their internalisation of the P2K course philosophy.

Another factor which seemed to have influenced the diplomates' perception of nursing during the P2K course was the apparent lack of skills. The identification of their lack of nursing skills, which was found to be due to their limited opportunities to practice nursing during their short clinical placements and a misinterpretation of their supernumerary status along with rapid changes in nursing, contributed to their need for further and continued learning. The findings about the diplomates' accountability and responsibility for patient care and their own professional development in terms of the extent of their learning, which emerged from the way they were taught in the classroom and their experiences of nursing in clinical settings, were also identified as contributive factors for continued learning. Hence, the emphasis on further learning was mostly on the practical aspects of nursing.

Hertzberg's (1966) theory of motivation suggested that responsibility, achievement, self-satisfaction and challenge of a job itself are motivating factors which Adair (1990) maintained have a positive and longer-lasting effect. Consequently, this situation of skills deficits motivated the diplomates to develop their clinical skills further in order to prove themselves capable and 'on a par' with the other nurses. It is thus evident that these diplomates' professional ideology of nursing developed through exposure to both classroom and clinical settings.

8.2.2 Conflict of interests between the classroom and clinical settings

It was evident from the account of the diplomates' learning experiences in the classroom and in practice areas that a tension existed between the two settings. Although the participants found the core subjects, which were translated in the theoretical knowledge learnt in the classroom, irrelevant in
the CFP, they later appreciated the relevance and importance of these subjects in the branch programme. The tension was between what the course aimed to achieve and the diplomates' expectations of a nursing course. This is consistent with previous findings of studies into the implementation of Project 2000 in England and Wales (see for example Robinson 1991, Elkan et al 1993, Luker et al 1993, Jowett et al 1994).

Thus learning became meaningful in the branch programme when the nurses were exposed to clinical settings for a longer period of time which enabled them to recognise and appreciate that theoretical knowledge was fundamental for the practice of nursing. They also found that the theoretical knowledge provided them with a rationale for holistic care which they viewed as underpinning the P2K course philosophy and gave them some continuity of learning from the classroom to clinical settings. In their writings on situated cognition theory, Brown et al (1989) presented a useful way in which formal knowledge can be applied to practice. These authors referred to the relevance and importance of the situated or contextual nature of learning which suggest that all the components of knowledge, whether formal or informal, are inextricably a product of learning activities and take place in situations in which they are produced. This contextual nature of learning would appear to be a feasible explanation for the nurses' meaningful learning experience in their branch programme since they viewed their experience of the common foundation programme as a "non-situated" nursing context, due to their minimal exposure to clinical settings and participation in nursing practice during the first eighteen months of the P2K course.

The mutual, peer support and group cohesiveness which were fostered through the ethos of the classroom and various educational activities such as shared/collaborative learning seem to be also in conflict with what the diplomates had experienced in clinical areas where they were labelled, hence alienated, by traditional nurses because of their lack of skills and 'excessive'
theoretical knowledge. They were also seen by non-P2K nurses as being different from and not part of the healthcare team because of their supernumerary status. Similarly, Van Maanen (1977) found that a lack of identity within an organisation can alienate the individual within their own culture. Stigma attached to the P2K course has been reported in other P2K studies such as Macleod Clark et al (1997). Bircumshaw and Chapman (1988) also found antagonistic reactions of other staff in their studies of newly qualified graduate nurses due to the fact that these nurses had a degree.

A conflict of interest was further evident here, emerging from the negative attitudes of traditional nurses who did not seem to appreciate the nature of the P2K course and the approach by which these nurses were learning. This situation could be partly explained by the lack of clinical staff preparation about the course curriculum, the appropriate level of supervision of P2K students and what to expect of the nurses qualifying from such a course as acknowledged by the lecturers interviewed in this study. Findings from other P2K studies (Robinson et al 1992, Twinn and Davies 1996, White et al 1994) also showed that the extent of non-P2K nurses' preparation for the supervision of the diplomates was inadequate and did not meet the requirements of the course.

Additionally, a conflict of interest was also identified particularly by the lecturers who found that the P2K philosophy did not match the reformed NHS Hospital Trusts' requirements of skilled-based nurses. Whilst the P2K course aimed at developing academically credible nurses, the Trusts were aiming at recruiting skilled nurses. Conflicts were therefore associated with these differences in emphasis. Hence, the lecturers' anxieties about whether these nurses would be employable and the Trusts' concern about these newly qualified nurses' skills deficit. This disquiet was justified since the Trusts have no legal obligation either to provide or to finance continuing professional education of the nurses as mandated by PREP (Nursing Times 1995).
8.2.3 The diplomates' readiness to practice

It is evident that skill deficits and alienation which emerged from the students' experience of the P2K course had also some effect on these nurses' readiness to practice. Although they felt ready to practice as staff nurses, there was a sense of vulnerability among them emanating from a feeling of self-doubt and apprehension about the extent of their nursing practice. These feelings were linked to the diplomates' lack of nursing skills which they perceived would lead to non-acceptance, being labelled and alienation of the traditional nurses in clinical areas. Subsequently, a lack of occupational role identity, self-worth and belongingness arose. However, Robinson et al's (1992) study drew attention to the similarity in the feelings and needs of all new staff nurses, in view of the change in role and responsibility which are inevitably experienced and the effects of any transition on confidence levels regardless of the type of pre-registration education they had received.

Furthermore, the findings showed that the occurrences of being labelled seemed to indicate a type of alienation consisting of three interconnected dimensions which had affected these nurses' readiness to practice. Firstly, the alienation as perceived by the diplomates from the traditional nurses e.g "P2K nurses don't know anything". Then there was alienation perpetuated by the participants themselves who considered themselves to be superior to and independent of traditional nurses and the third dimension was alienation instigated by the lecturers and the curricula, for instance the emphasis on P2K course being better, with a high academic profile which provides more opportunities for higher level of academic activities. Similarly, previous studies (Crocker and Brodie 1974, Conway 1983) of student nurses have shown that their views of the profession reflect those portrayed by their teachers which produces a conflict when these students begin their practice. Hence, the diplomates' readiness to practice as staff nurses was hindered by feelings of apprehension in the classroom and alienation in clinical areas at the end of the course because of the diplomates, their lecturers and the
traditional nurses' perception of P2K and their attitudes towards the course.

8.2.4 Diplomates' preparation to undertake the staff nurse role

Despite these conflicting feelings and hindering factors in the diplomates' readiness to practice, they were quite optimistic about their future practice and the theoretical knowledge acquired in the classroom gave them confidence and hope for their future in nursing. Thus the academic status and theoretically based knowledge contributed to what could be described as 'academic self-empowerment' which was used, among other strategies, 'to survive' as staff nurses in clinical areas. In this context the theory of empowerment which implies assisting and enabling others to develop their own self-helping skills (Nelson-Jones 1995) could be extended here as enabling these nurses to take control of their own practice through skills development.

Self-directed skills and interpersonal skills learnt in the classroom, largely influenced by the teaching and learning methods as confirmed by the lecturers and in the curricula, contributed to the manner in which the diplomates dealt with the negative attitudes of traditional nurses in clinical settings. The coping strategies which they discussed were based on, or influenced by, their past clinical learning experiences. The anticipated manner in which these nurses had planned to cope as staff nurses was to build on already acquired strategies utilised during their three year course as student nurses. They found that by adopting a non-confrontative and assertive approach towards the traditional nurses, as well as initiating their own learning needs, there were favourable outcomes in their attempt to cope with negative attitudes in clinical settings.

8.2.5 Effects of P2K course on professional learning

Despite the tension and conflicts of the diplomates' learning experiences in
the classroom and clinical settings, these two settings seemed to be nonetheless related as far as continued professional learning was concerned. The findings indicate that the classroom had influenced professional learning in clinical settings to a large extent as a result of the teaching and learning strategies used. Further learning needs were clearly identified by these nurses and anticipated measures to cope in the future articulated. Within the context of this study, the participants referred to further learning as short term learning activities whereas continued professional learning meant long term learning activities. Maben and Macleod Clark's (1997) study on the impact of Project 2000 also showed that the P2K students and diplomates were particularly committed to lifelong learning.

It is also evident from the interactive cognitive map (Figure 4.1, Chapter Four) of learning experiences in the classroom and in clinical settings that further learning and continued professional learning overlap in both settings. The course facilitated the participants' self-awareness which gave rise to the identification of their skills deficit and provoked feelings of inadequacy and vulnerability in clinical settings. Consequently, they were motivated to further learning and eventually to continued professional learning (CPL). Whilst in the classroom, further learning and CPL were influenced and facilitated by the course is self-directed teaching and learning style, and the development of these nurses taking responsibility for their own learning with a view “to foster a commitment to continued personal and professional development” as stated in the Course Document (1990, 1:14). The findings from the lecturers' interviews also highlighted the manner in which CPL underpins the aims and the teaching and learning of the course. The course ethos was presented as one which emphasises the students' learning process within a person-centred approach and developing skills of “learning how to learn” (Rogers 1969; Gagné 1975; Knowles 1980) which means a shift from a traditional educational approach.
The lecturers had also reported that, in class, the nursing code of professional conduct was used as a framework in their study of nursing profession and practice. These nurses were therefore prepared to follow the expectations of the code of professional conduct which states that "every registered nurse is accountable for his or her practice and in the exercise of professional accountability shall take every reasonable opportunity to maintain and improve professional knowledge and competence" (UKCC 1992:2). This clearly determines the manner in which nurses are required to conform and perform to a professional standard. Although Morton-Cooper and Palmer (1993) argued that this in itself is a powerful motivator to continuing learning, at this point the UKCC had not stipulated the extent of this expectation from the nurses. The mandatory requirements of PREP were agreed in 1995.

Nevertheless, a clear misfit between the diplomates' personal values and beliefs about the nature of nursing and the organisational culture of nursing was evident from the time they were exposed to clinical practice. This resulted in socialisation problems due to the way they internalised the nature of nursing which clearly stemmed from the P2K course. Thus, these diplomates' pre-registration notion of professional learning confirms the impact of the P2K course which had implications for their post-qualification professional learning.

8.2.6 P2K: A perspective of learning within a reformed nursing education programme

In order to understand more effectively these diplomates and lecturers' experience of the P2K course, the socialisation process within which the findings are located is examined and applied in the context of a reformed nurse education. Socialisation is referred here as a process of induction (Clausen 1968) and adaptation where values and norms are acquired within a defined situation, in this instance, a college of nursing structure. Values are
the collective beliefs which have been developed and held within the college and norms are the ways of thinking, feeling and acting that reflect those beliefs. In his writings on medical sociology, Tuckett (1977) insisted that norms and values have to be learnt and he referred to Freudian psychological theory to argue that a sense of reality has to be developed so as to allow the individual to behave in accordance with the demands of reality. Thus learning the reality of the P2K course was fundamental in the nurses' socialisation process at college as well as in clinical settings.

The three types of socialisation which are usually identified by sociologists are primary, secondary and anticipatory of which the last two are found to be relevant to nursing because they particularly relate to adults whereas primary socialisation occurs during childhood. Secondary socialisation, which operates throughout a person's life and forms a large and important part of what is learnt (Musgrave 1983) whilst being socialised, can therefore occur and be applied to nurse education. Anticipatory socialisation is the means by which individuals can be prepared for change and involves efficient learning of behaviour that would be later expected of them.

From the diplomates' and lecturers' perspectives of the P2K course, the findings suggest that secondary socialisation was determined by the nature of the newly reformed educational programme for nurses which was important to internalise in order to fulfil the P2K course philosophy. Such a socialisation process was primarily influenced by the norms and values which were essentially dictated by the P2K curriculum and the code of professional conduct. This is particularly evidenced by the way in which both the nurses and their lecturers perceived the nature of nursing and the personal and professional development of nurses as an on-going process of learning which is clearly in keeping with the P2K course philosophy.

However, an understanding of the process of anticipatory socialisation is also
useful and important because in this study it involved the way in which the nurses were prepared for the realities of nursing practice. Evidence of anticipatory socialisation can be found in the teaching and learning strategies which were used in the education of the diplomates. Although the nurses maintained that learning to nurse takes place in both the classroom and clinical settings, it is evident from the findings of this study that their conception of nursing practice was largely influenced by the expectations of a professional standard emanating from the classroom. The lecturers demonstrated this in their account of the framework used in the teaching of nursing profession and practice as a means of preparing the nurses in their nursing role. Consequently when these nurses were exposed to clinical practice they experienced a conflict of values acquired in college and those expected of them in clinical settings. Hence, they had difficulty in functioning within the norms of clinical practice because it was apparent that their ideology of nursing was incongruous with that of the traditional nurses who were from a different educational background.

