Strategic Engagement for a Quality Learning Experience in Practice: Impact on Mentors and Students

Thesis

By

Heather M. Simpson

Submitted in Partial Fulfilment of the Requirements for the

Degree of Doctor of Philosophy

School of Nursing, Midwifery and Social Care

Faculty of Health, Life and Social Sciences

Edinburgh Napier University

September 2009

Acknowledgements

I would like to take this opportunity to express my thanks to the managers, mentors, Link Lecturers, Practice Education Facilitators and students for giving time to be part of this study. I am appreciative of the valuable information given and their willingness to share experiences relating to practice based learning.

I am greatly indebted to my supervisors', Professor Morag Gray and Professor Fred Percival. My gratitude for support, guidance and encouragement during the challenges along my journey. I am particularly grateful to Professor Gray, who served as a catalyst in inspiring me prior to commencing the study. Her attention to detail clarity of thought and meticulous comments enabled me to keep focused along the journey.

I am especially grateful to Mr. Douglas Park, librarian for his help,
Mrs. Caroline Gibson and Mrs. Laura Selkirk for administrative support.
Mr. Alan Simpson who provided me with statistical advice. For the assistance with funding of this research goes to the former School of Health Studies at Bell College, Hamilton and the University of the West of Scotland.

My sincere gratitude goes to my husband, my sons Mark and Steven who have supported, encouraged and had faith in me throughout the journey of this research study.

Declaration

This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other degree or qualification to this or any other university. Except where otherwise indicated this thesis is my own work.

Signed: **Date:**

Abstract

The aims of this research study were threefold. Firstly, to explore the impact of the strategic arrangements and mechanisms to implement and support practice based learning. Secondly, to investigate the selection processes, preparation, support and evaluation of mentors. Thirdly, to explore the impact of mentorship from the viewpoint of mentors, students, managers and educational links within the clinical learning environment.

The study design incorporated both quantitative and qualitative approaches involving a three phased approach engaging three regional sites. The first phase involved a quantitative approach using a survey. Phase one data arose from senior staff in Higher Education Institutions (n = 10) and the National Health Service (n = 22). The results from the survey, which focused on the strategic implementation of practice based learning and the preparation of mentors in Scotland, were used to inform phases two and three of the study. Phases two and three of the research study used a modified grounded theory approach. A range of data collection methods were used to gain information from mentors, Link Lecturers, Practice Education Facilitators, managers and students. Data collection and analysis for phases two and three occurred simultaneously and incorporated the constant comparative method of analysis. Phase two provided data from interviews with mentors across the three regional sites giving a total of 30 with ten participants in each site. Focus groups were conducted with Link Lecturers (n=17); Practice Education Facilitators (n=13); ward managers (n=21) and third year student nurses in the adult branch of the undergraduate programme (n=34).

Three major categories were developed ‘Becoming a mentor to facilitate learning in practice’ ‘Operationalising the facilitation of learning in practice’, and ‘Quality infrastructure optimising learning in practice. From these major categories a core category emerged. The core category ‘Strategic

Engagement for a Quality Learning Experience in Practice' captured the process that mentors, Link Lecturers, Practice Education Facilitators, managers and students perceived as their experience related to the clinical learning environment. A tentative theory emerged which addresses the gap between strategy and operationalisation in order to enhance the learning experience in practice. The emerging tentative theory is closing the strategic and operational gap: strategic engagement for a quality learning experience in practice. A model is provided to illustrate how to manage the interface in order to provide quality learning in practice. The study provided useful insight into learning in practice and the roles of staff within the clinical learning environment with how learning maybe more effectively managed and strengthened.

TABLE OF CONTENTS

CHAPTER 4: PRESENTATION OF FINDINGS FROM PHASE 1

CHAPTER 5: PRESENTATION OF FINDINGS FROM PHASE 2 AND 3

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

List of Tables

Page

List of Figures **Page**

List of Diagrams **Page**

Appendices

Chapter One

1.0 Introduction to the Study

Mentorship and the support of learning in practice has been the subject of research since the introduction of Project 2000, however the stimulus for this research was the need to review the arrangements for practice based learning since this component comprises 50% of the pre-registration programmes. During the last ten years I have held different posts which related to quality assurance systems for practice learning, educational audit processes, mentorship courses and evaluation systems for students, and the resourcing of practice learning from a Higher Education Institution perspective. With the importance of joint responsibility for student learning, I was particularly interested in the need for partnerships with the National Health Service Establishments. The support that was given to students from the Higher Education Institutions particularly interested me, especially the impact of mentorship on the mentors and students. I had always a particular interest in the management systems for practice learning at ward level and how decisions were made on who should be a mentor, and the subsequent support systems needed to maintain quality. With the introduction of Practice Education Facilitators in 2004 this added another dimension to the learning environment and I was intrigued how this added resource would impact and connect with the Higher Education Institution and the National Health Service.

I decided to use both a quantitative and qualitative approach for the study, by adopting both the positivistic and interpretative paradigms in order to gain an overview of what was happening in Scotland. In relation to the strategic arrangements for practice learning and the preparation of mentor, a survey approach was used. However, the positivistic approach would not have fully answered all the research questions, hence the need to ultimately choose an interpretative exploratory approach, namely a

modified grounded theory approach. The research questions for the study are as follows:

- What are the strategic arrangements for practice based learning from a Higher Education Institution and Director of Nursing perspective?
- How are mentors selected and supported in their roles?
- How are mentors prepared and evaluated in their approach to teaching and facilitating learning within the practice setting?
- What are the strategic mechanisms to support mentors at ward manager level?
- What is the impact of Lecturers and Practice Education Facilitators on the role of the mentor?
- What is the mentors' involvement in providing a quality learning experience for students?

1.1 Place of Researcher within the Study

To help achieve transparency in the research study I have included some of my own values, beliefs, life and educational experiences to make visible any possible effect I may have had on the data collection and analysis.

My interest in supervision within the clinical learning environment and in particular the engagement between a mentor and a student was related to my own experiences many years ago in midwifery. Having moved from a staff nurse role to a student role in a midwifery environment was difficult particularly around the approach of senior midwifery staff to students. One of my memories of midwifery was being left in charge of an antenatal and postnatal area as a student with little support or infrastructure to find help and guidance. These encounters left me unsure of this whole field of practice. However, incidences which created uncertainty for me made me

determined to help other students so they would not feel vulnerable and apprehensive.

Even when reflecting back on my midwifery experiences as a student I still feel a depth of response. I believe I would have enjoyed my midwifery training if appropriate mechanisms for supervision and support had been structured in a different way. Life experiences had an influence on my perception of the value and belief in a supportive relationship to increase confidence. One particular event was around the support from the health visitor following the birth of my first son. Even though I had experience from midwifery perspective it was very different when faced with the reality of the situation. I still have memories of the uncertainty coping with conflicting advice and instructions coupled with feeling very vulnerable. This life experience heightened my awareness of the need for a consistent approach from health professionals and for each situation to be considered in a holistic way.

As a ward manager I was aware of the need for planning all aspects of the student experience. When learning about management systems and processes I needed to ensure students were not vulnerable and resources were in place to provide supervision and support. However, having staffing resources to effectively supervise students was not always available. By the time I became a Clinical Teacher it was really satisfying to be able to provide direct supervision for students but also facilitate indirect approaches as students gained in confidence. Clinical Teaching in contrast to ward management left me feeling I had made a difference to the student's development, educational and clinical achievements. Whilst working as a Nurse Teacher in the mid 1980's I had concerns for the support and supervision of student nurses within the clinical learning environment. The role of the Nurse Teacher had a strong theoretical focus in a classroom setting yet a substantial amount of the students

course was in practice. During this time the supervision arrangements from my local College of Nursing and Midwifery were changing as Clinical Teachers were not replaced yet this role and function previously undertaken by the clinical teacher was not fully taken up by Nurse Teachers. It was at this time I negotiated clinical time within a surgical environment to work directly with student nurses. I found this experience to be valuable but also challenging as it was not perceived by some senior educational colleagues as beneficial. During this time I gained further exposure of working collaboratively with clinical colleagues at ward level and I suspected that the involvement was helping staff develop their own style for supervising students and develop approaches to engage students in a meaningful experience.

In the early 1990's preparations, were in place for Project 2000 and I was able to link with clinical staff to identify and prepare staff for a supervisory role. I gained further exposure to the theoretical concepts associated with supervision and felt privileged to help prepare practitioners to engage with students. My role as a Link Lecturer involved working in collaboration with the students' mentors and it was very apparent the pressure mentors were under to fulfil their role. At the same time there was some anecdotal evidence that the mentor and student experience in some areas was causing concern.

For five years I was a Head of School for a Health Studies Department and it was a challenge to balance the clinical time required by Link Lecturers to contribute to the student experience. Recently my role has been to ensure equity of the student experience and in particular within the clinical learning environment. Whilst, my experience over several years heightened my awareness that the supervision for students in the clinical learning environment was causing some concerns with managers, educationalists and students I had some ideas why issues were raised.

However, I did make strident attempts to avoid preconceived ideas and views impacting on this study. Through my reflexive diary and robust discussion with my supervisors I can attest that this was a continual battle and I did my best to keep an open-mind.

1.2 The Use of the First Person within the Study

Porter (1996) views writing the researcher into the study by using the first person promotes the embodiment of the researcher in the process. This research study is written, where appropriate in the first person. Sandelowski (1986) advocated writing in the first person as the use of the third person suggested the researcher had no involvement in the study and conveyed a sense of objectivity. The views of Sandelowski (1986) were enforced by Webb (1992) who viewed the role of the third person as conveying objectivity in the research process, which was not consistent with interpretative research. The interpretative approach should acknowledge the researcher as being part of the social fabric and as such will have an influence upon the process (Morse 2001). The incorporation of the first person reflects the personal nature of the research process.

In the next chapter a review of the literature will follow.

Chapter Two

Literature Review

2.0 Introduction

This chapter provides a review of the impact of mentorship on student nurses within the clinical learning environment, incorporating relevant research studies in a pre-literature review. A preliminary literature review was conducted for my initial research proposal. Using a modified grounded theory approach there was a need to review the literature prior to the survey. However the place of literature review in a grounded theory study has long been disputed (Charmaz 2006). I was aware of the need to delay literature review in a grounded theory study so to avoid imposing predetermined ideas. The need to be reflexive was paramount and discussions with my supervisors helped sensitise me to what was going on.

As the research study progressed, literature was incorporated, which provided new insights into the study area. As the literature in a grounded theory study is linked to the data arising from the research (Glaser and Strauss 1967; Charmaz 1990; Strauss and Corbin 1990), previous relevant research was included in the research findings and linked the existing research and theory with the new emerging tentative theory. During the study I regularly reviewed the literature to enhance my theoretical sensitivity which helped me gain insight as I entered this research study with experience relevant to the area. The literature review presented commences with the background to mentorship leading into the introduction of mentors, mentorship and clinical support arrangements. The impact of mentorship preparation programmes incorporating the National Approach to Mentorship Preparation and the context in which mentorship can be implemented are included. Following this, aspects of the mentor role and practitioners' perception of the role, the effects of mentorship and the support in the mentor role are included. The student-

mentor relationships, students' view of mentorship, experiences of engagement, feedback processes as students are prepared for registration are also discussed. Student-mentor contact time leading to student development and peer support aspects are reviewed. Literature surrounding Link Lecturer and Clinical Educators in practice learning is incorporated in this review with management support systems within the clinical learning environment.

To place my study in context, I have brought all the literature together in one chapter. The chapter will then conclude with a summary which links to the research questions arising from gaps in the literature.

2.1 Literature Search Strategy

The methodology involved in this literature search was conducted in stages, and included the search strategy, the inclusion criteria and the relevance of the studies retrieved. As such the aim of the search was to retrieve published literature. The search strategy used terms which are as follows:

- Students Learning
- Mentorship
- Student Support
- Supernumerary Status
- Mentor Preparation
- Link Lecturer
- Clinical Educator
- Practice Educator
- Management Support Systems
- Clinical Learning Environment

All these terms were linked to undergraduate nursing in order to identify research literature and the following databases were searched. The databases accessed included:

- CINAHL
- NHS Scotland Journals @ Ovid
- Science Direct
- EBSCO Journals

Reference lists from retrieved papers were also included. The parameters for the search involved literature published between the years 1990 to 2008 to capture the context of mentorship within Project 2000 courses in the early nineties but also to include relevant research studies over the timeframe up to 2008. To increase the researcher's understanding of the impact of mentorship, the literature reviewed included the background of mentorship as well as more recent studies, conference papers, reports, government and professional documents. Through a process of assessing the studies some of the articles were excluded due to the specific nature of the mentor role in the community, and not being related to experiences within acute care settings. Some of the articles were excluded due to different contexts and cultures for practice learning.

Thus, a process of themes emerged which included the following;

- Supervision Arrangements for Clinical Learning.
- Mentor Preparation and Preparing Staff to Undertake the Role of Mentor.
- Mentorship and the Experiences of Students and Staff.
- Link Lecturer and Clinical Educators in Practice Learning.
- Management support systems within the clinical learning environment.

2.2 Background to Mentoring

The English National Board (ENB) brought in the first mention of the term 'mentor' within the United Kingdom in 1987 in relation to nurses preparation for practice (Morle 1990). The mentorship concept came into the educational curriculum and the nursing world from North America, and became part of the nurse education culture in the eighties and nineties (Morle 1990). Darling (1984) is commonly quoted as the most notable nurse who brought the value of mentorship to the profession's notice (Gray 1997). Given the importance of the mentoring relationship, within the literature, the application of the role of the mentor was unclear. According to Marriot (1991) there was a dearth of research into mentorship. While confusion existed into the definition of mentorship, the overall profile of mentoring required greater clarification (Andrews and Wallis 1999).

Whilst mentoring gained a strong foothold in many organisations the concept of a mentor being an authority figure or as Levinson in the 1970's described a mentor as a transitional figure in a man's life. Hay (1995) described mentoring as a developmental alliance in which someone is helped to develop themselves. This developmental model of mentoring fits more comfortably within the Higher Education Sector. Parsloe (1992) whilst viewing mentoring as a way to support and help people, suggested mentoring as an approach to manage learning in order to maximise potential. This concept of mentoring by Parsloe (1992) was further expanded upon by Clutterbuck (2001) who recommended mentoring as coaching, counselling and networking, the aim of which was not to dazzle the protégé with knowledge and experience. Morton-Cooper and Palmer (2000) both express caution when applying the mentorship model so as to facilitate rather than oppress learning. In other words, mentorship should not be prescriptive and pedagogical in nature but a developmental approach to enable the facilitation of learning.

In the United Kingdom, the label to describe student nurse supervision within a practice placement area was confused with the use of the term mentor, preceptor or practice supervisor and authors reported confusion with the roles of practitioners in nurse education (Andrews and Wallis 1999, Neary 2000). Whilst the United Kingdom Central Council (UKCC) advisory standards indicated that 'mentor' should be the term of choice the roles, responsibilities and involvement of mentors were set out by the UKCC (2000) and the standards for mentors and mentorship were launched in 2006 by the Nursing and Midwifery Council.

According to (ENB 2001) the term 'mentor' denotes the role of the nurse, midwife or health visitor who facilitates learning, supervises and assesses the students in the practice setting. The NMC (2008) further builds on the ENB (2001) definition of a mentor and defines the mentor as 'a registrant who, following successful completion of an NMC approved mentor preparation or comparable preparation that has been accredited by an HEI as meeting the NMC mentor requirements and has achieved the knowledge, skills and competence required to meet the defined outcomes'.

Within the UK educational context for undergraduate pre –registration programmes the official mentor is not self – selected but rather allocated for relatively short periods each time the student is in practice.

The following section links to the supervision arrangements for clinical learning.

2.3 Supervision Arrangements for Clinical Learning

2.3.1 Introduction of Mentors

Phillips et al., (1996a) conducted a research project, 'The practitioner teacher: a study in the introduction of mentors in the pre-registration nurse education programme' which was conducted across Wales. The introduction of mentors implied a clinically based nurse practitioner role (that of mentor) in the Pre-Registration Nurse Education Programme. The aim of the study was to investigate how educationalists, managers and practice-based staff defined and understood the role of practitioner teachers and their impact on the Common Foundation Programme (CFP). Qualified staff (n=360) were interviewed in a variety of clinical settings. Semi-structured interviews were conducted by Phillips et al., (1996a) using a combination of open-ended and closed questions. The semi-structured nature of the interviews allowed ideas from the interviewees to be explored. Contact with prospective interviewees was made through managers who selected a range of staff representative of the skill mix within the particular clinical area. A total of one thousand, three hundred and thirty two questionnaires were sent to practice-based staff, teachers and managers and a 72% (n = 959) response rate was achieved which is perceived to be good (Polit-O'Hara and Beck 2006). The aim of the questionnaire was designed to be a single instrument applicable to all respondents which was piloted on 100 teachers and practitioners from two separate locations outside Wales. The respondents in the pilot were involved in Project 2000 implementation in a different location.

The assessment of inter-rater reliability was particularly important in the development of a standard measuring instrument which would be used in a variety of settings. Non-participation observation focused on the student day and the interaction between students and mentors. From the focus of the students' day, students and mentors were asked to keep reflective diaries for ten days in the practice placements. The purpose of the reflective diaries was to provide data on the structure, process and

outcomes of the clinical learning experience. Of 622 sets of diaries, only 138 were returned by students and 133 by mentors. The poor response rate from the diaries could have been the lack of continued contact between researcher and diarist. Another reason acknowledged by Phillips et al (1996b) related to the significance of diaries which may have seemed unimportant in the scheme of busy lives. Overall the findings reported that ward managers were in the best position to select mentors, however, most of participants were either asked or told by their manager to attend a mentorship programme although it was felt mentors should have a minimum of twelve months post registration experience. The majority of interviewees reported the preparation for the role of mentor was inadequate. However, students felt positive about their experience of mentorship, with students reporting the assignment to a mentor meant reducing them 'hanging about' and therefore enabled engagement and facilitated a team approach to learning within the clinical setting. This finding confirmed previous research by Davies et al., (1994) who reported that students who do not have a mentor allocated are left 'hanging about' with no direction given to the learning experience.

Phillips et al.'s (1996b) mixed method approach to data collection, viewed the mentor role as critical to the clinical arena and the overall experience for the student. While the study valued the role of the mentor a limitation of the study was it only involved the impact on the Common Foundation Programme. Nevertheless the findings were consistent with other studies. While the response rate was 72% (n=959) extending the areas could have enhanced the study by using the branch programmes. Using combined methodologies may enhance reliability of the data, however no rationale was provided for using a mixed method approach (Polit-O'Hara and Beck 2006). Overall, the strength in the study by Phillips et al's (1996b) lies in the large return of questionnaires from practice-based staff, teachers and managers. Whilst the study was limited to one specific aspect of the

undergraduate programme which reduces transferability of the findings the combination of qualitative and quantitative methods could provide greater insight as experiences are viewed from multiple perspectives (Simons 2007).

2.3.2 Mentorship and Clinical Support Arrangements

White et al., (1993) conducted a two stage qualitative study using mixed methods approach of the relationships between teaching, support, supervision and role modelling in clinical areas, within the context of Project 2000 courses. Firstly, the study addressed three aims, which included analysing the concepts of the teacher, supporter, mentor and supervisor, both in the literature and as seen by those individuals involved in facilitating clinical learning. Secondly, to explore the perceptions and interpretations of the value of these roles, by those who were involved in the Adult and Mental Health Branch Programmes of Project 2000 courses. And lastly, the study was to make recommendations about the appropriate preparation for practitioners undertaking such roles in the clinical learning environment. Stage one of the study covered semi-structured interviews lasting 30-90 minutes using a purposive sample of (n=30) students, (n=17) practitioners and (n=17) tutors within the Adult Branch along with (n=8) tutors in the Mental Health Branch. The first stage of the study involved a purposive sample and stage two of the study explored a deeper understanding following on from stage one. Six separate case studies were undertaken and the case study approach required analysis of contemporary phenomena within their “real life” context. The approach involved a non-participant observation, debriefing interviews, extended interviews and documentary evidence, with observation of students occurring on two separate occasions to ensure data gained was relevant and gave a true reflection of the placement. Interactions between the mentor and the student were taped and tapes were selectively transcribed. Following these interactions students participated verbally in an individual

interview with their mentor for debriefing. However, the process of selectively transcribing tapes can give rise to difficulties as the totality of the data may not be captured (MacLean et al 2004). Group interviews were held with the student, their mentor, ward manager, link teacher and other team members to discuss issues arising from the debriefing interviews. Data were analysed using content analysis, which provided themes around the concepts of teacher, supporter, mentor and supervisor, giving insight into the value of these roles. The findings from the study demonstrated that students placed importance on having an assigned practitioner who was charged with the responsibility to help them with their learning needs and reported the importance of mentors who had a clear understanding of their role and a sound knowledge and understanding of the theoretical components of the course. Teaching that was patient-centred and orientated around individual learning needs was welcomed, although students felt practitioners were not well informed about their course, the assessment process or the assessment documents and felt they were not able to determine educational levels.

In further research by Jowett et al., (1994) there were problems associated with the assessment process for students coupled with the real demands of nursing, and the added pressures of ‘time to mentor’ was expressed by Le Var (1996) and Carlisle et al., (1997). This concurs with the research from White et al., (1993). White et al., (1993) reported that the student and mentor relationship was related to the quality of the experience within the learning environment, in which students were able to relate with appropriate role models and had insight into good and bad practice. Students in White et al’s study reported that their mentors should be a first level nurse and having a mentor gave security, however, the role of a mentor was reported not to work when there is a lack of understanding or enjoyment for their role. The competing demands of “mentoring” students and providing patient care have impacted on the quality of the learning

experience (White et al. 1993). White et al., (1993) reported some practitioners were unprepared to accommodate students and the students felt they helped prepare the staff in the practice areas regarding course information and assessment issues.

Furthermore, there were competing demands on the mentor, which impacted on the clinical learning environment. Whilst the findings of White et al's study gave some useful insights into supervision arrangements some limitations of the study require consideration. For qualitative studies to have credibility the research process requires an audit trail, with evidence of the researcher having been involved in reflexivity (Huberman and Myles 1994). White et al., (1993) in this grounded theory study only transcribed one third of the tapes and consequently the process of deciding why only one third of the tapes were transcribed was unclear. However, the tapes that were not included had the information summarised. Saturation of the categories was quickly achieved as the interviews were analysed. In addition, since not all tapes were transcribed, it could be argued that this resulted in bias being introduced to the methodology. The issue around researcher bias arises in the methodology which was acknowledged by the researchers. The findings from the study add support to the importance of the student-mentor relationship. However, the student mentor relationship required to be linked to the preparation for the role of mentor and the importance of role modelling for students. As such the competing demands on the mentor in terms of time to engage in teaching and supervising students are hindrances to providing a quality learning experience.

Wilson-Barnett et al., (1995) reported on research commissioned by the English National Board for Nursing, Midwifery & Health Visiting into mentorship and clinical support arrangements for Project 2000 nursing students in the Adult and Mental Health branches. This study used a

mixed method approach and involved two main components, semi-structured interviews and six case studies. The sample for stage one included thirty students, seventeen practitioners and seventeen tutors within the Adult Branch, and twenty-three students, twenty practitioners and eight tutors within the Mental Health Branch. While the students were from two branch programmes the year the students were in was unclear. For example, to be in the branch programme both cohorts of students could be in the second or third year. This meant students had some experience of mentorship and clinical support arrangements. Participants were positively selected which encouraged full and voluntary participation which could be perceived as beneficial to the study. Interview tapes were transcribed, coded and searched for themes, then compared across respondents and branches. The transcribed tapes and the analysed data were then exchanged with the research team to check for inter-rater reliability. This process of exchanging the transcribed tapes in order to check interpretations is valuable adding to the credibility of the study.

The case studies involved the Adult and Mental Health branch consisting of hospital and community settings. The data were collected through non-participant observation, the second were staff and student interviews and the third was the review of assessment and student documents. Observation and interviews were recorded and selectively transcribed with data being analysed and compared within each case setting. The process of the selectively transcribed data gives rise to issues particularly relating to capturing the totality of the data. Selective transcription does save time however there is a risk of losing patterns in the data which may never be discovered. From their data analysis, several themes emerged relevant to the quality of support with mentors expressing a wish to be supportive, however the pressing demand of patient care took priority. An expression of inadequacy of preparation into the mentor role made staff feel ill-equipped. Some students viewed supernumerary status positively, whilst

some students in the Mental Health Branch expressed strong feelings against supernumerary status. The team spirit theme was deemed vital with staff working together for the benefit of students. A significant finding from this study, was the connection between a good atmosphere, being included as part of a team, and having the potential to make their own contributions. However, students reported that when staff were dissatisfied, students were perceived as an extra burden with little input from tutors. Nevertheless, students in the study felt supported when there was continuity of care and accountability by a named nurse, which led to a supportive learning environment for the student, linked to learning opportunities.

Wilson-Barnett et al., (1995) reported that staff who support each other are more able to support students and it is this peer support, which enhances the mentors' ability to work effectively. The study by Wilson-Barnett et al., (1995) also found that the concept of supernumerary status should be included in the mentorship role and the preparation for that role, and that the lack of clarity regarding supernumerary status caused confusion and disillusionment particularly when there are staff resourcing issues. This concurs with Parahoo (1992) who reported attitudes of clinical staff and organisation of care obstructed the implementation of supernumerary status. As a result it is reported by Robinson (1992) that students experienced stress within the practice based learning environment due to the organisation and resourcing of the students learning which was often unplanned and uncoordinated, resulting in students feeling like "spare parts". Overall, the findings from Wilson-Barnett et al., (1995) had the potential to alert managers to the importance of morale in the clinical area and the impact this can have on the learning environment and the support for mentorship. Of particular relevance in the study by Wilson-Barnett et al., (1995) is the finding that in clinical areas where staff worked in a cohesive team and were motivated, students felt more supported.

However, in clinical areas demonstrating dissatisfaction and low morale, students were seen as an imposition (Wilson-Barnett et al., 1995). These findings along with the issues of supernumerary status for students are consistent with the findings from White et al.'s study in (1993), Jowett et al., (1994), and by May et al., (1997), who support the view that supernumerary status was often associated with confusion.

Scholes et al.'s (2004) study was an evaluation of nurse education partnerships involving sixteen demonstration sites in England. The study had three phrases incorporating multiple research methods using both quantitative and qualitative approaches. Phase one of the research involved an institutional focus, with phase two using case studies, and the third phase tested the emergent issues in other demonstration sites. All sixteen sites submitted a copy of curriculum documentation to the researchers. Subsequently, the curricula were analysed to identify course configuration, practice assessment, assessment strategies and the intentions for the preparation and support of assessors. The analysis compared and contrasted content across different providers, to identify how content reflected policy and service developments to meet the challenges in 'making a difference' and 'fitness for practice'.

A total of between twelve to sixteen interviews were conducted per site with representatives from education, the local consortium, practice staff and groups of students from the Adult and Mental Health Branches. After each visit a summary account of the data was returned to all the participants for verification. Member validation was also a means of seeking feedback from the participants to ensure the findings were reflective of their experiences (Schneider et al., 2003). The return of data to participants was a way to ensure all the main issues had been identified. Based on a review of the literature a pre-tested survey was sent to a sample of one thousand, four hundred and sixty-two students from

Adult or Mental Health Nursing who were completing the Common Foundation Programme. Data were then coded and analysed using the statistical package SPSS. During phase two, four case studies were selected with interviews, including students, clinical stakeholders and purchases of education. The case studies were compared, contrasted and data coded. Consequently, data collection for phase three was driven by the findings from phase two acknowledging the process of data collection and the constant interplay between data, the dialogue with the interview transcripts, and the interpretations of findings facilitated an analytical process. A second survey was also used to capture any changes from the students' perspective between phases 1 and 3 and at the same time, the first survey was repeated with a new cohort of students in each of the demonstration sites. Five hundred and nine questionnaires were completed with three hundred and seventy from Adult branch and one hundred and thirty six from Mental Health branch. Whilst attempts were made to distribute the same number of questionnaires as in the first survey there was relatively lower numbers of responses from some universities.

Scholes et al.' s (2004) study reported on a range of issues however, the aspects relating to mentorship and supervision partnerships, Practice Educators are discussed only within the context of this study. Firstly, much work was undertaken to increase placement partnerships with Trust nurses taking responsibility for student learning. Whilst, Practice Educators were used to maintain the quality of learning environments and enhance the quality of mentorship and supervision, one of the reported challenges was to ensure consistently high quality mentorship and supervision. The role of Practice Educators was identified to address the theory practice gap that had emerged with teachers based away from practice setting, and often at a distance from the students they supported in clinical areas. The Practice Educators in Scholes et al.'s (2004) study

had achieved much to enhance the quality of supervision, nevertheless students in all three surveys reported mentors' required additional preparation in undertaking practice assessment. Findings relating to quality mentorship and supervision included competing with demands on time, the need for continued support from line managers and HEI's including updates and workshops and training days.

Secondly, Scholes et al.'s study raised specific issues relating to the need for mentoring investment in the quality of mentoring and time ring fenced for mentoring responsibilities. Overall, while improvements have been made, the study indicated the need for further work to enhance the quality of practice supervision. It was felt learning in practice was influenced, and affected by poor role modelling, support and supervision. Hence the need for improvements to ensure a high quality practice component to the curriculum. The study also reported there were improvements in partnership working with systems set in place to make a difference, however as a result greater insight was gained into the requirements to facilitate effective student learning. Practice Educators were seen to be the key in enabling partnership working, increasing the capacity and quality of placement, facilitating mentors and working with students. Lastly, the dedicated role of Practice Educators enhanced mentor support and facilitated direct support for students, however the research indicated a need for a clear career pathway. While the Practice Educator role had an enabling aspect, on the other hand there was an emphasis placed on requiring the ongoing presence of Practice Educators in the practice settings. The findings from this study by Scholes et al., (2004) provided a strong basis for learning and support within the practice arena, involving a large representative grouping reflecting a wide geographical spread. The phases involved multi research methods, and the approach regarding analysis of data was documented, which adds to the validity of the study (Burns and Grove 2007).

Elcock et al., (2007) suggest that for many students the apprenticeship model still exists and that supernumerary status has created new challenges for learning in practice. Themes from the literature centred around the confusion over the meaning and effect of supernumerary status on becoming part of the team (Chesser-Smythe 2005; Gray and Smith 1999; O'Callaghan and Slevin 2003). McGowan (2004) describes how students found it easier to describe their experiences when they were not supernumerary rather than when they were. Becoming a mentor and operationalising learning in practice needs to be part of resource strategy so students are not counted in workforce numbers. However, Nolan (1998) reports that real learning cannot take place until the student feels accepted by the staff, which requires appropriate preparation of staff as well as students.

2.4 Mentorship Preparation and Preparing Staff to Undertake the Role of Mentor

2.4.1 The impact of Mentorship for Learning in Practice

Jinks and Williams (1994) reported on a study into the effectiveness of an educational strategy for teaching, assessing and mentoring roles with student nurses undertaking a Project 2000 Diploma Programme. A descriptive survey approach using a previously piloted questionnaire and semi–structured face-to-face interviews were used to collect the data. Jinks and Williams (1994) used a mixed method approach giving breadth and depth to the findings. The sample consisted of registered district nurses with the questionnaire being sent to the total population (n=74) within a specific health district. The response rate to the questionnaire was 82% (n=61). Just over half the sample had undertaken a teaching and assessing course and felt adequately prepared for their role. The results of the interviews confirmed and validated the findings from the questionnaire however of the participants (n=10) who had undertaken a

five day teaching and assessing course, felt unprepared and 'short changed' in comparison to those who had undertaken a formal teaching and assessing course. It was also reported that information regarding the curriculum and assessment process for district nurses and students generated uncertainty.

The uncertainty experienced by district nurses and students is reflected in the comments by Jinks and Williams (1994) who claim: 'It is the blind leading the blind'. Overall, the study by Jinks and Williams (1994) revealed there was some perception that district nurses were already equipped with teaching and assessing skills. However, it was concluded from this study that district nurses felt there was a need to undertake further formal training. A limitation of the study related to the use of only one health authority, which had an obvious influence on the external validity of the results, and as such generalisation from the findings could not be made. Since the Jinks and Williams (1994) study focused on district nurses in comparison to hospital based nurses this in turn may have influenced the results as many district nurses are senior individuals in a team with more experience in teaching and supervising students. This particular article was included in the literature review as the focus was on the preparation for mentorship and this study involved senior practitioners.

Duffy et al., (2000) reported on the results of a survey investigating the effectiveness of the arrangements for mentor preparation and ongoing mentor support. The study focused on the Adult placement areas within a specific Scottish geographical location, which included a sample of one hundred and fifty mentors. The questionnaire survey approach resulted in a response rate of 47% (n=71). Watson (2000) confirms a response rate of 30% or greater is required for reliability. However other researchers claim that a response rate below 60% is barely acceptable (Edwards et al.,

2002). Parahoo (2006: 279) states “the lower the response rate the less representative the achieved sample is likely to be of the target population”. Whilst the results indicated a satisfaction with the preparation of mentors, respondents felt that current mentor support was problematic. Although there was support from lecturers for the preparation of mentors, this was different to the findings of Bewley (1995) who found some mentors felt ill prepared, however, the study by Bewley (1995) was small scale and included eight interviews which were locally based in a clinical area, relating to a midwifery focus and was five years earlier.

In Duffy et al.’ s (2000) study the mentors felt more input was needed from lecturers at placement level and some mentors would have valued on-site support from the Higher Education Institute (HEI). Respondents in the study reported on the need for more effective communication from HEI’s, namely the academic staff, within the placement areas. There was a need to ensure support from management, particularly relating to information on study days and managers facilitating opportunities for staff to attend study days. While this questionnaire provided some useful data particularly around the support and information needs of mentors since the study focused only on one geographical area the findings cannot be generalisable, but would need to be tested across a wider geographical area with a broader range of placement areas.

Watson (2004) conducted a study in England to explore the impact of a mentor preparation course and reasons for undertaking the course and expectations of the candidates. Two cohorts of post-registration students (n=127) were sent a questionnaire, and a 90.6% response rate (n=115) was achieved. The questionnaires from the participants were completed whilst attending a programme which possibly contributed to the good response rate. The majority of the participants had more than one year’s experience, both in relation to time qualified and experience in the clinical

location. Participants had extensive experience mentoring students with a high number already mentoring or in the role as an associate mentor. Findings particularly relevant to this study suggest the undertaking of the mentor role was not the only motivating factor, but there was indication that 'E' Grade staff perceived a mentorship course as a means of obtaining a promotion. Evidence suggests the course was undertaken for professional self-interest. Fifty-eight percent (n=67) identified enhanced job prospects as a benefit of the course. While participants derive benefits from the course, it was recommended by Watson that the course should be for mentor preparation, and not seen as a means for promotion. It was reported in the study, that a national approach to mentorship was required in Scotland and Wales. Scotland followed closely behind Wales in having a National approach to mentorship preparation, which will provide consistency across the HEIs and NHS establishments (NES, 2007). The National Approach to Mentorship Preparation (NES 2007) is a means to assist mentors and those engaged in mentorship preparation programmes to focus on the importance the mentor plays in facilitating learning in practice. Having a core curriculum framework provides a national approach to preparing mentors and ensures that all mentorship preparation meets the Nursing and Midwifery Council Standard to support learning and assessment in practice (NMC 2008).

2.4.2 Context of the Mentorship Programme

van Eps et al., (2006) reported on a descriptive, exploratory study to evaluate the mentorship programme for undergraduate students in Australia. The study involved 39 students during a year-long programme with information been gathered through surveys, focus group interviews twice a year. The information about the mentorship programme was routinely collected from focus groups as well as a questionnaire at the end of each year-long programme. The questionnaire was derived from a literature review and clinical experience of the project team. Research

questions were structured and focused on the perceived strengths and weaknesses of the programme, adequacy of the mechanisms to support the programmes and personal and educational benefits.

Through the use of a reference group the questionnaire was reviewed by nurse educators, registered nurses and academics, which enhanced the face and content validity (Oppenheim, 1992). Student responses were gathered and then classified into specific themes by analysing the content of responses and clustering similar data.

Three themes emerged from the analysis of data which included: 'The doing of nursing', 'The thinking of nursing' and 'Being a nurse'. Since students were in their final year it was predictable the emphasis was on psychomotor skills, and being able to achieve competence with the majority of students identifying that the mentorship programme gave opportunities for guidance and promoted the development of skills. Many of the students viewed the 'doing' work of nursing as an important aspect of providing patient care. The 'thinking' of nursing captured the opportunity for mentoring to enable the students to relate and apply their theoretical knowledge to their practice. Mentoring also facilitated 'thinking' practices such as prioritising, management issues, problem solving and critiquing their own work. The mode of delivery of this mentorship programme was over a year and was evaluated as being beneficial for both professional growth and development.

Being a nurse was enabled by providing an opportunity for students to develop professional identity. Students identified that the process involved in developing professional identity was around increased understanding of health professional roles and responsibilities. Students gained confidence in clinical skills and the integration of theory to practice which helped develop a professional identity. This study reported a strong sense of

team membership and acceptance in the clinical environment with students emphasising the benefits of mentorship in preparing them for practice, as well as registered nurses. van Eps et al., (2006) claim the benefits of mentorship were delivered from a long term, supportive relationship with the same registered nurse. This year long mentorship programme had similarities to preceptorship in United Kingdom. The value of this relationship was linked to preparation for the workplace, and therefore considered as a worthwhile investment for quality clinical learning. Whilst the numbers in this study were not large valuable data were gathered indicating the importance of mentorship in preparing nursing students for the workplace. On reflection this model of mentorship of a year long duration would not be feasible within the current UK systems for student nurse supervision, however this is a model of practice, which in principle would be worth exploring to ensure mentors have the support, supervision and nurturing in their role with a named individual for a year long duration. It could for example be implemented in areas using the Open University pre-registration programme where students remain in their previous place of practice or during the consolidation period at the end of the pre-registration programme. This would enable a development of a reflective approach on learning and teaching developments, assessment issues and the mentor's personal and professional growth.

2.4.3 Aspects of the Mentor Role

Cameron-Jones and O'Hara (1996) conducted a study on the mentor role using an adapted version of Darling's work (1985). The research included nurse mentors (n=87) and student nurses (n=39). All the nurse mentors completed a role analysis of aspects of the mentor role and on how much emphasis was placed on each aspect of being a mentor using a scale from one to five, with five indicating the highest amount of emphasis and so on down to one. The results from the nurse mentors indicated most emphasis was given to the supporting aspect of the students with the least

emphasis on being a challenger of the students. The student nurses were asked to use the same analysis of the mentor role as had been used by the nurse mentors and the focus of the student nurses instrument related to them being nurse mentors in the future. Thirty-nine final year students out of forty took part in the study indicating the most important role for the mentor was to be a supporter of students and the least important was to be an intermediary. The interesting findings from the study report the views of nurse mentors presenting a traditional and supportive role, whereas students wanted mentors of the future to be more challenging. The challenging aspect of mentoring needed to reflect the cultures within the health professionals' workplace, and the results from the study are limited in relation to the sample size. As a result of the sample size the implications that could possibly arise are bias and a weak analysis (Parahoo 2006). Nevertheless, the findings offered a foundation to take forward the challenging role of the mentor.

However, the study does not make it clear if the nurse mentors were geographically located or spread over a locality. The same applied to the thirty-nine final year students, as the authors did not reveal the location of the students or which branch the students were from. Furthermore, the rationale for underpinning the sample size and details of the participants was lacking. According to Streubert and Carpenter (2003), including participant details is required to determine the credibility of the study. Overall, the findings alerted nurse mentors to the supportive functional role of the mentor and the study also demonstrated the need for mentors to be more challenging. These findings from Cameron-Jones and O'Hara (1996) link to studies indicating that for many students the theoretical component of the student's learning has no real meaning, unless it is related to and challenged in practice. This concurs with the research from (Macleod Clarke et al., 1997, Neary 1997; Scholes et al. 2004). This

highlights that further research into the challenging aspects of mentoring needed to be considered as part of the impact of mentorship.

2.4.4 Practitioners' Perception of the Role

In a study exploring the views of nurses relating to supervision of students, Rogers and Lawton (1995) undertook a mixed methods study involving two stages. In the first stage a qualitative approach using unstructured focus group interviews was used to find out about practitioners' (n=34) perceptions of their role and development needs. Stage two used a questionnaire to survey the opinions of a larger sample (n=300) on the issues raised during the focus group interviews. In relation to this seven small group interviews (n= 34) were undertaken from medical, surgical and elderly care areas within two large hospitals which reflected the care areas in which students had clinical experience. The first stage of the study focused on Project 2000 supervisors incorporating the views of 34 first-level nurses and the interviews were taped and the contents analysed using a constant comparative method.

A review of the categories following each interview was discussed with the researchers and checked for inter-rater reliability which enabled the process of confirmation and in turn demonstrated the researchers' efforts to enhance or evaluate the trustworthiness of the data by discussing this with other researchers which contributed to the credibility of the data (Lindsay 2007). Rogers and Lawton (1995) found that the focus group interviews identified key emergent issues which included preparation for the role, communication between service and education, profiles and language used, practitioners' knowledge relating to level and content of course benefits of the role, teaching skills and the time associated for staff to be involved in supervision. The second stage of the research was also used to test the validity of the interview content by incorporating a large sample comprising three hundred supervisors or assessors. One hundred

and thirty four questionnaires were returned giving a response rate of 48% from one hospital and 41% from the other. The response rate could have been better for the second stage of the research, which could influence the reliability of the data (Schneider et al., 2003). With the poor response rate the findings need to be viewed with caution. Rogers and Lawton (1995) did not discuss the poor response rate in the limitations of the study. Most of the participants reported enjoying supervising students, and that the majority had completed a supervisor or assessor course. Qualified nurses working with the students were generally satisfied with their preparation, however the lack of knowledge among practitioners was around student programmes and assessment which may have indicated a problem with the transferability of the information and that communication between educational institutions and practice needed to be improved with a feeling from practitioners regarding lack of support from the Higher Education Institution. The lack of knowledge among practitioners could suggest a lack of information transfer from the preparatory course. The perceived lack of support from educational institutions was apparent, with contact mainly involving problem-orientated difficulties around assessment which needed resolution.

In the study by Rogers and Lawton (1995) it should be noted that the research only engaged the opinions of general nurses who were working within two hospital environments, which reduces transferability of the findings. However, the sample size and the combination of data collection methods could be seen as strength by Rogers and Lawton (1995) in exploring the views of nurses relating to supervision of students. Using a two staged approach to methodology gave practitioners an opportunity to identify the areas of significance on which the questionnaire was based. Using a constant comparison of method of data analysis can give rise to the study being subject to researcher bias, however the researcher seeks believability based on insight and trustworthiness through a process of

verification rather than through validity and reliability (Lincoln and Guba 1985). Rogers and Lawton (1995) checked data by having a second person examining transcripts and results. However, it is crucial the researcher uses a reflexive approach to the research situation. The process of a reflexive approach enables the researcher to explore personal feelings and experiences that may influence the study. As such this study indicates there was an indication from practitioners in support of students, however the findings have the potential to alert educational institutions that the input around communication with practice was unsatisfactory, as were the resourcing implications for mentors to contribute effectively. This suggests that interventions require to be in place from the educational institutions.

2.4.5 The Effects of Mentorship

Gray and Smith (2000) investigated, using Grounded Theory methodology, the effects of mentorship on student nurses following the introduction of the 1992 programme of education leading to a Diploma of Higher Education in Nursing and registration with the United Kingdom Central Council. The focus of this study was to capture changes in the student's perspective of their mentor over time, and consisted of ten students from a large Scottish College of Nursing and Midwifery. The students were interviewed on five occasions during the three years of their course, and kept a diary to record their thoughts and experiences regarding supernumerary status and mentorship during their practice placements with a further seven students volunteering to participate by diary only. Data were collected by using informal, in-depth interviews at the beginning of their course and on four subsequent occasions. Gray and Smith (2000) reported prior to the first placement experience for the students, the mentor was seen as playing a major role and was viewed positively. Students believed the mentor would be a supporter, guide, assessor and supervisor with personal qualities and be a respected

member of the ward team. Furthermore, the impact of previous research, which adds to the work of Gray and Smith (2000) is that a good mentor, from the student's perspective, is supportive, acts as a good role model, and is someone who has a genuine concern, having the student's interests at heart (Neary 2000; Wilson-Barnett et al., 1995). Gray and Smith (2000) report placements in which the students described having a mentor as crucial to their learning. However, students realised their mentors had other priorities, but appreciated their mentor's efforts to achieve time with the student. From the students' perspective advantage was taken of learning opportunities as they arose. Students felt confident when they became accustomed to the ward routine and staff expectations of them, which resulted in their dependency on the mentor being reduced.

In Gray and Smith's study, students were very aware of the need to develop realistic expectations of their mentor although students within the study expected mentors to be knowledgeable and skilled practitioners, and students had developed a sense of realism regarding the supervision arrangements between student and mentor. After four placements, the role of the mentor from the students' perspective was as a supporter, guide and teacher, supervisor and assessor. It was reported that as students progressed in their programme, self-confidence increased, and there was a reduction in the reliance on the mentor. However, students emphasised the need for a mentor and referred to the mentor as the gatekeeper of learning. Students valued a good mentor and viewed the mentor as the lynchpin of their learning in the clinical practice arena. This supports the study by Davies et al., (1994) who showed that a 'good mentor' was confident of his or her ability to teach and devoted a considerable time to this activity.

Despite students in Gray and Smith's study having an idealistic view of their mentor, the insight gained over time brought changes as students

focused on the learning opportunities available to achieve assessment criteria. Students in the study reported a gradual distancing from their mentor, which coincided with the students gaining confidence in care delivery while taking on a holistic perspective of care.

Kilcullen (2007) reported on the impact of mentorship on clinical learning from a qualitative study. A purposive sample of 29 student nurses in their third year of a Diploma Programme participated in the study. The participants in the study were chosen on the basis of their stage of education and clinical experience. Data collection was by focus group interviews using three groups. An interview guide was used to enable a focus with the researcher using the adapted version of the Darling Measuring Mentoring Potential tool to explore students' nurses' perceptions of the role of the mentor (Cameron-Jones and O'Hara 1996). The focus group interviews were taped and transcribed verbatim by the researcher which captures all the data. Data were analysed using content analysis and various aspects of students' experiences of mentor engagement were identified.

The findings from the study indicated students' understanding of the concept 'mentor' was closely linked to the role of the mentor, which emerged as a facilitator of learning. Those involved in mentoring were junior staff, and whilst having advantages of understanding the course, there were difficulties with having the confidence to challenge assertive staff. It was found that some senior staff had a poor understanding of the course, which subsequently impacted on students' learning. A particular finding from this study was that students reported the lack of recognition for mentors particularly relating to time to fulfil the role giving rise to areas of conflict, which was perceived to affect students' learning. As a result of a diluted skill mix the organisation of care was task allocation.

Kilcullen (2007) reported that the socialisation role was perceived as important by students, with the ideal mentor giving support by negotiating learning objectives and giving constructive feedback. Role modelling was considered an important aspect of learning for students. Many mentors were perceived to have difficulties giving feedback to students. Feedback was given at the end of the placement, which gave no opportunity for improvement or discussion on progress. The findings around feedback were consistent with other studies and add support to the view of the importance of feedback for students (Jowett et al., 1994; Glover 2000). In Kilcullen's study students felt they had few ideal mentors, and perceived the ideal mentor had the ability to integrate theory and practice. The ability of the mentor was found to be lacking in many clinical placements particularly relating to the challenging aspect. The findings from the study add support to Cameron-Jones and O'Hara's (1996) work on the challenging aspect of the mentor role to be taken on board by the mentors. Furthermore, the poor motivation, heavy workload, and poor morale conveyed in Kilcullen's findings required further consideration. The interpersonal aspect of the mentoring relationship had an impact on enhancing or inhibiting learning but there needed to be greater emphasis on developing analytical and problem solving skills. Kilcullen's (2007) study has implications for the preparation of mentors and for providing quality clinical learning environments. Whilst this study used a qualitative research design with emphasis on description, the findings reiterated the importance of a clinical learning environment and have the potential to increase awareness of the importance of feedback issues and more importantly interventions to ensure analytical and problem solving situations were built into the learning experiences.

2.4.6 Support in the Mentor Role

Pulsford et al., (2002) reported on a survey of practitioners who acted as mentors for student nurses. The study involved an overview of

practitioners who acted as mentors for pre-registration nursing students within a catchment area in order to gain information as to mentor's perceived levels of support in undertaking the mentoring role and factors that would have enabled them to carry out that role more effectively. Additionally they aimed to ascertain mentors' experiences of the effectiveness of annual sessions for updating of knowledge and their views as to how these sessions may be best facilitated. A self-complete questionnaire was sent to 400 mentors with a total of one hundred and ninety-eight questionnaires being returned giving a response rate of just under 50%. It is reported by Edwards et al., (2002) that poor response rates reduce sample size and are a potential source of bias. Edwards et al., (2002) suggest that while there is no 'standard' for an acceptable response rate to questionnaires, the opinion from the research community indicates that below 80% bias is likely to occur, and a response rate below 60% is 'barely' acceptable. In previous research Watson (2000) confirms a response rate of 30% or greater is required for reliability. The findings from Pulsford et al.'s study therefore need to be viewed with some caution.

Participants in Pulsford et al.'s (2002) study were selected by choosing a random sample with one mentor from every second clinical placement area to ensure representation from all the areas and the branches of nursing. Respondents were experienced as mentors with around 60% (n=35) having been mentors for more than five years. The mean number of students for whom respondents had acted as mentors during the past year was 3.3 students. These data revealed a mixed picture regarding support for the mentoring role with at least a quarter of the respondents feeling their managers gave them no support. From the data, respondents looked to managers to assist them with the demands of the role and in particular, to provide them with time for mentoring activities within the working day. This aspect reflected previous findings by Watson (1999), and Phillips et al., (2000). It was reported by Pulsford et al., (2002) that

there was the need for more information regarding students' placements with more feedback from the Higher Education Institution (HEI) as to students' progress but also evaluations of placement experiences. Interestingly there was a strong feeling of more support required as a whole from the Higher Education Institution, going beyond a link role from the lecturer to encompass educational and clinical inputs with students and clinicians.

Half of the practitioners in Pulsford et al.'s (2002) study had attended an update session with the remainder of the respondents not attending due to staff shortages. The communication mechanisms between the Higher Education Institution and practice placements were perceived to be inadequate. Pulsford et al., (2002) found that no respondents expressed difficulty with the time aspect of mentoring, contrasting with previous research, which may suggest that mentors did not spend time with students or if time was spent this was limited (Alderman 1998, Phillips et al., 2000). Several studies have reported the contact between students and mentors was often limited either through mentors being away from work or through different shift patterns which impact on the student experience (Cahill 1996, Lloyd Jones et al., 2001). Pulsford et al.'s (2002) study complements previous research indicating ongoing issues with mentorship. However, the study was limited to one Higher Education Institution within one locality and would need to be replicated in other geographical areas for the findings to be generalisable.

Myall et al., (2008) explored the role of the mentor in contemporary nursing practice in the United Kingdom. The study involved a two phased design with phase 1 using semi-structured interviews with key academic, clinical and wider stakeholders, and a survey of pre-qualifying students via a self-administered questionnaire. Phase 2 involved a survey of academics, practice, mentors and pre-qualifying students. Myall et al.,

(2008) presented the findings from phase 2 of the study. Student participants were recruited from a Higher Education Institution, and were given information on the intranet websites, where a link was made to an online questionnaire and information about the study.

The total population sampled different branches, awards, five localities and three years of intake. A total of 161 (10%) questionnaires were returned. The response rate for the questionnaires was poor, which may be due to the electronic format, as this has been shown to be more poorly completed than conventional paper questionnaires (Nully, 2008).

A random sample of mentors (25%, n=187) was selected to guard against under or over-representation of certain clinical areas or job types and was across eight National Health Service Trusts and asked to complete a self-administered questionnaire. A total of 156 (21%) were returned with 127 completed, which gave a representation of practice settings and nursing roles. The findings although illuminating required to be viewed with caution due to the poor response rate. The mentor questionnaire, involved 31-items and was given electronically to nurses supporting students in eight National Health Service Trusts. The questionnaire was designed to collect both quantitative and qualitative data to elicit mentors' views on the role, relationship with students, and support received for mentoring. A statistical package for the Social Sciences (SPSS Version 14) was used to produce a descriptive statistical analysis. Qualitative data derived from open-ended questions were analysed inductively and coded and categorized to identify the main themes.

Findings reported the experiences of mentorship relating to the students' experiences found that half of the students (n=57, 50%) had been allocated a named mentor before starting in a practice area with a minority of (n=12, 10%) indicating that they 'never' been assigned a named mentor

in advance of commencing a new placement. Students reported having a designated mentor was seen as important as was the quality of the relationship between the mentor and the mentee. A finding supported by the work of Gray and Smith (1999; 2000). Most students reported positively on their experiences, particularly with the mentor providing feedback, opportunities to discuss progress, challenge their practice and offer constructive criticism. The amount of time students spent with their mentor was seen as influencing the quality of their placement experience. More than three-quarters of students (n=86, 76%) indicated that they had worked three or more shifts out of five with their mentors. Almost one-quarter of students (n=27, 24%) reported working less than three out of five shifts with their mentor.

Mentors' experiences indicated that mentors seemed to understand the nature and purpose of their role and the importance of supporting students in placement. In relation to carrying out the mentor role 57% (n=72), reported working on average three to four shifts out of five with students, with 17% (n=22) claiming to work out of five shifts with their student. Only 2% of mentors (n=2) stated not working any shift with their students.

Findings also reported the importance of welcoming a student to a new practice area with the majority of mentors reporting that the mentor was allocated to work with a student prior to commencement of their placement, with students assigned an associate or 'buddy mentor' system. Seventy-seven per cent of mentors (n=98) reported ensuring students were given an orientation to a new placement. Mentors were aware of the significance of their role in providing students with their clinical skills and experience. This was also linked to theory and practice through assessment, evaluation and provision of feedback on their performance. Ninety-seven per cent (n=125) agreed that it is essential for mentors to provide opportunities for learning and assessment.

Students reported the importance of being inducted and orientated to a new placement. However, less than half in the study felt they had ‘always’ received an orientation (n=56/116, 48%) and induction (n=44/115, 38%) when they arrived in a practice area. Students identified benefits of mentorship but also felt the organisational and contextual constraints on the mentor role had implications for the quality of placement experience. Students were aware of staff shortages, which sometimes led to students being used as an ‘extra pair of hands’ leading to a number of students reporting feeling a ‘burden’ or an ‘imposition’. In previous research (Watson 1999, Neary 2000, Lloyd-Jones et al., 2001) reported having insufficient time with their mentor can have an impact on students achieving their learning outcomes. The support given by the university was adequate with 38% (n=48) of mentors reporting this, although the same number (n=48; 38%), considered the level to be inadequate. This reflects findings from Hutchings et al.’s (2005) study which highlighted the need for dedicated university support in practice for mentors. According to Mallik and McGowan (2006) mentors welcomed the input of the Link Tutors in the placement areas and sharing of the responsibility of students with academic staff.

Overall the study by Myall et al., (2008) further highlighted the role of the mentor as pivotal to students’ clinical learning experiences. However, they identified that there is a need for ongoing support and preparation for the role. Previous research Mallik and Aylott (2005) recommended that there needs to be shift away from the goodwill expected of mentors, to recognition of the importance of the role in relation to organisational support, effective partnership, good communication with the establishment of collegial relationships between academics and clinicians. Myall et al., (2008) concluded that mentorship was integral to students’ clinical experience which concurs with previous research (Gray and Smith 2000).

2.5 Mentorship and the Experiences of Students and Staff

2.5.1 Student – Mentor Relationship

Spouse (1996) used a qualitative approach to gain understanding of issues expressed by nursing students regarding the relationship between student and mentor, and its influence on the development of their professional knowledge during clinical practice. The longitudinal a naturalistic approach of eight nursing degree students during a four-year programmes. Since the aim of the study was to describe the lived experience of becoming a nurse the approach taken using naturalistic inquiry was a mixture between ethnography and phenomenology (Tesch 1990). A naturalistic inquiry uses natural settings, tacit knowledge, purposive sampling, and the use of inductive methods to analyse data. In this study the purposive sampling involved eight individuals in a nursing degree programme. The naturalistic inquiry allowed an exploration of the lived experiences and interpretations, whilst incorporating aspects of culture. Data were collected using informal unstructured interviews, which focused on students' placement experiences. Over the whole of the course students normally experienced 12 different clinical placements and students were interviewed after each experience. In total there were 86 interviews. The students' written assignments, reports of critical incidents and accounts during clinical placements were reviewed for how nursing students developed their professional knowledge while working in clinical areas. This study involved the use of context analysis and resulted in five categories emerging from the mentor-student relationship, and the quality of their educational activities.

Following transcription and analysis participants checked the content, which was useful in providing verification and authenticity of the material (Abbott and Sapsford 1998). The findings relevant to the study were discovered to be befriending, planning, collaborating, coaching and reflection. The students reported befriending to be the key to all of the

other learning activities in clinical practice, with particular importance to the first two years of the students' clinical placements. The students also believed the mentor was the gatekeeper in helping them to adjust to the new environments and in learning the rules within the practice setting which reflects findings from Gray and Smith (1999; 2000).

Students perceived that mentors also required to be knowledgeable about their curriculum, assessment processes, know the clinical location and the care group. Whilst the student's ability to identify their own learning needs increased, there was still the strong feeling of support required from their mentors in planning the learning programme. This fits with the importance of linking theory and practice and learning needs, in which the relationship between student and mentor links to the learning experience, the learning environment and ultimately to the impact of the supervisors on the students. The latter was supported by Hallet et al., (1996), who reported the view of students was that learning only took place when theory and practice were closely linked, hence the importance of planning for learning. The category of collaborating resulted in two major concepts, training and partnership.

During Spouse's (1996) study, the mentors carried a full workload and had to balance this with the needs of the student, which resulted in students being left to work alone with little apparent supervision, and left trailing around seeking learning opportunities. The final category involved coaching and reflection, and some interviewees expressed concern that not all mentors were able to provide students with this opportunity. Students perceived that when the relationship was fragile with the mentor there was not meaningful dialogue. This was coupled with the fact mentors had little experience or opportunities for reflection themselves. This is supported by Hoyles et al., (2000), who suggest the need for discussion within clinical areas, which would enable students to arrive at a

deeper and more meaningful understanding of the practice of nursing. Again this reinforces a previous study by Hallet et al., (1996), who claimed that students could not take full advantage of clinical experiences, as discussions are simplistic rather than challenging and the linking of appropriate theories are not utilised.

Throughout the students' programme Spouse (1996) found that there was involvement with different members of the clinical team, however the ability to relate to clinical colleagues was influenced by the support received from mentors. Spouse recommended that mentor preparation included information about the curriculum as it applied to the practice setting, and the mentor's role in assessment strategies. Spouse's study (1996) involved a small number of students, eight at degree level. The aim of her naturalistic inquiry was however not to provide generalisable findings but rather to illuminate the lived experience of the students during their clinical placements. Nevertheless, the strengths of the study related to a longitudinal approach, which provided consistent contact with the participants. The use of a multi-method approach to data collection with participants verifying findings can be seen to be a strength (Patton 1990) and all the instruments were piloted prior to use. Even though the study involved small numbers of participants' valuable in–depth insight was provided with implications for nurse education and the role of clinical staff. The findings reported useful data on the clinical team and planning learning about how the relationship between the student and mentor can work. Spouse's study concluded that the quality of the relationship between student and mentor is fundamental to a successful outcome.

Nettleton and Bray (2008) reported on a multi-professional research study to explore mentee and mentors perceptions of the mentorship role within nursing, midwifery and medicine. The study focused on the conceptualisation of mentoring within the health setting, the factors that

influence the mentor-mentee relationship in a positive/negative way, what the professional and personal needs of the mentees are and what are the training and development needs of mentors. Medicine was incorporated with nursing and midwifery in this multi-professional research study but Nettleton and Bray (2008) focused on reporting the nursing responses from a questionnaire and semi-structured interviews. The questionnaire was designed following consultation with practitioners with the questionnaire being pre-tested which should have reduced measurement errors (Burns and Grove 2007). A postal questionnaire was distributed to mentors (n=844) in five acute trusts within the North West of England with a return of 110 questionnaires, which gave a percentage response rate of 13% which would be perceived as not favourable. No reasons were given for the poor response rate. Perhaps this could have been due to the geographical coverage across five trust areas. There was no indication of a second wave of questionnaires following the poor response rate. A separate questionnaire was distributed to mentees in their third year of the programme with two hundred and ninety one questionnaires been distributed. The return rate for the questionnaires was 174 questionnaires giving a response rate of 60%. The mentees had a higher response rate to questionnaires which could be perceived as their willingness and eagerness to share experiences. Respondents were asked at the end of the questionnaire to self-select to take part in a further semi-structured interview with respondents given a choice of telephone, face-to-face or email interview. The mentors and mentees chose a telephone interview lasting between twenty and sixty minutes. The thirty seven nursing interviews were recorded, transcribed and analysed using the principles of framework analysis (Ritchie and Lewis 2003). The codes and categories from analysis were independently created and verified by two members who were part of the research team along with Nettleton and Bray.

The results reported by Nettleton and Bray (2008) focused on the recognition of the mentor role, improving the mentoring system and the allocation of mentors. Most nursing respondents gained minimal recognition or reward, with mentors recognising inconsistencies within the mentoring system and the variance in local practices. Of particular note the study by Nettleton and Bray (2008) was the finding that the mentor role was seen as part of the job description (41% n=45) or existing role (15% n=17), with respondents identifying it being expected of them to be a mentor. A common issue arising in the study focused on improving the system for mentors with the need for dedicated time, followed by increased Higher Education Institution input and training and updating for mentors. Firstly, the mentee findings reported time (26% n=45) as an important factor, followed by increased awareness of students training (22% n=38) and lastly the need for mentors to choose their role voluntarily (15% n=26). This study had limitations relating to poor response rates and the fact the focus was on a specific region which reduced the wider applicability of findings. Nevertheless, the time factor was highlighted in previous research by (Philips et al., 2000). The need to recognise the importance of mentorship and plan for mentor training and updates was previously reported by Jones (2005). Overall, Nettleton and Bray (2008) highlight concerns that the current provision and support of mentors is insufficient, resulting in a poor commitment for time and resources.

2.5.2 Students' View of Mentorship

A survey was conducted by Earnshaw (1995) to review mentorship from the student's perspective. The survey was administered to 19 third-year students undertaking general nurse training in England. Following on from a previous pilot study the students were asked to complete a ten-item questionnaire concerning their experiences of mentorship. However, there were no details testing the reliability and validity of the tool particularly relating to the terminology associated with mentorship. Analysis of the

data suggested the mentor played a significant role in ward-based training, however there were no details on how the data analysis was carried out. Some participants felt the mentor role had little or no influence on them, although the mentor had particular influences in the early stages of training but it was reported that students did not become dependent on their mentors. In fact, as a result of good and bad experiences, some students saw the mentor as having an influence on how they would function themselves as mentors. The study reported having a mentor allocated to the students created a sense of belonging with someone seeking them out engendering a feeling of security. Furthermore, it was also found that having an allocated mentor and getting the identical off duty was a useful way of linking together the mentor and the student. Whilst there were positive aspects of having the identical off duty of the mentor, it was reported the drawbacks were with problems of personality clashes. In relation to the grade of staff involved with the students, there was no grade of staff that was singled out with all the qualities that students were looking for in a mentor. Sister Levels (Grades F and G) were perceived as potentially good mentors, however, there was an issue regarding the time available to be a mentor as a senior member of a team. It was found that Grade E was valued for their wide-ranging experience and knowledge. However, nursing students preferred the newly appointed registered nurses (Grade D) as their mentors, as they felt closest to them in a hierarchical sense.