The discussion above indicates that an understanding of this process of anticipatory socialisation is crucial in the education of nurses because it has important implications for the nurse's adaptation to clinical practice and for changes within clinical settings. Such a process is clearly relevant and applicable to the learning of a nurse's role. Thus, it would seem that carefully planned, realistic preparation of students or qualified nurses for clinical practice could help them cope with any emerging conflicts so as to make a positive adaptation into their future positions. However, Bradby (1990) argued that whatever anticipations are made, all aspects of the role cannot be entirely revealed until the person actually becomes part of the organization and Louis (1980) warned that there will always be surprises to negotiate.
8.3 The diplomates' professional learning experience during registered practice

Significant issues within the context of the P2K diplomates' professional learning experience during the two years of registered practice were identified and considered important in order to understand the nurses continued professional learning. The following discussion therefore addresses the other three objectives of the study:

⇒ an examination of the perception and commitment of the diplomates to CPL
⇒ the exploration of the nature of these P2K nurses' professional learning during the first two years of registered practice
⇒ the identification of the way in which they plan and organise their professional learning.

8.3.1 The diplomates' entry to the world of nursing

It was evident that the diplomates experienced difficulties in their socialization into nursing. The passage through the 'nursing rites' was problematic, largely due to a lack of understanding of the P2K philosophy among the traditional nurses. Consequently there was a discrepancy in the perception of nursing between the two types of nurses which was reflected in the incompatibility and incongruity of role expectations. A conflict of values between the initial education of nurses and the world of work was very much present. This reflects Kramer's (1974) research findings of nurses' 'reality shock' which brought into focus the discrepancy when students first experienced the realities of registered practice. Findings from other studies which addressed the socialization process in nursing also showed a degree of incongruence between the nurses' role concept and the role reality (for example, Wilson and Startup 1991, Bradby 1990, Horsburgh 1989). Such findings can also be found among other healthcare professionals. For
instance, Rugg's (1996) study showed that there was a mismatch between the occupational therapists' expectations and their experience of practice once they qualified.

On the other hand, there is evidence that the P2K course had prepared these diplomates to be responsible for their professional learning and their commitment to it was clearly indicated. This emerged from the way in which the course had influenced their views of the dynamic nature of nursing, discussed earlier in this chapter (Section 8.2.1), which had resulted in a self-expectation of on-going learning during their nursing career. They also demonstrated the transfer of self-directed learning from the classroom to their clinical practice. Jarvis (1987) confirmed that developing self-directed learners fosters learning throughout their professional career. This would, therefore, suggest self-directed learning had empowered these nurses to take control in their own professional learning.

8.3.2 Methods of professional learning

Four significant methods of professional learning emerged from recurrent themes during the diplomates' first two years of registered practice:

- learning through nursing practice
- self-directed learning
- learning through mentorship/preceptorship
- peer group learning

8.3.2.1 Learning through nursing practice

The diplomates had identified a process of reflection on their nursing practice which suggests a generation of knowledge from practice and not only the application of theory to practice. This supports Schön's (1983) research on learning in the workplace, the reflective practitioner.
Tongue's (1997) study of the nature of nursing practice and its relationship to theory is relevant here when she concluded that practice is essentially inarticulable and that it can only be learned through participation, whereas theory relates to practice in a variety of ways. Although James and Clarke (1994) argued that the assessing and measuring reflection is problematic, the diplomates' accounts clearly showed that reflection on practice took place.

This reflective learning process led to an increased self-awareness of the diplomates' role expectations and demands at various stages of their two years of registered practice and changes in their conception of professional learning took place accordingly. Hence, they continuously reviewed their nursing practice and clarified its meaning. This process is in keeping with Boyd and Fales' (1983) description of reflective learning which suggests a change in conceptual perspective as a result of thinking about and exploring an issue of concern. Within this context, reflective learning enabled these diplomates to respond to the challenge of their practice and was a means of continued professional learning. However, the diplomates' conception of reflective nursing practice caused some conflict with traditional nurses on the wards especially when they began to take charge of the wards and a group of patients, and started to question their practice and that of others. Gerrish (1992) argues that when distrust and lack of understanding remain between these two groups of nurses it will continue to have a negative effect on the process of learning.

Nonetheless, the diplomates also clearly demonstrated that in order to progress in practice it was crucial to monitor clinical performance so as to plan meaningful and relevant learning. Limited feedback, guidance, encouragement and clinical support was evident from the findings. This might be partly due to the conflict of interests on the wards which was as a result of the disparity of outlook on nursing care approach between the P2K nurses and traditional nurses. The traditional nurses retained the same
perception of nursing acquired from their own training. Similarly, Macleod Clark et al's (1997) findings from their study of the impact of P2K on perceptions of the nature and discipline of nursing also showed that diplomates do differ from the traditional nurses as far as nursing care is concerned. They also found that diplomates perceived themselves as professional practitioners with theoretical knowledge, holistic in their nursing approach and prepared to be life-long learners.

Consequently, the self-initiated monitoring which was present was largely based on personal judgement of clinical performance and instincts. Benner (1984) recognised intuitive knowledge within the context of the notion of intuition which she viewed as a feature of professional expertise. She, therefore, identified expert nurses as strongly intuitive. However, critiques of Benner's work (such as English 1993, and Cash 1995) on expertise in clinical practice have questioned the role of the concept of intuition in nursing. They argued that aspects of expertise are defined but not clearly within the role of intuition as a function of the expert nurse. Thus, the relationship between intuition and expertise does not clarify whether only the expert thinks in an intuitive manner. Cash (1995) insisted that what has been described is a feature of all learning and that Benner (1984) only differentiated the experienced and inexperienced nurse and English (1993) concluded that there is a need for some objective measurement of what constitutes expertise.

This self-initiated monitoring was achieved by learning from the outcomes of the diplomates' past experiences and clinical supervision for the mental health nurses who at the time of the study could not be viewed as experts. Although some of them had had their Individual Personal Reviews (IPRs), they felt that these were not skill specific. They were therefore in need of regular, individualistic and specific skill-based feedback. This supports Jowett et al's (1994) findings which call for a rigorous scrutiny of diplomates'
individual learning needs.

8.3.2.2 Self-directed learning

The philosophy underpinning the P2K course has required a significant shift in the teaching and learning approach used in nurse education. This shift resulted in more emphasis being placed upon self-directed learning as a means of acquiring knowledge and skills.

Lathlean et al (1986) argued that the beneficial changes in pre-registration learning should enhance the efficiency of post-registration education. One of the pre-registration curricular changes related to this research was the introduction and development of learning skills such as self-directed learning which aim to foster continued professional learning among P2K nurses (Course document 1990, 1:11). However, this major feature of the P2K course which was introduced to ensure nurses' personal commitment to continued learning does not seem to have been recognised by the traditional nurses. Thus, from the traditional nurses' perspectives, this situation reflects the structural-functional view (Parsons 1951, Merton 1968) of role socialization which emphasises the socialization of professional 'trainees' and consists of nurses adopting and internalizing the role expectations which already exist in the system. Consequently, this raises important issues within the realm of contemporary nursing education and nursing practice which focus on an adult-centred learning approach.

Additionally, in his discussion on 'lifelong learning and nursing', Jarvis (1987) argued that, during the initial professional preparation, students should be developed into self-directed learners rather than teacher-directed which would foster learning throughout their professional lifespan, and therefore equip them better for their career. Hence, it was not surprising that these nurses' decisions about their professional learning were mainly self-initiated including attendance at mandatory courses and study days.
This approach to learning which to these diplomates meant “going and finding out for oneself” also proved to be beneficial in their registered practice for a number of reasons. Apart from the limited feedback and clinical support, as discussed in the previous section (Section 8.3.2.1), the diplomates also found that there was frequently a lack of time to ask other nurses on the wards and they often had to check information for themselves due to previous conflicting messages from traditional nurses. They also felt that their self-motivation to be inquisitive and questioning of their own practice and their wish to delve deeper into what they had been told or taught by others influenced a self-directed approach to their learning. This therefore suggests that the diplomates felt responsible for the quality and quantity of their professional learning which Morton-Cooper and Palmer (1993:8) described as “freedom to learn with responsibility”.

8.3.2.3 Learning through mentorship/preceptorship system

The findings revealed that learning on the wards depended on the availability of an appropriate staff nurse to act as a temporary preceptor at a given time, staffing levels at any given time and the preceptors’ attitudes towards them. This last factor referred to whether the preceptors were interested and willing to teach and understand P2K nurses’ learning needs. However, the UKCC’s (1993) guidelines for the preparation of preceptors specifies a preparation for the role. It requires that the preceptor has sufficient knowledge of the nurse’s programme leading to registration so as to identify their learning needs and to assist the newly qualified nurse to integrate into their new practice setting.

Bain’s (1996) review of the literature on preceptorship revealed that there is a lack of definitional clarity. She also found that many of the empirical studies failed to identify strategies for successful implementation of preceptor programmes. Macleod Clark et al’s (1997) study also identified poor implementation of preceptorship for newly qualified P2K nurses which could
be due to the lack of staff preparation for the supervision role as is evident in this study. Kramer (1993) suggested a preceptorship policy with structured guidelines for the roles and responsibilities of the preceptor and the newly qualified nurse.

There was also evidence of a laissez faire attitude of mentors/preceptors among some of the traditional nurses. This was described by the diplomates as 'getting on with it' which they accepted as part of the nursing culture. This is an area of concern for professional learning. Darling (1985:43) referred to such mentors as "dumpers" who, she found from her interviews with nurses, "throw people into a new role or situation and let them flounder, either to sink or swim". She, therefore, warned nurses that such behaviour, whether purposeful or unintentional, could cause "a transition trauma that leaves lasting scars on the junior person".

After about the first six months of registered practice, some of the diplomates were mentoring student nurses and six months later involvement with preceptorship began. The diplomates maintained that their involvement with student nurses and newly qualified nurses kept them abreast with their professional learning. They also seemed more organised than their traditionally trained nursing colleagues because they had the opportunity to attend relevant courses and work through learning packages relating to mentorship and preceptorship.

8.3.2.4 Peer group learning

Despite an improved relationship with the traditional nurses during the second year of registered practice, minimal clinical support was still evident on the wards. This could be due to the self-directed approach to learning of the participants and the traditional nurses failing to recognise the diplomates' needs for further learning which continued to be evident eighteen months
after they had been qualified. There was evidence of continued peer support network outside work with nurses from the same cohort throughout the study. The diplomates maintained this link because they found that such peer support helped them to learn from each other and motivated them to learn further.

The process of learning here occurs by exploring issues of concern experienced on the wards. This supports Boyd and Fales’ (1983) working definition of reflective learning which they suggest involves a cognitive review of a lived experience. Additionally, this process takes the diplomates’ notion of learning through nursing practice, as discussed in section 8.3.2.1, further. It shows that they also continuously reviewed their experiences of nursing practice outside clinical settings, clearly another means of continued professional learning. It can thus be argued that for the diplomates’, peer group learning also involved an element of reflective learning outside the workplace.

8.3.3 Factors influencing professional learning

The factors which were considered to have influenced the diplomates’ professional learning were classified into three types: personal, organisational and professional. These factors emerged at varying times in the diplomates’ registered practice.

Personal factors: These were initially derived from these nurses’ perceptions of professional development which remained consistent in all the findings. They viewed it as a dynamic process through which there is a need and a professional requirement of every nurse to be responsible to learn continuously and maintain their skills and knowledge, updated at various stages and at different levels of their career. Thus, their notion of professional development clearly demonstrates a personal commitment and
accountability to the profession which is reflected in their accounts of the factors influencing their professional learning. However, these personal factors consisted of the ones which had influenced them as individuals:
* the recognition of skills deficit;
* personal achievement;
* career progression due to lack of challenge in the job, having reached "saturation point" when little learning was taking place;
* their academic status which provided further formal learning opportunities and
* self-directed learning.