Participants suggested the mentors personal qualities were more important than the grade of the mentor, which led to the students attaching themselves to mentors who they perceived had the right qualities. Indeed having the right personal qualities required to be a mentor were more important than the grade of mentor. In support of the mentor and mentee relationship, the students reported the need for a ‘settling-in’ period, however some students suggested the lack of mutual respect and rapport

had a negative influence on them. On the other hand, it was found that the relationship between mentor and mentee worked when both parties contributed equally. In conclusion, Earnshaw (1995) found mentorship to be a useful form of support in the early stages of training, with mentors fulfilling a socialising role. Acknowledging the limitations of this study, which included a very small sample with nineteen questionnaires distributed with eleven returned, giving a response rate of 58%, which would need to be tested in other areas with a larger sample size in order to generate generalisable findings (Boyd 2001).

To gain an understanding into student nurses' experiences of mentorship, Cahill (1996) used a qualitative approach to explore the nature and significance of interactions students had with their mentors. The study also sought to assess the degree of congruence between the literature on mentorship and the role in practice with the focus of the study from the student's perspective. By using group discussion and individual interviews, the views of sixteen third year students participating on an RGN Programme in England were interviewed on an individual basis. Interviews were taped and lasted between 45 minutes to an hour. The data generated from these interviews were analysed using thematic content analysis although the discussion on the process involved was lacking, which made it difficult to get a clear picture of how the themes were generated. The findings into the student nurses' experience of mentorship were presented through four major themes which included impressions and expectations, covert operation, a different job and rocking the boat.

Cahill (1996) stated there was a lack of understanding of the role of the mentor and asserted that it was also evident there was a lack of coherent preparation and support for mentors from the teachers and managers. A ward culture existed in which the hierarchy and division of labour

separated and caused a major barrier in the development of supportive relationships. A positive mentor and student relationship is based on partnership consistency and mutual respect (Cahill 1996). Andrews and Wallis (1999) reported similar findings. According to Cahill (1996) students expressed dissatisfaction regarding the lack of contact with their mentors, with relationships being described as superficial. Furthermore, students were preoccupied with ward reports, which influenced students' relationships and behaviour with trained staff. Cahill (1996) suggested the limitations of contact between students and mentors was attributed to poor planning, lack of managerial support or lack of interest on the part of mentors. In the study, it was difficult to eliminate the possibility of participant bias as students may have participated in the study just to express dissatisfaction.

Watson (1999) reported on an investigative case study of pre-registration nursing students' experiences and perceptions of mentoring in one theory and practice module of the Common Foundation Programme on a Project 2000 course. The case study approach focused on one organisation involving a purposive sample of thirty-five students and fifteen clinical supervisors who were interviewed in clinical areas consisting of seven wards from local hospitals. Participants were interviewed with the aid of a semi-structured interview guide which enabled the participants to give their own perceptions of reality. The participants within this study (n=35), reported the role of the mentor involved assessing, facilitating role modelling, planning, providing a supportive role, and it was reported that the staff mentors (n=15) had similar views to the students.

However, the mentors did not have planning for the students' experience as part of their role, whilst the students saw this component as important particularly in the identification of the learning menu, which would support the students in practice. This supports the findings from Veitch et al.,

(1997), who identified the need for coherence between theory and the students' clinical experience, hence the need for planning to make learning easier.

Watson (1999) also found that the preparation for the role of the mentor was lacking with the lack of protected time to have training to attend mentorship programmes. When the contact between mentor and student was minimal, the mentoring process was perceived to be less effective, making it difficult for the mentor to carry out their role and it was reported that the managers required to take a proactive role ensuring staff were on the same shifts as the students. While this study demonstrated many important areas, further research into the mentoring process would give insight into requirements for the future. Watson's (1999) study only considered one module during the Common Foundation programme and such the use of a module in the first year of the programme limited the study to junior students in one locality and which therefore limits the generalisability of the findings.

2.5.3 Student – Mentor Experiences

Andrews and Chilton (2000) conducted a small pilot study involving quantitative research approaches over a three-month period, which ascertained the views of the staff nurses and students regarding the mentoring process. The purpose of the study was to evaluate staff nurses' perceptions of their own aptitude for mentoring, and to ascertain student's perceptions of their mentors' mentoring ability. A comparison of staff nurses and student's perceptions of mentoring effectiveness was undertaken, and the study also identified if the possession of teaching and assessing qualification influenced the effectiveness of mentors. The research was conducted in two parts, on two wards in a district general hospital within Northern Wales. The first part involved a sample of twenty-two qualified nurses at staff nurse level, who were mentors to students,

and the second part included eleven student nurses during a three-month period who were allocated to two wards. The study did not provide any details around the type of wards. A purposive sample was used with staff nurses drawn from an age range between twenty-one years to forty-five years old who had been qualified between one to twenty-one years. From this sample half of the staff nurses already possessed a teaching and assessing qualification, and at the time of the study eleven of the staff nurses were mentoring students. The students were obtained from first, second and third year levels, and ages ranged from between eighteen years to forty-five years old. Data were collected concurrently using questionnaires, which had been previously piloted.

The questionnaires utilised Darling's (1984) Measuring and Mentoring Potential (MMP) tool, which involves three basic mentoring roles and nine action roles. The purpose of using the MMP scale in a questionnaire format enabled individuals to evaluate their own and another's mentoring potential to which a scoring system was used with a rating criterion from one (low) to five (high). According to Darling (1984) the higher the overall score, the more rounded the mentor. Using a data collection tool previously tested should ensure the questions are unambiguous and there is a spread of responses thus ensuring the tool is error-free (Oppenheim 1992). The original tool devised by Darling (1984) was used and was not adapted even though there may be cultural influences since it is American.

Despite the fact that numerical scoring provided general trends, it was not the numbers that were important to Andrews and Chilton (2000), but the effectiveness of the perceived monitoring. The findings demonstrated that staff nurses with a teaching and assessing qualification rated themselves as more effective and supportive than those without. However, the possession of a teaching qualification did influence mentors perceptions of themselves as the knowledge and understanding of curriculum processes,

learning and teaching approaches, assessment criteria enhanced their ability to perform the role. From analysis of the student responses it was described that students consistently rate their mentors positively. However, students rate their mentors higher than the mentors awarded themselves. Fundamentally the students in the study viewed mentorship positively. Whilst the findings from this study provide some interesting information, they need to be viewed with caution due to the small sample size from one geographical location limiting their generalisability.

The research work of Darling (1984) identified three basic mentoring roles, namely, inspirer, inventor and supporter with the mentor role defined incorporating 14 parameters. One of the parameters that have particular relevance from the work of Darling (1984) which comes through in Andrew and Chilton's (2000) study connects with the teaching and coaching role.

Andrews and Chilton's (2000) study indicated implications for future practice to ensure consistency of mentorship to establish criteria for the selection processes of mentors, and to link mentor preparation programmes to standards, with the need for research to examine the models of mentorship. The national approach to mentorship preparation in Scotland (NES 2007) provides a framework to take forward a consistent approach to preparation.

To gain an understanding of the role of clinical nursing staff in the planned clinical experience of undergraduate nursing students, Jackson and Mannix (2001) used a story-telling approach. The use of stories enables participants to retain a control of the nature and depth of information revealed while facilitating a process of engagement. The aim of story-telling is to gain another or a different understanding and provides a means of generating insights into experiences (Koch, 1998). The study involved an exploration of the role of clinical nursing staff in students'

learning experiences, from the perspective of the students. Following input on reflection and storytelling, students were provided with a guided statement with forty-nine students in the first year of a Bachelor of Nursing Degree responding with stories around 1000-1500 words in length. Analysis of the stories allowed findings to be grouped into helpful and unhelpful behaviours for nursing students, and the findings were validated by going back to the student group and discussing the emerging ideas from the stories, which enhanced the credibility of the research (Koch 1998). The student group validated the information as well as giving the students an opportunity to comment on the insights gained by the researchers. The importance of taking data back to the study participants was to measure how plausible the description of the findings were and by checking the research thus ensure the truth aspect and the believability of the findings. The involvement of participants in checking the findings is supported by Lincoln and Guba (1985), and Leininger (1994). Robson (1993) also suggests this is a way of enhancing the credibility of a study however researchers must be aware of member bias.

Students identified understanding, being friendly, sharing interest and explaining as the most common helpful behaviours, and they felt very aware of their lack of skills and experience. However, students highly valued the staff's recognition of them as newcomers and showing them understanding. Findings reported the importance of feeling safe when asking questions which had a beneficial effect on clinical learning and students believed that feelings of uncertainty could be minimised by encouragement from clinicians with positive interactions and showing interest through questioning students about their learning, and their planned learning goals for the duration of the clinical placement. For the student, the explanation of the needs of patients, nursing actions and other activities of the ward were crucial not only in relation to learning, but also perceived to be helpful to the students' learning as well as an aid to

their socialisation into the ward. On the other hand, students felt acutely aware of being disliked and barely tolerated by some mentors hence the message conveyed was disinterest in the education and socialisation process for the students. Whilst some students' stories revealed they had been left on their own to care for patients, other stories revealed that students were not encouraged to ask questions or observe clinical procedures.

Overall, the findings from this study by Jackson and Mannix (2001) highlighted the importance of clinicians and academic nurses working together for the benefit of students, by ensuring exposure to the best possible opportunities for clinical learning. However, this study was limited to students of nursing in the first year of a Bachelor of Nursing degree in an Australian Metropolitan University. Due to the nature of the research, the sample understandably was small. However the students who participated had limited experience so findings need to be considered within this context. The inclusion of more senior students would have enabled a breadth and depth of experience as the result of longer exposure to clinical learning and the subsequent clinical environment if the study included larger cohorts. Jackson and Mannix's (2001) study was based in Australia so the impact of cultural issues also needs to be considered when reviewing the findings.

2.5.4 Student Feedback Processes

Glover (2000) reported on a case study used to identify third year nursing students' perception and use of feedback in the clinical area. The adoption of a case study approach was chosen to answer the 'how', 'who', or 'what' questions (Stake, 1994). The methods of data collection used were questionnaires, a clinical log and interviews. These various ranges of techniques gave multiple sources of data, which enabled the triangulation of data, therefore improving the validity and reliability of the

findings (Polit and Beck 2004). Participants in Glover's study were selected by purposive sampling with the sample group comprising six third year nursing students who were allocated to general medical and surgical wards. The study was explained to students and written consent gained for the four phases of the study which included a pre-clinical questionnaire, a clinical log, an interview and a post-clinical questionnaire.

There was no evidence the pre-clinical questionnaire was piloted. The pre-clinical questionnaire was devised to answer the timing of feedback, where it occurs, the elements and strategies the students used to self-evaluate their practice. The findings from the pre-clinical questionnaire reported the value of explaining and assisting the students by providing both positive and negative feedback. It was also found that feedback that explained rationales for practice was beneficial. Positive feedback provided encouragement, while negative feedback caused apprehension. Elements of feedback from the clinical log included increased confidence and self-esteem feedback, also increased skills and knowledge, therefore enhancing learning.

Interviews were undertaken with the purpose of getting the participants to focus on the most important piece of feedback. Interviews were transcribed and checked by the participants. The practice of returning transcribed data to the participants to check for accuracy can be seen to be necessary to establish dependability and conformability (Easton et al 2000). From the students' perspective the most important feedback related to skills and tasks with encouragement given, which made them feel accepted as part of the team. The interview findings were similar to those from the clinical log. Post-clinical questionnaires reflected the pre-clinical questionnaire with the focus on the willingness to pass on information and give feedback. The most significant examples of feedback related to skills, which were used to improve practice and future

goal setting. Elements of feedback focused on behaviour which was immediate and positive with a link to the person was perceived to be beneficial. Another benefit of feedback was when the feedback giver checked with the student in order to elicit the understanding aspect. Of particular relevance in the study by Glover's (2000), was the finding that feedback is an essential component in the education of nurses and enables growth. Although Glover's (2000) study had a small sample group and her findings were non-generalisable, they have resonance for nurse education and in particular the improvement of practice and student experience.

In Glover's (2000) study managers within ward areas required to provide leadership within the clinical learning environment as experiences for some students were still not structured nor planned to fully capture the opportunities for clinical learning. This impacted on the lack of supervision for students which impacted on the credibility of assessment. The clinical learning environment is an interactive network of forces influencing student learning outcomes in the clinical setting (Dunn and Hansford, 1997). As such, the clinical environment as a learning environment remains fundamental and multidimensional, but not all areas provide positive clinical experiences for students (Chan 2002).

2.5.5 Student's Preparation for Registration

Lauder et al., (2008) conducted an evaluation of Fitness for Practice curricula: self-efficacy, support and self-reported competence in pre registration student nurses and midwives in Scotland. They used a cross sectional survey of a stratified random sample of student nurses and midwives (n=777) which provided a 39% response rate. Data were collected by self completion questionnaires and were analysed by using SPSS 12-0 (SPSS Inc., Chicago, IL, USA). The results indicated high levels of students' self reported competency however, students may have

an unrealistic high perception of their competence, although older students may have a more realistic perception of their capability. The study reported there were no differences in self-efficacy between different access routes into the profession whilst there are considerable resources invested in mentorship these investments were less valued by the students in comparison to informal peer and family networks. Lauder et al., (2008) reported informal support mechanisms were seldom factored into curriculum design. This research study suggested the need for further discussion on the effectiveness and cost-effectiveness of student support systems. Limitations in Lauder et al's (2008) study include self reports of competence which may have overestimated competence. The response rate was a limitation as non-responders may have reported different scores. Students rated support from family and friends highest and support from HEI the lowest. However, support from HEI was seen as less satisfactory and varied from one institution to another. The level of mentor support and peer support was different between institutions.

2.5.6 Student – Mentor Contact Time

To examine the extent to which pre-registration nursing and midwifery students in England have contact with their named mentor, Jones et al., (2001) asked students and their named mentors to keep a diary for one week. While the main focus of the study was to provide data for service providers, on the costs and benefits of clinical placements, the extent to which mentors were available to students was also explored. A total of one hundred and twenty-five students, and one hundred and seventeen mentors completed and returned the diary from a total sample of two hundred and seventy. The overall student response rate was 46.3% with a mentor response rate of 45%. The authors reported that mentor and student contact was lacking which may be attributed to poor organisation, and there was an absence by management to plan mentor's days off and shift patterns to facilitate contact. The importance of regular contact with

the mentor was deemed important, and mentorship was seen as a managerial issue as well as having an educational focus. The data in this study found mentors did not have the time to mentor at the level they would want. The important issue of time as a factor is well reported elsewhere (Jowett et al., 1994, Neary et al., 1996). Those who saw mentorship as an integral part of their job profile had less difficulty with the time aspect of mentoring students (Atkins and Williams 1995). Jones et al., (2001) reported mentors used their own time in order to meet their responsibilities as a mentor, however the contact between students and mentors was compromised due to shift patterns and mentor unavailability which reflects findings from (Alderman 1998) and Lloyd Jones et al., (2001).

In a previously reported study, there was a need for managers to facilitate mentors working on the same shifts as students, thus allowing time for engagement of mentoring activities (Watson 1999). The importance of a management role in the overall educational quality of placement learning was essential so learning opportunities were planned. Hoyles et al., (2001) reported some mentors used other staff to supervise students however, if it was not planned students were left unsupervised. The lack of a structured approach with regards to the supervision of students was confirmed in previous work by Davies et al., (1994) and Payne and Gray (1991). In the report by Neary (2000) some students were left to carry out new nursing procedures when trained staff were not always available to supervise them or instruct them. In a previous report by Atkins and Williams (1995), it stated that value was found in a teamwork approach to mentoring using a supportive collaborative role. While Jones et al., (2001) study produced useful information, the study would need to be replicated before policies could have been taken forward into the costs and benefits of the clinical placements in order to provide a secure foundation for the development of educational policies.

2.5.7 Student Development

Building on her previous work, Spouse (2001) used a small naturalistic, longitudinal study, which was designed to investigate the processes and factors influencing nursing student acquisition of professional knowledge in clinical settings. The study used a multi-method approach for data collection using individual interviews as the main approach, supplemented by observation, illuminative art and documentary analysis of the student's critical incidents. The eight volunteer students were undertaking a nursing degree course in England within a single education setting although participants visited approximately ten care delivery sites during their programme, which consisted of twelve placements. The sample consisted of eight students from a group of 35 in the first year of a 4 year Bachelor of Science Nursing Programme and was a random convenience sample. In the study, Spouse investigated addressed the kinds of knowledge and understanding students acquired whilst learning to nurse. Spouse reported seven specific categories of knowledge concerned with activity factors and the theoretical aspects which demonstrated that students were concerned with the categories of professional knowledge development. Students relied very heavily upon their mentor, however with increasing confidence there was more self-direction, a finding supported by Gray (1997) and Gray and Smith (1999,2000). It was found without appropriate support from their mentor students' had difficulty with the psychomotor component of nursing. This was supported in previous research as students were left feeling vulnerable in clinical placements, because they were unable to help with basic clinical nursing skills (Elkan and Robinson 1993, O'Neil et al., 1993, Jowett et al., 1994). Spouse reported the limitations of the study related to the small sample and the involvement of a single educational setting.

2.5.8 Student Peer Support

Aston and Molassiotis (2003) reported on the dynamics of a student peer support supervision programme in England, whereby senior students supervised and supported junior students in their clinical placements. The initiative was under the overall supervision of a mentor, which was to enhance student learning within the clinical area, empowering senior students to develop, and assist junior students in developing within reflective practice, along with the support of more senior students. This initiative was to complement the existing mentorship schemes, with thirty-one senior and twenty-seven junior students completing an evaluation questionnaire. Senior students were in third year with junior students in the first year. Descriptive statistics were calculated for the quantitative aspect of the questionnaire for senior and junior students, with content analysis of both senior and junior students used to analyse the qualitative comments. Through analysis, themes emerged which included preparation, support and feedback, and personal and professional development.

Findings revealed that no preparation for reflective practice had taken place in respect to junior students, however the senior students' responses varied with the need for the system to be better organised in placements whilst twelve (38.7%) of the senior students felt the preparation for the role was well organised, twelve (38.7%) received a short introduction and seven (22.5%) students had to initiate the role of supervision themselves. The support and feedback aspect received a positive review from the junior students with a more variable response from senior students. Fourteen (45.1%) senior students received no support for the role in supervision of junior students. The junior students reported the benefit of feedback, which had a motivational effect and stressed the importance of the aspect of supervision, to support and reduce anxieties within the practice arena, particularly relating to junior

students. Senior students reported on their own personal and professional development by reflecting on their own learning, and in particular this increased their attention to the clinical skills being taught. The senior students commented on gaining confidence, but the students also wanted to be good role models. Whilst the concept of senior students involved in a supervisory capacity with junior students seemed a positive approach, the study did not reveal the role of management in ensuring resources were available which was a limitation in the study.

Reflecting on the research methods there was a lack of detail on how the questionnaire was constructed, and also how the reliability and validity of the tool was established. As such this has implications on the reliability of the findings from the questionnaire however the interviews were transcribed verbatim which indicates a degree of precision capturing all the data. The three themes which emerged are consistent with other studies (White et al., 1993, Glover 2000).

Papp et al., (2003) used a phenomenological approach to describe student nurses' perceptions of clinical learning experiences in the context of the clinical learning environment. Sixteen student nurses were asked to describe the significance of clinical learning experiences, which were good and bad as defined by the participants. These data were collected through unstructured interviews involving second, third and fourth year student nurses with students being observed in their clinical practice placements. The processing and analysing data from the participants followed a method created by Colaizzi (1978) which enhanced the neutrality of the results. Two researchers analysed the data which enabled discussion around any possible differences. Objectivity was assured by the use of a structured framework for data analysis. The results of the study were shown to six of the participants, who provided

confirmation of the findings as being a reflection of the descriptions which enhanced applicability.

Papp et al., (2003) reported that four elements sum up students' perceptions of clinical learning experiences: appreciation and support the students received, the quality of mentoring and patient care and students' self-directedness. Obvious previously reported findings from this study were that students valued practice placements and reported suitable surroundings for clinical practice were vital for a good learning experience, although they could also learn from bad experiences. However, on a good ward students were given opportunities to meet their objectives. Student nurses voiced the need to feel appreciated and if staff were not interested in mentoring them they regarded this as a negative experience. Overall, Papp et al., reported that students' perceived a good clinical learning environment as one with good co-operation and collaborative links between nurse mentors and teachers. This qualitative study provided valuable insights into student nurses' lived experiences within the clinical environment.

2.6 Link Lecturer and Clinical Educators in Practice Learning

2.6.1 Impact of the Role of Link Lecturer and Clinical Educators in the Clinical Learning Environment

For many years there has been a debate regarding the role of the lecturer in practice areas. Clifford (1993) using a survey of sixty-six nurse teachers gathered information on the clinical role of nurse teachers. Forty questionnaires were returned and the results showed that the frequency and timing of teacher's clinical involvement were not evenly distributed. With over half of the respondents completing the questionnaires this provided an adequate response and allowed some generalisation of findings. The results gave no indication of the nature of clinical involvement but there was a visiting role for the nurse teacher within the

clinical area. Clifford (1993) demonstrated the variable extent of nurse teacher's involvement in the clinical area. She found that the clinical role of the nurse teacher was unplanned, and not formally integrated into the clinical educational component. This study also supported previous reports into the clinical role of nurse teachers and the perceptions of the role in the clinical area (McHale 1991, Crotty 1992).

It was also reported by Crotty (1992) utilising a Delphi survey into the role of seven nurse teachers that the practitioner's role was to supervise and teach students in the clinical area while nurse teachers continued with a supportive liaison role. Acton et al., (1992) support the liaison input of the lecturer and asserted that the teachers should support the learning environments and facilitate the development of clinical competence however, the practitioners should demonstrate the skills component. Osbourne (1991) reported the view of the nurse teachers acting and serving as consultants to create and develop the educational clinical environment.

Baillie (1994) in an exploratory study in England within one locality using a qualitative approach into nurse teacher's views (n=10) about participating in clinical practice found that five out of ten teachers did not participate in patient care. The sample was purposive and the method of data collection was by focused interviews. The tapes were transcribed with meaningful statements extracted and categorized. However, it was reported there was uncertainty as to whether clinical practice should be part of their role although there was confusion surrounding the role, which led to the lack of a concerted effort in the provision of educational input possibly due to a covert college philosophy, which failed to give clear direction into the role of nurse teachers. This led to the perceived lack of support from clinical staff which prevented nurse teachers from teaching and practicing in the clinical setting. Finally, the lack of time was reported as another factor

preventing and impeding nurse teacher's input into clinical practice. However, this was a small exploratory study with a limited sample and in order to provide more generalisable findings the study would need to be replicated in other higher education institutions.

Murphy (2000) conducted an action research project to evaluate a teaching programme in the practice setting for pre-registration nursing students but also to identify the benefits for students, practitioners and the nurse lecturer in participating in this collaboration. Data were collected using a questionnaire from seventeen students, focused interviews with nine practitioners and analysis of a reflective diary which was kept by the nurse lecturer. The research project was conducted in the gynaecological unit of a District General Hospital in the United Kingdom over a period of twenty-one months between 1996 and 1998 in Wales. Over this period the students were from the Common Foundation and Adult Branch Programme. Findings from the questionnaire reported students responded very positively to the teaching programme, which helped link theory with practice therefore improving their learning and assisting the student to bring incidents from practice for discussion.

The practitioner interviews were transcribed and analysed to identify the key themes and categories. Practitioners were unanimous that teaching in more formal sessions was part of the role of a registered nurse. There were pressures on practitioners in that the educational remit of their role was not their primary aim, however it was reported teaching gave them opportunities to demonstrate their knowledge and enhanced their professional role. The reflective aspect and analysing incidents enabled an approach, which facilitated a review of their practice. The other theme, which emerged from the transcripts, was the role of the lecturer and the practitioner's perception of the impact of lecturer. The lecturers' role was seen as facilitating, also identifying potential problems and acting as a

resource for students and staff. The lecturer's presence helped to compensate with any unfamiliarity with the curriculum. The presence of the lecturer in a liaison role was perceived to ensure a favourable clinical learning environment for students.

Murphy (2000) reported the teaching role of the nurse lecturer in the clinical area which was also highlighted in a previous research studies (Cahill 1997, Willis 1997). Furthermore, it was reported there was a lack of teaching by lecturers in clinical areas a finding supported by Davies et al., (1994) and Jeffree (1991). Practitioners felt they had benefited from developing their teaching role in collaboration with the lecturer. Murphy's (2000) study found it possible for a nurse lecturer to fulfil liaison teaching, practice and research roles within practice areas an aspect of the role reflected in previous research by (Rolfe 1996). Murphy's action research project was small scale, and within a specific context and not designed to produce generalisable findings. Murphy's suggested collaboration between nurse educationalists and practitioners offers a potential model for developing the clinical role of the nurse lecturer.

Dale (1994) confirmed that if nurse teachers were to be able to demonstrate their ability to utilise theory within the practice settings, liaison and social clinical links would not be enough.

Recommendation twenty-nine from Fitness for Practice document (UKCC 1999) states:

> 'Funding to support learning in practice should be reviewed to take account of the cost of mentoring and assessment by practice staff and the cost of lecturers having regular contact with practice'

Developing the learning environment to enable a culture which enhances personal and professional development requires the influence at ward

manager level and the relationship between practice and the academic institution. The importance of developing 'fit for purpose' nurses needs to be high on the agenda by establishing the clinical placement as a positive learning experience, with a strong interface between theory and practice supported by appropriately prepared practitioners with input from Higher Education Institutions. Maslin-Prothero and Owen (2001) explored a number of realistic pragmatic approaches, which could be used to enhance clinical links and credibility of the nurse lecturer and teacher in clinical practice. Maslin-Prothero and Owen identified that working clinically with an honorary clinical contract enables lecturers to practice within their area of expertise. Extending this further there is strong support and emphasis on the need for clinically competent lecturers, which led to discussion on academic and clinical careers (Council of Deans and Heads of Nursing 1999). Lecturers getting involved in practice development, developing links to involve clinicians in teaching, doing clinically orientated research enhances their credibility. Extending the role of nurse lecturers and teachers in clinical practice, Maslin-Prothero and Owen (2001) argue that nurse lecturers need to develop an individualised practice-based role. These authors claim that it is vital that teachers need an up to date understanding of current practice issues.

While, there is not a universally accepted model for the lecturer in practice, Holland (2001) adds that nurse lecturers are expected to maintain clinical credibility, and competence in order to be able to integrate theory and practice. In addition, other authors have reported on lecturer involvement in practice setting to enhance the learning environment for students (Owen 1993, Aston et al., 2001).

Koh (2002) aimed to analyse the perceptions of nursing students at a senior level within the Adult programme of practice-based teaching facilitated by Link Lecturers in pre-registration education. The study was

located in England in two hospital trusts. A qualitative approach was adopted with the use of focus groups as the method of data collection. A mix of opportunistic and convenience sampling was used to recruit participants for the study. A total of 24 participants were recruited and divided into three focus groups. Focus group interviews lasted an hour and were audio taped. Data were transcribed and analysed verbatim to identify common themes in which five areas emerged.

Findings revealed that the integration of theory to practice with teaching sessions was perceived to be important for the participants particularly in relation to patient care. While theory was taught in the university prior to the practice experience the impact of teaching theory in the practice area was seen as valuable with a connection and link to clinical situations, which had a meaningful impact on the participants mind. The second theme, which emerged, focused on the development of the skill of reflection. Participants felt reflection through presentations, questioning and the use of theory with an opportunity to discuss experiences was valuable. In the third theme, student support was perceived to be important and participants reported the benefit of practice-based teaching.

Regular contact with Link Lecturers was useful and it was reported that participants had feelings of loneliness when Link Lecturers were not there. The value of lecturer's involvement was confirmed by Wills (1997) who found students valued the lecturers interpersonal skills, competence, evaluation skills and teaching ability, and it was felt Link Lecturers needed to organise and facilitate learning. Therefore, another aspect relevant to this study was the value of peer support and shared learning particularly if a link lecturer could facilitate a group. Participants in Koh's (2002) study considered motivation as a significant benefit associated with practice based learning, with results reflecting Link Lecturers were an important means of educational support. Whilst this study by Koh (2002) had

limitations in terms of it taking place within one geographical placement area and the nature of qualitative research not to produce generalisable findings, her recommendations which included the need for an educational structure that supported regular teaching sessions in practice settings has resonance with other research (Neary 2000).

O'Flanagan (2002) used students from each year of the pre-registration programme in England to reveal what students and assessors thought about clinical placements. Four focus groups were used comprising of three student groups and one assessor group with each group consisting of eight people who were chosen at random. In total, 24 students and 8 assessors formed the sample. O'Flanagan (2002) reported that six major themes emerged from the transcribed and analysed data: the learning environment: the acquisition of clinical skills: teaching in clinical areas: assessment in practice: role conflict: and education resources and support. Participants all agreed that all staff determined a good learning environment. Although, the role of the ward manager was perceived as essential in creating the environment, the emphasis was placed on all members of the team being responsible for maintaining an effective learning environment. From a historical perspective, authors have reported the complexity of providing an effective learning environment (Orton 1981, Pembrey 1980, Orton and Prowse 1993).

Ogier (1982) found the ward sister was a key figure in the quality of student learning. This finding concurs with the work of Pembrey (1980) who reported that the student experience was dependant on the emphasis each ward placed upon learning. Moreover, the common factor from Ogier (1982) and Pembrey (1980) findings lie with the ward sister playing a key role. Helping students learn was part of the role of the Sister/Charge nurse (Smith 1992).

Gerrish (1990) presented an analysis of the educational role of the ward sister and considered the extent to which clinical and management roles inhibited the ability to effectively fulfil an educational role. Whilst there were issues of role expectations role conflict and role ambiguity the need for nurse educators to be more empathic towards the role of the ward sister required supportive measures to be in place.

Gerrish (1990) supported the view that the ward manager had a dominant influence in providing a good learning environment. Factors relating to the development of clinical skills appeared to equate with the lack of continuity with practice placements. The report also suggested factors that affected students gaining clinical skills were staff having sufficient time to supervise and teach students. Indeed, the use of additional skills workshops held to increased student confidence. First year students felt the longer specific placements and the additional skills enabled students to gain competencies. Watkins (2000) ascertained student's views regarding longer clinical placements and input with a focus on clinical skills workshops made students feel more 'fit for purpose'.

Gerrish (1990) and O'Flanagan's (2002) reports focused on students often feeling pressurised into carrying out duties to feel accepted by the team members. However, Morgan (2002) supported the view of the need to give students time to feel part of the team and become familiar with procedures. Teaching in clinical areas was reported by Gerrish (1990) as beneficial and valuable however, all focus groups emphasised that time was the factor as to whether teaching could take place. This finding supported research by Davies et al., (1995) who found time was essential and the support aspect as a key factor in ensuring students have positive learning experiences. O'Flanagan (2002) also reported the need for guidance and support with assessments for students, but also the need for streamlined less repetitive assessment documents. This aspect by

O'Flanagan (2002) is supported by more recent research by Turner et al., (2003) who support the need for well-designed clinical practice documents to assist the assessors.

A study of nurse education by Shields (1995) suggested that staff in clinical areas could contribute to positive learning experiences by involvement of students in a reflective process. However, mentors need to elicit students' understanding so transfer of learning can take place enabling students to implement their new experience into future situations (Shields 1995). O'Flanagan (2002) found the need for better support systems for students and trust staff, in conjunction for the need of clearer links and communication systems with the university. The importance of practitioners supporting student learning is well recognised and its success depends on the collaboration between clinical and teaching staff (Corlett 2000). Previous research by Gerrish (1990) argued that nurse teachers need to be perceived as clinically competent by student nurses and clinical staff.

While O'Flanagan's (2002) study gave a useful perspective into the support required for practice placements to make them effective there were issues with research design and methodology. The study was limited as there was a lack of information on the cohorts involved in the study and the engagement of the researcher with the methodology. For a research study to have conformability the research method needs to demonstrate evidence of an audit trail and the involvement of the researcher in reflexivity (Leininger 1994; Huberman and Myles 1994). Since the study sample was related to one geographical area, this therefore restricted the generalisation of the findings.

Chapple and Aston (2004) reflected on the need for change, as the liaison role of the lecturer was inconsistent with a lack of clarity around the role

and therefore the role was perceived not to be valued. Day et al., (1998) previously reported on the role of the nurse teacher or lecturer in practice providing communication and a link between education and service.

However, the expectations of the role were unclear for all stakeholders. As a result lecturers failed to make an impact, therefore an integrated partnership approach emerged with lecturers and practitioners working collaboratively to develop the practice-learning environment. In line with the Fitness to Practice document, the UKCC (1999:48) recommendation twenty-five emphasized the need for:

> 'Service Providers and Higher Education Institutions should work together to develop diverse teams of practice and academic staff who will offer student's expertise in practice, management, assessment and mentoring and research'.

The practice learning teams in Chapple and Aston's (2004) study comprised of a group of nursing practice staff, and lecturers who worked collaboratively to make a contribution to student learning within a clinical setting. The rationale was to encourage lecturers to contribute actively and have an impact on the quality of student's clinical learning. While there were only informal evaluation strategies reported from the team member's perspective in Chapple and Aston's study (2004), they provide an early indication that practice learning teams were received enthusiastically by the majority of lecturers and nursing practice staff. However, the impact on mentors, students and other stakeholders was not explored. The next stage of the partnership approach to supporting students' clinical learning would require formal evaluative research to establish the strategic and operational overviews with the benefits for clinical learning through teachers and practitioners working in partnership.

Walsh and Jones (2005) identified the need to strengthen links between higher education providers and service providers to ensure the delivery of a seamless curriculum. A tripartite approach to practice learning was used to enable innovation and the bringing together of a cohesive approach between one English University, service provider organisations and workforce development.

Walsh and Jones (2005) focused on the multi-faceted developments that facilitated effective practice learning for students. Walsh and Jones' (2005) conclusions that having meaningful collaborative partnerships with effective communication networks are of particular note. While it was acknowledged by UKCC (1999) that pre-registration nurse education in the United Kingdom was delivered within a complex system, practice learning had many influences, which would either enhance or undermine the student experience.

The approach taken from one-university involving service provider organisations' within a tripartite approach had challenges. Student perceptions of support in practice reported deficits particularly in the preparation for each placement, the level of support received during placements, link lecturer's involvement and feeling part of the team. It was stated that the University involved in this tripartite approach will take forward an action research approach. Approaches have been developed through tripartite collaboration, but the need for further research was highlighted into the impact of this model for practice learning, across a larger number of other educational establishments.

Newton and Smith (1998) conducted research to ascertain the value, as perceived by the students, of having the personal tutor supervise them in college as well as in the four branch placements of foundation studies in one Scottish Institution. A descriptive study was employed utilising a self-

administered questionnaire involving a convenience sample consisting of 108 students. A total of 94 completed questionnaires were returned giving a response rate of 87%. Statistical analysis was descriptive in nature the findings demonstrated that 55 students (n=94) perceived value in having one nurse teacher supervising them in college and in placements compared with 39 students who did not perceive any value. The study revealed that inequalities exist in the nature and delivery of practice placement supervision. The study by Newton and Smith (1998) was quantitative in nature and the researchers recommended the need for further exploration utilising either focus groups or semi-structured in-depth interviews. This would generate data of a qualitative nature and seek to clarify some of the issues around supervision in practice placement. Newton and Smith (1998) found that students rated the social aspects of the lecturer role highly, along with teaching and tutorial ability.

Brown et al., (2005) conducted a retrospective qualitative study involving the experiences of a group of senior nurses who had a learning relationship with a lecturer in a clinical placement to enhance supervision and support with practice. In order to provide collaborative support during practice a cohort of sixty-five third year Adult Branch nursing students in one Scottish Higher Education Institution were approached, however, only twenty-five students volunteered to participate in five focus group discussions. The authors felt focus groups provided a method which enabled a dynamic interaction between participants and researchers. Kevern and Webb (2001) highlight both advantages and disadvantages to focus groups as a research method. In Brown et al.'s study the dynamic interaction created by promoting discussion, exchange of views and ideas between participants and researchers would be supported by the research team (Mansell et al., 2004). However, disadvantages of focus groups as a research method include the domination of the group by participants, which highlights the need for the researcher to have expertise in group

facilitation (Kevern and Webb 2001, Verpeet et al., 2005). The experience of the researchers was not however apparent from the report.

Curtis and Redmond (2007) support the view that individuals are a product of the environment. This study by Brown et al., (2005) used focus groups as a single method approach the study could have been extended to use focus groups as a component of a mixed method research design to expand the methodology. In order to gain a larger sample a survey approach may have enhanced the study.

Brown et al., (2005) undertook thematic analysis from the focus groups data. They reported the students' need for support from the lecturer and the need for visits from a lecturer while on clinical placement. According to May et al., (1997), students value the lecturer's role and contact in clinical placements. This is further confirmed by the work of Gillespie (2002) who found students expressed a desire to 'connect' to the lecturer. In previous research studies by Cahill (1996) and Wills (1997) both suggest that the lecturer's role includes support of students and staff.

2.7 Management Support Systems which Impact on the Clinical Learning Environment

Turner (2001) reports on the foundation of a Clinical Programme Support Unit (CPSU) to manage the clinical experiences of health care students and promote a healthy dialogue between the staff in the faculty and clinical colleagues. Turner argues that the support from educationalists for students whilst on placement and for service colleagues was adversely affected primarily by the move of nurse education from schools and colleges of nursing into higher education institutions (HEIs) with the loss of the previous close links between education and service. Secondly, the pressure on the clinical situation manifested as unsupported clinical staff had little time for student supervision. Lastly, the situation was developing

that practice was beginning to be seen as the ‘poor cousin’ to academia a view supported by Cuthbertson (1996).

Furthermore Turner (2001:326) reports ‘that the teaching and supervision of students by clinical staff was in danger of being perceived as yet another onerous task to an already overburdened workforce’. The Clinical Placement Support Unit (CPSU) used an assessor’s newsletter and a website. The unit conducted a survey of all clinical placements (n=600) to find out which psychomotor skills were most commonly practiced with a 78% return rate. The findings were used to influence the foundation programme curriculum, branch programmes and the production of a skills booklet at a local level. In accordance with the Peach Report, practice placements and using a partnership approach, this initiative to support clinical placements in nursing curricula gave access to information which was relevant and useful for students. While Turner’s innovation sought to further promote a healthy dialogue between academic and clinical colleagues, as well as supporting the students’ experience before, during and after placement, the impact evaluation from a stakeholder, student and academic perspective however was not covered. Acknowledging the strategic approach taken and what would appear to be a robust strategy of enhancement for clinical placements an audit of the effectiveness would have enabled an account to be given on the value of such an innovation.

Lewin (2007) reflected on a longitudinal study conducted in 1978, to illuminate criteria for the evaluation of hospital wards as clinical learning environments for student nurses. The 1978 study focused on three cohorts of student nurses from three different training schools in England, which comprised 87 students. The research team interviewed the students towards the end of the clinical placement, which was followed by a questionnaire specific to the placement. This was a large study comprising 1065 in–depth interviews. In 2003, a second study employed

a retrospective, cross-sectional analytic survey designed to map the clinical learning of 272 students. A mix of structured and open-ended questions were used for the questionnaire, which was reviewed by the school's quality monitoring committee both before and after piloting with sixteen student nurses. The study was based in one English School of Health Studies, using clinical placements in three National Health Service trusts and was part of a quality assurance and enhancement initiative. While the second study was cross-sectional rather than longitudinal, the data from the second study comprised evidence from 99 first, 75 second and 98 third year student nurses.

Lewin (2007) revisited the two studies which were undertaken by the same researcher. The purpose of the study was explained to the participants by letter and assurances were given confidentiality, anonymity and the safe storage and custody of data. Participants were also informed that all the information would be used to inform future educational practices and procedures. Data were analysed using SPSS software.

Clinical learning indices focused on learning and placed into five categories: grade of staff: how often trained staff demonstrated practical procedures: how much time trained staff performed practical procedures: how much time trained staff were involved in personal supervision: and how often trained staff and mentors tested theoretical knowledge. The grades of staff with which students worked mostly were third year students with enrolled nurses as partners in the learning experience. Out of the four hospitals surveyed there were variations in the frequency of demonstrations. Within all cohorts there was an indication some students' might receive very little supervision. Comments commended the excellent teaching available from clinical staff with students speaking about their increased sense of motivation, competence and responsibility. However, Lewin (2007) reported there was an average 20% improvement in the

quality of hospital based clinical learning environments over a 25 year period. This improvement was based on trained staff personally supervising students more extensively, testing their theoretical knowledge more frequently, and spending more time performing practical procedures with them. However, unacceptable clinical learning opportunities did present difficulties, even though there was improvement the experience for some students was haphazard.

2.8 Summary

Much of the research centred on the importance of the mentor for students and the supportive function, which was demonstrated from the student's perspective. The discussion of the grade of staff involved in mentoring varied with more emphasis being placed on the need to have the right qualities. To ensure meaningful engagement with mentors, students required a planned coordinated approach to ensure appropriately prepared staff supervised students. Some of the research indicated a need to examine the models of mentorship. Overall, mentors were seen as central to the learning experience to enable appropriate linking of theory and practice. In order to facilitate partnership working between education and practice, the role of practice educators were seen as supportive to the learning environment. The emphasis from the research studies was on the need for investment in resources for mentorship and the need for improvements with partnerships between education and practice to ensure staff and students were well informed about the curriculum. The research studies revealed the need for qualified practitioners to undertake mentorship training, as many felt ill prepared to undertake the role. However, mentors required more support from academic staff in Higher Education Institutions namely from academic staff. The literature suggested gaps highlighting the need for the impact of mentor preparation on the mentors to be explored with a focus on support required for the role. The research studies revealed the need for support

from lecturers with the role of the lecturer into practice requiring more clarification. There was a need for a partnership approach to develop the practice and learning environment and establish better support systems for staff and students. While specific approaches, namely tripartite collaboration were used the impact of this approach requires further research. Many of the previous research studies had a broad focus (Neary 2000, Pulsford et al., 2002) with a lack of generalisable evidence. Other studies had methodological issues (Aston and Molassiotis 2003, Brown et al., 2005; Cahill 1996, Cameron Jones 1996, Davies et al., 1994, Earnshaw 1995, Neary et al., 1996, Rogers and Lawton 1995, White et al., 1993).

As Schneider (2003) indicates the aim of the literature review is to identify gaps or conflicts in knowledge. It was from the identification of these gaps below that the issues underpinning the research questions arose.

- Strategic perspective on mentor selection and preparation for the role
- Support for mentors and the impact of mentorship on the mentors
- Impact of engagement from mentors on students
- Partnership engagement between the Higher Education Institution and the National Health Service
- Theoretical preparation for mentorship
- Evaluation performance of the mentor
- Role of the lecturer, practice education facilitator and ward manager to support learning within a strategic context

The next chapter details the aims, research questions and research methods.

Chapter Three

Research Design and Methods

3.0 Introduction

This chapter commences with the aims and research questions for this study, into the impact of the strategic arrangements to support practice based learning by focusing on the processes for mentorship and the impact within the clinical learning environment.

The chapter also reflects on quantitative and qualitative approaches, addressing the choice of research methodology in order to answer the research questions. Included within the chapter is an illustrated summary of the rationale for the rejection of the positivist paradigm for phases 2 and 3 of the research study.

The origins of grounded theory and the underlying philosophy are discussed with specific reference to the development of grounded theory, and the underpinnings of this theory, namely symbolic interactionism. Incorporated within the chapter are some of the issues around literature review in grounded theory methodology. Reflexivity is included within the chapter and my engagement in a reflexive approach is discussed. Ethical considerations, the background to establishing principles of ethical research and the application of ethical principles of the research study are discussed. The chapter will identify the study design and the sampling strategy. Details of the participants for phase one, two and three of the research study and methods of data collection to answer the research questions are summarised. For each of the three phases, the data collection methods are explored in detail followed by a discussion of the data analysis techniques used for the questionnaires, interviews and focus groups.

Phase one of the study gives an account of the use of a programme for the design, administration, processing and analysis of surveys. The constant comparative method will be detailed for phase two and three of the research study.

3.1 Aims of the Research Study

3.1.1 To explore the impact of the strategic arrangements and mechanisms to implement and support practice based learning.

3.1.2 To investigate the selection processes preparation, support and evaluation of mentors.

3.1.3 To explore the impact of mentorship from the viewpoint of mentors, students, managers and educational links within the clinical learning environment.

3.2 Research Questions

3.2.1 What are the strategic arrangements for practice based learning from a Higher Education Institution and Director of Nursing perspective?

3.2.2 How are mentors selected and supported in their roles?

3.2.3 How are mentors prepared and evaluated in their approach to teaching and facilitating learning within the practice setting?

3.2.4 What are the strategic mechanisms to support mentors at ward manager level?

3.2.5 What is the impact of Lecturers and Practice Education Facilitators on the role of the mentor?

3.2.6 What is the mentors' involvement in providing a quality learning experience for students?

3.3 Choice of Research Design

When the research methodology was reviewed for this study, I reflected on both quantitative and qualitative approaches to ensure the choice of methodology was guided by the research questions (Houser 2008).

3.4 Exploration of Quantitative Research Design

The positivist paradigm was explored which would have tested existing theories, investigated cause – effect relationships and placed emphasis on measurement and explanation (Graziano and Raulin 2007). Quantitative research has its origins in positivism, which maintains that in the world there is an objective reality, which can be observed and measured or quantified in some way (Alasuutar et al., 2008). Quantitative methods are appropriate when verification is required, in which the data are subject to statistical analysis. The samples within a quantitative approach are referred to as subjects, cases or respondents, with the researcher using measuring instruments or tools. Data elements are in numerical form and statistical analysis using software to facilitate examination of quantitative data. The outcomes in quantitative research must be measurable, and are reported in numerical terms (Schneider and Deenan 2004). The approach involved is reductionism, in which the information is put into component parts in order to appreciate the whole situation. The quantitative approach has a focus which is concise and narrow at the reductionist level giving logistic and deductive reasoning (Bryman 2008).

Primarily, this research study focused on the strategic implementation of practice based learning and the impact of mentorship within the clinical learning environment. As such the initial phase required an overview of the current approach which was conducive to the use of the traditional scientific approach. A survey approach was used to answer the research questions (3.2.1 & 3.2.2) for phase one of the study.

While the focus of quantitative research is on verification and originates from logical positivism, reflecting the traditional scientific approach, the focus of qualitative methods on the other hand involves an exploratory approach, which comes from the social sciences (Polit-O'Hara and Beck 2008).

3.5 Exploration of Qualitative Research Design

Qualitative research is an exploratory approach which reflects the interpretative paradigm, which gave me an opportunity to explore how the phenomenon from the participants' view and perspective would be understood (Creswell 2007). The choice of research methods should be guided by the problem to be investigated which applies to all research and according to Morse and Field (2002) by what is already known about the subject area. This is supported by Silverman (2005), who suggests that the choice of research methodology should be guided by the nature of the question or problem to be investigated and by what is already known about the phenomenon. Furthermore, qualitative research methods are more appropriate when there is a lack of research within a field. This would apply to the impact of mentorship from a mentor' perspective, including selection, preparation and support of practice learning from a strategic perspective. Thus, the approach undertaken in qualitative research aims to capture subjective and objective views while understanding the participants' experience (Polit and Hungler 2007). Thus qualitative research can use multi-methods involving an interpretive approach to its subject matter. More specifically, this means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. According to Denzin and Lincoln (2000) a wide range of methods are used in qualitative research and as such this enabled me to engage in an interconnected approach as methods were brought together to enhance and enrich the subject matter.

Streubert and Carpenter (1999:29) report four significant characteristics of qualitative research:

> '… A belief in multiple realities, a commitment to identifying an approach to understanding that will support the phenomena studied, commitment to the participant's point of view, conduct of inquiry in a literary style, rich with participant's commentary'.

Indeed, the term 'qualitative research' includes a range of methods and designs (Boyd 2001). Specifically, what these methods and designs have in common is that they approach the research questions holistically with a focus on human experience and the ways people create meaning in their lives. Lowenberg (1993) identified three principal approaches to qualitative research as phenomenology, ethnography and grounded theory. Holloway and Wheeler (2002) illustrated a diagrammatic representation of the three methodological approaches to qualitative research from the theoretical origins to application **(Figure 1).**

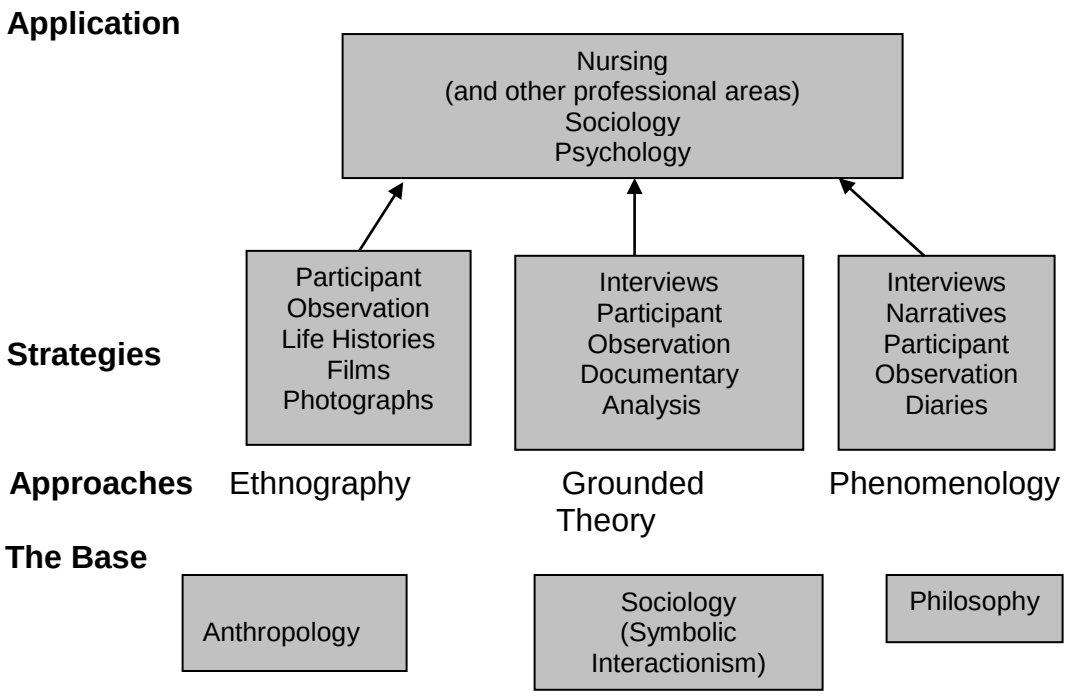


Figure 1 – Three methodological approaches to qualitative research (Holloway and Wheeler 2002).

The qualitative method of grounded theory was used in phases 2 and 3 of this research study because of its application to the research of experiences of the participants which facilitated questions in Figure 2 to be addressed (Beyea and Nicoll 1997; Sim 1998). Before justifying this, the rationale for rejecting the use of the positivist paradigm in phases two and three can be found in Figure 2.

	Research Questions	**Rationale for choice of the paradigm used in each phase of the study**
3.24.1	What are the strategic arrangements for practice based learning from a Higher Education Institution and Director of Nursing perspective?	The positivist paradigm was used as this allowed this question to be addressed.
3.24.2	How are mentors selected and supported in their roles?	Using a positivist paradigm here would not have answered this question fully so the interpretative paradigm was used.
3.24.3	How are mentors prepared and evaluated in their approach to teaching and facilitating learning within the practice setting?	In addition to the positivist paradigm a qualitative approach was needed to illuminate and provide meaning to the area of mentor preparation and evaluation.
3.24.4	What are the strategic mechanisms to support mentors at Ward Manager level?	In addition to the positivist paradigm a qualitative approach was needed place the strategic mechanisms in context.
3.24.5	What is the impact of Lecturers and practice educators on the role of the mentor?	The exploration of this question required the use of the interpretative paradigm in order to facilitate in a focused way a dialogue to take place with two groups.
3.24.6	What is the mentors' involvement in providing a quality learning experience for students?	Rejection of the positivist paradigm was due to the need to capture the subjective and objective views encompassing the totality of the mentors' involvement.

Figure 2 – Rationale for choice of the paradigm used in each phase of the study to address research questions.

Prior to discussing grounded theory, the underpinning of this theory will be explored with particular emphasis on symbolic Interactionism.

3.5.1 Symbolic Interactionism

The roots of grounded theory lie in symbolic interactionism, which comes from the ideas of Dewey, Cooley and Mead (Hammersley 1989). Mead (1934) was a social psychologist, who provided a framework and structure for the study of human social behaviour, however it was Blumer (1937) who coined the term 'symbolic interactionism'. The development of the interactionism approach, which was coupled with naturalistic inquiry ultimately, influenced grounded theory (Benzies and Allen 2001).

In the literature it is reported that Blumer (1969) further developed the interactionism approach with naturalistic inquiry, which assisted in the infrastructure of the grounded theory approach (Hall and Callery 2001; Heath and Cowley 2004).

Moreover Blumer (1969) stated symbolic interactionism had its basis in three assumptions:

- Human beings acted towards things on the basis of the meaning they had to them.
- Such meanings were derived from, or arose out of, interactions with one's fellow human beings.
- Such meaning were dealt with, and modified, through an interpretative process by the individual as they dealt with the things they encountered.

In fact, symbolic interactionism is both a theory about human behaviour and an approach to inquiring about human conduct and group behaviour (Annells 1996).

Indeed, as a theoretical perspective, symbolic interactionism posed a challenge to functionalism, which was the dominant sociological theory of the time. The functionalist approach was highly structured with clearly defined parameters, whilst symbolic interactionism viewed society based on a myriad of interactions. The main focus of symbolic interactionism is on the inner or 'experiential' aspects of human behaviour, it allows an understanding of how people define events and reality and how they act according to their beliefs (Chenitz and Swanson 1986). Accordingly, the symbolic interactionism position is that human behaviour acts and interacts with the use of symbols providing meaning to situations, which was described by Seaman (1987), and Silverman (2004) as a process of interaction which is dynamic with roles changing and adjusting over time.

Grounded theory's aim is to explore basic social processes and to understand the multiplicity of interactions that produces variation in that process. Thus social interactions have meaning and help shape society, and it is in the social interaction that the individual achieves a sense of self. Consequently, 'grounded theorists' search for social processes present in human interaction (Morse 2002). In other words, symbolic interactionism claims that people are in a continual process of interpretation with individuals being creative in their interactions with others (Munhall 2007).

Therefore, to understand the world from the participant's perspective, research should be conducted in the context of the participant's social world (Schwandt 2000). To ensure the research was conducted in the context and involved social processes in human interaction 'verstehen' was used in this research situation, ensuring the research had meaning I engaged in an empathetic way with participants. Verstehen is a German word meaning knowledge, insight or understanding.

In conjunction with the social theorist Max Weber (1864-1920), the word is used to describe the approach used to gain knowledge, insight or understanding in environments and situations in which the individuals do not officially belong. In my study I used the time to appreciate and engage in the research situation to understand what was happening. Verstehen not only gives meaning and insight into people, but this aspect was extended by Weber to provide insight by means of personal involvement through the process of reflexivity. Melia (1983:24) stated that:

> 'The central idea of verstehen is that the understanding of meaning is essential to the explanation of human action, in other words to observe is not enough'.

Developing this theme further, I needed to gain an understanding of the effect of situations on the participants. In relation to this research study, the meaning of the impact of mentorship on individuals is critical with the importance of the understanding of situations for those involved ensuring events are interpreted, and the meaning of these events put into context was essential in the study.

It was the difficulty that Glaser and Strauss (1965) had in describing the meaning of dying from a symbolic interactionists approach that led to the development of existing methods hence producing 'grounded theory'. Consequently, symbolic interactionism was the primary theoretical underpinning of grounded theory and the grounded theory method was derived from the theoretical framework of symbolic interactionism. It has been suggested that Glaser and Strauss are known as the proverbial 'fathers' of grounded theory. The next section explores the origins of grounded theory and the rationale for using this research methodology.

3.5.2 Grounded Theory

The discovery of grounded theory (GT) was born out of an intriguing union between Barney Glaser and Anslem Strauss (Glaser and Strauss 1967). Grounded theory emerged to address and challenge the dominance of the pure science approach. However, Glaser and Strauss came to the application of grounded theory from very different research backgrounds and experiences. Strauss, from the University of Chicago, with a background in social science offered a qualitative perspective and was strongly influenced by the work of Thomas, Mead and Blumer, whilst Glaser, from Columbia University had an emphasis on a quantitative approach with a focus on a systematic way of generating theory and coding (Hardey 1994), through explicit sets of techniques and procedures (Strauss and Corbin 1990).

Grounded theory is a unique approach, which fused the two perspectives and a means was articulated, whereby qualitative and quantitative researchers could generate theory by constantly comparing data, discovering concepts relevant for an area and building on that theory by focusing on the emerging issues (Glaser and Strauss 1967). It was the impact of an awareness of dying in which the research involved processes, which were grounded in reality and information derived from the data, which helped address quantitative forms of analysis, which were highly featured across the social sciences. More specifically, grounded theory is a systematic way of generating new theory grounded in the field but also set in the context of existing theory by refocusing and clarifying established theory (Hutchinson 1993). Even though the approach of grounded theory seeks to generate theory from the research situation in the field, it enables an exploration of rich meaningful data in relatively unchartered waters (Stern 1985).

Glaser (1978) and Strauss (1987) stated that generating an explanatory theory from the data being analysed, rather than trying to fit the data into an existing theoretical framework. Nevertheless, it was Lincoln and Guba (1985) who emphasised that a grounded theory was a theory that was induced from the data rather than preceding them, by using inductive and deductive approaches to enable theory generation (Clifford 1997). As Glaser and Strauss developed grounded theory methodology both saw the need to focus on the data and generate theory reflective of the perspective of the participants (Glaser 1992). Ensuring the theory generated reflects the participant's perspective the grounded theory approach enabled me to keep one foot in the world of the participants and the other foot outside their experiences (Chenitz and Swanson 1986).

Developing the theme of grounded theory it is seen as a general methodology, and is reported by Strauss and Corbin (1990) as an approach that is discovered and developed. Hence it is derived inductively through data collection and analysis. Thus it is through a systematic process of data collection and analysis the areas of relevance emerge. The view of grounded theory as a general methodology was further supported by Glaser (1992), who described grounded theory as a process of analysis linked with data collection with the aim of generating an inductive theory about a substantive area.

Strauss and Corbin (1994) purport that as theory evolves by a process of continuous engagement during the actual research, it enables interplay between analysis and data collection. The basic purposes associated with the analytic procedures of grounded theory are to generate rather than test theory and to give the research process rigour (Strauss and Corbin 1990). Glaser (2001) reported on the approach and continuous interplay to generating theory by providing explanation for interactions and inter-relationships of those involved ensuring the research process has rigour.

Therefore the purpose of grounded theory is to generate theory, namely formal theory or substantive theory (Charmaz 2006). According to Streubert and Carpenter (1999) formal theory involves wider issues, which can be seen as having a higher level of theoretical development. The wider issues can be applied to a range of disciplines. While the focus of formal theory is higher level with an overarching, broader concept, substantive theory has a narrower focus with a strong sense of relevancy to the participants. The involvement of social processes with a contextual focus is characteristic of substantive theory (Morse 2001). Additionally, Chenitz and Swanson (1986) viewed the grounded theory approach as an understanding of human behaviour by generating theories about social and psychological phenomena.

Therefore, grounded theory is a qualitative research design that was developed for the purpose of studying social phenomena from the perspective of symbolic interactionism (Bowers 1988). Denzin (1989) links symbolic interactionism to naturalistic qualitative research methods, which connects the research with the interactive world of human beings to understand them. As such naturalistic inquiry is characterised by research in natural settings and is seen as an alternative to traditional positivistic inquiry. Gubrium and Holstein (2002) suggest naturalism seeks to understand social reality and provides rich descriptions of people. Since grounded theory has a shared ontological perspective based on the ontological view of symbolic interactionism this ultimately reflects the perspective of critical realism (Annells 1996). The latter perspective deals with reality as a social construct and as Glaser (1992) points out the focus of the research is what is happening in the situation and not on what might be.

Grounded theory method is considered to be an interpretivist approach, stemming from the constructivist view as a reaction against objectivity and

theory and hypothesis testing (Holloway and Wheeler 2002). Therefore, the research paradigms underpinning grounded theory are constructivism and interpretivism. The methodology of grounded theory begins not with a hypothesis but with a research situation enabling a systematic investigation in the field. More specifically, the theory being 'grounded' in the data from which it originates creates a perspective on a known area or elicits information about a phenomenon, which has limited research (Glaser and Strauss 1967) or where a new and exciting look is needed in familiar settings (Stern, 1980).

Because of this grounded theory is particularly apt when studying mentorship within the clinical learning environment, as the impact of mentorship requires further critical investigation from the perspectives of mentors, managers, educators and students. This shows the impact of mentorship while exploring the strategic arrangements and mechanisms of implementation to support practice based learning. To gain insight into the processes involved in the preparation and performance of the mentor I investigated the reality of mentorship and explored the strategic components around the partnership arrangements for Higher Education Institutions and the National Health Service establishments. Grounded theory focuses on the importance of context aiming to understand how individuals interact, through the reality of their world (Stern, 1985). Facilitating rigorous data collection and ongoing analysis allowed theory to emerge rather than forcing the data Glaser (1992), thus enabling an explanation of issues and problems and behaviours, which seeks resolution. As such constant comparative analysis occurs simultaneously throughout the collection and analysis of data, thus enabling the researcher to go back and forth between the data and the emerging concepts and theory.

The process involves the researcher going back to the data and returning to the participants.

Glaser (2004:7) views the final output of a grounded theory study to be detailed as follows:

> ‘A set of grounded concepts organised around a core category and integrated into hypotheses which explains how people deal with problems and concerns by engaging in behaviour that resolves those problems for them’.

It is recognised by Glaser and Strauss (1967) that the researcher does not approach the study with an empty mind, I became part of a socially constructed reality and engaged in the study world. I therefore felt it was also important to maintain as much objectivity as I could. I did this through the consistent use of reflexivity and in my discussions with my supervisors. I also worked hard at separating my job role from my researcher role. Whilst I believe I was successful in this, I cannot claim that this separation worked for participants who knew me in both these roles.

Crooks (2001) suggested that a grounded theory approach enables the researcher to gain a picture of what people do, and as a result of the engagement elicit the participants concerns, but also provides a focus of how they deal with these. Whilst there are different approaches to grounded theory the original form is referred to as ‘traditional grounded theory’ (Glaser and Strauss 1967). From the development of grounded theory, Glaser and Strauss have diversified and as such there are different versions. Glaser is associated more with the qualitative paradigm which is guided by the participants’ world. Hence it is argued that Glaser held to the traditional and original grounded theory (Glaser 1978; 1992), while Strauss appears to be more concerned with the detail and description of

the cultural scene. Strauss' emphasis retains a scientific focus which may be argued to be closer to the quantitative paradigm.