Organisational factors: As the diplomates became more settled into their role as staff nurses they identified other factors which were more linked to the demands of the organisation for whom they were working. These factors were both positive and negative including:
♦ meeting the needs of the NHS Trusts, their employers;
♦ attitudes of the traditional nurses which determine access to courses and learning opportunities, for instance, the ward manager who has control over course attendance, getting time off work to participate in learning activities and senior nurses failing to recognise the needs of more junior nurses' further learning;
♦ availability of learning opportunities to practice on the wards such as taking charge of the ward and attending self-identified relevant courses;
♦ nursing grade because some skills had to be learnt at a certain grade e.g venous puncture
♦ the nature of their working environment, whether there were on-going changes of procedures, techniques as well as the types of patients being cared for, such as acute, continuing care or those requiring specialist care.

Professional factors: Finally, on a professional level the factors influencing professional learning were based on the nurses' sense of on-going
commitment to, responsibility and accountability for patient care. These include:

→ maintaining safe practice for the benefit of the patients and enhancement of the nursing profession;
→ challenging rituals and routines which were found to cause a hindrance to professional learning;
→ periodical and mandatory updating for the provision of improved nursing care.

All these factors reflect what is expected of the registered nurse as stated in their code of professional conduct (UKCC 1992). They also clearly demonstrate that the diplomates' socialization into the professional role was facilitated or hindered by the extent of congruity between the role expectations and demands of their 'agents' of socialization (Lum 1988) who, in this case, were the managers, professional body (UKCC) and the diplomates themselves.

8.3.4 The development of the diplomates' staff nurse role

An examination of the diplomates' post-registration socialisation is useful here in order to illuminate the findings of their learning experience within the context of their staff nurse role. In her insightful exploration into the concept of role, Clifford (1996) found that it lacks clarity due to the various interpretations of its meaning by different authors. She, nevertheless, recognised that 'role' continues to be used within a general description of a defined position and that it can be expressed with other components. It is within this context that the role of the staff nurse is being discussed here and includes occupational role, nursing role, role acquisition and role conflict to discuss the diplomates' experiences of registered practice as staff nurses.

In the language of the sociologists, roles are behavioural expectations within a defined situation. Tuckett (1977:190) maintained that "a role has duties, or
at least expectations of carrying out particular tasks and activities, attached to it" which implies certain prescribed actions. It has, thus, common features of certain individuals' tasks and activities. The findings in this study showed that there was a lack of consensus within the confines of the diplomats' expectations of their roles during registered practice. This appeared to be due to their different sets of values about the nature of nursing which did not fall within the norms of the nursing culture at their place of work. Other studies in nursing have also identified this lack of a unified professional role model (Gott 1982, Melia 1987, Wilson and Startup 1991). Since socialisation involves the learning of a culture these nurses, therefore, experienced role conflicts and their process of socialisation became problematic.

Further complications arose for these nurses because the process of learning is embodied in the concept of socialisation and the evidence from this study showed that these diplomats found it difficult to learn aspects of their role from nurses who they felt did not share a similar nursing ideology. During the nurses' registered practice their main agents of socialisation were clearly the traditional nurses with whom they worked on the wards. Consequently they experienced a lack of occupational role identity especially within the initial months of registered practice. Bradby (1990) maintained that unless a person develops a firm identity, that person is likely to be very vulnerable when undergoing a major transition such as the status passage from student to staff nurse.

Graham (1996) argued that clarifying the nurse's role is dependent upon the value one holds of nursing and that it is the values and beliefs of practice which help to define the nurses' role. Hence it would appear that the diplomats studied defined their role as more dynamic and influenced by their progressive approach to nursing care which they had internalised from the P2K course. They were thus seeking to create their own nursing roles rather than the ones being prescribed for them. This process clearly reflects
Mead's (1934) symbolic interactionist interpretation of roles and role behaviour. In this study, the diplomates' were involved in the discovery and interpretation of the meaning of the expectations and constant modification of their roles according to changes that took place. The process evoked a number of uncomfortable feelings especially when they were striving to resist the inevitable pressures of occupational socialisation and at the same time seeking recognition and acceptance from the more senior colleagues.

Examination of the concept of socialization within role theory helped to clarify some pertinent issues about the complexity of these diplomates' role acquisition and the role conflict experienced as a result of undergoing the P2K course. The socialisation of the nurses also suggests the impact which the P2K course had had on them. Thus the P2K course had affected the development of professional learning of the diplomates' who were being socialized in a different way from their traditionally trained nursing colleagues.

8.3.5 The development of professional learning through the realities of learning to nurse

The transitory stages within the socialisation process which were identified by the lecturers and implicit in the diplomates' findings had a bearing upon the development of professional learning from the point of commencing the P2K course. An exploration of the developmental transition phases, which took place in the diplomates' status passage from students to the two years of registered practice, provided an insight into their impact on professional learning. Thus, Nicholson's (1990) transition cycle is used here as a framework to demonstrate the extent to which the diplomates' professional learning had developed during the study. This model was considered particularly relevant because it is a systematic general framework which allows for a full range of different experiences which are met in transition to be interpolated and interpreted. The model also allows for the unpredictable cyclical nature of experiences during transitions which are evident in this study.
Nicholson’s cycle moves from the preparation phase to the encounter, to adjustment and then to stabilization, on the basis that going through these phases enables moving forward to a new transition. These four stages are interdependent; what happens at one stage influences the next stage. Thus each experience of transitions in some way affects future experiences of transitions. Table 8.1 (p.332) summarises the way in which the diplomates’ professional learning development can be conceptualised by applying Nicholson’s theory of transition.

Three transition cycles could be identified in this study:

a. the pre-registration learning;
b. the first year of professional learning and

c. the second year of professional learning

An interpretation of this study’s transitional cycles are illustrated in Figure 8.1 (p.308) and it highlights the onset of the different factors which were reported to have occurred in the transition process of the diplomates’ professional learning. A dominant and recurrent theme observed from the transition cycles is the affective component of professional learning. This includes feelings of uncertainty and unrest at the end of the first year and the beginning of the second year of registered practice.

8.3.5.1 Affective aspects of professional learning

In their classification of educational goals, Krathwohl et al (1964) distinguished the affective domain of learning which deals with the feelings, emotions, attitudes and values of the learner whilst the cognitive domain as the skills of recall and analysis. The affective aspect of professional learning in the curriculum seemed to have been neglected to some extent by the planners of this P2K course, especially given the newness of the course at the time.
**Table 8.1: ONSET OF THE FACTORS IN THE TRANSITION PROCESS OF DIPLOMATES’ PROFESSIONAL LEARNING: The four stages**

<table>
<thead>
<tr>
<th>Preparation: Motives and expectations</th>
<th>Encounter: Sense making</th>
<th>Adjustment: Assimilation and Accommodation</th>
<th>Stabilisation: Relating and Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Pre-Registration Learning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring for patients</td>
<td>Conflict between</td>
<td>Accepting theoretical</td>
<td>Ability to apply</td>
</tr>
<tr>
<td>Doing practical</td>
<td>self-perception of</td>
<td>course content</td>
<td>theory to practice</td>
</tr>
<tr>
<td>nursing</td>
<td>nursing and P2K</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. First Year of Professional Learning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting expectations of staff</td>
<td>Professional and</td>
<td>Learning staff nurse related skills and</td>
<td>Need for further</td>
</tr>
<tr>
<td>nurse role</td>
<td>bureaucratic</td>
<td>feel part of the team</td>
<td>skill progression</td>
</tr>
<tr>
<td></td>
<td>conflicts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Second Year of Professional Learning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconsideration of professional</td>
<td>Conflicts of</td>
<td>Self-initiated monitoring</td>
<td>Ability to fit</td>
</tr>
<tr>
<td>development</td>
<td>expectation</td>
<td>of professional</td>
<td>learning with nursing</td>
</tr>
<tr>
<td></td>
<td>(Senior nurses vs</td>
<td>performance</td>
<td>culture</td>
</tr>
<tr>
<td></td>
<td>P2K nurses)</td>
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</tbody>
</table>
Table 8.1: ONSET OF THE FACTORS IN THE TRANSITION PROCESS OF DIPLOMATES' PROFESSIONAL LEARNING: The four stages - (Continued)

1. Preparation stage: motives and expectations at the time leading up to the point of change.
   a) The pre-entry motive to do a nursing course is (assumed) to care for patients thus on entry expectation of practical nursing.
   b) Pre-entry motive to staff nurse role: identification of learning needs based on personal and professional expectations of the role; skills deficits and meeting the needs of the employer. Feelings of apprehension and vulnerability.
   c) Motive: lack of professional challenge; reconsideration of professional development to combat feeling of being at a cross-road and reaching saturation point. Moving to a higher grade, different speciality.

2. Encounter stage: emotions and perception during the first days and weeks of familiarisation/sense making with the new situation.
   a) Sense making: CFP caused feelings of confusion and frustration; conflict between personal perception of nursing and the academic nature of P2K.
   b) Sense making of the realities of nursing: disparity of nursing care; limited theoretical-based approach; established ward culture. Feeling of alienation, labelling of P2K from tradition nurses. Professional and bureaucratic conflicts.
   c) Sense making: senior nurses inability to recognise diplomas' need for further learning; ward manager control over learning opportunities. Conflicts of expectations produced feeling of discomfort.
Table 8.1: ONSET OF THE FACTORS IN THE TRANSITION PROCESS OF DIPLOMATES' PROFESSIONAL LEARNING: The four stages - (Continued)

3. **Adjustment stage: assimilation and accommodation period of developing performance and psychological change.**
   a) During CFP, adjustment involved coming to terms with the theoretical content of the course by meeting educational expectations. This followed by the realisation of skills deficits, due to a lack of clinical experiences, in the transition from CFP to the branch programme and in an attempt to meet the expectations of the clinical settings. Feelings of vulnerability and insecurity.
   b) Awareness of the consolidation of basic skills and the need to learn skills related to new staff nurse role. Feelings of hope and optimism despite limited learning from preceptorship system and having to justify the staff nurse identity.

4. **Stabilisation stage: relating and performing at the steady state which has been achieved.**
   a) Half way through the branch programme: able to apply theory to practice; realisation of course relevance, the P2K philosophy and what it aimed to achieve. The beginning of positive self-concept.
   b) A need for skill progression and further learning of specialist/technical nursing skills. Feel on a par with traditional nurses; feel part of the team and able to make valuable contribution to nursing care.
   c) Fitting personal professional learning value system with nursing culture. Mentoring student nurses and preceptoring newly qualified nurses. Maintaining external peer support group network. Feel resourceful and secure.
Table 8.1: ONSET OF THE FACTORS IN THE TRANSITION PROCESS OF DIPLOMATES' PROFESSIONAL LEARNING: The four stages

<table>
<thead>
<tr>
<th>Preparation:</th>
<th>Encounter:</th>
<th>Adjustment:</th>
<th>Stabilisation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motives and expectations</td>
<td>Sense making</td>
<td>Assimilation and Accommodation</td>
<td>Relating and Performing</td>
</tr>
</tbody>
</table>

a. Pre-Registration Learning

- Caring for patients
- Doing practical nursing

b. First Year of Professional Learning

- Meeting expectations of staff nurse role
- Professional and bureaucratic conflicts

- Learning staff nurse related skills and feel part of the team

- Need for further skill progression

c. Second Year of Professional Learning

- Reconsideration of professional development
- Conflicts of expectation (Senior nurses vs P2K nurses)

- Self-initiated monitoring of professional performance

- Ability to fit learning with nursing culture
An increase in the diplomates' confidence was particularly evident during the second year of their registered practice when the dichotomy between the P2K nurses and traditional nurses was less obvious. The diplomates felt more able to make valuable clinical contribution as well as feeling that their clinical expertise was on a par with traditional nurses of similar grades. This therefore indicated that they had established their occupational role identity and were working in partnership with the other nurses on the wards.

An increase of confidence was also due to advanced skills and added knowledge in aspects of nursing gained during the two years of nursing practice. They had all attended clinically-based courses and study days although a lack of learning opportunities was reported. Consequently, the diplomates' security and adjustment in their staff nurses' role contributed to their increased capability to act as mentors to student nurses and preceptors to newly qualified nurses. This progress is congruent with the empirical work of Benner (1984) and Dreyfus and Dreyfus' (1986) theory of skill acquisition which focus on the development of professional expertise in clinical practice.

Another area of significance was the dilemma expressed by those in the same nursing grade at the end of the first year. Those diplomates felt uncertain about their future and described their feelings of being at a "cross-road" whilst those who had secured a higher grade were more confident and positive about their future plans. Although a similar period of unrest was also detected in some of the participants at the beginning of the second year of registered practice, this was more to do with what was described as "reaching saturation point" with regard to their learning on the wards where they were working. This situation was due to the monotony of the job not only from those nurses who were at a "cross-road" six months previously. Nonetheless, both affective aspects clearly had implications in their continued professional learning.
8.3.6 Diplomates' process of professional learning development

The process of professional learning can be seen to have gone through eight clearly identified stages. Table 8.2 overleaf is a linear diagram which illustrates the flow from one stage to another.

1. Upon entry as professional practitioners, the learning process started with self-directed, spontaneous and cyclical identification of learning needs to address skills deficits and to cope with staff nurse role expectations. Involvement in the preceptorship system also commenced at this stage.

2. Consolidation of basic nursing skills was followed by the need to justify their staff nurse role and proof of safe practice in preparation to take charge of a group of patients and the ward. This was a time when a broad and general stance in "learning everything" was considered important in order to undertake their staff nurse role with emphasis on safe practice.

3. When the responsibility of being in charge of a group of patients began, there was an expressed need for management skills to be acquired.

4. The responsibility of taking charge of the whole ward soon followed. Reflection on practice was considered to be paramount for the development of non-ritualistic nursing care and professional development. A progression towards the need for more technical, specialist skills which was classified as learning skills at a higher level was also identified.

5. At the end of the first year, an "at a cross-road", situation was identified whereby a reconsideration of career paths took place. A need for career progression became of concern. Seeking for a higher nursing grade was evident here.

6. At the beginning of year two, the development of 'reaching saturation point' occurred which led to the reconsideration of professional
Table 8.2: STAGES OF P2K DIPLOMATES' PROFESSIONAL LEARNING

<table>
<thead>
<tr>
<th>Stages</th>
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<tbody>
<tr>
<td>'Inaugural' Professional Learning</td>
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<tr>
<td>Indiscriminate Learning</td>
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<td>↓</td>
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<tr>
<td>Role-directed Learning</td>
</tr>
<tr>
<td>↓</td>
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<tr>
<td>Change of Learning Emphasis</td>
</tr>
<tr>
<td>↓</td>
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<tr>
<td>At a 'Cross Road' Learning (End of Year One)</td>
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<tr>
<td>↓</td>
</tr>
<tr>
<td>'Saturation point' Learning</td>
</tr>
<tr>
<td>↓</td>
</tr>
<tr>
<td>Discriminate Learning</td>
</tr>
<tr>
<td>↓</td>
</tr>
<tr>
<td>Continued Professional Learning (End of Year Two)</td>
</tr>
</tbody>
</table>

338
learning related to speciality and nursing environment.

7. At this stage, learning became more specific and focused on aspects of the job. Confidence in mentoring student nurses and preceptoring newly qualified nurses was apparent at this stage.

8. At the end of the second year of registered practice, the last stage of the process involved a need to continue to learn and update to progress further and meet the employers' needs despite feeling that the level of expertise had been achieved at the end of the second second year of registered practice.

This developmental process clearly demonstrates the manner in which the diplomates attempted to make sense of what they were learning and the nature of their professional learning during the first two years of registered practice. The transferring of previously acquired educational knowledge to practical skills was done by an on-going critical reflection on their practice which they considered crucial during continued professional learning. This pro-active approach to learning echoes Mezirow's (1990) belief that to make sense of an experience is to interpret it and when this interpretation guides decision making or an action then making sense becomes learning. Thus, reflecting on their practice enabled the nurses to correct any distortions or errors which they might have encountered during their professional learning experiences. Accordingly, they used reflection on practice to monitor performance and to learn from past experiences in the delivery of informed patient care. This model of learning clearly does not reflect an apprenticeship model of learning to maintain the status quo as earlier studies of newly qualified nurses had indicated (Kramer 1974, and Horsburgh 1989), but is in keeping with the findings of other studies of P2K diplomates such as Macleod Clark et al (1997).

Furthermore, the identified process of professional learning reveals that these diplomates clearly initiated, planned and organised their own professional learning in order to enhance their nursing competencies of knowledge, skills
and attitudes regardless whether it was from one nursing grade to another and one speciality to another or in the same grade and speciality. Bradby's (1990) study of the 'ritualised status passage into nursing' appears to be of some relevance here. It showed that student nurses in the main had to chart their own status passage. Although her findings were related to the provision of patient care in those areas which tended to arouse ambivalent feelings, she implied that some staff did not seem to know how to cope with certain situations and that it might be partly due to a lack of available staff to provide direct guidance in a busy ward. This situation suggests that organisational requirements take precedence when there is a conflict between the needs of the organization and the nurse's professional development needs, as Wakefield et al (1988) found in their study of work outcomes in nursing. However, Bradby's (1990) findings clearly highlighted a lack of preparation to manage or cope with certain situations and the lack of support from qualified nurses, as evident in this study. A lack of a warm and supportive working environment had also been found in previous studies due to the negative attitudes of clinical staff (West and Rushton 1988).

8.4 Conclusion

This chapter offered a discussion of the data based on the key findings of the study, primarily in terms of what the diplomates themselves considered significant during their first two years of post-registered professional learning experiences. The different perspectives of these findings were addressed without losing sight of the context within which the research took place. The link between pre-registration education and post-registration professional learning of nurses was also established. This confirmed the relevance and significance of the diplomates' P2K course experience in their continued professional learning during registered practice.
CHAPTER NINE: CONCLUSIONS AND IMPLICATIONS

9.1 Introduction

The previous chapters provided the description, explanation and justification of the progressive stages of the research process so as to enable an 'audit trail' of the research to meet the criteria of reporting a naturalistic inquiry. This chapter, therefore, concludes the thesis by bringing together the various perspectives of, and insights gained from, the study which aimed to understand the continued professional learning of a group of Project 2000 diplomates. It provides a summary of the significant findings related to the diplomates' experience of professional learning in terms of five key issues:

- Effects of the P2K course on the diplomates' professional learning
- Methods of professional learning
- Factors influencing professional learning during registered practice
- Diplomates' professional learning development
- Plans for future professional learning.

It also reviews the findings in the light of key theoretical ideas and propositions that emerged from the study in relation to its aim and the five objectives.

In addition this final chapter presents the implications of the study for nurse education, some recommendations are made and potential areas for further research are highlighted. A reflection on the research is offered in the last section. A personal approach is used and was considered appropriate to help identify areas for future development. The final paragraph addresses the extent to which the research questions have been answered.
P2K DIPLOMATES' EXPERIENCE OF PROFESSIONAL LEARNING

9.2 Effects of the P2K course on the diplomates' professional learning

The inception and development of professional learning, within the context of professional development of these P2K diplomates, commenced upon entry to the course. Hence, the pre-registration learning on the P2K course equipped the nurses studied with a fundamental framework for their professional learning once they were qualified.

The diplomates' definition of professional learning which derived from their experiences of P2K course remained consistent throughout their post-qualification experiences. Their definition, which supports that of their lecturers, suggests that professional learning is a dynamic learning cycle which evolves through a critical reflective process of nursing knowledge, skills and attitudes to improve the competence of a registered nurse, and it does not necessarily involve gaining an academic qualification. Thus, this definition clearly suggests some of the ideals of professionalism by virtue of its quest for on-going learning and updating. It could also be concluded here that the findings from the diplomates and lecturers', along with those from the course documents, clearly highlight a philosophy of continuing learning which is embedded in the aims of the P2K course.

9.2.1 Conflict between P2K and the traditional notion of professional learning in nursing

The conflict found between the two learning settings was derived from the diplomates' pre-conceived perception of nursing. Some of them had reported and others implied that they did not expect the nursing course to be so academically orientated and that they could not initially see the relevance of theoretical knowledge to the practice of nursing which to them was essentially the traditional practical nature of nursing.
These diplomates' academic status which was promoted in the classroom seemed to 'alienate' in clinical settings, because the diplomated were more theoretically orientated but possessed less nursing skills than the traditional nurses. However, they valued their academic status a great deal and they linked it with their potential for further learning and continued professional learning because of the availability of more academic opportunities which would be more readily opened to them than the traditional nurses. A great deal of emphasis was placed here on the progression from a diploma to a university degree.

Nonetheless, the traditional nurses had opportunity to progress to a degree level through the higher awards but, at the time of the study, those nurses seemed to have little insight into their academic potential. It seems that such conflicts between P2K and traditional nurses' notion of professional learning could be addressed by making all nurses aware of academic opportunities. It is obvious that these two groups of nurses complement each other in terms of skill and theoretical orientations. However, the source of conflicts seem to be from the nurses different nursing education background. For instance, they followed a curriculum with a different focus, the context of learning was moved from an NHS School of Nursing to a Higher Education institution and a change in healthcare demands and approaches to nursing care. In view of this change of emphasis, it would have been unrealistic to expect similar outcomes and types of nurses. In a way, one could argue that conflict was bound to occur as seen among graduate nurses, although such nurses have not been so intensively studied as P2K nurses.

9.2.2 Extent of preparation for professional learning

The diplomates' lack of skills was clearly evident especially in the first part of the findings. This was perpetuated by the alienation of the traditional nurses which had caused these nurses a lot of anger in the early months of registered practice. The implication was that in this respect the P2K course
had failed them. Subsequently, both skills deficits and alienation subsided and the dichotomy between the P2K nurses and traditional nurses gradually disappeared. This seemed to have occurred towards the end of the first year when they had had a chance to demonstrate their capability to learn what was expected of them in order to function at the required level.

It was evident that these diplomates maintained their perception of professional learning as an on-going process. They demonstrated this when they discussed the extent to which the course had prepared them for professional learning. They also mentioned aspects of their approach to nursing care within which they felt professional learning takes place including being responsible and accountable for patient care, continuously questioning, reflecting on and evaluating their practice as well as initiating their own learning. Although the P2K course seemed to have initially failed them in terms of their skills deficit, they had benefited from the P2K course's approach to learning. This clearly implied a commitment which is reflected in the nurses' perception of CPL.

9.3 Methods of professional learning

The methods of professional learning that the diplomates had experienced during the study revealed a variety of learning strategies which illustrate a continued commitment to and responsibility for their own learning as advocated by the P2K curriculum. These were primarily linked to their identification of learning needs which the nurses identified independently especially during the early months of registered practice. They considered this activity to be on-going and of crucial importance in the planning of professional learning. This was demonstrated by the way they themselves spontaneously identified their learning needs during the course of their work. It was also evident that the nurses carefully planned and chose what and how to learn.
9.3.1 Identification of learning needs

During the initial post-qualification practice, occupational role identity was a main concern in the learning of the staff nurse role. Learning needs, therefore, were based on clinical skills they felt they lacked as staff nurses. They therefore developed those skills which they identified as the most important aspects of nursing. These included communicating with other members of the healthcare teams, management and safe nursing practice. It was evident at that time that the diplomates’ belief in their skills deficit influenced their self-concept which had resulted in a self-fulfilling prophecy. At that time the diplomates’ belief in their skills deficit influenced their self-concept and they felt that this was due to having been the first cohort of P2K nurses. Once they had settled into their staff nurse role their needs became more specialist orientated at higher and deeper level according to their responsibilities and the demands of their nursing grades and speciality. Thus, it appears that identification of learning needs were progressive and followed a linear process from the general to the specific during the two years of registered practice.

9.3.2 Learning through nursing practice

Learning through practice consisted of reflecting on practice and monitoring of performance. Besides the learning of skills on the wards there was evidence that the diplomates believed that professional learning takes place through on-going reflection on practice. This was quite a different process from gaining knowledge through textbooks. These nurses found that critical reflection on practice helped them to clarify the meaning of their nursing practice. Thus reflecting on performance facilitated and motivated the furthering of professional learning.
9.3.3 *Learning through mentorship/preceptorship system*

When those diplomates became involved themselves in mentoring student nurses and preceptoring newly qualified nurses, they learnt from this process. At that time the preceptorship system had not been fully established and this resulted in a lack of guidelines and minimal support from a named preceptor. Thus learning within this system was on an ad hoc basis with minimal structure and at the nurses request. This situation did not, however, last long because the preceptorship system coincided with the emergence of the first P2K staff nurses and it seemed that both newly qualified nurses and preceptors learnt the system at the same time.