Strauss focused his ideas for evolving grounded theory in the development of a conditional matrix to shape the data being analysed. Furthermore, Strauss (1987), and Strauss and Corbin (1990; 1998) focused on a structured form of steps in order to develop analytic techniques. This structured format adopted by Strauss and Corbin was seen by Glaser as a method which forced data and was therefore prescriptive in approach. Glaser (1992) thought this approach caused forcing of the data resulting in preconceived descriptions which are not commensurate with grounded theory. Another form of grounded theory is the constructivist view. Charmaz was the first researcher to name her work constructivist grounded theory (Charmaz 1994, Charmaz 2000, Charmaz 2006). Charmaz engaged in a review of what she described as a postmodern critique of traditional grounded theory. This meant that the underpinning lies between positivism and postmodernism with an interactive approach to data collection and analysis. As such Charmaz (2006) reports that she is a critical interpretivist, building on the pragmatist underpinnings in grounded theory and advances interpretive analyses. The researcher, in Charmaz view, is involved in the construction of meaning with participants in the generation of data and engaged in the reconstruction of the data into a theory.

While there are different approaches used in grounded theory, the chosen method for this research study follows the original grounded theory. From my viewpoint it was critical that my research did not have a restrictive focus but rather that the theory produced was reflective of the mentors', practice education facilitators', link lecturers', managers' and students' experiences of the approaches, strategies and impact of practice based learning within the clinical learning environment.

3.5.3 Literature Review in Grounded Theory Methodology

Some advocates of a grounded theory approach suggest that a pre-study literature review should be avoided as the review could affect objectivity when data are collected and analysed (Glaser and Strauss 1967; Charmaz 1990; Strauss and Corbin 1990). Stern (1985) reported that the pre-study literature review might lead to pre-judgment and so a closing of ideas and research inquiry which was supported by Artininian (1998) and Benton (2000). However, Hutchison (1993) supported the view that the literature review can identify gaps, a view supported by (Hickey 1997; Smith and Strauss 1998). Specifically, this links well with any study in which literature is used to identify areas where there are gaps or a dearth of research.

Whilst acknowledging the controversy surrounding the place of the literature review in grounded theory methodology, I was guided by Stodulski (1984) and May (1994) to conduct a pre-literature review to highlight gaps in the literature but also to prevent unnecessary reinvention of previous research work (Morse and Field 1991). Furthermore, the literature review was used to provide a rationale for further research (Holloway and Todres 2006) and assisted with the research proposal, which in my study, was seen as crucial in forming and refining the research questions (Polit and Hungler 2008).

I kept a reflexive diary and an open dialogue with my supervisors to guard against premature closure of data collection and analysis. My reflexive diary assisted me to reflect on my interactions and was a more personal record of my feelings. This record enabled me to separate my feelings from those of the participants as well as providing more analytic notes. I recorded my responses to the emerging thoughts so that I could separate any pre-existing ideas about the analysis.

This allowed me to analyse the data to understand the complexities and interactions in practice learning within the clinical learning environment. I did this through being reflexive and recording notes through constant memo writing and comparison between different data gathered.

The literature in a grounded theory study is also linked to the data arising from the research, however some authors suggest the literature should be used when data is collected and analysed (Field and Morse 1996). In contrast to this it was advocated by Glaser and Strauss (1967) that literature should be incorporated when the categories are established. I followed this advice and incorporated the literature when the categories were established.

3.5.4 Mixed Methods

Mixed methods research combines elements of both qualitative and quantitative paradigms. The label 'mixed method research' intends to be inclusive of the 'process of mixing different research methods and approaches to research generally' (Bryman 2008:5). Central to the effectiveness of a mixed methods approach is a clear and strategic relationship among the methods in order to produce greater insight than a single method could. As qualitative and quantitative methods are derived from different traditions, mixed method research must make sure there is negotiation between both methods. The benefits of using mixed methods are to gain greater insights from viewing phenomena from multiple perspectives and combined approaches utilising a mixed method (Simons 2007).

A mixed method approach enabled me to move through different roles as the study progressed as well as enabling the research questions to be fully addressed. Johnstone (2004) and Gilbert (2006) view mixed method research as an accepted approach to investigate organisational

phenomena. Utilising a mixed methods approach enabled me to use a survey to address research questions in phase 1 of the study and interviews for questions in phases 2 and 3. Gilbert (2006) states that the most commonly used type of mixed – method study is characterised by a linear two-staged approach with the quantitative or qualitative stages occurring independently of one another and this is reflected in my study. In my study the aim was to obtain descriptive quantitative information around the strategic implementation of practice based learning and the preparation of mentors, which was followed up by a qualitative approach to enable the research questions to be fully answered by using an exploratory approach.

3.6 Methods

This research study involved a three phased mixed method design. The research study involved three phases. Phase 1 involved a survey and phases 2 and 3 used a modified grounded theory approach. Phase 1 employed questionnaires with Heads of Schools (or their representative) in Higher Education Institutions and Directors of Nursing (or their representative) within the National Health Service. Phase 2 used one-to-one interviews with mentors and focus groups with Lecturers, and Practice Education Facilitators and managers. Phase 3 involved focus group interviews with students.

Three regional sites were chosen to represent different institutions and geographical locations. For the purposes of the study all of the locations that were selected were contracting universities, which meant they had a contract to provide nursing and midwifery education was agreed with the Scottish Executive Health Department (now the Scottish Government), which determined student numbers for each institution. I chose the sites for the research study to ensure that each site had different features, with two of the sites in one of the regions of Scotland being very different in

relation to the number of students and mentors. Whilst one of the sites covered a large geographical area, the other site featured a smaller contract area in a rural locality, which involved fewer students being allocated to the contracting Higher Education Institution. A smaller contractual agreement was perceived to be around two hundred and fifty undergraduate students per annum, whilst a larger contracting Higher Education Institution had one thousand or more undergraduate students.

A major factor in choosing the third site in a different region was to represent an area out-with my own employment area. It also reflected one of the largest contract areas in Scotland within an urban locality with a high number of students and mentors. Each study area constituted a Higher Education Institution, a National Health Service location involving mentors and ward managers, Practice Education Facilitators and Link Lecturers. The learning experience of senior students were also included as part of each site. The three regional sites and the rationale for selection are summarised in Table 1.

Study Sites	**Rationale for Selection of the Study Site**
Regional Site A	Both an urban and a rural locality covering a widespread geographical area. High number of undergraduate students (approx. 1000 students per annum).
Regional Site B	Study site demonstrated a rural profile but was condensed into a smaller geographical area. Small number of undergraduate students (approx. 250 students per annum).
Regional Site C	Study site was a large city location. High number of undergraduate students (approx. 1200 students per annum).

Table 1- Rationale for selection of each study site

Maps illustrating the Higher Education Institutions and National Health Service establishments in the North, East and West Scotland and the Maps illustrating the Higher Education Institutions and contracting Universities for pre-registration Nursing and Midwifery are included in Diagrams 1 and 2.

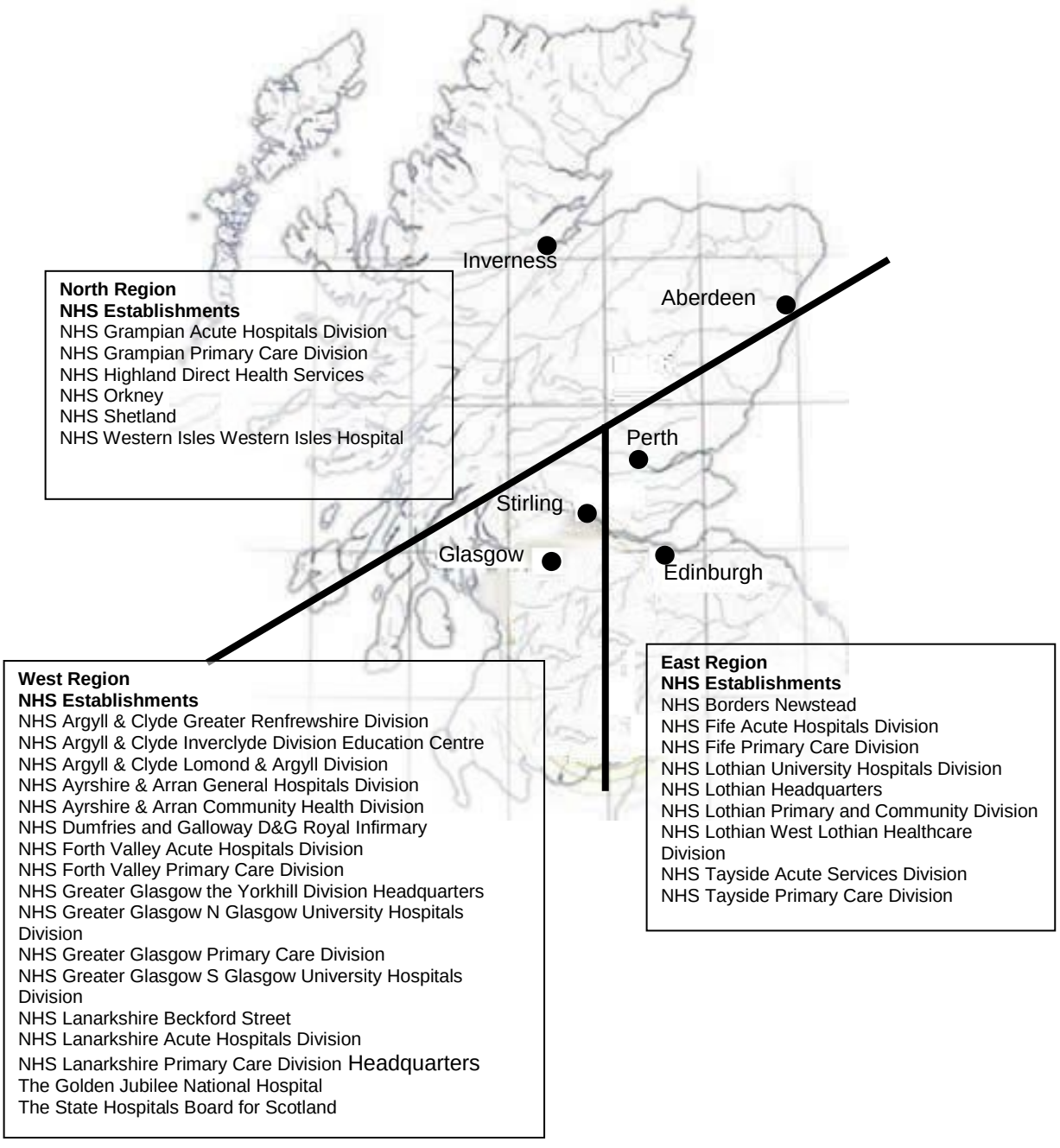
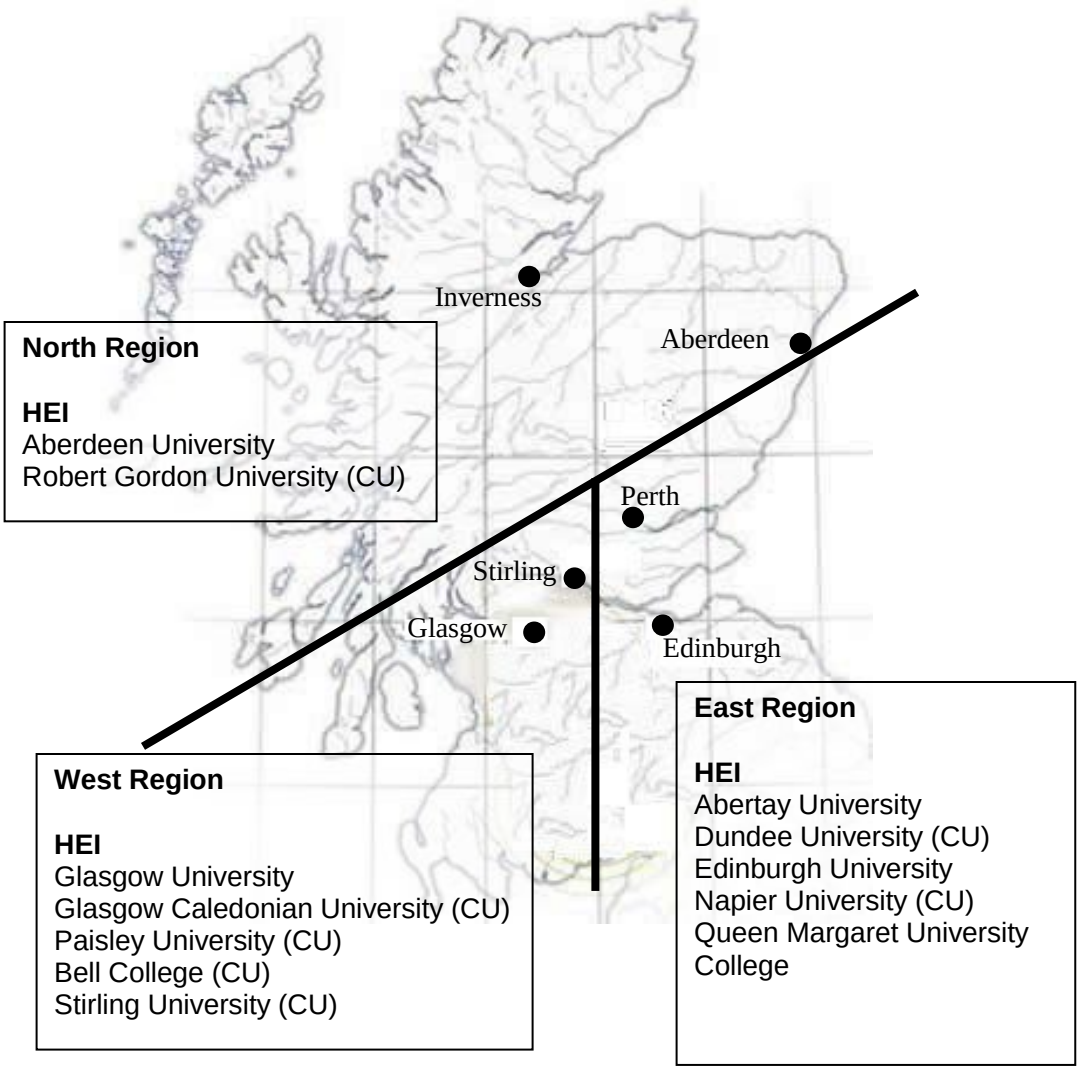


Diagram 1 – National Health Service Establishments in the North, East and West.



Key: CU – Contracting University for Pre-Registration Nursing/Midwifery Education

Diagram 2 – Contracting Universities for Pre-Registration Nursing/Midwifery Education in Scotland

3.6.1 Sampling Strategy

At the beginning of the study, I made preliminary sampling decisions about the selection of participants, which were based on specific criteria. The rationale was to get participants from specific areas of work that had appropriate professional experience at a senior level within the National Health Service and Higher Education Institutions. In phase 1, I sampled all NHS Health Directorates (n=32) and all Higher Education Institutions offering pre-registration nursing and midwifery programmes (n=11).

In Phases 2 and 3, I used purposive sampling which is sampling using predetermined criteria (Patton, 1990). The inclusion criteria used for purposive sampling involved mentors, who had completed a recognised mentor preparation programme and had a minimum of two years experience of practice of mentoring students. These criteria were considered important so that mentors would be able to reflect on and share their actual experiences with me. For similar reasons, Practice Education Facilitators (PEFs) and Link Lecturers were also required to have a minimum of two years experience in those roles. There were no exclusion criteria.

Glaser (1978) acknowledges that in the initial stages of a study, the researcher will go to participants who will maximise the opportunity for obtaining data. Therefore, purposive sampling was determined by the researcher reflecting the phenomenon been studied (Streubert and Carpenter 1999). Furthermore, the reason for engaging with staff that had strategic responsibility for practice learning enabled gathering of data from those who had knowledge of subject area.

While the initial decisions about sampling are based upon an understanding of the area under investigation it was Haber (1994) who suggested, theoretical sampling involves the participants who might be

'typical' of the study population. As such the use of theoretical sampling is seen as a necessity due to the inductive deductive nature of the research (Denzin and Lincoln 2000).

Glaser (1978:36) reports that theoretical sampling is a:

> 'Process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides which data to collect next and where to find them, in order to develop his theory, whether substantative or formal'.

Therefore, theoretical sampling allows the sample and sample size to be determined in order to achieve theoretical saturation. As such, the sample and the sample size are derived from the theory (Benton, 2000). The process of theoretical sampling is ongoing, and is an integral part of grounded theory. The process of data collection continues until the emerging categories become saturated, therefore the decisions regarding sampling are made 'theoretically' (Glaser and Strauss 1967).

Overall, in qualitative research it is important to have sufficient data. While there are no specific guidelines on how many participants are needed it is claimed that around twenty to fifty interviews are necessary (Chenitz and Swanson 1986, Patton 1990). The following section provides details of the participants in the study.

3.6.2 Participants for Phase One, Two and Three of the Research Study

3.6.2.1 Participants – Phase One of the Study

Participants for phase one of the study involved (n=32) National Health Service (NHS) and Higher Education Institutions (HEIs) (n=11). The participants for phase one of the study were at Director of Nursing level within the NHS, who had management experience and responsibility for learning within the practice setting.

Selection of staff from the NHS were obtained from each establishment in the north, west and east regions of Scotland (see Diagram 1), which included representation from the acute hospitals division, the primary care division and the specific hospitals who had specialties. Within each of the three regions, the named contact for each area was accessed from Health Board Headquarters and sent a questionnaire.

Other participants were at Head of School or Department level from HEIs, who had strategic responsibility for practice-based learning. Identification of participants from the Higher Education environment was either the Dean of the Faculty, the Head of Department/School or a senior representative within the institution. In total, forty-three questionnaires were sent to the aforementioned NHS and HEI participants. Thirty-two questionnaires were returned giving a response rate of 74%.

3.6.3 Participants – Phases Two and Three of the Study

Participants for phases two and three of the research study involved Mentors, Practice Education Facilitators, Link Lecturers, ward managers and third year Adult Nursing students from all three regional sites. The selection of these various groups will now be discussed in more detail.

3.6.3.1 Selection of Mentors

Mentors from three geographical locations within Scotland (see diagram 1) were purposively selected using the inclusion criteria previously described. To avoid the danger of coercion being introduced, I decided not to involve line management from the NHS establishments in their selection. I therefore discussed my study with a Senior PEF in each of the regional sites (n=3) who provided access to the mentors. An assumption was made that the PEFs would facilitate access but in a non-coercive way.

Each Senior PEF was sent a total of fifteen participant information sheets (see Appendix 1) and asked to distribute these to mentors from four main areas within each location reflecting a variety of care management areas. The four main areas included a medical, surgical, elderly, high dependency or an accident emergency focus. Once the tear off slip from the participants' information sheets was returned, ten participants, in each region, were selected from the fifteen returned. An individual who had no direct involvement in my study was given a box containing the tear off slips and asked to select 10 for each regional site. This meant the Senior Practice Education Facilitators would not know which mentors had been selected for the research study, which in turn also minimised the inherent risk of coercion to take part. Informed consent forms were used prior to interviews and focus groups (see Appendix 2).

Regional Site	Mentors
A	n=10
B	n=10
C	n=10

Table 2 – Numbers of mentors involved from each regional site.

3.6.3.2 Selection of Link Lecturers and Practice Education Facilitators

Link Lecturers and Practice Education Facilitators (n=30) within three geographical locations in Scotland, and from the same sites as the mentor population (see diagrams 1 and 2) were purposively selected using the inclusion criteria previously described. I was given access to each region's and HEI's database of PEFs and Link Lecturers. An individual not directly associated with my project chose the names of 8 PEFs and 8 Link Lecturers as potential participants. These individuals were sent a

participant information sheet. The number of tear off slips returned varied across the regions and is detailed in Table 3.

Regional Site	Link Lecturers	Practice Education Facilitators
A	n=6	n=4
B	n=7	n=5
C	n=4	n=4

Table 3 – Numbers involved in focus groups for Link Lecturers and Practice Education Facilitators.

3.6.3.3 Selection of Ward Managers

Following on from written communication, a discussion took place with each Senior Nurse regarding my research study, giving an opportunity for them to ask questions and clarify any issues they wished to ensure that they had a clear understanding of the aims of the research. The Senior Nurse who led forums for ward managers on all three regional sites were given 15 participant information sheets to distribute. The criteria for the selection of ward managers included offering placements to student nurses in the undergraduate programme for adult nursing, currently involved with mentoring students and had been involved in the selection of mentors for programmes within their areas of responsibility. The number of tear off slips returned varied across the regions and is detailed in Table 4.

Regional Site	Ward Managers
A	n=8
B	n=7
C	n=6

Table 4 – Numbers of participants involved in the focus groups at ward management level.

3.6.3.4 Selection of Students

Participants for phase three involved senior students in the third year of the undergraduate adult nursing programme in each participating HEI. Access to the student population was gained by engaging a member of the academic staff who had a leadership role within the Higher Education Institutions. A letter of invitation was used to inform students of the researcher's visit to the institution and stated the purpose of the research (Appendix 3). This was followed up by an information session to a group of third year undergraduate adult nursing students in each regional site. Placing the letter of invitation regarding the research study on WebCT enabled the student groups to be informed prior to my information session. At the information sessions in region A, there were 120 students, 35 students in region B, and 180 students in region C. At the end of the information session, I asked students who would be willing to participate if they would complete the tear off sheet and place in a box as they left the classroom. Again in an attempt to avoid researcher bias, an individual not directly involved in my study selected sufficient participants for the focus groups within the three research study sites. The numbers of students involved in each site can be seen in Table 5.

Regional Site	Students
A	n=12
B	n=10
C	n=12

Table 5 – Numbers involved in focus groups for students.

The data collection methods will be explored within the next section.

3.7 Methods of Data Collection

A mixed method approach to data collection was used with phase one of the study involving a questionnaire to gain a strategic overview of practice learning and the preparation of mentors in Scotland. The purpose of the survey approach to data collection was to obtain data, which would inform phase two of the research study. Data collection methods used in phase two involved individual interviews and focus groups. Phase three of the research study involved the use of focus groups for each study site. The methods of data collection will be discussed under the three phases of the study. A summary of the phases of the study and the data collection methods used are illustrated in Table 6.

Phase	Data Collection Method used	Participants
Phase 1	Survey	NHS & HEI representatives (n=34)
Phase 2	Individual Interviews	Mentors (n=30)
	Focus Groups	Link Lecturers and PEFs (n=30) Ward Managers (n=21)
Phase 3	Focus Groups	3rd year adult nursing students (n=34)

Table 6 – Phases of the research study, methods of data collection and participants involved.

The 14 item questionnaire used had two sections and can be found in Appendix 4. Interview schedules were used in the individual interviews and focus groups and these can be found in Appendix 5.

3.7.1 Phase 1 Questionnaire

During phase 1, a questionnaire was used to provide a strategic overview of practice based learning and to serve as a baseline prior to the second phase of the study. Oppenheim (1992) suggests questions should be simply worded avoiding the use of unusual words, acronyms and abbreviations. Not only was question wording important, but the sequencing and arranging of questions in a way to minimise bias. For each question a focus was given, utilising closed-ended questions, which would limit the responses given. Munhall (2007) reports that the greater number of closed questions, the more highly structured the questionnaire becomes. To ensure all circumstances were covered, the category 'other' was used with 'please specify'. This was included to open up areas not included and allow an opportunity for further comment. Instructions were included following each question, which was considered important to ensure the questionnaire was appropriately signposted thereby reducing errors of comprehension and completion on the researcher's and participant's part (Murray, 1999). I also obtained valuable input from a statistician at an early stage relating to how the data could be collected in a valid manner to ensure reliability. Reliability was an important factor to ensure measurements were not biased or inconsistent, with validity by ensuring the data gained was in line with what was intended.

Emphasis was placed by Oppenheim (1992) on the importance of pilot work in the construction of questionnaires prior to the main study. Furthermore, evidence by Tingle and Marsland (2001) recommend pilot work as a means of ensuring questions have meaning to participants. Questionnaire development is indeed an art form with distinctive specific characteristics giving a valid measure of the factors of interest by extracting acceptably accurate information (McGibbon, 1997). Therefore, the main characteristic of a good questionnaire is that it is convincing and influencing respondents to co-operate (Czaja and Blair 1996).

For some sections of the questionnaire a Likert scale was used to get participants to rank the importance of each research item. The instructions regarding ranking were included under each question. Ranking also allowed the participants to state their order of preference, however, participants may have an equal preference for two items. Considering the ranking of items, the number of items participants could rank was carefully reviewed in light of work by Polit and Hungler (1999), who suggest that participants should be asked to rank no more than ten items. As a result, the maximum number of questions to be ranked in the questionnaire was eight.

A pilot study was seen as a fundamental part prior to using the questionnaire in the main study. Three individuals with different backgrounds and experience but reflective of the target sample were used in the pilot study. As suggested by Mead (1993) I gave the pilot study respondents an opportunity to comment on any questions they found difficult or ambiguous. Additionally I asked them to comment on the overall presentation, layout and length of the questionnaire. These three areas were reinforced by examining the clarity, phrasing and understanding of the questions with the data obtained, illustrating areas, which required greater illumination and enlightenment. Final polishing of the questionnaire was achieved following analysis of the pilot data. The final questionnaire can be found along with the covering letter, which would accompany it (Appendix 4). Areas covered in the letter included the processes involved in the construction of the questionnaire and the fact this was a doctoral research study, which had been through the Multi-Centre Research Ethics Committee and Management Approval System through Research and Development at each study site (Appendix 6 and 8).

Emphasis was placed on the doctoral aspect as I felt it to be important to provide participants with reassurance that the research would be supervised and the researcher's specific interest in the subject area was included. An acknowledgment was made regarding the participant's time, expertise and the value of the respondent's participation in the study emphasising the importance their contribution could have on future arrangements for practice based learning. It was essential to ensure recognition of the effort required to complete the questionnaire by the respondent with a suggested amount of time required to complete to enable respondents' to plan and schedule time in their diary. In accordance with the ethical considerations discussed later, assurances were given in respect of confidentiality.

By utilising the supervising institution's stationery for the covering letter, it was hoped this would encourage the completion of the questionnaire and also help to reassure participants that the research was been undertaken and supervised through a Higher Education Institution. The latter was also emphasised in the other phases of the research.

3.7.2 Phase 2 Interviews

During phase 2 of the study data were collected via individual interviews with mentors (n=30). Barriball and White (1994) advocate the use of the interview approach by stating that it is well suited to the exploration of values, beliefs and motives whilst also giving the opportunity for observation of non-verbal indicators. Interviews have been referred to as 'conversations with a purpose' or 'guided conversations' (Burgess 1984; Rubin and Rubin 1995). To fully address the research questions, the researcher required rich data and interviews were a way to explore the participants' perspectives and to seek clarification (Burns and Grove 2007; Bryman 2008).

In keeping with grounded theory methodology, interviews were open-ended and in-depth. Wimpenny and Gass (2000) report on the grounded theory approach, with ongoing analysis, which gives direction to the interviews driven by emerging theory. Using an interview guide (Appendix 5) is congruent with grounded theory methodology and I asked key questions in a similar format each time, hence, allowing flexibility in the sequencing of questions and in the depth of exploration (Fielding 1994).

Within the qualitative paradigm the use of interviewing is viewed as an opportunity for the interviewee to convey in their own words what is relevant and therefore pertinent to them in their own words (Pontin 2000; Field and Morse 1996). According to Glaser and Strauss (1967) and Glaser (1978; 1992), in-depth interview yields the softer data and it is the preferred approach to this study so that participants can fully engage to give data which was rich and meaningful.

The use of an interview guide is supported by Gray (1994), Duffy et al., (2004), Polit and Hungler (1999) and May (2001) who view it as an approach to take forward participant's responses and used to give direction to the discussion. Glaser (2001) views the researcher as having a role in facilitating participants to engage and talk freely about experiences. This approach enables the participants to guide the research, with the researcher ensuring a non-directive style in the interview situation. Glaser (2001:173) points out that the passive approach of the researcher as, an adapted form of interviewing, which is adjusted so the approach is conversational. Through the constant comparative process, interviews increased in focus, as categories were tested against the experiences of subsequent participants.

Glaser and Strauss (1967:75-76) view interviews as a means of:

> ‘Listening to participants recounting their stories is prominent during the early stages of the research, later, theoretical sampling based upon the emerging theory brings a sharper focus to subsequent interviews’.

From a grounded theory perspective, the ongoing analysis influenced the questions that were asked with the direction of the interview becoming driven by the emerging theory (theoretical sampling).

Glaser (1992:25) noted that in the context of asking questions, the grounded theory researcher uses a non-direct approach in the style of questioning by never asking direct questions, which would influence the data generated. Hinds et al., (1992) has pointed out it is the researcher’s ability to interpret and attach meaning to interviewee’s accounts, which enables the researcher to ‘read in between the lines’.

As was the case in phase 1, I also tested the process of conducting and analysing data from individual interviews with an experienced mentor, who would not be involved in the main research study. The open ended questions were flexible and allowed me to probe more in-depth enabling a rich account of from the participant’s perspective. This provided me an opportunity to engage with all the stages of the interview process and to reflect on setting up the interview, the place, time factor and the use of recording equipment, transcription and analysis. This aspect of testing was particularly insightful as it gave me an indication of the time required for transcription and analysis thus informing the scheduling of interviews to ensure that there was sufficient opportunity for constant comparative analysis.

Following the testing of the interview process, reflecting on the transcribed interview made me aware of repeating phrases at the end of questions.

While the repeated phrases were perceived to be encouraging, this provided insight into my technique for interviewing which was invaluable before the main interviews. Another insight gained was the need to use open ended questions, which would prevent me leading the participants. The importance of having an open minded approach is critical to ensure the data generated is grounded in reality.

I thought I could conduct interviews but the testing of my interview technique was invaluable. I was able to reflect my tone and style of questioning. This was a steep learning curve. My level of patience with the enormous amount of data helped me to think conceptually, kept me alert and my supervisors added richness during supervision sessions. *Discussions keep me inspired during the 'highs' and 'lows' which enables me to get balanced again and start again* (Reflexive account from Journal).

The interviews with the mentor participants (n=30) were divided into key areas, which included an introduction, the purpose of the interview, assurances of confidentiality and asking permission to tape and/or make notes. The use of a warm-up question gave me and the participant time to settle. Asking the participant to choose their own pseudonym was a useful icebreaker. Although an interview schedule was used, there was no fixed format to asking the questions but rather a conversational style adopted in an attempt to make the participant feel comfortable.

At the end of the interview I asked two questions: 'Is there anything you would like to ask me?' and 'Is there anything I should have asked you?' (Field and Morse 1995). The closure aspect of the interview gave me an opportunity to express thanks, which were also followed up by a hand written thank you note.

Following the interview I then wrote up notes, recorded impressions and ideas as well as planning in time to listen to the tape prior to the subsequent interviews. As such the data were subjected to constant comparative analysis as additional data were collected and compared. Listening to the tape following each interview was useful to check the audibility of the tape, and I had an opportunity to compose other questions that could be asked in the subsequent interview. It was always beneficial to check the tape for clarity following each interview as I could immediately make notes to fill in any gaps if some of the recordings were inaudible perhaps due to volume of voice, and in particular accents within some geographical locations. Reflecting on the interview style for example, the tone, volume of voice and the clarity of questions I needed to invest myself in the research process to enable the participants to respond and feel an equal partner in the interview. The effect of the interviewer's presence and personality could have an impact on how participants responded (Le Compte et al., 1993). As such I had an impact on the data and the research process, which is acknowledged and captured in my reflexive journal.

3.7.3 Phases 2 and 3: Focus Groups

The use of focus groups can be traced back as far as the 1920s with Krueger and Casey (2000) reporting on how the sociologist Robert Merton first used the focus group interview with soldiers during the Second World War. MacLeod Clark et al., (1996) define focus groups as simply a discussion in which a small group of people under the guidance of a facilitator or moderator talk about topics selected for discussion. Indeed the use of focus groups can be used to draw out participants' understandings and meanings as well as their underlying belief and value systems (Wilkinson, 1998). In addition, Parahoo (2006) views the purpose of focus groups as a means to identify all the different views no matter how little or how much they are supported in the group.

Curtis and Redmond (2007:25) advise on the importance of the environment and how those present influence the whole interaction process.

Krueger (1994) reported on the three stages for focus groups involving planning, conducting the focus groups and analysing the data with the subsequent reporting. I carefully planned the pre-pilot, the pilot study and the main focus groups.

As with the questionnaire and individual interviews, I also tested the process of conducting and analysing data obtained from a focus group. Participants involved in the test focus group were selected from a database of Link Lecturers and Practice Education Facilitators, who would not be involved in the main study. The purpose of the test focus group was explained and an interview guide drawn up. Bloor (2001) states the minimum numbers for in-depth discussion varied between six and ten. McLafferty (2004) experiences of conducting focus groups interviews demonstrated smaller groups were more manageable and that groups with strangers required more moderator intervention.

Fifteen participants were invited to participate, however, only five individuals attended. I 'guided' the conversation and provided direction by allowing time for the discussion, which enabled a flow between participants. Achieving an effective environment with a conducive atmosphere made participants feel relaxed. I maintained good eye contact, encouraged and showed interest in the participant's contributions, which facilitated good group dynamics with checks and balances put in relating to the views expressed. Reflecting on the number of questions asked I was enabled to theme the questions for the main focus groups and develop an appropriate sequencing of questions to ensure coverage of topic areas (Krueger and Casey 2000).

Reflecting on the test focus group process was invaluable as it enabled me to gain experience in facilitating a focus group. The organisation of the focus group was carefully managed due to Link Lecturers and Practice Education Facilitators not physically being located in one place. Having sufficient time to organise the group was essential to ensure an adequate number of participants. Reed (2005) alerts to the difficulty in the organisation of focus groups which can lead to the researcher undertaking individual interviews due to lack of numbers. For this reason focus group interviews were scheduled to take place during the working day to facilitate higher levels of participation.

During the test focus group I was aware of the potential for domination by a small number or even one participant. Another aspect was the different roles and functions of the staff involved, which could have inhibited participants being unwilling to speak out. Facilitating the group interaction was a key element for a successful focus group without the researcher exercising undue control (Bryman, 2004; 2008).

One of the difficulties with the test focus group was capturing each contribution clearly, even though the equipment used was checked carefully, reflecting on this I needed to ensure the recording equipment was placed nearer the softer-spoken members of the focus group. I also identified a means of recording when a Link Lecturer contributed and when a Practice Education Facilitator contributed to ensure all the participants had an opportunity to speak in a group situation.

Conducting the main focus groups provided a great opportunity to get Link Lecturers and Practice Education Facilitators together at the same time. Mansell et al., (2004) view focus groups as not simply discussions between people, but are focused interviews exploring interactions between participants. According to Howatson – Jones (2007) it is

reported there are differing views as to the combination of people with different roles in focus groups. However, the reason Link Lecturers and Practice Education Facilitators were involved in the focus groups, was that both groups have responsibility to support mentors within the clinical learning environment. Both groups were also part of an established infrastructure and communication system to support practice-based learning. Link Lecturers and Practice Education Facilitators were senior staff within Higher Education and the National Health Service and as such both groups would be perceived as equal partners in practice based learning. In fact, focus groups where a hierarchical relationship exists would be unsuitable for participants (Krueger and Casey 2000). In many Higher Education Institutions, a strategic investment had been made into Link Lecturers with funding allocated for Practice Education Facilitators from the Higher Education Institutions, Scottish Executive Health Department (now the Scottish Government) and the National Health Service Establishments.

I made the decision to interview the ward managers in a focus group within their 'home' regional site as the majority of participants knew each other and were steeped in their own cultural and organisational norms.

The preparation of the environment for the main focus groups was critical and the provision of comfortable setting with seats in a circle ensured participants felt relaxed and could enjoy the experience. I promoted discussion and exchange of ideas between participants ensuring quieter members of the focus group were included, but also having the heightened awareness of the potential domination of the group by one or a small number of participants (Parsons and Greenwood 2000). Following on from this I was mindful that an emerging group view could have suppressed the perspective of the quieter participants, hence the

importance of capturing the interaction between participants (Curtis and Redmond 2007; Denzin and Lincoln 2003).

Linking this interaction into analysing the data to capture what the participants were saying was crucial, however, the key points noted during the focus group related to the interaction of both groups and individual participants'. Interaction was critical to capture the richness of the information gained. The importance of non-verbal communication was highlighted in my notes during and after the focus groups and linked to the transcribed data.

The data collected in each of the three phases built on the previous one so the melding of the cumulative data gave deeper understandings of the experience of participants.

3.8 Data Analysis

3.8.1 Phase 1

The survey findings were analysed using Sphinx Survey (2006). This is an all-in-one programme for the design, administration, processing and analysis of surveys. The figures were taken as a percentage of the number of responses in that category showing the reduction in the numbers as one progresses down the rankings. Respondents were able to give other rankings, however not all respondents gave second and third rankings hence the number of responses for these categories was often less than the total number of responses. To demonstrate a worked example of the calculation of the percentages from the data generated an illustrated account is presented in (Appendix 7).

3.8.2 Phases 2 and 3

Data collection and data analysis were carried out simultaneously using the constant comparative method. Using a Grounded Theory approach data collection and analysis commenced at the beginning of the phase two of the research and continued in parallel with continuous interaction (Wainwright, 1994). In accordance with Glaser and Strauss (1967), the constant comparative method is an activity, whereby I was comparing concepts and subcategories in the data, which establishes categories that explain the data.

Transcribing of the tapes 'verbatim' was useful as the verbatim record was facilitative to the data analysis process as the experience brought me very close to the data. The benefit of the verbatim transcription combined with the written field note accounts made immediately following each interview, (which included verbal and non-verbal exchanges within the interview context) added richness to the data process.

> *Each encounter with the data enables me to look at a transcript with freshness and keep me going backwards and forwards comparing, analysing, thinking, planning, discussing. Every encounter with participants is a pleasure and their keenness to participate and share with me is a humbling experience. Something I will never forget* (Reflexive account from journal).

It is reported a combination of verbatim transcription and researcher notation of participant's non-verbal behaviour are central to the reliability, validity and veracity of qualitative data collection (MacLean et al., 2004). Interviews were transcribed word by word which was time consuming process as some of the interviews material was difficult to listen to even though I checked all equipment prior to the commencement of the interview. Wellard and McKenna (2001) confirm that transcribing interviews can be fraught with technical difficulties.

Therefore, to ensure the interviews were transcribed in an efficient way the process of transcribing commenced shortly after the interview to enable the researcher to capture any important areas not recorded by the interviewees (Atkinson 2000; Pontin 2000). The discipline of making field notes directly after each interview was important in facilitating this.

As data were recorded and transcribed the coding of the data were facilitated by the use of 'QSR NUD*IST Vivo' (Qualitative Solutions, 2007) known as 'Nvivo' 7. The process was purely one of facilitation and was therefore, not to carry out the analysis itself. Memos were also recorded with Nvivo.

According to Britten (1995) for every hour of taped interview, six to seven hours of transcribing is required. However, the process of transcribing the interview data took me between six to twelve hours which is in line with that indicated by Chenitz & Swanson (1986). Glaser (1992) advocated that the researcher should transcribe and analyse the first interview. I engaged in transcribing several of the interviews but it was the time factor and being a part-time research student that proved difficult to achieve, so I commissioned the use of an experienced audio-typist to facilitate transcribing, a process advocated by Cerinus (2001). When I received the transcripts from the typist, the recordings were listened to and the transcripts checked to ensure there were no errors. Engagement with the data by listening to the recording immediately following the interview enabled an immediate connection with the data, and allowed the piecing together of any unclear sentences (Porter 2000). Hence I ensured all the data from the interviews were included with any missing information added.

The interviews were transcribed in a format which enabled me to put in the initial coding of the data down the right hand side of the paper.

To ensure I had a working copy of the transcript two copies of the interview transcript were kept. Tarling and Crofts (2002) suggest that two printouts of each interview should be used. The printouts were dated, had page numbers and the participants pseudonym was identified.

Data analysis was an ongoing rigorous process which enabled the interview transcripts to be coded, moving to substantive and theoretical coding leading to theoretical saturation and the emergence of theory (Glaser 1978; Glaser 1992, Wainwright 1994). Therefore, coding substantively conceptualises an event, while theoretical coding makes relationships between the substantive codes. Hence theoretical coding involved a process of examining the data in a theoretical way rather than in descriptive terms.

While incorporating the types of coding, namely substantive and theoretical, the levels of coding were progressed. Firstly, the initial process of coding was at level one. This involved a line by line analysis to ensure that all the data gained were captured. Prior to commencing with level one coding the transcript was read to gain an overall overview of the information and the initial impressions of the data. As the line-by-line analysis commenced and progressed a label was put to sentences which included specific phrases relating to the participants own words and included larger sentences and paragraphs of data. By using labels this created a conceptual approach. As such the conceptual approach conveyed a sense of the data beginning to be grounded in reality, particularly with the actual words from participants being used. The use of participants' words is referred to as 'in vivo' codes (Polit and Beck 2004). Level two coding was when the data became categorised with level three coding enabling categories to be developed and become integrated. This

process of development was enhanced through reflection, memo taking and theoretical literature sampling (Wilson and Hutchinson 1996).

I was careful with the analysis of the interviews and was mindful of the advice of Holloway and Wheeler (2002) who advocate not rushing the analysis, as there is the potential to miss out on valuable data. This implied the importance of taking the time to transcribe and carefully analyse the data.

3.8.3 Open Coding

Open coding was enhanced through the use of reflection and focusing on the issues expressed by the participants and the category which the data related to. I was very aware of the need to be reflective so the data generated directed the development of the issues. While this process of reflecting and questioning was continuous it was helped by memo writing, which enabled the capturing of ideas and reflections. Hence, memo writing commenced following each interview, when data were analysed and the results were reflected upon, and in preparation for writing up. Writing the memos enabled me to develop the thinking around the emerging data and as such provided an opportunity to have notes and ideas as they emerged. Memos helped to give me a distance from the data and enabled clarity and purpose to be developed as the study progressed. Therefore, the relationship between one code to another was reflected on with clarification around the cause and the conditions which influenced the codes. Overall, memo writing was a reflective process, which enabled me to make meaning about the time spent with participants and the data generated (Birks et al., 2008). Open coding was very much about producing concepts that fitted the data and as such the concepts were like building blocks. Codes were quickly identified and the added values of the participants' own words gave a clear and meaningful representation of the phenomenon. Glaser's (1992) opinion was that axial coding prematurely forces the conceptualization of data, therefore, as

axial coding was not part of the original grounded theory (Glaser and Strauss 1967) this was not used in my study.

3.8.4 Selective Coding

As a result of patterns emerging I began to code more selectively. Once all the interviews and focus groups were completed the goal of selective coding was the coming together of a set of categories which fitted the data, could work, be modifiable and were relevant to the integrating theory (Glaser, 1978). As such categories were developed through theoretical coding forming connections between categories with the substantive codes relating to each other. Hence the data were developed to a more abstract level. Therefore, substantive and theoretical coding was a means for informing the development of the emerging tentative theory. The emergence of categories explained the impact of mentorship on different areas and how the participants' viewed the reality of the mentoring relationship. At this stage the coding was at a higher level, which enabled the higher order substantive codes to be condensed into major categories. By constantly comparing and contrasting the codes patterns appeared and the higher level codes emerged, which were linked to the core category.

3.8.5 Core Category

The core category is the crux of the theory, and as such concurs with the goal of grounded theory which is to generate theory (Holloway and Wheeler 2002; Wainwright 1994). The core category generated from interviews and focus groups across three geographical sites was derived by a process of constantly reflecting and thinking about the data, constantly comparing group by group, site by site, through the use of memos, and incorporating relevant literature. Once the categories were established in my study I searched through the data for evidence that was consistent with or disconfirmed the themes. According to Creswell and Miller (2000) the search for disconfirming evidence provides credibility for

the validity of a narrative account. Several key areas were identified in the literature and used as a check against what would serve as a 'core category'.

A core category is one which reoccurs frequently and with a pattern developing which was stable. A key characteristic of the core category is it must be central and provide explanation of the other variables (Burns and Grove 2007).

While having a central focus the core category must link to and relate with other categories. As the core category progressed and with the theory developing more detail emerged. This resulted in the core category having implications for a tentative emerging theory. Hence the core category moves the theory forward having explanatory power and occurs near the end of the research (Glaser 1978; Holloway and Wheeler 2002). It is to this end the core category captures processes over time and is referred to as basic social psychological process (Glaser, 1978).

3.9 Quality of Research

The main strengths of quantitative approaches are in the objectivity, precision and control afforded through design, sampling strategies, and analytical tests (Polit-O'Hara and Beck 2008). Quantitative data can be analysed using statistical analysis to establish generalisability of the findings from a representative sample (Polit and Hungler 2001; Polit-O'Hara and Beck 2008). Terminology associated with the quantitative paradigm includes internal validity, external validity and reliability. Internal validity requires the researcher to rule out other factors or threats as rival explanations of the relationship between the variables. External validity is the degree to which findings of a study can be generalised to other populations or environments. Reliability relates to the consistency or constancy of a measuring instrument. Reliability is viewed as a necessary

pre-condition for validity (Sandelowski 1996). Piloting the questionnaires was a way to check the consistency and validity of the survey as was data checking post entry.

There has been criticism of qualitative research approaches in the past, particularly relating to researcher bias, with the findings of qualitative research viewed as anecdotal (Koch and Harrington 1997). These criticisms centred around rigour, which link to the quantitative paradigm with the impact on internal validity, external validity and reliability. However, it was the work of Koch (1994) building on research by Guba and Lincoln (1989) that subsequently developed criteria, using the umbrella term of trustworthiness, for evaluation of research within the qualitative paradigm. The criteria for evaluating qualitative research involve the concepts of credibility, transferability, dependability and conformability.

Credibility refers to the focus of the research and the confidence in how well data and process of analysis address the intended focus (Polit and Hungler 1999). In order to enhance the credibility, participants can be asked to check the transcripts and themes that emerged following data analysis. Although I offered to send participants a copy of the transcribed interview, none availed themselves of this opportunity.

Transferability is concerned with how findings can be transferred from one sample of the population, to a whole group. In this study the findings could be transferable since the data were generated from three regional sites covering a large geographical spread. Another aspect of trustworthiness is dependability which seeks to take into account the degree to which data can change over time and the way in which the researchers' decisions can alter. This was established by an audit trail, to enable an independent auditor to come to conclusions about the data

(Graneheim and Lundman 2003). In my study, the audit trail took the form of my reflexive diary, field notes following interviews and focus groups, memos, and meetings with my supervisors.

Conformability involves establishing that the data, findings and interpretation were clearly linked (Topping 2006), which was enhanced by linking areas of significance from the data to their sources. This helped clarify how conclusions were derived from the data.

As criteria for judging the quality of a theory and in the case of a grounded theory study, Glaser and Strauss (1967) purport the theory must 'fit', 'work' and have 'grab'. Further work by Glaser (1992) suggests the criteria for grounded theory requires to 'fit, 'work', have 'relevance' and 'modifiability'. Following the terminology associated with the quantitative and qualitative paradigm and the criteria for a grounded theory are illustrated in Table 7.

Quantitative Paradigm	**Qualitative Paradigm**	**Grounded Theory Criteria**
Internal Validity	Credibility	Fit
External Validity	Transferability	Work
Reliability	Dependability	Relevance
	Conformability	Modifiability

Table 7 – Quantitative and Qualitative paradigm linked to criteria for grounded theory.

'Fit' means that the categories generated must be derived from the data and applied readily to the data (Chenitz and Swanson 1986). Thus, categories need to be well matched to the data which links to the credibility of the study. Therefore, the categories must emerge from the data and should not be selected from a pre-established theoretical perspective (Lomborg and Kirkevold 2003).

Grounded theory is based on data collection and analysis using constant comparative analysis (Glaser and Strauss 1967). Glaser (1992) views the degree of 'fit' when concepts and categories emerge until saturation is achieved. By 'work' the theory must be able to explain the behaviour under study by predicting what will happen in and interpret what is happening (Glaser, 1978). The theory works when concepts and categories generated explain the patterns in the data. Therefore, in order to work the theory should have interpretative, explanatory and predictive power. Chenitz and Swanson (1986:13) claim 'work' refers to the 'usefulness of the theory to explain, interpret and predict phenomena under study'. According to Glaser (2001) relevance relates to the core category and the basic social psychological processes. In order to achieve relevance no new categories should emerge from the data saturation and the theory generated for the participants should have relevance (Glaser, 1978).

By modifiability, the grounded theory might go through changes when new data emerge, generating qualifications to the theory (Glaser and Strauss 1967; Glaser 1978). Glaser (2001) points out that a grounded theory has the ability to accommodate the phenomenon under examination and be modifiable throughout development. Therefore, modifiability is about the potential of the research being transferred to situations.

Furthermore, it is asserted that an important feature of grounded theory is its 'fitness' and according to Glaser and Strauss (1967:238-239):

> 'A grounded theory that is faithful to the everyday realities of a substantive area is one that has been carefully induced from diverse data. Only in this way will the theory be closely related to the daily realities (what is actually going on) of substantive areas and so be highly applicable to dealing with the data'.

Overall, my engagement whilst in the field enabled a dialogue to take place and as Glaser (1978) pointed out the involvement the researcher has with the data and the process of continually asking questions and enables them to find out what is going on. To enable the dialogue to be meaningful and ensure fit, have relevance and workability, the importance of reflexivity and the researcher is stressed (Abbott and Sapsford 1998).

3.9.1 Reflexivity and the Researcher

According to Horsburgh (2003) reflexivity is the ability to acknowledge and examine one's own actions, beliefs, values, feelings and decisions. The examining and reflecting on events suggests a turning back on the original action (Freshwater and Rolfe 2001). By focusing on the original action it was key to incorporate reflexivity into the research study. Furthermore, this required a reflexive approach after each encounter in order to critically review the engagement with the data, and the effects I could have had on the data (Hall and Callery 2001). The origin of reflexivity is attributed to Mead (1962). By including reflexivity in the research study I was required to ensure I was integral to the research, and therefore could not be detached from the research situation. Smith (1996) claims the researcher in qualitative research can never be objective and indeed I cannot claim to have been totally independent despite my attempts.

Glaser (1992) suggests the researcher has a facilitative role, which enables the participants to express what was going on, yet not directly referring to reflexivity. Constructivist grounded theory studies are reflexive with the researcher engaging as a co-constructor of meaning with participants in the generation of data (Charmaz 2000). According to Olesen (1994) it is reported that subjective thoughts are a resource for the study area and I was enabled to have a reflexive approach with sources of data recorded. It was the original grounded theorists, who viewed participants' words as a source of data, which were obtained in an

objective manner (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1990). I was in a unique situation which must not be underestimated in the research process, with interaction and involvement in a non-hierarchical way with me assuming a reflexive approach in a relationship of reciprocity with the participants. This enabled an engagement with the data and the visibility of this is consistent with symbolic interactionism (Hall and Callery 2001).

Hutchinson (1993) views the importance of the relationship between the researcher and the participants, which needs to include the context of the research situation. I was aware that while I was able to separate my researcher role from that of being a Head of School, I could not assume that participants from two of the regions where I was known would necessarily be able to disentangle my two roles. This could therefore have had an effect on information and views they chose to share with me.

Grounded theory approach requires an interpersonal dialogue and as part of the process I tried hard to adopt a non-judgmental stance (Holloway and Fulbrook 2001; Hutchinson 1993). The assumption that in qualitative research the researcher is separate from the data is a false one (Hand 2003; Porter 1993). These views are reinforced by Horsburgh (2003) who claims that qualitative research cannot operate with the researcher being detached from the study. By incorporating the level of engagement within the research process and through the use of reflexivity, it indicates the 'personal involvement' of the researcher in which reflexivity seeks to ensure a reciprocal relationship between the researcher and the research in an open and transparent way (Koch and Harrington 1998). The purpose of reflexivity is therefore to prevent or minimise researcher bias and the avoidance of making prejudicial judgment.

To facilitate a reflexive approach, I kept a reflexive journal throughout the study which maintained a record of the decision-making throughout the research process. It was Hall and Callery (2001) who viewed the reflexive journal as a means of developing a process of critical thinking around the research, but also as a means of promoting rigour. Strauss and Corbin (1998) advocate that researchers use a journal to record their thinking about the research area, and how it might influence the analysis of the data. Koch (1994) also reported on the importance of recording beliefs and feelings about the research process particularly relating to processes influencing the process of learning. Reflexivity occurred every time a decision was taken by ensuring I was sensitive to the effects of an action undertaken (Smith, 1996). I was mindful of reflecting on the research process, research articles and the research experiences gained. Supervision sessions were a means of exploring reflexivity as I was able to look back on the progress of my research study. At the supervision meetings I was able to recount the thinking, feelings involved and the decision making process in the research process. Ensuring the process of research was dealt with sensitively, I scheduled the interviews at the time, which was convenient to the participants. At the commencement of each interview I engaged in an open exchange with the participant, which explained the purpose of the interview and gave the participants an opportunity to ask questions.

Also at the beginning of the interview it was important to create space for the participants giving reassurances that all areas of concern would be answered at the end of the interview. During the interview process I recorded the feelings of the participants, during and following the interview, capturing the non-verbal cues and ensuring the context of the environment was recorded.

Glaser (1992) views the importance of listening to ensure participants views are incorporated which reinforces the relationship the researcher had extended beyond the interview. Through the use of field notes, thoughts and feelings were recorded and reflected upon (Holloway and Wheeler 2002).

The feelings which caused me professional concern were recorded and I took time to reflect upon these prior to taking action. On two occasions I reported to the appropriate Senior Nurse as I felt it was important to alert them to issues which could have an influence on the quality of patient care.

The interaction and the process of reflexivity was further enhanced by the use of memos, which enabled self-awareness and increased my reflexivity by ensuring the decision making process was clear. Hence, reflexivity is intended to be an open and honest expression of values and beliefs which Koch and Harrington (1998) view as enabling the research to be both accepted and credible. Reflexivity required me to make visible the processes of analysis, which in accordance with Freshwater and Rolfe (2001) should be clearly review initial reactions enabling self awareness. Therefore, to ensure at every stage of the research, that the processes were clear and transparent I also incorporated ethical considerations which are considered in the next section.

3.10 Ethical Considerations

The importance of ethical issues involved in the research process has permeated every aspect of the design and implementation of the study. Reflections on the ethical aspects are key factors not only to ethics and research committees but also to the researcher, research supervisors and the participants.

United Kingdom Central Council (UKCC 1992), now the Nursing and Midwifery Council (NMC), follow the principles that protect participants contained within the Code of Conduct. The standards set up under the Research Governance Framework (2006) have also been followed. In accordance with Research Governance guidelines, the research proposal has successfully been approved by the Multi-Centre Research Ethics Committee for Scotland (04/MRE00/82) (Appendix 8). Research should cause no harm or distress hence the value and usefulness of ethical reviews by unbiased groups. The value of presenting the research proposal at the Research Ethics Committee enabled scrutiny and evaluation to ensure the research study addressed principles and standards for research (Williams 1997, Gelling 1999). Since this research project involved a Multi-Centre Research approach, the National Health Centre Research and development groups within each site processed the research proposal through the Management Approval System. Management approval was given by the Research and Development Director on behalf of the Chief Executive (Appendix 6).

3.10.1 Background to Establishing Principles of Ethical Research

The Nuremberg Trials were influential in establishing principles of ethical research, particularly that of informed consent. The Nuremberg Code contained guidelines for consent and discontinuation of studies and advised on the balance of risks and benefits. This code was developed in 1947 as a means to protect human participants and to prevent coercion in the research activity (Williamson 2001).

The United States Government (1949) declared that voluntary consent of the human subject is absolutely essential, which means that the person involved should have the legal capacity to give consent and should be so situated as to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reacting or any other ulterior form of constraint or coercion and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.

The Declaration of Helsinki (World Medical Association 1964) built on the work of the Nuremberg War Trials, is of more directly practical relevance to health research. The Declaration based ethically sound research firmly on the principles of beneficence, respect for dignity and justice (Talbot, 1995). It is the declaration of Helsinki, revised in 2004, which is still the principal guide for all research. One of the most fundamental principles in research is beneficence, which encompasses the maxim: above all, do no harm (Polit and Beck 2004). Beneficence is seen as the first ethical principle, which means that the benefits gained from participating in the research study should outweigh the risks. Following ethical guidelines, the researcher would terminate the research if there were reason to suspect undue pressure to the participants. Beneficence is the obligation

to protect the research participant from harm by maximising possible benefits and minimising possible harm.

Respect for human dignity is the second ethical principle, which includes the right to self-determination. The participants in the study have a right to participate and be valued. In line with the research governance framework, the first responsibility of the principal investigator was to ensure dignity with the rights, safety and well being of participants of paramount importance. Respect for persons implies that the researcher must consider the autonomy or vulnerability of study participants (Morrison, 1993). Following the guidance of Holloway and Wheeler (2002) and Rubin and Rubin (1995), each participant was given written information about the study (Appendix 3). The importance of ensuring participants have the sufficient knowledge is critical so that they can make an informed decision as to whether to take part or not (Alderson 1995; Burns and Groves 2007; Beauchamp and Childress 2009). Of equal importance is to have a suitably informed individual who is external to the study to be available to participants should they wish to discuss any aspects of the study in the process of making their informed decision. This was achieved in my study.

Justice, the third ethical principle, means treating others fairly and equitably which involves the right to privacy by ensuring anonymity. Anonymity was guaranteed for the participants by ensuring that their real names were not included. Confidentiality was maintained by assuring the participants that every effort was made to remove any records that may identify teams, areas or individuals and instructions were provided to the participants not to mention staff or name areas during any part of the research. The importance of confidentiality for the participants is supported by (May 2001; NMC, 2008, Beauchamp and Childress, 2009). In each communication with the participants the focus of the dialogue

centred on why the research was being undertaken, why the participants' views were important, and what the participants were requested to do.

3.10.2 Application of Ethical Principles

The application of ethical principles of beneficence, human dignity and justice, occurs through the informed consent process. Informed consent means that potential participants receive adequate information about the research study, comprehend the information and choose freely whether to participate as a study volunteer (Polit and Beck 2004). However, Meade (1994) makes a number of suggestions for improving the process of consent by ensuring the researcher knows the target audience, places the purpose of the study early in the consent form (Appendix 4) and logically presents the elements of informed consent. The process during the first phase of the research study involved data collection using a questionnaire to a specific target audience involving those who had a strategic responsibility for practice-based learning. Considering the importance of communicating a clear message to the participants, an accompanying letter stating the purpose of the research study was included (Appendix 6). However, it was also important there was no coercion or participants feeling vulnerable. Therefore, the assurance was provided in terms of confidentiality and anonymity, the option to participate or not. Participants were made aware that they had the right to withdraw from the study at any time or refuse to permit particular information to be used.

The position of the researcher was clearly identified as was the purpose for undertaking the research. In the second and third phases of the research study, the researcher followed ethical guidelines (Field and Morse 1985; Burns and Grove 2007), by giving written information to each participant using a participant information sheet and an informed consent form *(*Appendix 1 and 2*)*.

The purpose of the participant information sheet was to give the overall aim and focus of the study with the commitment required from the participant. Contact details enabled me to personally discuss with the participant their willingness to be interviewed. While that first contact was informal and by telephone, it was essential I built a trust and confidence with the participant. According to Polit and Hungler (1999) time is required for the potential participants to reflect on areas which would require further information or clarification. This was afforded to all participants along with a reminder of the person who was external to the study for contact for more information should they wish. Participants were reassured that the information provided would not be used inappropriately and the participant anonymity would be protected.

At the beginning of the interview participants were asked to choose a pseudonym which was used as an 'icebreaker' when the participants arrived for the interview. By using a pseudonym the participant's identity was preserved.

The process of gaining informed consent involves voluntarism, freedom of choice and the provision of sufficient knowledge and comprehension. Informed consent was extended to include dissemination of the findings with emphasis being placed on the preservation of anonymity. Giving adequate information, ensuring mental competence and freedom from coercion and vulnerability within key areas ensure participants are protected (Garity 1995). While participants all received a participant information sheet prior to each interview, signed informed consent was obtained prior to each interview. Consent is viewed as an ongoing process referred to as process consent. This allowed the confirmation that individuals continued to be willing to participate in the study. The interviews were tape-recorded and the participant's permission was sought for this. All tapes were being stored in a locked cupboard and the

computer was password protected. I made contact with senior managers on all three sites who had responsibility for ward managers. This level of communication was essential to ensure the key personnel were informed and the researcher was able to outline the key areas of the research study (Tarling and Croft 2002). This level of co-operation with key staff was critical to ensure I was given access to the potential participants and to the ward manager's forums (Bowling 2002; Cormack 2000).

3.11 Summary

This chapter focused on the aims and research questions reflecting on the mixed method design using quantitative and qualitative approaches. Each phase of the research has been discussed along with the data collection methods and the analysis of the data. The first phase involved a quantitative approach using a survey. The results from the survey, which focused on the strategic implementation of practice based learning and the preparation of mentors in Scotland, were used to inform phases two and three of the study. Phases two and three of the research study used a modified grounded theory approach. A range of data collection methods were used to gain information from mentors, Link Lecturers, Practice Education Facilitators, managers and students. Data collection and analysis for phases two and three occurred simultaneously and incorporated the constant comparative method of analysis. Ethical principles for research have been applied throughout.

The next chapter reports on the findings from stage one, two and three of the research study.

Chapter Four

Presentation of Findings from Phase 1

4.0 Introduction

In this chapter, the findings from phases 1 of the study are presented. The survey provides results from a national perspective of the strategic implementation of practice based learning and the preparation of mentors. The results of the analysis from phases 2 and 3 of the study, the findings from interviews with mentors and focus groups with practice education facilitators, link lecturers, managers and students are presented in the next chapter. Each regional site is presented using an alphabetical system and where appropriate participants are identified by their chosen pseudonym.

4.1 Data Analysis Process for Phase 1 of the Study and Response Rates from the Survey.

This section provides the responses and the analysis of the survey resulting in six themes relating to the strategic perspective of practice based learning and preparation of mentors in Scotland. A survey approach was used with forty-three questionnaires sent to a combination of Higher Education Institutions (HEI) and National Health Service (NHS) establishments across the North, East and West regions in Scotland. Thirty-two questionnaires were returned giving a response rate of 74% which can be considered a good response rate (Newell and Burnard 2006). The profiles of participants and the number of years in post are now presented.

4.2 Profiles of Respondents

The profiles of respondents were varied, for example Directors of Nursing, Heads of Department, Practice Education Facilitators and Senior Lecturers. Further details of respondents are provided in Table 8.

Higher Education Institutions
Head of School (n=3)
Head of Division (n=1)
Head of Department (n= 2)
Practice Placement Co-ordinator/ Teaching Fellow (n=1)
Senior Lecturer Practice Education (n=1)
Senior Nurse/Senior Lecturer(n= 2)
NHS Establishments
Director of Nursing (n=3)
Director Clinical Practice Placement and Support Unit (n=1)
Interim Director of Nursing (n=1)
Deputy Director of Nursing (n= 2)
Associate Director (Clinical Workforce Development) (n=1)
Head of Nursing (n=1)
Head of Practice and Professional Development (n=2)
Clinical Nurse Manager (n=1)
Clinical Services Manager (Practice Development) (n=1)
Professional Practice Development Manager (n=1)
Clinical Practice Development Officer (n=1)
NHS (Senior Nurse) (n= 3)
Lead Practice Education Facilitator (n=1)
Practice Education Facilitator (n=2)
Practice Educator (n=1)

Table 8- Roles of Respondents

The number of years in post for those completing the questionnaire ranged from less that one year to eighteen years with a median value of two years which are expanded on in Table 9.