9.3.4 *Peer support*

The diplomates' clearly distinguished peer support from P2K colleagues and that of other nurses on the wards. Peer support as a registered nurse was found to be similar to the kind of experience on the course. This support network was considered necessary and productive. The diplomates found that by meeting with their peers from college was a useful way of learning. There was thus evidence of continued peer support network outside work with nurses from the same cohort throughout the study. The diplomates' maintained this link because they found that such peer support helped them to learn from each other and motivated them to learn further.

Relationships with other nurses on the wards appeared somewhat tense especially in the initial months of registered practice and depended on certain identified attributes, such as being 'young, flexible and not long qualified'. The importance of clinical and peer support emerged from diplomates' own experiences of preceptorship, as newly qualified staff nurses which they viewed as professional learning during their initial stage of practice. Whilst clinical and peer support from other nurses on the wards was viewed as a
method of professional learning, it was difficult to achieve due to the conflict of interests found in clinical areas between the diplomates and traditional nurses.

Despite an improved relationship with the traditional nurses during the second year of registered practice, minimal clinical support was still evident on the wards. This was largely due to the traditional nurses failing to recognise the diplomates' needs for further learning which continued to be evident eighteen months after they had been qualified. Also the learning strategies used in the classroom clearly demonstrate that the course had fostered a self-directed approach to learning and had given these nurses the opportunity to become more effective in managing their own learning.

9.3.5 Participation in learning activities

These diplomates believed and demonstrated that participation in various learning activities was fundamental to professional learning and updating of skills and knowledge. It was evident that their learning of skills was on-going and mostly took place on the wards during their involvement with patients, by teaching others and sharing clinical information and by reading and discussing relevant nursing literature with others. They also attended work related study days, conferences and workshops. A lot of these methods reflected the ones in which these nurses had participated during the P2K course. However, these methods constituted the types of learning strategies which were referred to as 'learning as you go along' whilst the academic learning strategies involved attending short or long, clinically related courses where knowledge and/or skills can be learnt. Thus for these nurses, reflecting on their nursing practice also led them to identify, plan and participate in both academic and non-academic learning activities throughout the two years of study in keeping with their own notion of professional learning.
9.4 Factors influencing professional learning during registered practice

9.4.1 Adjustment to staff nurse role

This study portrays the experiences of a group of diplomates' professional learning which took place through the confrontation of a number of conflicts during their registered practice. These conflicts experienced by the diplomates were found within a series of adjustment phases, some of which were not anticipated and occurred during both the pre- and post-registration practice. A certain amount of conflict was to be expected since the diplomates had undertaken a new reformed nurse education which had a different philosophy from that of the traditional training. However, the findings suggest that conflict from various sources had an effect on the nurses' learning at various points of transitions from the time of entry to nursing.

Thus the P2K diplomates studied had to justify their staff nurse role identity which had developed into that of knowledgeable, autonomous and credible practitioners. This had resulted in incongruity between the diplomates' perceptions and expectations of professional learning and that of the traditional nurses.

A lack of role definition and expectations emerged from the role conflict and had implications in the professional learning of these diplomates in terms of determining priorities of educational needs and those aspects of the role which required further knowledge and appropriate skills and attitudes. Consequently, there were tensions between the new staff nurse role and the competences which these new aspiring professional diplomates were stressing, against the 'caring' and often ritualistic skills of those traditionally trained nurses. It seems that both P2K and traditional nurses need to recognise that the process of adjustment to the staff nurse role is one of the
influencing factors which has implications in the professional learning of newly qualified nurses. This aspect of professional learning could be included in the preceptorship and staff development programme for nurses.

However, the lack of congruence emanating from the previous learning experiences on the P2K course which these nurses brought to their professional learning situation in clinical practice did not always lead to conflict. There was evidence of new thinking which occurred accordingly and stimulated the development of the diplomates' roles within the P2K philosophy. Out of these conflicts, strategies for coping with the new staff nurse role emerged which allowed the role to change and become acceptable to others. In fact, in light of the increased knowledge which these nurses brought to nursing practice, the nursing role on the wards had already begun to change. Nurses were becoming more engaged in their professional learning and began to acknowledge the importance of continuing professional education. They were attending knowledge based courses in relation to their already acquired skills, for instance diploma and degree courses. They also seemed to demonstrate a better understanding of the P2K philosophy, were becoming more questioning and were asking for help from the P2K nurses, recognising and valuing the diplomates' knowledge.

9.4.2 Affective aspects of learning

It is evident in this study that no opportunities were given to explore and discuss the diplomates' conflicting values and problems of adjustments, especially during the initial months of registered practice. The reason for this could be that the affective aspect of learning was not recognised during the transitory phases of the staff nurse role which the diplomates experienced. Hence, in the planning of future courses consideration should be given to this essential aspect of learning which clearly has implications for curriculum development at both pre- and post-registration level.
Structured support systems, such as the promotion of peer support network similar to the one initiated by the diplomates in this study, could help the student, the newly qualified as well as the qualified and experienced nurse to cope and manage change in order to 'survive' the on-going challenging transitions that lie ahead of them. The deployment of a more systematic approach, essentially in practice settings, to assist and to address problems of adjustment from the point of entry and throughout the nurses' career is therefore recommended and is considered crucial when addressing the affective aspect of learning in the curriculum. Thus, in order to determine successful professional learning both the positive and negative influences, including the emotional responses that can affect nurses' readiness and willingness to learn, need to be taken into consideration throughout the education of nurses.

Additionally, on the basis of findings on the affective aspects of professional learning it can be argued that support networks are required and are related to the individual nurse's professional learning needs and development for specific transitions which occur in various professional circumstances. As the findings of this study indicated, a peer support group has the benefit of allowing the nurse to learn and reflect on their practice and monitor their clinical progress within the safety of their own colleagues. This process has also been referred to as peer evaluation, peer audit and peer review (Burnard 1988, Kenworthy and Nicklin 1989). Thus, in this study the diplomates used their peer support groups to address the cognitive as well as the affective aspects of their learning and these clearly empowered them to resolve their conflict of values and make a positive adaptation to their staff nurses' role.

9.4.3 Preceptorship system

Responsibilities for mentoring/preceptoring were not clear especially during the initial stage nor did the preceptors have the attitude and/or the skills to carry them out. There was also a failure to inform potential
mentors/preceptors of the course teaching/learning strategies and a lack of clinical staff's full involvement in curriculum planning which had an effect on the professional learning of these nurses. This omission resulted in the mentors/preceptors' inability to fully meet the learners' needs in clinical practice, hence a lack of continuity with classroom teaching/learning approach. However, if the aim of P2K was to influence future learning in practice, this gap between classroom and clinical teaching/learning, which is commonly described in the literature as 'theory-practice gap' (Alexander 1984, Melia 1987), as well as the lack of mentors and staff awareness, does have implications for the professional development of qualified nurses in the future.

Thus, it is crucial that all clinical nurses involved in the education of nurses should be fully informed of and understand changes in all aspects of the nursing curriculum including teaching/learning strategies as well as the course content. Systematic mentoring of student nurses and preceptoring of newly qualified nurses which have obvious implications for professional learning should also be provided with clear guidelines and role definitions.

A collaborative approach between educational and clinical staff could help to enhance the transition from student to staff nurse and the professional socialization process especially during the initial months of registered practice, thus decreasing the role conflict evident in this study. This approach would also help to address the emotional reactions of staff in an attempt to conquer the resistance to change from a profession which is seen as traditional in its outlook. From his examination of published work over a twenty year period, Orr (1990) found that the nursing profession is just as traditional to-day as it was in the 1960s and he concluded that perhaps the traditionalism of nursing is resistant to all major changes. Such findings obviously have had cause for concern in the development of nursing. However, P2K educational programmes seem to address this by producing
potential agents of change with the necessary skills to challenge traditional expectations of newly qualified nurses, which supports Maben and Macleod Clark's (1997) study.

9.5 The diplomates' professional learning development

Specific experiences of change and transitions which took place in the real world of nursing were clearly identified by these P2K diplomates during their registered practice. Various forms of transition are evident in this study's three main transition cycles as illustrated in Figure 8.1. It is, however, apparent that the external forces and events which had been considered in the model are various but they clearly impinge on the diplomates' professional learning process. These cycles, therefore, highlight the extent and nature of the nurses' vulnerability and resilience and the manner in which the diplomates coped with their professional learning development during their first two years of registered practice.

Although Nicholson's transition cycle is a process model designed primarily for management practice, taking such a transitions' perspective has demonstrated that it can restructure the thinking on the practice of nurse education and professional development. This study focused on the significant forms of transitions within specific events which occurred for the diplomates studied. Viewing the transitions as these diplomates had experienced them through time showed the manner by which the nature of their experiences had altered as they moved from the initial point of impact into more strategic and focused adjustments.

The identified process of professional learning identified in this study cannot automatically be generalised more widely. Individual learning characteristics such as the speed of development, self-motivation, individual learning choice and other external influencing factors should also be taken into consideration when interpreting and evaluating the conclusions of these findings.
However, this sequence of professional learning development in registered practice clearly illustrates a developmental process of learning (Table 4.11 in Chapter 4) which was developed throughout the course of the diplomates' experiences of nursing practice and the manner in which their conceptions of professional learning had gradually evolved during the two years of the study. They continuously gained practical experience which reflects their notion of the professional learning process for nurses, especially the type of practical learning which they considered could not be 'gained from textbooks'.

9.6 Plans for future professional learning

During this study the diplomates consistently provided specific, on-going professional development plans which included attending formal academic and clinically relevant courses and/or study days as well as informal learning activities. Additionally, they expected to continue with the learning of more advanced and specialist nursing skills as required by their nursing post. This was mentioned by all of them regardless of their nursing grades and whether they were employed full or part-time. Hence there is clear evidence that the diplomates studied were committed to continued professional learning. However, such commitment needs to be fostered by planners and managers of continuing professional education programmes, since these nurses would require the necessary support and facilities to maintain their notion of continuing professional learning which they considered an important part of nursing practice.

By the end of the second year of registered practice, nine out of the twelve diplomates who were still involved in the study had secured an 'E' grade post. Of the three 'D' grade nurses, only one of them was working part-time because he was on a full-time degree course. The diplomates' mobility and their intentions for their future professional development are summarised in Appendix F.
9.7 Further studies

The two main themes which emerged from the findings of this study and seemed to dominate the research were the impact of role transition on the P2K diplomates' professional learning and their developmental process of professional learning. Both of these themes have an impact on nurses' continued professional learning which in turn has implications for curriculum development. As no previous UK literature seemed to have addressed these areas specifically, it is appropriate to propose that further studies should be undertaken to illuminate these experiences of transition, especially during such a cumulative professional learning process, and their effects on nurses. The significant effects which should be considered here are those linked with the affective aspects emerging from professional learning.

Similarly, Orr (1990) implied such a need and called for the incorporation of comprehensive stress management programmes into the nursing curricula and the facilitation of interpersonal skills among nurses so that they feel confident about their professional role. Furthermore, Gregory (1994) suggested that nurses should learn to cope with their own vulnerability and psychosocial needs so as to be able to manage those of others and be competent role models for their junior nurses entering the profession as well as their patients.

A study of transitions which P2K nurses experience during their pre-registration course would also be valuable and relevant to professional learning since it is evident that professional learning commences upon entry to the nursing course. Previous studies have also supported this claim, notably the study carried out, over a decade ago, by Alexander (1984) who asserted that the beginning of learning to nurse has implications for continuing to learn to nurse. Furthermore, the P2K course philosophy clearly advocates a commitment to professional learning from the outset of the nurse's teaching and learning experience.
With regard to the developmental process of professional learning, it would be helpful to explore and ascertain whether any part of the process becomes cyclical after the two years of registered practice, for instance stages five to eight (see Table 4.11, Chapter 4). If nursing education is considered as an instrument of change in nursing practice, the insights gained from such a developmental professional learning process would be particularly useful for post-registration curriculum development.

Thus further studies in both the developmental transition phases and the process of professional learning would benefit not only curriculum developers but also clinical staff especially those involved in mentorship and preceptorship systems. Findings from such studies could also assist service managers whose awareness and evidence-base understanding of their staff's professional learning needs are crucial in the profession's pursuit of maintaining efficient and effective quality nursing care delivery. There is no doubt that clinical staff are becoming increasingly involved and equally responsible in the education of nurses to face the reality of nursing.