Years	Number of Participants	Percentage
Less than 2	12	38%
From 2 to 4	6	19%
From 4 to 6	1	3%
From 6 to 8	3	9%
From 8 to 10	2	6%
From 10 to 12	2	6%
12 and more	6	19%
TOTAL	**32**	

Table 9- Years in post within establishments.

4.3 Presentation of the Results from Phase 1

The findings are now presented under the following headings reflecting elements within the questionnaire (Appendix 4).

- Practice based learning.
- Supportive mechanisms for students in practice based learning.
- Process of mentor selection and pre-qualifications to mentor.
- Mentor support within practice based learning.
- Process of mentor preparation.
- Mentor evaluation.

4.3.1 Practice Based Learning

Questions one, three and four in the questionnaire asked about planning involvement and implementation of practice based learning. Participants were asked who was involved in the planning and implementation of practice based learning and in particular how this was achieved. The responses reported that a senior individual with specific responsibility was ranked highest by (n=13) of respondents, closely followed by lecturers with a specific focus on clinical placements. There were some regional differences. In the North (n=6) and West (n=11) a senior individual with specific responsibility was ranked highest by (n=16) of respondents, whereas in the East, lecturers with a specific focus and Directors of Clinical Practice Development were ranked more highly as indicated in Figure 3.

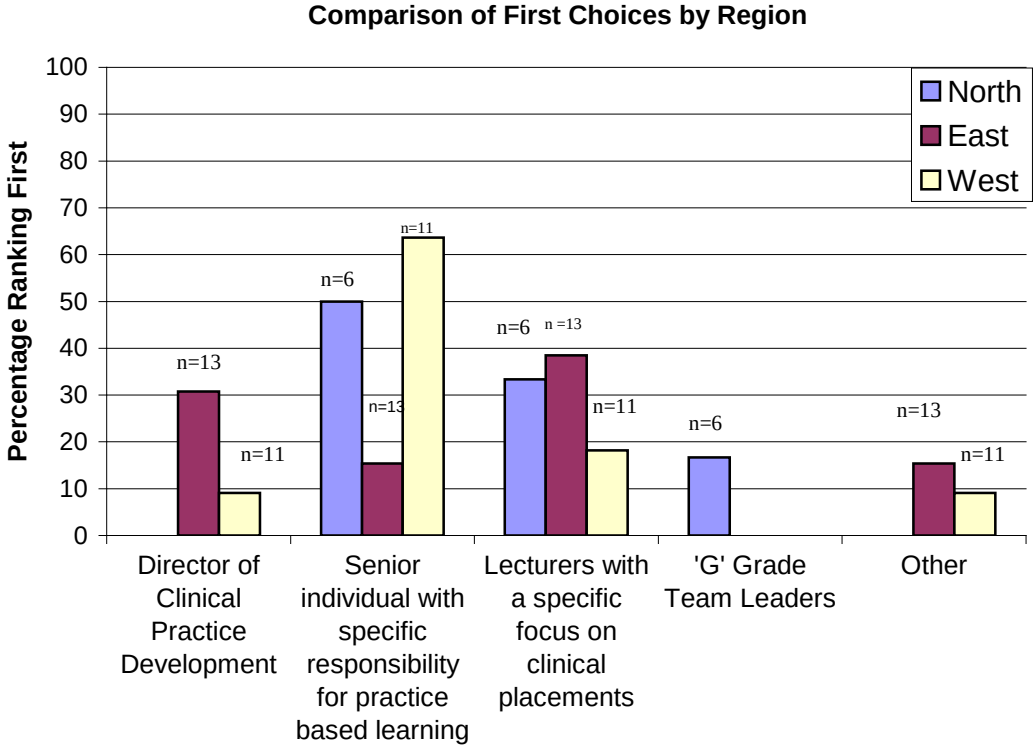


Figure 3 - Strategic arrangements for practice based learning by region.

Across the HEIs and NHS establishments similar ranks were identified with a senior individual with specific responsibility highest. In NHS establishments the response with the next highest percentage was Directors of Clinical Practice Development, whereas in HEIs the response with the next highest percentage was lecturers who have a specific focus for clinical placements. The 'other' category included the Director of Nursing, the Deputy Director of Nursing, programme leaders and practice education facilitators as illustrated in Figure 4.

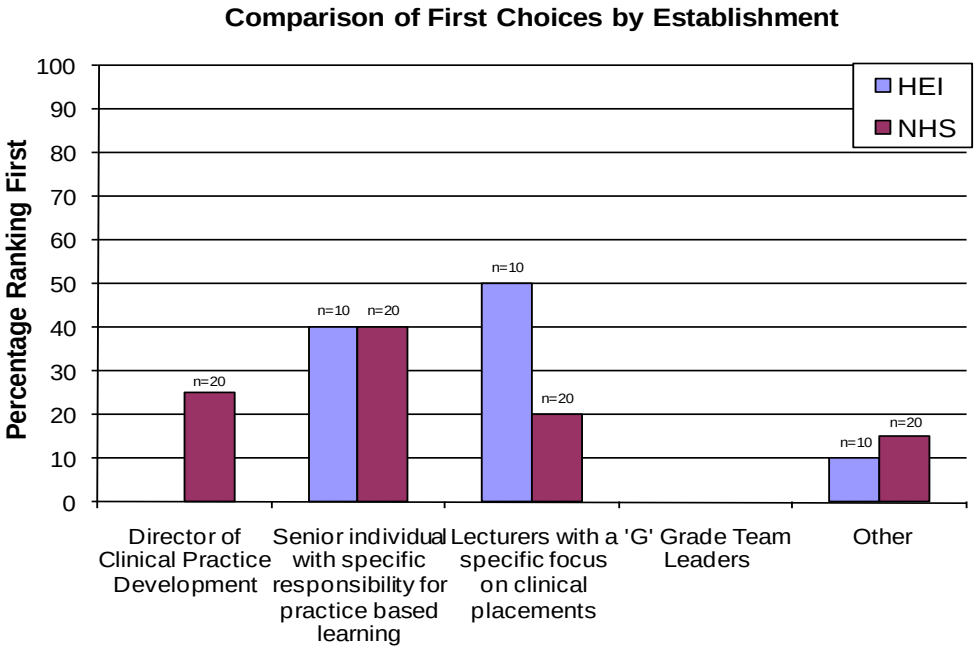


Figure 4- The strategic arrangements for practice based learning by establishment.

Planning practice based learning through Joint Education and Service Partnership Agreements was the first choice for 16 respondents. Planning through the linking of theory and practice was the first choice for 11 respondents.

However, there was some evidence of regional differences. In the North, planning practice based learning through Joint Education and Service

Partnership Agreements seemed to dominate while the East and West regions appeared almost equally split between this and planning through the linking of theory and practice. In HEIs joint education and service partnerships and linking of theory and practice were equally popular. However, in the NHS Joint Education and Service Partnership Agreements were most frequent. As illustrated in Figure 5.

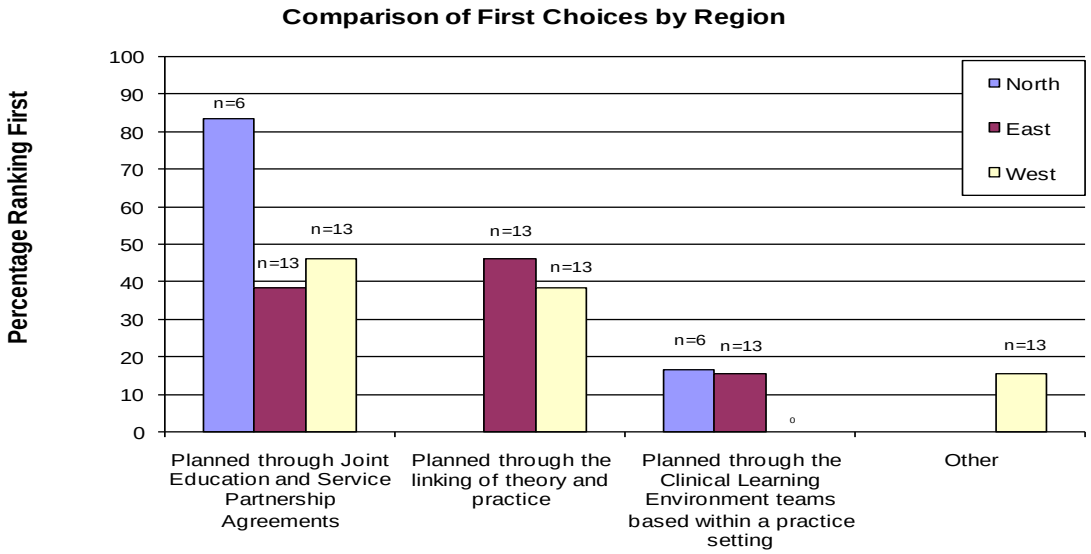


Figure 5 – Planning practice based learning by region.

Participants were able to comment under the 'other' category and the responses were subjected to content analysis. Themes occurring highlighted utilising mentors, practice education facilitators and link lecturers in planning practice based learning.

The most important element of implementing practice based learning was by ensuring adequate numbers of mentors with appropriate qualifications and experience were available was the view of 19 of respondents. This view was shown most clearly by those in the North and West.

Implementation by Ward Managers or Team Leaders in line with student learning outcomes was viewed as most important by 12 respondents. The pattern in the East was 13. There was no apparent difference between HEIs and NHS establishments.

4.3.2 Supportive Mechanisms for Students in Practice Based Learning

Question two focused on student needs and interests in relation to practice based learning. Taking account of student needs and interests in relation to practice based learning, 23 respondents said that allocating placements according to a particular emphasis (to link theory with practice) was their first priority (Figure 6). However there was, again, some evidence of regional differences here.

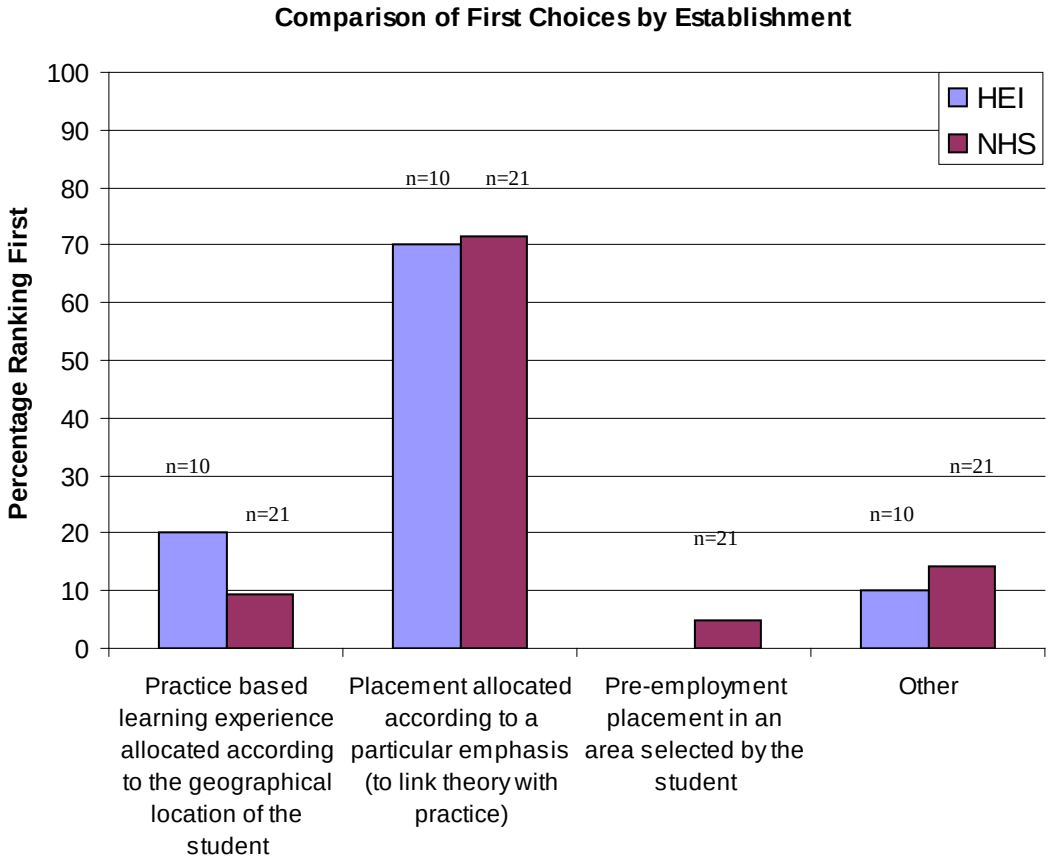


Figure 6 – Student needs and interests in relation to practice based learning by establishment.

Figure 7 provides information on the regional aspect, with the North (n=6) and East (n=13) ranking the allocation of placements in order to link theory to practice highest. It is predominantly first choice for these establishments but it is less favoured in the West region (n=12).

In the West region basing the students' learning experience according to geographical location was ranked highest by 7 respondents. Other considerations such as learning objectives and student requests were also viewed as important. There were negligible differences between HEIs and NHS establishments. Other areas under the comments section included the use of a learning opportunities database to provide support for student needs and interests.

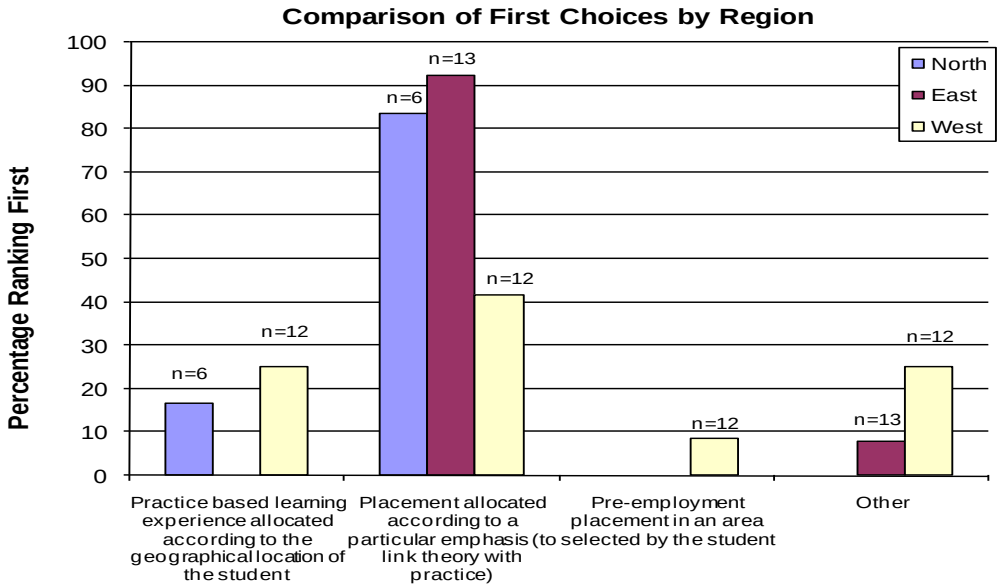


Figure 7 – Student needs and interests in relation to practice based learning by region.

Question five investigated the support mechanisms for students in practice based learning, and the following gives an account of the participants' views.

Using named mentors or named and associate mentors is seen as the most important support mechanism for students in practice based learning by 19 respondents. The named mentor takes responsibility for all aspects of the support mechanisms for practice based learning whereas the named and associate mentors share responsibility for the students.

Comprehensive induction and orientation to each placement was important, with 9 respondents rating this highest. In the West region support using mentors was more highly rated than in the North and East which were more evenly split between using mentors and placement induction. NHS establishments tend to favour mentoring more than placement induction as their first choice support mechanism, compared to HEIs. In the 'other' category, a key area highlighted was the preparation for placement and the involvement of practice education facilitators in supporting students. Under the support for students in the practice area, a recurring based theme was a dedicated individual at ward level, who was the main contact for supporting students in practice based learning, other than either the mentor or associate mentor. The next section reviews the process of mentor selection and pre-qualifications to mentor.

4.3.3 Process of Mentor Selection and Pre-Qualifications to Mentor

Questions 6, 7 and 8 elicited the participants' views on mentor selection, process of selection and pre-qualifications to mentor. Participants were asked about the process of mentor selection, which showed potential mentors predominantly nominated themselves by self selecting through their line manager. This pattern was repeated across the regions and across the HEIs and NHS establishments. Other comments occurring

included the involvement of Practice Education Facilitators in mentor selection co-ordinating with the Higher Education Institutions. Figures 8 and 9 detail participants' views as to the level of pre-qualifications required for a person entering mentorship training. In most organisations being qualified as a staff nurse for more than a year was seen as being the only pre-requisite for being accepted onto a mentorship programme.

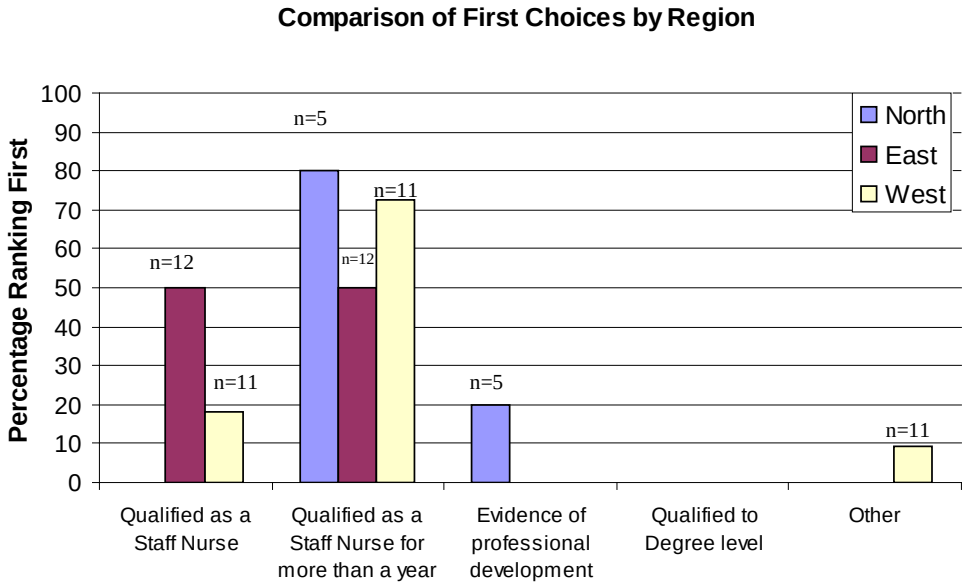


Figure 8- Pre-qualifications required for a person entering mentorship training by region.

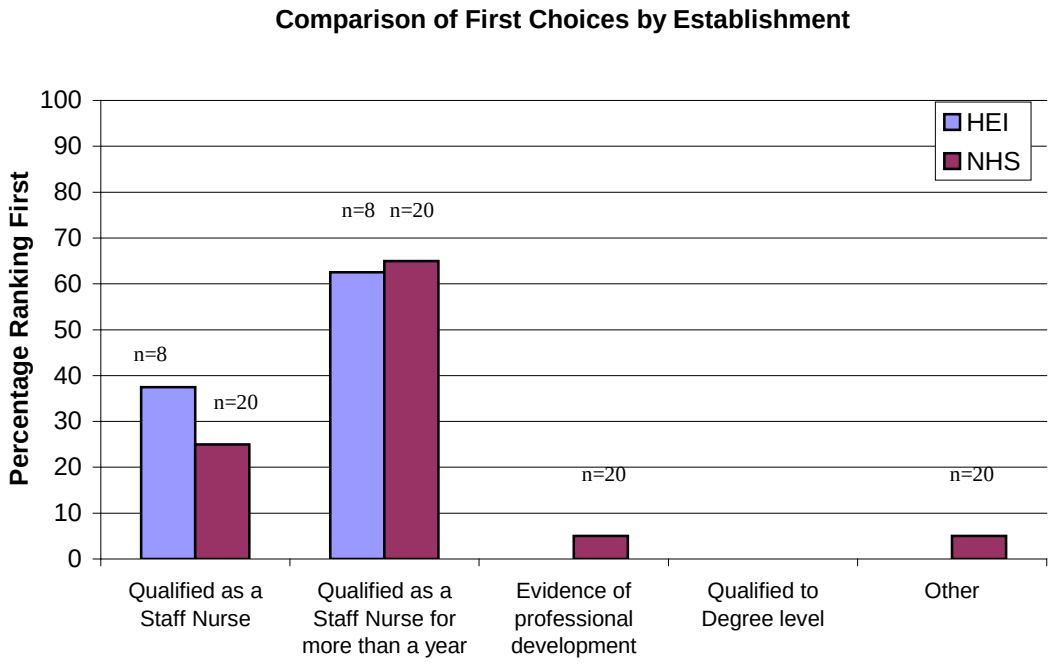


Figure 9- Pre-qualifications required for a person entering mentorship training by establishment.

However, being qualified as a staff nurse, regardless of the length of experience, appears to be sufficient for a fairly high percentage of organisations, mainly in the East region. In fact, in the East region, there was an equal split between being qualified as a staff nurse and being qualified more than a year. In both Higher Education Institution (n = 8) and National Health Service (n =20) establishments, most ranked being qualified as a staff nurse for more than a year as the most important pre-qualification for mentorship preparation. The remainder saw being qualified only as a staff nurse as sufficient. The following area reviews mentor support within practice based learning.

4.3.4 Mentors Support within Practice Based Learning

Question 9 aimed to elicit how mentors are supported within practice based learning. Within all organisations (n = 19) support for mentors within practice based learning was through Practice Education Facilitators.

The use of Link Lecturers and team approaches were the main alternative support mechanisms. Figures 10 and 11 illustrate mentor support within an establishment and region.

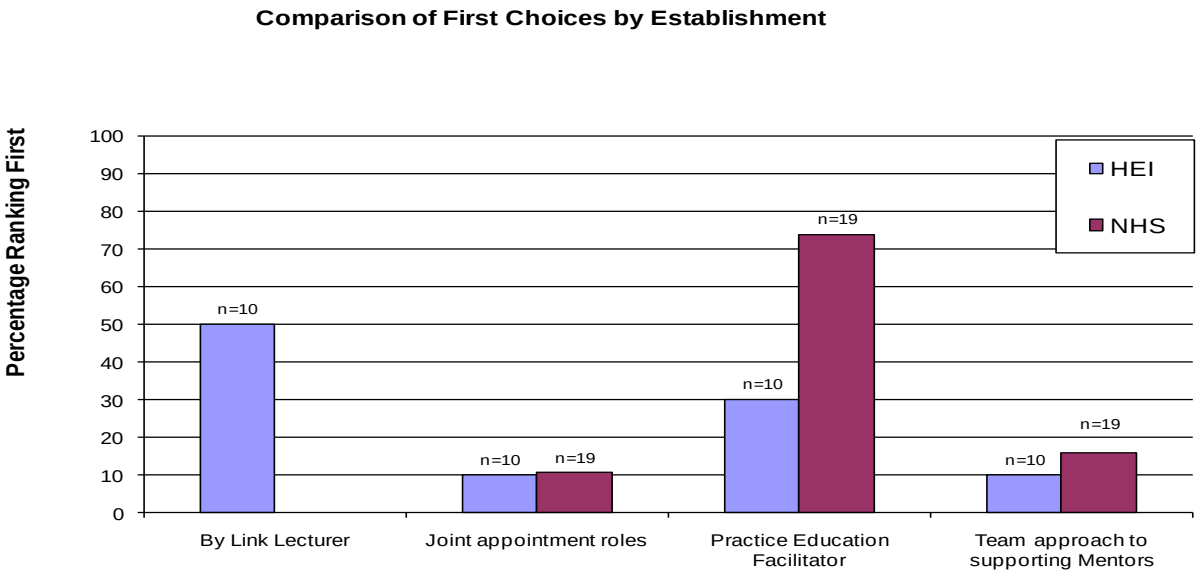


Figure 10 - Mentors support within practice based learning by establishment.

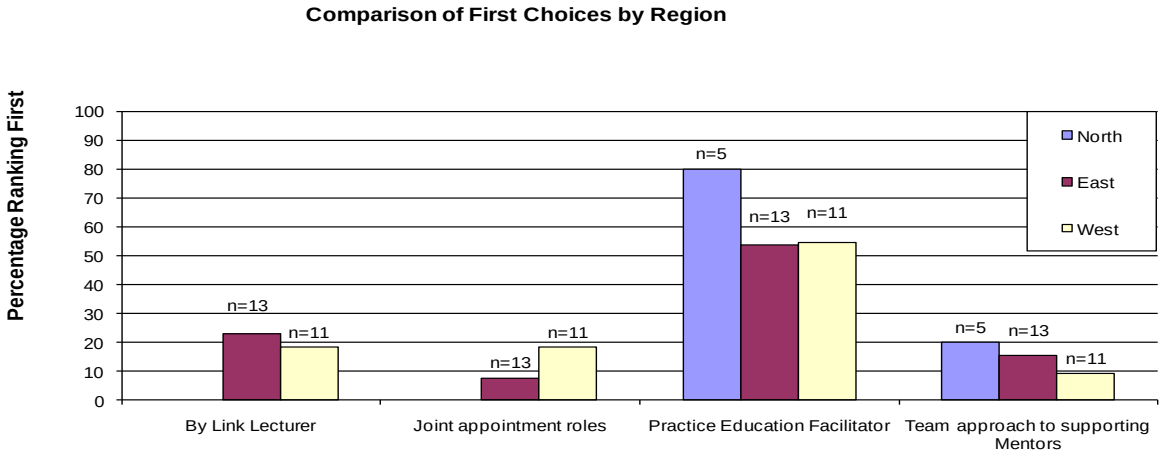


Figure 11 – Mentors support within practice based learning by region.

4.3.5 Process of Mentor Preparation

Questions 10 and 11 aimed to ascertain how mentors were prepared for the role and the content of the preparation programme. Mentor preparation involved 17 organisations preparing mentors through a face to face preparation session delivered at a HEI with additional distance learning including a resource pack. Thirty organisations prepared mentors through a face-to-face preparation session delivered at NHS premises with additional distance learning, including a resource pack. Delivery at a HEI was more common in the East and West regions, while in the North delivery at NHS premises was more common. Other combinations involved in mentor preparation included the HEI and the practice education facilitators working collaboratively. Figures 12 and 13 demonstrate mentor preparation by establishment and region.

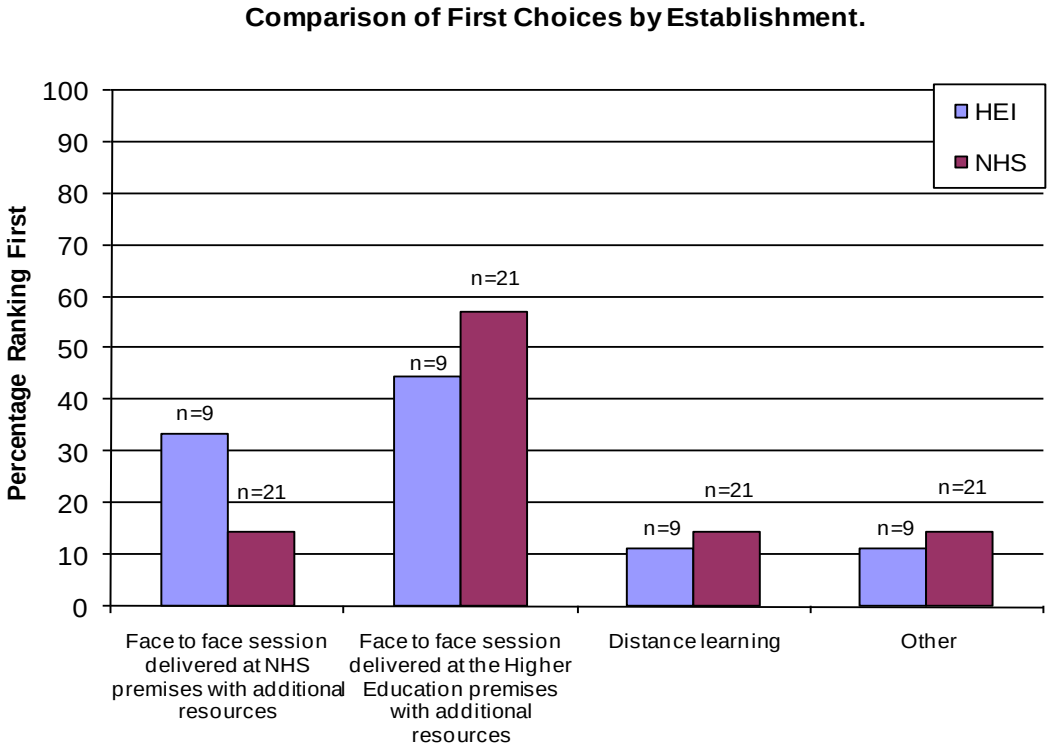


Figure 12 - Mentor preparation for their role by establishment.

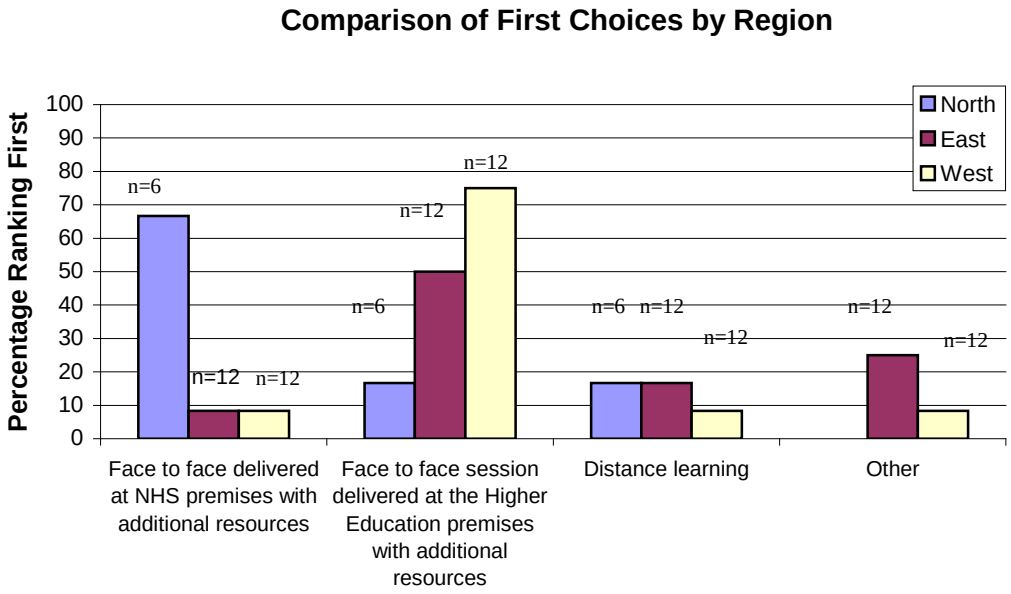


Figure 13 – Mentor preparation for their role by region.

Within the content of the mentorship programme the role of the mentor in teaching and facilitating learning was seen to be of major importance, thereafter, the important areas were seen to be assessment procedures and course programme familiarisation.

These results were repeated in both the regional and establishment analyses. Comments in the other section related to the context of mentorship were: contemporary issues in nursing, changes in nurse education, the learning environment, theories of learning, experiential taxonomy and the role of the Practice Education Facilitator.

4.3.6 Mentor Evaluation

Questions 12, 13, 14 related to the evaluation and performance of the mentor. Participants were asked how mentors were evaluated in their approach to teaching and facilitating learning, the frequency of mentor evaluation and policies relating to mentor performance.

Figures 14 and 15 illustrate how the mentors were evaluated in their approach to teaching and learning within the practice setting. Findings reported that where evaluation does take place, it was predominantly through self evaluation and annual appraisal by the line manager. Two issues arising from the other option related to mentor evaluation involved the Practice Education Facilitators and feedback from annual placement audit.