9.8 Reflections on the research

This section of the concluding chapter adopts a reflexive stance on the research process. The discussion demonstrates how this research could be improved, extended or illuminated from another angle. It also describes the study's limitations and some of the problems I encountered in conducting this qualitative, longitudinal study. In addition, the professional and personal development which occurred whilst undertaking this research is discussed. This reflective process raised my awareness about the extent of my own professional learning which took place during the course of the study.

Reinharz (1979:24) argued that "since knowledge is situated in particular contexts, researchers must discover their own role imbeddedness". The open reporting of the research process from which knowledge could be
produced on three levels:
* the researcher as a person;
* the problem studied
* the method used in the research process.

Thus, this section exposes my research experience and reflects on the actual dynamics of the research process. Denzin (1970:7) maintained that 'an investigation seldom runs to entirely successful completion' and this study is no exception.

9.8.1 Research design and approach

Reflection took place at various stages during the process of this research and I addressed the issues accordingly. Thus, the issues raised here are primarily derived from my initial decisions about the research approach and those which emerged from the later stage of the study, from the discussion of the findings onwards. However, a review of the research approach that I used suggests that adopting a naturalistic design does fit in with the nature of my study which was to establish an understanding of continued professional learning of a group of P2K diplomates. I feel that the proposed aim and its objectives, as stated in Chapter one, have been achieved and the research questions addressed accordingly, during the development of the research.

During the planning stage, my decision about the two year duration of data collection for the study was somewhat arbitrary and on reflection this seemed to have been largely based on, and influenced by, the time constraint. However, as the study progressed I became aware that a maximum of two post-qualification years as a cutting off point for data collection is in keeping with Benner's (1984) definition of a competent nurse. According to Benner, competent nurses are those with two years experience in registered practice. She maintained that it is a time when those nurses are able to take more responsibility, are more likely to recognise changing situations and have more
confidence in their decisions which in essence is reflected in the last stage of the diplomats' professional learning as discussed in Chapter eight (Section 8.3.4.1). I therefore feel that the duration of data collection was adequate to ascertain these diplomats' continued professional learning.

### 9.8.2 Sources and nature of the data

At the inception of the study I was tempted to compare the diplomats' post-qualification professional learning with that of traditional nurses. I then decided that it would be more beneficial and illuminating to concentrate on gaining an understanding of these P2K diplomats whose learning of nursing was within a completely different reformed course and curriculum philosophy. Furthermore, no similar literature seemed to exist about the topic of this research. After the study had begun when I found some theoretical ideas from other studies on the P2K course and views of P2K-educated nurses who had qualified, for instance, Jowett et al (1994), Maben and Macleod Clark (1997).

However, there is evidence which suggests that some of these professional learning experiences were not exclusive to P2K nurses. For instance Lathlean (1987) found that newly qualified nurses from the traditional courses also experienced lack of management skills and there are also other studies of non-P2K nurses such as Wakefield et al (1988) and Bradby (1990) which addressed the problems of the transition from student to staff nurse.

At the planning stage of the study, I thought that the three identified sources of data collection were adequate to answer the research question. Towards the end of data collection and increasingly during the analysis of the data and the discussion of the findings, I realised that it might have been helpful if the interviews had been extended to a small number of the mentors/preceptors who were closely related to those diplomats. This would have been useful to further justify the other sources of my data.
This study gives an account of what the diplomates said they did and what happened during their experience of P2K and the two years of professional learning, but this may not necessarily reflect all that they actually did and everything that occurred at the time. Thus, the added data could have provided another dimension to the research and helped me to check further the extent of the 'authenticity' of the diplomates' as well as the lecturers' data. However, the time constraint did not allow negotiating and gaining access to clinical staff for such authentication to take place.

Moreover, given the evidence in this study of the powerful influence that the ward managers exert over their environment in terms of control over course attendance, together with the emerging conflicts and the seemingly apprenticeship model that existed on the wards, mentors/preceptors' data could have been gained to assess and confirm these situations.

I also feel that it would have been useful to have asked these diplomates about their perception of nursing prior to entry to the P2K course and at the time of qualification. This would have helped to ascertain whether a change of perception had an effect on the diplomates' transitions from lay person to professional nurse. I could have, therefore, explored the diplomates' pre-P2K course perception of nursing and their rationale for undertaking a nursing course in more depth and compared between a lay person's and a professional's perception following the nurses' experience of the course and professional learning in nursing. Although I recognise that these nurses' perception of nursing were expressed to some extent and made explicit during the initial interviews about their experience of the course, such data could have added more strength to my arguments in respect of the interpretations of findings about the P2K course influence on the nurses' notion of the nature of nursing and professional learning once qualified.
9.8.3 Methods of data collection

The data I collected for the study relied primarily on in-depth interviews since the aim of the research was to understand the diplomates' own perspectives through their perceptions and own views about their experience of the course and professional learning. Thus the knowledge which emerged from this research is gained from the experiences, the active engagement and involvement of both myself and the participants rather than from decontextualized verbal behaviours or observed activities which are measured and counted. My interpretations of the findings which included the affective aspects of professional learning conveys immersion in a context-specific study without any manipulation of the environment. It can thus be argued that personal experiences can be authentic and replicable when these are described in sufficient detail and justified in a manner which is related to what could have been observed. In his writings Reinharz (1979:259) cites Mao Tse-tung's (1954:282) statement when he asserted that:

"whoever wants to know a thing has no way of doing so except by coming into contact with it. All genuine knowledge originates in direct experience".

However, despite the qualitative nature of the inquiry it was not practical to observe the nurses so as to check on what they reported in the interviews about their professional learning. The authenticity of the responses were, nevertheless, justified and confirmed by the examples given. This area of concern was identified during the initial planning stage of the research process and I attempted to address this by asking the participants to keep an account of their professional learning. I had to abandon this request at the analysis stage because, despite frequent reminders throughout data collection, only two participants had actually kept their diaries. I therefore felt that it would be unethical to coerce the other participants to produce these diaries which some did not feel were important.
With regard to documents as sources of data collection, I am aware that sometimes these could be incomplete and inaccurate. In this study, there was evidence that the curriculum had to be reviewed and adapted from its original version according to the on-going feedback from the nurses about their learning needs and their evaluation at various stages of the course. There were also incidences whereby the original time-tables did not always reflect what was actually taught in the classroom.

9.8.4 External influencing factors

Reflection on this study also led me to question whether there were possible external factors which could have influenced the findings of this research. The P2K course had caused much controversy from its conception in 1986. This was apparent in some of the negative views which were expressed at the time in the nursing media. There is substantial evidence to support this claim (see for example Crabbe 1989, Nursing Times 1990, Orr 1990, Rogers 1991, Gilbert 1993, Hayward 1994, Payne 1994). Thus evidence of alienation and labelling as found in this study might have been partly instigated by these negative messages. Such negative views can still be found in more recent articles on nursing. For instance, Munro (1999) who discusses a DoH funded study report which questions newly qualified nurses' basic education in relation to their level of practical skills.

I also addressed the effect of the diplomates' participation in the study and PREP on their professional learning. At the end of the last set of interviews I asked the diplomates for their views about participating in the research in order to establish whether they felt this had influenced their continued professional learning in any way. These nurses claimed that they would have achieved and followed a similar professional development path regardless of whether they participated or not. There was a consensus of opinion that participation in the study helped and gave them the opportunity to reflect on their professional development but did not necessarily influence it.
They saw it as personal and professional growth through participation rather than being dictated by the demands of the study. Joe, Liz and Anne's responses typify the participants' views about the effect of their participation in my research:

"It was good because no one comes to see you and ask you how you're getting on professionally".

"I wouldn't say that (participation in the study) has made me do more. I suppose by reflecting with you made me realise that I have actually progressed".

"I enjoyed somebody asking me questions about me for a change; asking me how I'm getting on and what I've learnt and about my professional development".

These responses therefore indicate that the way in which the diplomates' developed professionally seemed to have been as a result of their strongly held beliefs and notions of professional learning in nursing. However, they all felt quite optimistic about a progressive nursing system within a reformed educational programme such as theirs. From their involvement in registered practice, these diplomates had observed that the advent of Project 2000 and the UKCC mandatory Post Registration Education and Practice were beginning to influence the traditional nurses who were addressing their own continuing professional education by updating their nursing competencies and keeping abreast of developments in nursing.

9.9 Conclusion

To conclude this qualitative study, which aimed to address the continued professional learning of a small group of P2K diplomates during their first two years of registered practice, provided an insight in the nature of P2K nurses' professional learning as they experienced it. It was evident that the P2K nurses' ideology of nursing was incongruous with that of traditional nurses who were from a different educational background. The diplomates' values and beliefs about the nature of nursing did not match those of the
organisational culture of nursing from the time they were exposed to nursing practice. Thus, the primary goal of the study was to illuminate the meaning and process of post-registration professional learning to be in a position to theoretically, rather than statistically, generalise.

The relevance and significance of the diplomates' experience of the P2K course and their registered practice reflected the link between their pre- and post-registration professional learning. This was demonstrated by the extent to which the P2K course equipped the nurses for CPL and the nurse educators' perspectives in their contribution to the post-registration learning of P2K nurses.

Additionally, the diplomates' perception and commitment to CPL could be found in the manner in which they chose, planned, organised and participated in their professional learning during their registered practice. These nurses clearly took control of their own CPL mainly through skills development. Hence, their on-going conceptualisation of professional learning can be identified in the developmental process of their CPL during the two years of the study.
REFERENCES


363


Department of Health (1989b) *Caring for People: Community Care in the Next Decade and Beyond*. HMSO: London


370


Judge, H. (1985) The Education of Nurses; A New Dispensation. A report of the Royal College of Nursing Commission on Nursing Education. Royal College of Nursing: London


374


376


Munro, R. (1999) Mental Health education accused of losing touch. *Nursing Times*, 95 (9): 10


Nightingale, F. (1859) *Notes on Nursing: What it is and what it is not.* Harrison: London


Orem, D.E. (1956) *Hospital nursing service: an analysis*. Division of Hospital and Institutional Services, Indiana State Board of Health, Indianapolis


378


Platt Report - Royal College of Nursing, Committee on Nurse Education: (1964) *A Reform of Nursing Education.* RCN: London.


Robinson, J., Rex, S. and Boorman, L. (1992) *Exploring the potential impact of Project 2000 on local staff nurse development: A collaborative research project*. The Suffolk & Great Yarmouth College in partnership with the Suffolk College: Nursing and Health Care research Unit: Ipswich, Suffolk.


Salvage, J. (1999) Nursing education should be as much about self-development as about fact-cramming. *Nursing Times*, 95 (9): 22


UKCC (1996) *Prep: putting the record straight*. UKCC Register, 18: 6-7


Welch, M. (1986) Nineteenth-Century philosophic influences on Nightingale’s concept of person. 1: 3-12 (No.2)


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APPENDIX A
DETAILS OF PARTICIPANTS’ WORKPLACE

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
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<tbody>
<tr>
<td>‘Adam’</td>
<td>Mixed medical ward</td>
</tr>
<tr>
<td>‘Angie’</td>
<td>Female medical ward</td>
</tr>
<tr>
<td>‘Anne’</td>
<td>Male surgical ward</td>
</tr>
<tr>
<td>‘Claire’</td>
<td>Acute admission was for adults with Mental Health problems</td>
</tr>
<tr>
<td>‘David’</td>
<td>Psychiatric Day Hospital</td>
</tr>
<tr>
<td>‘Donna’</td>
<td>Acute admission was for adults with Mental Health problems</td>
</tr>
<tr>
<td>‘Jeanne’</td>
<td>Pre-discharge mixed medical unit</td>
</tr>
<tr>
<td>‘Joe’</td>
<td>Mixed surgical ward</td>
</tr>
<tr>
<td>‘John’</td>
<td>Coronary care unit</td>
</tr>
<tr>
<td>‘June’</td>
<td>Acute male medical ward</td>
</tr>
<tr>
<td>‘Liz’</td>
<td>Acute male medical ward</td>
</tr>
<tr>
<td>‘Maureen’</td>
<td>Mixed surgical ward</td>
</tr>
<tr>
<td>‘Sarah’</td>
<td>Acute male medical ward</td>
</tr>
<tr>
<td>‘Sinead’</td>
<td>Female medical ward</td>
</tr>
<tr>
<td>‘Teresa’</td>
<td>Child and adolescent psychiatric unit</td>
</tr>
<tr>
<td>‘Tommy’</td>
<td>Male medical ward</td>
</tr>
</tbody>
</table>
APPENDIX B
ATTRITION HISTORY

In this study, after the initial individual interviews two of the sixteen participants, Grace and Jason, failed to respond to attempts which were being made to arrange for the second interview. Another two of the remaining fourteen, Jimmy and Lorraine, did not have a third and fourth interview respectively. The actions taken on each occasion and the outcomes were as follows:

Grace: Three messages were left on her answer machine at a weekly interval and a Christmas card was sent at her home address. Outcome: A message of acknowledgement was received through another participant with a promise of making time for the pending interview. Grace claimed to be still interested in participating but she was extremely busy with her work and family life. No further contact was made.

Jason: Personal telephone conversations took place on two occasions. Both requested a delay in the interview because of problems at work and within the family respectively. However, it was mutually agreed that he was to make contact when he felt ready to be interviewed. Outcome: A month later he came to see the researcher and an interviewing appointment was duly arranged but this was cancelled on the morning of the interview. A further attempt to arrange another interview proved unsuccessful.

Jimmy: When the third interview was due, a telephone contact revealed a sudden move out of the area with no forwarding address or telephone number. A letter which was sent to the next of kin’s address was forwarded to the new address. A message through another participant was received to acknowledge receipt of the letter and a telephone contact number was given. This was followed by a personal telephone conversation. Jimmy was willing to arrange for an interview appointment when he had planned to visit his next
of kin the following month. **Outcome:** A message was received some six weeks later through another participant who indicated that the visit did not take place and that he was in the process of changing his job once again. No further contact took place.

**Lorraine:** During the third interview the data collected revealed plans to move abroad in the near future but it was not likely to take place before the last interview. Lorraine was reminded of the change of address card in the event of a move. An in-between interview telephone contact revealed a vacation abroad. When the fourth interview was due it was not possible to contact her since she resigned on her return from her holiday without notification of a forwarding address. A letter and a Christmas card were addressed to the next of kin who acknowledged forwarding them to the new address. **Outcome:** No response received and no attempt of further contact was made.
APPENDIX C

DIPLOMATES' SECOND INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS

ATTITUDES OF P2K NURSES TOWARDS PROFESSIONAL LEARNING

P2K course influenced independent, self-directed professional learning. Professional learning perceived as a continuous learning process due to the need to further learn & develop nursing skills and update them in order to cope with the ongoing changes in nursing practice.

LEARNING TO COPE WITH STAFF NURSE ROLE

Staff nurse identity seemed to have been an area of concern in the learning of staff nurse role. Lack of managerial & specialist experiences hindered them to cope adequately during the initial months of registered practice which led to the feeling of vulnerability. Learning to cope therefore involved acquiring those skill deficits. Adjustment to s/n role was a gradual process. Basic skills and knowledge acquired on the course helped further learning and to clarify meaning of clinical practice. P2K nurses' conception of nursing care caused some conflict with other nurses on the ward, especially when started to be in charge of the wards or a group of patients and began to question their practice and that of others. Various coping strategies were applied to deal with conflict of interests on the wards in a non-confrontative manner. The preceptorship system seemed to have worked quite well despite the lack of guidelines during the initial stage. The importance of self-initiated clinical support emerged from their preceptorship experiences. Peer group support meetings outside work were found to be a useful way to learn unconditionally, whilst the relationship with other nurses on the wards depended on certain identified personal attributes. Being labelled P2K staff nurses was a sensitive issue which was addressed by demonstrating their capability to learn what was expected of them in order to function at the required level.
APPENDIX C -Continued

METHODS OF PROFESSIONAL LEARNING

Ongoing learning needs were spontaneously identified during the course of their work. Formal learning strategies consisted of attendance to short and/or long courses (and study days) whilst informal learning strategies were those learning activities which involved the on-going learning of clinically based skills on the wards. Sharing of clinical information was another identified method of informal learning which contributed to improved relationship with traditional nurses. Decisions about professional learning which included clinical supervision was mainly self-initiated, although most of the courses and study days were mandatory, but self-initiated.

APPROACH TO NURSING CARE

Participants’ approach to nursing care created conflict on the wards due to disparity of outlook between P2K nurses and traditional nurses. P2K nurses approached nursing care by questioning their practice which meant maintaining an understanding and applying theoretically based knowledge underpinning nursing care; by self-assessing performance and critically evaluating nursing practice; by ensuring patients’ safety and by being responsible and accountable for patient care. All these approaches were viewed as important aspects of nursing within which professional learning takes place.

FACTORS INFLUENCING PROFESSIONAL LEARNING

Learning opportunities to practice on the wards and to attend relevant courses were identified as enhancing factors influencing their professional learning. Whilst lack of opportunities to attend relevant clinical courses and difficulties to get time off work were identified as hindering factors.
APPENDIX C - Continued

PROFESSIONAL DEVELOPMENT STATUS

Despite being aware of professional development plan some felt uncertain about the future and this was described as being at a 'cross-road' or being in a dilemma (whilst those promoted to a higher nursing grade seemed more confident and positive). Professional development planning consisted of attending formal, clinically relevant courses/study days and informal learning activities to meet the demands of their present and future employers. Some had already started to keep a record of their learning activities whilst others were in the process of doing so.
<table>
<thead>
<tr>
<th>LEARNING EXPERIENCE (Recurrent Themes)</th>
<th>NOTION OF PROFESSIONAL LEARNING (Emerging Concepts)</th>
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<tbody>
<tr>
<td>Attitudes of P2K nurses towards professional learning</td>
<td>Dynamic learning process</td>
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<td>Learning to cope with staff nurse role</td>
<td>Self-directed learning</td>
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<td>Methods of professional learning</td>
<td>Conflict of interest on the wards</td>
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<td>Gradual adjustment period</td>
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<td>Self occupational identity</td>
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<td>Feeling vulnerable</td>
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<td>Peer group support</td>
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<td>Catching up with traditional nurses</td>
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<td>Approach to nursing care</td>
<td>On-going learning needs</td>
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<td>Formal and informal studies</td>
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<td>Self-initiated learning</td>
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<td>Conflict of interest</td>
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<td>Reflective practice</td>
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<td>Safe practice</td>
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<td>Responsibility and accountability for patient care</td>
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</tbody>
</table>
### Factors influencing professional learning

- Learning opportunities to practice
- Opportunities to develop knowledge and skills

### Professional development status

- Status at 'cross-road'
- Uncertainty about the future
- Emphasis on clinical knowledge and skills
DIPLOMATES' THIRD INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS

PROJECT 2000 NURSES' PERCEPTION OF PROFESSIONAL DEVELOPMENT
An ongoing process of developing oneself professionally identified. A need & requirement to continuously learn new skills and knowledge & update them for the benefit of patients and enhancement of the nursing profession. Process involved learning of skills in clinical settings; attending relevant clinically-based courses; readings books and nursing journals. Whilst knowledge was seen to be gained through doing academic courses. Other dimensions were the development of nurse's role within the healthcare team and learning taking place at various level of a nurse's career.

PROFESSIONAL LEARNING IN CLINICAL SETTINGS
Always something new to learn on the wards due to different types of patients and new clinical procedures. Influencing factors identified for choice/rationale for further learning: needed to build on basic skills and learn specialist skills at higher & deeper level; specific skills & knowledge required for career progression; periodical & mandatory updating and greater demands from the whole of the MTD healthcare team. Dichotomy between P2K nurses and traditional nurses seemed to gradually disappear. Felt able to make valuable clinical contribution and dependence of other nurses evident. Minimal clinical support on the wards despite an improved relationship. Continued to maintain peer support network outside work with nurses from same cohort which motivated them to learn further. Influencing factors for professional learning in clinical settings: senior nurses failing to recognize P2K nurses' needs for further learning; having to cope with rituals & routines considered an hindrance unless addressed proactively and lastly maintaining safe practice perceived as a continuous learning process due to accountability & responsibility for patient care.

MONITORING OF CLINICAL PERFORMANCE
Recognition of value of clinical monitoring when planning further learning. Assumption that positive outcome of performance meant function satisfactorily. Ward manager generally responsible for clinical monitoring (only for course attendance and updating) otherwise the ways used to monitor clinical performances were by IPR, informal feedback from others; self-initiated monitoring and reflection on clinical practice. IPR was not skill specific; feedback considered essential in clinical learning but a lack of regular, individualistic and specific feedback which led to self-initiated monitoring & reflecting on clinical practice (involving a self-evaluation & a way of learning from past experiences & clinical supervision) to establish level of clinical performance. Self-initiated monitoring also identified to be due laissez-faire nursing culture. Added clinical experience had increased participants' self-confidence.
DIPLOMATES' THIRD INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS - (CONTINUED)

METHODS OF PROFESSIONAL LEARNING AND UPDATING
Learning and updating fundamental to professional development and involved participation in various learning activities. Learning of skills took place: on wards; attending clinically-based courses & reading nursing literature. Knowledge acquired from academic courses such as a degree. Self-directed approach evident. Learning in practice setting involves: by practising; through informal teaching and collaboration as well as students/newly qualified nurses in the mentorship & preceptorship system.

PROFESSIONAL DEVELOPMENT STATUS
Clinical expertise perceived to be on par with traditional nurses of similar grades. Period of unrest experienced having reached saturation point' due to not much learning taking place. Lack of learning opportunities to attend relevant courses but all had attended clinically-based, mandatory courses. Course attendance under control of ward manager. Specific, on-going professional development plan evident.
A THEMATIC CONCEPTUAL FRAMEWORK: P2K DIPLOMATES’ NOTION OF PROFESSIONAL LEARNING: THIRD INTERVIEW

<table>
<thead>
<tr>
<th>Learning Experience (recurrent themes)</th>
<th>Notion of professional learning (emerging concepts)</th>
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<tr>
<td>Perception of professional development</td>
<td>On-going need and requirement</td>
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<td>Individual responsibility</td>
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<td>Benefits for patient care</td>
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<td>Career progression</td>
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<td>Enhancement of nursing profession</td>
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<td>Skills learnt in clinical settings</td>
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<td>Application of academic knowledge</td>
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<td>Role development within healthcare system</td>
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<td>Professional learning in clinical settings</td>
<td>Rationale for further learning</td>
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<td>Clinical support</td>
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<td>Basic and specialist skills</td>
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<td>Dependence of others</td>
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<td>Lack of recognition for further learning by others</td>
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<td></td>
<td>Coping with rituals and routines (conflict of interest)</td>
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<td>Safe practice</td>
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<td>Clinical development</td>
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DIPLOMATES' FOURTH INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS

PERCEPTION OF PROFESSIONAL DEVELOPMENT
Development expressed as development of knowledge, skills and attitude. Professional development means an on-going process which is responsibility of every nurse at various stages of her nursing career. It can thus be at different level.

EXPERIENCE OF PROFESSIONAL DEVELOPMENT
Initially the emphasis was on clinical skills which were felt to be lacking. The belief of skills deficit influenced self-concept resulting in self-fulfilling prophecy due to being the first cohort of P2k nurses. Once basic skills were consolidated and self-confidence had increased in the staff nurses' role, progress towards more specialist, technical and managerial skills took place. A period of reflection and a pause at the end of the first year was also experienced followed by more focused and in-depth professional learning. Strong belief that Professional development is essentially through on-going reflection on practice which could not be gained by, just reading textbooks. A change of speciality and grade were also seen as part of professional development. Development was through continuous practice and learning of skills on the wards as well as attending short and/or long-term clinical courses, keeping updated through reading relevant work-related literature. Learning needs were developed through what was expected to be learnt at work of which communication, management and safe nursing practice were identified as the most important aspects of nursing. Commitment to professional development was demonstrated by self-directed formal &/or informal learning. Self-reflection on performance facilitated and motivated learning. Feeling of responsibility for own professional development. Lack of feedback, guidance, direction, encouragement and support from others on the wards were also contributive factors to self-directed learning. Professional development was based on personal judgement of clinical performance and instincts.

RATIONALE FOR CONTINUED PROFESSIONAL LEARNING
Three main sources of rationale were identified. Expectations of the self, of the employing organization and of the Profession. Learning was thus expected all the time; a certain amount of skills and knowledge were expected of them from their employers according to their grade and speciality and the dynamic nature of nursing as well as the nursing professional code of conduct which also requires nurses to keep updated with relevant skills and knowledge which should be reflected in nursing care.
DIPLOMATES' FOURTH INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS - (CONTINUED)

FACTORS INFLUENCING PROFESSIONAL LEARNING

Six positive and negative factors were clearly identified. 1. Personal perception of the on-going nature of professional development. 2. Lack of challenge: boredom and repetitiveness of the job & feeling of non-progression having reached a peak. 3. Nursing grade: some skills were grade related. Higher nursing grade or the wish to develop skills at higher level: continued professional learning was according to career paths to some extent. 4. Access to courses: knowing how and what relevant courses were important. Not always possible to attend self-identified courses and would do what was available. 5. Attitude of the ward manager determines learning opportunities such as attendance to courses. 6. Type of ward: on-going changes e.g. new procedures, techniques and types of patients as well as being given the opportunity to manage the ward.

STAGE OF PROFESSIONAL DEVELOPMENT AND PLANS

Current grade: four D' grades & seven E' grades. Two applying for F' grades. Professional learning activities consisted of continuously attending work-related courses as well as attendance to study days, conferences and workshops. Increased confidence was due to advanced skills and added knowledge in aspects of nursing gained during the two years of practice. Reported feelings of security and adjustment in staff nurses' role. Increased capability as mentors and preceptors was also reported. Expectation to continue with professional learning of more advanced and specialist skills mentioned regardless of grades and whether employed full or part-time.
APPENDIX D

LECTURERS INDIVIDUAL INTERVIEWS: SUMMARY OF FINDINGS

PERCEPTION OF P2K COURSE COURSE
P2k aimed to prepare nurses to gain 'one specialist qualification in all clinical settings i.e. hospital & community to meet the demands of nursing in the year 2000 & beyond'. To provide the nurse with 'an holistic, knowledge-based view of nursing care'. A 'knowledgeable practitioner' with the 'ability to challenge nursing practice in an informed manner'. The 'patient will eventually benefit from safe, up to date nursing' practice. Implications of the aim were identified at four different transitional stages of the course implementation. 1. At the time of commencing the course (Pre-conceived idea of practical aspect of nursing versus academic status). 2. Transition from CFP in to the branch programme. 3. Half way through the branch programme. 4. The passage from student nurse to becoming a stall nurse.

OUTCOMES OF P2K COURSE
Main area of concern: conflict of interests between reformed nurse education philosophy and that of the NHS Trusts. (i.e. Knowledgeable nurse practitioners vs skill-based nurses). (P2K philosophy did not match Trusts requirements). Consequently, the course had to be adapted in an attempt to address identified skills deficits. Clinical performance of P2K nurses revealed positive outcome of the course. Nurses observed on the wards to be reflective, critical, questioning of nursing practice and self-directed in their professional learning.

PERCEPTION OF PROFESSIONAL DEVELOPMENT
Continuous learning process of professional development identified. Professional development seen as part of the course & as one of the functions of being a qualified nurse which entails responsibility for own professional learning. It was gradually introduced throughout the course & evolved from the classroom through reflection on clinical practice. Personal resources seen as essential to develop professionally. In class professional development was fostered through concept of professionalism. Structured classroom sessions on professional development organization and use of reflective journals & learning contracts facilitated preparation for professional development.
PROMOTION OF PROFESSIONAL LEARNING
Facilitation of professional development consisted of students being made responsible for own learning in the classroom & clinical practice. In order to promote responsibility of learning, individual learning needs met by the flexibility of the curriculum reflected in the time-tables. Students' responsibilities for own learning in the classroom also achieved by lecturers' own attitudes, acting as role models as well as expectations of students to address own identified deficits. Immediate benefits of self-directed, guided learning activities not appreciated by students during the course. In clinical settings, students responsibility to achieve specific learning outcomes. Teaching strategies included a two-way process of continuous reflection on clinical practice in the classroom through ward-based case studies and in clinical settings reflection on theory learnt, in classroom. Gap between classroom and clinical teaching identified due to mentors' lack of awareness of the way nurses were being taught in class. An adult approach to the education of nurses identified. The aim was for nurses to become self-directed, critical and independent learners which meant, the initiation and pursuit of own learning in order to promote on-going professional learning in the future.
THEMATIC CONCEPTUAL FRAMEWORK: Nursing educators' contribution to the professional learning of P2K nurses

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<tr>
<th>(Recurring Themes)</th>
<th>(Emerging Concepts)</th>
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<td>Perception of P2K course:</td>
<td>Holistic care</td>
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<td>Knowledgeable practitioner</td>
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<td>Patients' safety</td>
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<td>Transitional stages</td>
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<td>Outcomes of P2K course:</td>
<td>Conflict of interests (P2K vs NHS Reforms)</td>
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<td>Reflective practice</td>
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<td>Analytical critical practice</td>
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<td>Skills deficit</td>
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<td>Self-directedness</td>
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<td>Perception of Professional Development:</td>
<td>Continuous learning process</td>
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<td>Reflective clinical practice</td>
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<td>Responsibility of individual learning</td>
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<td>Personal resources</td>
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<td>Promotion of Professional Learning:</td>
<td>Individual learning responsibility</td>
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<td>Flexibility of the curriculum</td>
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<td>Lecturers' positive attitudes</td>
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<td>Continuous reflection (on clinical practice)</td>
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<td>Self-directed and critical learning</td>
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<td>Lack of (mentors') awareness of P2K</td>
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<td>teaching/learning strategies</td>
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# APPENDIX F

## INFORMAL LEARNING ACTIVITIES AND METHODS OF PROFESSIONAL LEARNING

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<tr>
<th>Activities</th>
<th>Methods of learning used</th>
<th>Illustration</th>
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<tr>
<td>1. Reading; finding out for self</td>
<td>Public &amp; Hospital libraries: books, journals; literature search(CD-ROM)</td>
<td>I use the library quite extensively to borrow books to read, look up references and to use the on-line computer. Sometimes, there are things that I would see on the ward or that I would hear about and don't know enough about them, so I would want to check them out, then I would read up about them. Besides the Trust's library, I use public libraries which have been helpful. If I find a good piece of research, I'll read it for myself and for my own benefit and if this helps on the ward and anybody else, I just share it. I have a few of my own books but then again it's good to use libraries and there is plenty of information in journals, they are more up to date than books.</td>
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<td>2. Practical skills</td>
<td>Observation, Making use of mentors, Questioning peers, Practising on the ward with patients</td>
<td>Practical things that you can actually observe and see how it's done. I like to learn that way. I'd use mentors for practical things; to learn how to deal with unfamiliar situations. Sometimes I would meet others, from my set, after work and we'll quiz each each other. That way is best. You need to be on the ward to learn, to be with the</td>
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You are busy, you are on your feet, you learn as you go along, you pick more things by practising. If you are given guidance from other student nurses you pick up a lot as you go along with the background knowledge from the course.

Asking the 'right' person

By finding out who on the ward is motivated to teach, share their clinical knowledge and who is not going to be negative about us (P2K) and you approach that person. You just have to ask the right person, someone approachable.

Observing & practising

Actually, I learn by seeing, especially if you are looking at skills, by observing then doing it myself, practice myself, just observation won't do any good, I have to practice myself.

Seeing the patient

I do learn better when I see the patient, whatever the condition might be, then looking up what the problems are and being able to visualize that.

Listening, observing & doing

I learn probably just from listening to people on the ward, observing someone doing it and then doing it myself. This is probably my best learning style.

Linking theory to practice

I learn more by putting theory into practice, especially understanding, theories like psychology, sociology, physiology. When I do something on the ward, I know what I'm doing all the time and why I'm doing it.
<table>
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<th>Using policy/procedure</th>
<th>If it's a policy or procedure, I'll look it up in the relevant document.</th>
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<tr>
<td>Questioning self</td>
<td>Gradually feeling ok about what you're doing and asking yourself. What could I have done better? What other method could I use? What was good about to-day?</td>
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<td>Trial &amp; Error</td>
<td>Quite often I learn through my mistakes. I think, more than anything else and even though on the wards because we have to do things on our own, you just learn from your own mistakes. You just know that in the future not to do it that way.</td>
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<td>3. Specific Ward</td>
<td>I make use of libraries, of a lot of people, professionals, I ask questions. On the ward if there's issues/situations something that's bothering me e.g. certain drugs, treatment, I try to analyse it on my own first, then I'd ask a member of staff and if it's still puzzling, I go and look it up, to confirm what they've said, then I'm sure what I've learnt is the right way to use it in my practice</td>
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<td>Use of Libraries, ask professionals and read for self</td>
<td>I also find TV, videos useful ways to learn. If I can see it in front of me it's better for me and then I would have discussions with other people. I learn through books but the main way is through talking to people if I didn't understand something.</td>
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<td>TV programmes, videos followed by discussion Talking and listening to people</td>
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## APPENDIX E - (Continuation)

| 4. Ward-based teaching sessions | Asking for explanations | If I listen then I can remember more than reading, really I think I take things in better, verbally. Things that you come across and you are not sure about.
| 1 : 1 demonstration | Teaching others | I would ask someone to explain it to me.
| 5. Group learning | Reading and reflecting on real work situations | On the ward, with some practical skills, it's much nicer, easier to learn on a 1:1 basis, for somebody to show you.
| 6. Group Sessions on the Ward | Group discussions, shared learning and participation | By doing a little teaching session, by way of teaching others, I learn myself by doing the background reading on, for instance, wound care, the research that's available on the subject.
I do like learning with others sometimes. I would learn with my friends. We would read something, interpret it and simplify it, or like the incident I just told you, it would be a good idea that I look it up with friends and say 'oh yes, that was right'; I wished I had said that and how I would have said it. I like someone to question me after I've read something, done something for the first time to see if I've learnt it and if I still remember it.
If it's a group session, I will get something out of it but I still need to go back and go over some of it myself
Normally, I work alone but sometimes I find that in some situations, group discussion is better.
APPENDIX E - (Continued)

7. Theoretical issues
   Alone, discuss with another
   Listening, making notes and reflecting

8. Miscellaneous learning activities
   Attending a specialist meeting
   Clinical supervision

Discussing things on the ward with others you learn about their ideas, their ways of doing things and you can share your opinion as well. You learn a lot more when you participate in group discussion.

If it's theoretical learning, I have to be alone and gather all the information, then I decide whether I want to discuss with somebody else or whatever.

You can learn by listening, by making notes, something you can reflect on when you are at home and clarify things for yourself. When you are on the ward something might not make sense and when you look at it again, later on, it becomes much clearer.

I'm the wound care link nurse for the ward. I attend monthly meetings and there is a lot of sharing of information that takes place there.

If I'm doing a counselling session I would just go and explain it to my mentor before and after the session - I get feedback and I learn from it.
SUMMARY OF P2K DIPLOMATES STATUS AND PROFESSIONAL MOBILITY AT THE END OF TWO YEARS OF REGISTERED PRACTICE

By the end of their second year of registered practice the eleven diplomates, who were still involved in the study, except three, had secured a 'E' grade. Out of these three 'D' grade nurses, only one of them was working part-time because he was on a full-time degree course. The diplomates' mobility and their intentions for their future professional development are summarized here:

'Adam' was working in the same hospital and he was going to apply for an 'E' grade on completion of his degree.

'Liz' remained on the same ward and she was consolidating her management skills further.

'Sarah' was concentrating on technical, specialist nursing skills on the same ward.

'Anne' had recently moved to a different speciality and she was going through settling in period and learning new skills.

'David' moved to a community setting six months previously and he planned to do work-related degree shortly.

'Donna' moved to a highly specialised setting a year previously and she was in the process of applying for an 'F' grade there.

'Joe' was working on the same ward and he had applied for an 'E' grade and a health-related degree course.

'Sinead' was concentrating on specialist skills with an opportunity to apply for an 'E' grade shortly on the same ward.

'Teresa' was working in the same specialist unit and she was doing a degree following completion of a current diploma in health studies course.
'Claire' was applying for an 'T' grade on the same ward and she was on her first year of a part-time degree in health studies.

'Maureen' was working on the same ward and she was seeking a further nursing qualification in another speciality.
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