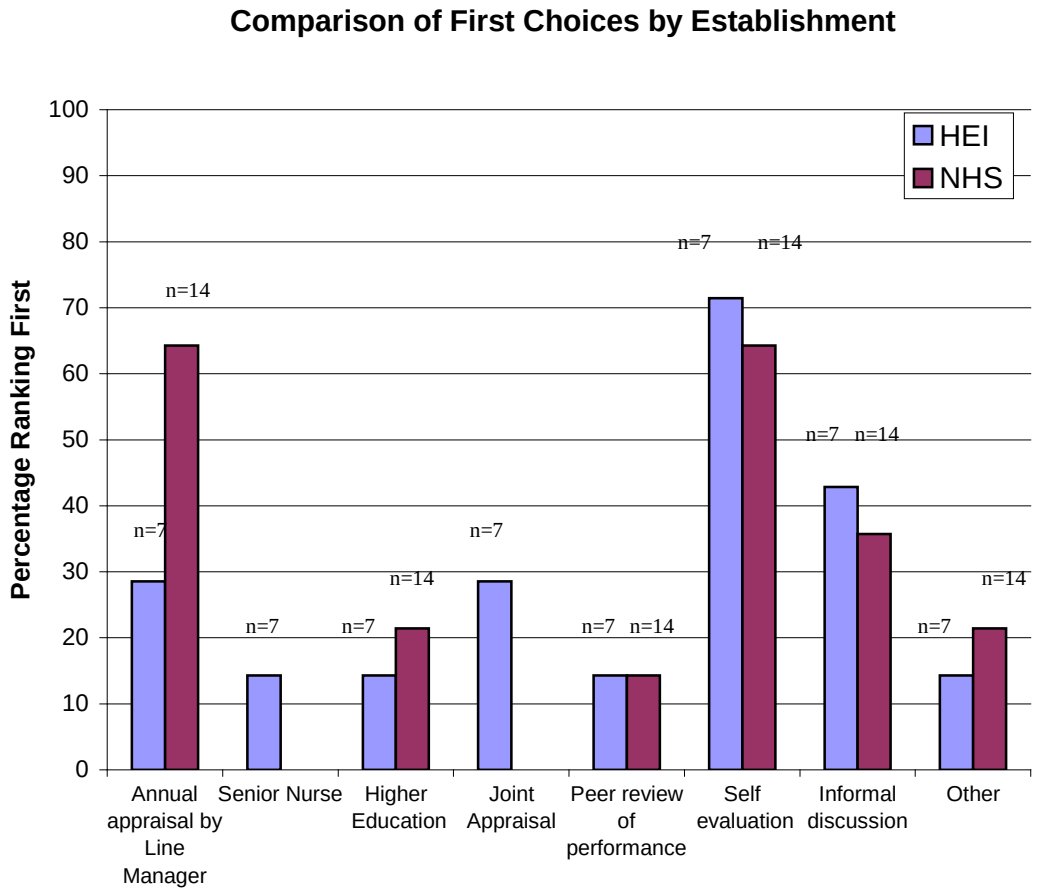


Figure 14 – How Mentors are evaluated in their approach to teaching and facilitating learning within the practice setting by establishment.

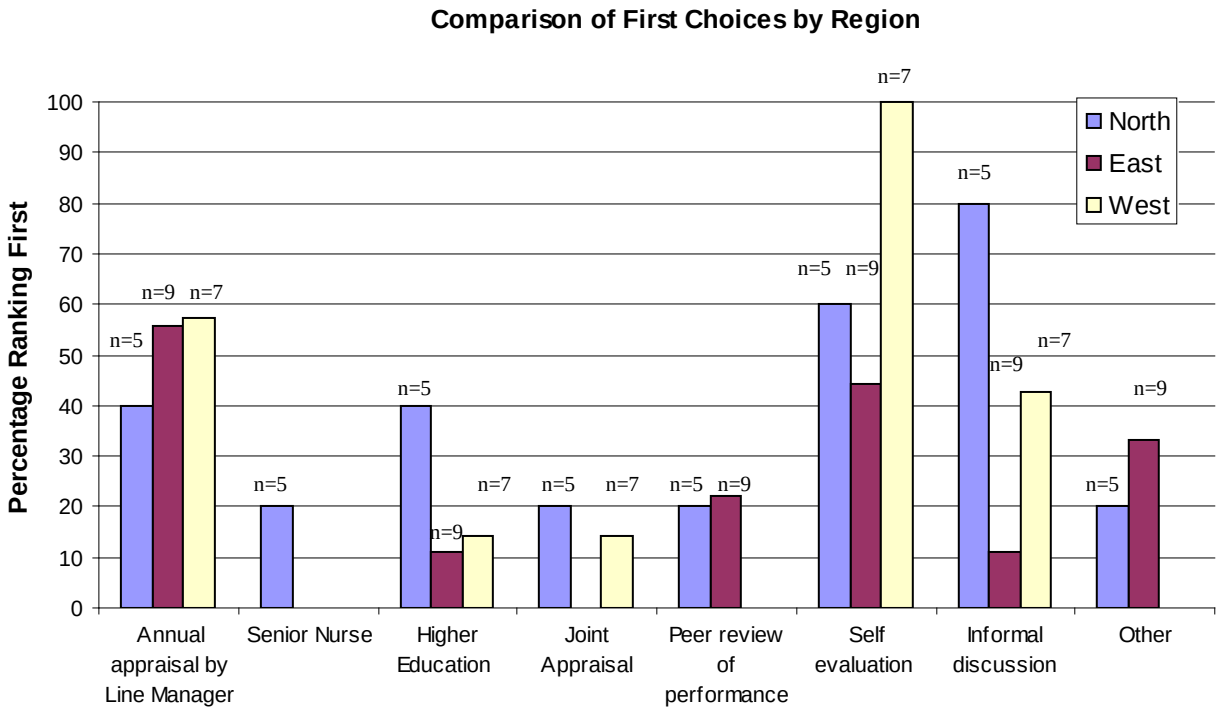


Figure 15 – Mentors evaluated in their approach to teaching and facilitating learning within the practice setting by region.

About one third of respondents reported that no evaluation of mentors took place, whilst, similar proportions reported that evaluation was carried out either continuously or on an annual basis. The West region had a higher percentage of respondents reporting that no evaluation took place compared to both the North and East. Higher Education Institutions tend to evaluate continuously, whereas the National Health Service establishments that did evaluate tend to do so annually. However approximately 13 NHS establishments reported that no evaluation of mentors takes place. Figure 16 and Figure 17 illustrates the frequency of mentor evaluation by establishment and region.

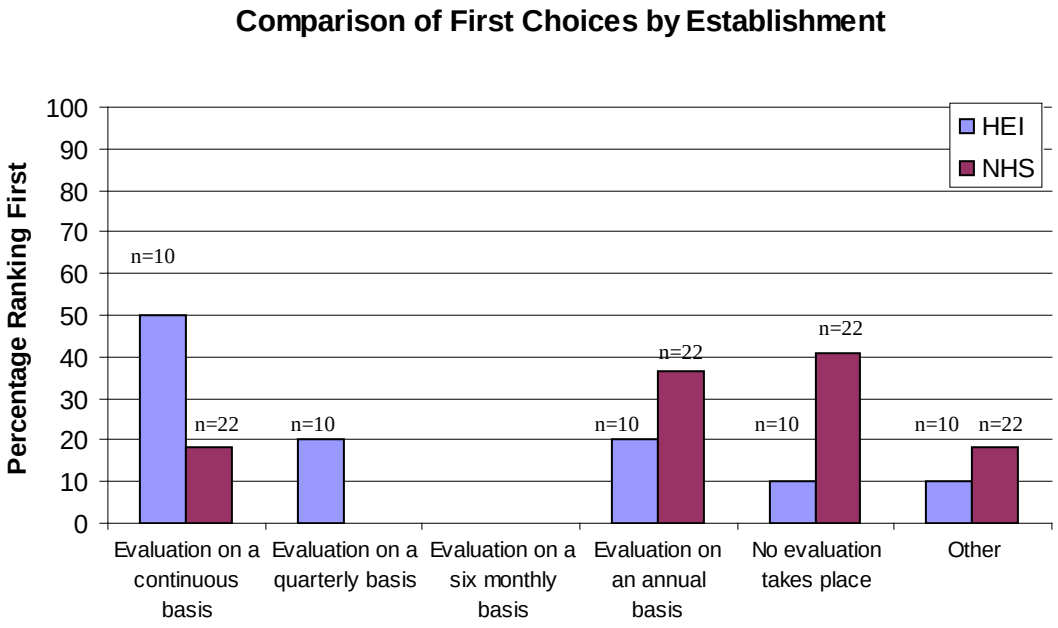


Figure 16 – Frequency of mentor evaluation by establishment.

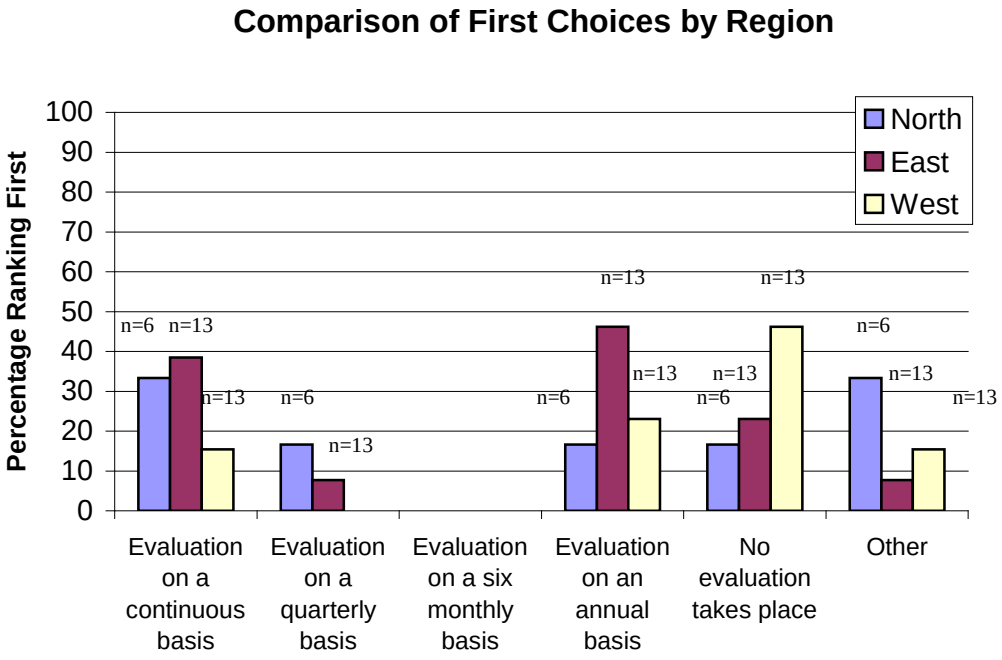


Figure 17 – Frequency of mentor evaluation by region.

In respect to the presence or otherwise of a policy framework for mentor performance, 14 respondents indicated that there was no policy in place for addressing the unsatisfactory performance of a mentor. Similarly, 14 reported that action relating to poor performance was made on a case by case basis. Overall responses varied quite considerably over all three regions. Some comments included were that while there was no policy currently in place a policy was being developed in conjunction with the practice education facilitators. Figures 18 and 19 provide an illustrated view of whether a policy was in place and when the performance of a mentor was deemed to be unsatisfactory on an establishment and regional basis.

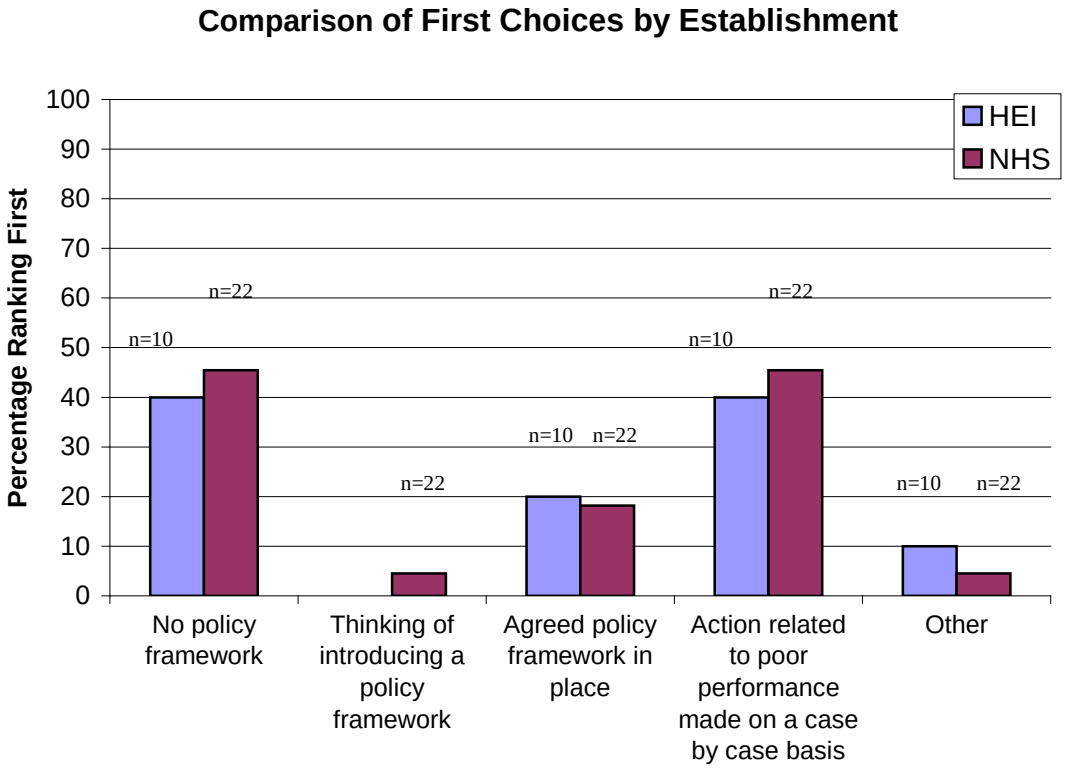


Figure 18 - Policy in place when the performance of a mentor is deemed to be unsatisfactory by establishment.

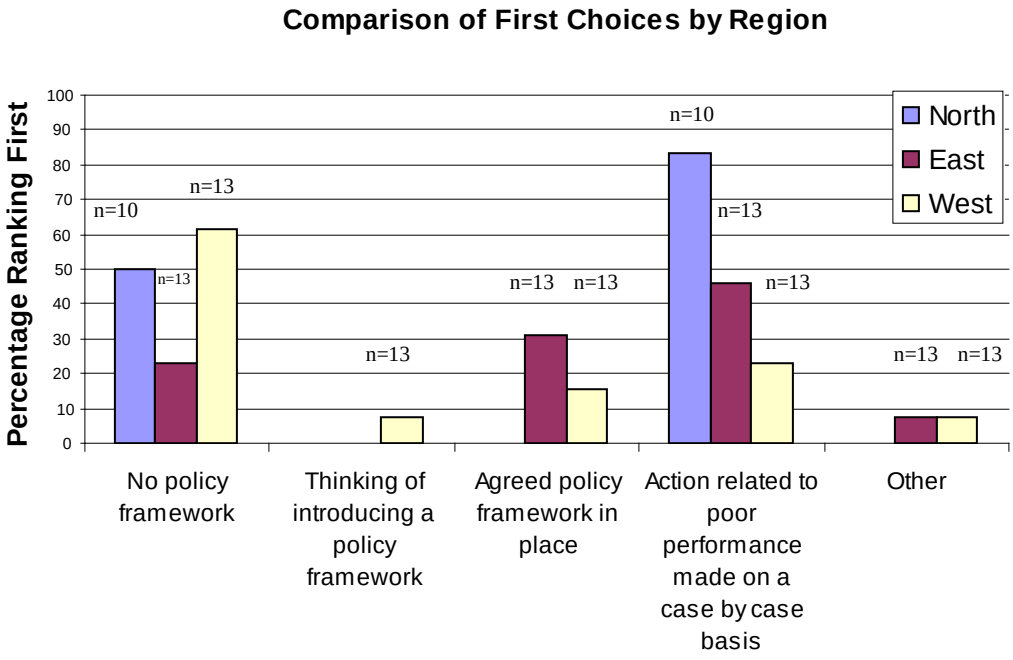


Figure 19 - Policy in place when the performance of a mentor is deemed to be unsatisfactory by region.

4.4 Summary

The strategic implementation of practice learning and the preparation of practitioners with adequate support and monitoring whilst in the role were considered by managers within the HEI and NHS establishments as essential to ensure students are well prepared. Partnership working at a strategic level between educational and clinical staff was paramount so mentors could be supported so that they could provide adequate supervision to students' practice learning experience a strategic partnership approach based on shared ownership, commitment and responsibility was deemed necessary by HEI and NHS establishments to ensure that the concept of mentorship develops, survives and grows in the current climate of staff shortages and competing demands. Without dialogue among the various stakeholders at a strategic level, the realities of practice may be ignored and resolution to problems could be difficult. The research questions were partially addressed through the

questionnaire and as a result the findings from phase 1 of the study informed phases 2 and 3. Table 10 summarises the main issues and sub-issues which informed the design of phases 2 and 3.

Main Issues	Sub-Issues
Practice Based Learning	o Infrastructures for planning and the implementation of practice based learning o Partnership Agreements
Supportive Mechanisms for Students	o Planning of a supportive learning environment for students o Structures to Support a Quality Learning Experience
Mentor Support within Practice Based Learning	o Structures and Processes to Maintain Quality Standards o Higher Education Involvement o National Health Service Infrastructures o Models of Support for Mentors
Process of Mentor Preparation	o Selection Systems o Delivery of Programmes
Mentor Evaluation	o Structures and Processes to Maintain Quality Standards o Policy and Performance Criteria

Table 10 – Summary of main issues and sub-issues from phase 1.

Chapter Five

Presentation of Findings from Phase 2 and 3

5.0 Introduction

In the previous chapter the findings from phases 1 of the study were presented. In this chapter the findings from phases 2 and 3 are presented. In phases 2 and 3 individual interviews with mentors, focus groups with Link Lecturers and Practice Education Facilitators and Ward Managers and Students produced a large volume of rich data. As described in Chapter 3, the constant comparative method was used which generated 22 conceptual categories, 9 substantive codes and 3 major categories. The presentation of findings includes verbatim quotes from participants to give credibility and adds to the value of the study by ensuring the data gained was grounded in reality (Topping, 2006). Diagram 3 illustrates the conceptual categories, substantive codes and major categories.

PUT IN DIAGRAM 3

The presentation and discussion of findings will focus on the conceptual categories, substantive codes and major categories

The first conceptual category ‘Person Specification for Mentor Role’ will now be discussed.

5.1 Person Specification for Mentor Role

In Regional site A, the majority of mentors and some managers reported that a template specifying key areas required should be made available for all potential mentors, as they felt this would create more equity, and give a guideline to what potential mentors should be striving for. In all Regional sites post-qualifying experience was over a year and in areas of speciality two years or more. The majority of mentors agreed that a template, used by managers in the decision making process, would ensure an equitable system was available across all areas of the NHS. Having criteria for mentor selection was clearly evident in two out of three Regional sites with Regional site C reporting the additional need for educational criteria (linked to a portfolio of evidence giving examples of teaching abilities), which should be used by managers in mentor selection. It was only in Regional site C that the majority of mentors wanted an evidence based portfolio linked to the criteria for mentorship. Furthermore the need expressed by all students in Regional site C was for evidence of contemporary thinking related to education for potential mentors.

In all three Regional sites managers wanted potential mentors that could be adaptable within the learning environment, and have the skills and qualities to be responsive to the changing needs of service. However, in Regional site B the importance some mentors placed on mentorship was to fulfil their own ambitions, as they wanted an educational pathway for future career development, however these mentors were also keen to

teach students and had participated in student supervision prior to becoming a mentor. This element of self selection was linked to the mentor's own reflections and experiences of the value of being a good mentor, hence the reason for pursuing mentorship:

> 'You need to be able to work with students and participate in structured teaching sessions and evaluate your performance you need to push yourself forward to be sure you are able to be a mentor.' (Regional Site B – Julie – Mentor: p10).

All mentors identified the need for continuing professional development as a requirement before undertaking mentorship training.

In my study the possession of a teaching qualification did positively influence the mentors' perception of their abilities. The participants also reported the need to establish criteria for selection processes of mentors:

> 'In order to establish a fair system for all potential mentors each clinical area should have clear criteria, which is part of a career pathway so there is a transparent approach to mentor selection. Criteria should be jointly planned with the NHS and HEI. It is also useful for potential mentors to undertake specific degree modules which have an educational focus.' (Regional Site C Focus Group – Link Lecturers/Practice Education Facilitators: p2).

The next section reviews the second conceptual category, 'Mentor Characteristics'.

5.1.1 Mentor Characteristics

The labelling of this conceptual category emerged from the views expressed by some ward managers. In all Regional sites, the characteristics and qualities of a mentor were important; however the level of emphasis was not uniform practice. The characteristics and qualities required to be a mentor was more explicit in some areas than in others.

In Regional sites A, B and C all the managers viewed the personal qualities as important, but also expressed the need for prospective mentors to be self motivated, and have the ability to teach students, which should be clearly demonstrated before mentorship training was undertaken. The following extract illustrates this point:

> 'You require potential mentors to have the same qualities as a good nurse, caring, compassionate and confident.' (Regional Site A Focus Group – Managers: p9)

In Regional site A, the following quote was captured from a mentor expressing the importance of having the qualities to mentor:

> 'You require to be adaptable and have personal motivation, so you can motivate and enthuse others. You must have the ability to develop empathetic and constructive relationships. There is the importance of being a role model.' (Regional Site A – Jane – Mentor: p8).

In two out of three sites students expressed the view that some mentors adopted the role out of necessity and not because they wanted to be involved. The majority of students indicated that the qualities to be a mentor were very much personality driven. In addition, students related the qualities of been a good nurse to the qualities of being a good mentor. This reflects the findings from Gray & Smith (1999; 2000).

Reflections focused on the learning experience by the students, which was captured in the following quote with consensus from the focus group:

> 'You watch the good nurse and think I want to be like that, the way they dealt with bereavement or post operative care, and you think gosh they are really good at that, and you want to learn how they have been taught. On the other hand you see a bad nurse and you think if I have learnt nothing else I am not going to be a bad nurse, and would never speak to anyone in that manner. How did they ever become mentors or continue in the role as a mentor?' (Regional Site B Focus Group – Students: p10).

The majority of mentors felt the qualities required centred on the need to be effective communicators with a positive outlook:

> 'You would not approach someone who had a lot of negativity coming from them. You need to look at the person.' (Regional Site B – Lynn – Mentor: p10).

However, in all three sites, there were similarities focusing on the lack of qualities existing mentors had.

The majority of students reported the lack of these qualities from some mentors and expressed the need for much clearer guidelines for mentor selection. All students reported the importance for potential mentors to have knowledge of the educational initiatives and the rationale for current student programmes. Students reported mentors with several years nursing experience voiced the view for the need to return to previous preparations for students and have less theoretical components but more practice.

This resulted in students recalling their frustrations and disappointments with mentors when the current education programme was not the fault of the students:

> ‘We do not get the ‘old training’ oh the students come in now and know nothing, they are qualified and are worse than useless when they come on to the ward, because they have not had enough practical experience.’ (Regional Site B Focus Group – Students: p4).

The majority of students in Regional Site B Focus Group viewed mentors positively if they were engaged in further learning as this meant that they were more likely to demonstrated additional understanding towards educational programmes and had a more realistic view of changes in healthcare.

Students all felt mentors should not be allowed to mentor the next generation of nurses if they did not have appropriate attitudes, which was voiced in the following quote:

> ‘Why are these staff mentoring students when they make them feel stigmatised about the training programme?’ (Regional Site B Focus Group – Students: p11).

All students expressed the view that staff nurses were undertaking mentorship for development and some needed to have much better interpersonal qualities which is demonstrated in the quotes below:

> ‘Many mentors should not be selected for the course as they are unapproachable they have very negative attitudes so you have to question why they are in nursing.’ (Regional Site C Focus Group – Students: p3).

> ‘Many mentors have positive qualities but in some instances it can be the lack of support at ward level which portrays a negative picture. It is not just the mentors but the whole environment.’ (Regional Site C Focus Group – Ward Managers: p5).

These quotes from Regional site Focus Group expressed the importance of appropriate attitudes linked to suitability for a mentorship programme. It also illustrates the need to link the qualities to be a nurse tied into qualities for mentorship.

In addition, within Regional site C, all the mentors focused on the credibility factor of the applicant for mentorship, and the ability to impact positively within the clinical learning environment:

> ‘You know you are really good with the students when your approach is encouraging and the personal involvement with students qualifies you to go on the mentorship programme.’ (Regional Site C – Susan – Mentor: p2).

In addition, the majority of students in all three sites felt some mentors should not have been selected for a mentorship course as the manner in which they approached the mentorship role was not conducive, and did not add to the learning environment. In fact, students became aware of the reputation of some mentors before going to the placement area. This particular comment mainly focused on general ward environments and was less of an issue in speciality placements. Similarly across the Regional sites, all the students voiced the need for the qualities of a mentor to be revisited and linked to the qualities of a good nurse. Gray (1997) found that the qualities of a ‘good’ nurse reflected those of being a ‘good’ mentor.

5.1.2 Impact of Mentoring Policy within the Learning Environment

In Regional site A, it was reported to be a policy decision in some areas that all 'E' grade nurses were mentors, with the majority of mentors referring to a step ladder approach to development as they progressed through the grading system as mentorship training was a requirement for future opportunities and promotions. In previous research by Watson (2004) it was reported that the impact of a mentor preparation related to the development of the role of the mentor, with the course being undertaken as a means to obtain a higher grade.

In Regional site A, the policy in the general ward areas, namely surgical and medical was for part-time staff to be included in mentorship. While the part-time members of staff did not take a lead role in the overall supervision of the student, they were involved in a secondary mentoring system. In some of the areas there were clearly defined systems of operating mentorship with a primary mentor having overall responsibility for the student journey supported by a secondary mentoring system. Mentors expressed the view that as trained nurses, all the experienced staff should be role models, as the quote below illustrates:

> 'The philosophy of some ward managers is to have as many people who are mentors to give students the best quality of experience.' (Regional Site A – Jean – Mentor: p3).

While some of the areas within Regional site A had a ward policy relating to mentorship training, it was evident in the majority of areas that there was no selection criteria or prior discussion with staff.

The following was voiced and illustrated the lack of process:

> ‘You are going on a two day mentorship programme or you find your name on the allocation sheet ‘mentorship course’, it would be nice to be spoken to so you could make preparation and read relevant material.’ (Regional Site A – James – Mentor).

In two out of three regional sites mentorship selection was also through individual members of staff involved in ‘self selection’, which was processed through the line manager. Individual mentors felt they knew best when to self select for the course and expressed feeling targeted to go on a course without prior consultation:

> ‘Mentorship it is not for everyone. It can be very stressful with little support. You do not get any reward or feedback. You can be on your own in difficult situations.’ (Regional Site B – Morag – Mentor: p10).

Managers within Regional site B reinforced that the selection of mentors was linked to self awareness of the individual’s abilities and primarily by self selection of interested individuals. However, the final authorisation for who should attend mentorship courses lies with the ward manager. Andrews and Chilton (2000) reported the need for the establishment of clear and specific criteria for the selection process of mentors. In previous research by Earnshaw (1995) nursing students preferred newly qualified nurses, as they felt closest to them in a hierarchical sense.

While there was no policy in Regional site B, the consensus view was that mentors should not be newly qualified staff. The importance of mentorship training was viewed by all managers as having an impact on the learning culture and the managers linked this development opportunity to lifelong learning.

Within Regional sites A, B and C Practice Education Facilitators had a role in all the areas to ensure adequate numbers were attending mentorship training courses and also ensured areas had sufficient numbers of mentors prepared. There was no involvement of Link Lecturers in mentorship selection in any of the sites. In all Regional sites, all students felt mentor selection was a case of putting your name forward, but were under the impression that as a registered nurse you have a responsibility to be a mentor and provide a good learning environment.

The majority of participants expressed that for progression through a career framework you had to do the mentor course. Nomination of staff by the ward manager was seen to be in the majority of cases to be the main mode of selection to be a mentor. Students reported that there were staff in the system, going on mentorship courses and accepting students, who should not have been selected to be mentors in the first place, as illustrated in the following quote:

> 'You feel their hearts are not in mentorship, because it is not really part of the job that they want to do.' (Regional Site B Focus Group – Students: p12).

All managers within the Regional site B expressed the view that while there was no formal policy for mentorship selection, the unwritten philosophy was that all staff should mentor students.

There was consensus around the professional responsibility of a mentor, however the length of time an individual was qualified before been a mentor varied from a year up to two years:

> 'Everyone should be a mentor and responsibilities for education of the future workforce should be taken seriously in line with the code of conduct.' (Regional Site B Focus Group – Link Lecturers/Practice Education Facilitators: p10).

Again within Regional site B, some of the mentors reported they had no knowledge of written selection criteria to be a mentor, and felt there was not a policy at ward level, yet they were unaware of management's views, although there appeared, as in other regions, to be a hidden philosophy. Views expressed echoed the need to be qualified at least a year before going on a mentorship course.

The majority of mentors reported there was no choice given as to whether you felt confident enough to be a mentor:

> 'You were just sent on the course, no discussion, just selected by the Manager.' (Regional Site B – John – Mentor: p6).

Most of the trained staff were expected to be mentors, whilst some of the staff felt everyone should be given a chance to be a mentor. Mentors felt recently qualified staff were targeted to be mentors by the ward manager, yet on the other hand in some of the areas it was the length of time an individual had been in the area.

Quotes from Carol, Graeme and Marie captured the need to plan and discuss with staff prior to course selection:

> 'Put on the mentorship course as you were the longest person there – told you are going on a mentorship course.' (Regional Site B – Carol – Mentor: p7).

Essentially, decisions were made by line managers of who should attend mentorship training with no consultation with those involved:

> 'Just told to go on preparation course to be a mentor.' (Regional Site C – Graeme – Mentor: p9).

In Regional site C, the educational co-coordinator decided who should go on mentorship courses. Mentors report managers want as many people as possible to be mentors:

> ‘Everybody has the potential to be a mentor. It is actually to get the numbers on board.’ (Regional Site C – Marie – Mentor: p11).

In addition, across all three Regional sites, the majority of mentors felt it would be important to have an organisational strategy which impacted across areas and divisions so a clear policy could be followed. In some cases mentors had established themselves in their role within one area and voiced the need for some time to settle into their mentor role within new clinical environments prior to taking students. Managers had individual views on the selection of mentors, ranging from self selection to management directing who should attend. There was no evidence of a selection strategy based on policy decisions to establish a consistent approach and equity across ward areas and directorates.

All managers interviewed agreed the lack of a coherent strategy could lead to staff being disadvantaged, and not prepared for the opportunities to be involved in development. In ward areas that had educational co-coordinators some managers viewed this was a point of contact for all staff training to be co-coordinated by one individual. However, all the managers felt the approach of an educational co-coordinator appeared to work in some areas, but strong views were expressed that they wanted a uniform policy with named individuals taking responsibility for what was a key component within undergraduate nursing programmes:

> ‘As managers there needs to be structures and pathways which have a strong educational focus to ensure standards within the clinical learning environment are maintained and enhanced but there needs to be better leadership from Senior Managers across clinical areas and departments.’ (Regional Site A Focus Group – Managers: p9).

> "My initial thoughts relate to the context of the environment in which students are placed for experience. This sparked the need to link the quality of the learning environment to the need to organise students' allocation from the university to the link to a named mentor. The importance of structure to support mentors linked to the nature of relationships between HEIs and NHS need to be part of joint processes, enabling joint decision making and responsibility. Relationships with students, mentors, with manager linked to systems processes and outcomes are needed, so all stakeholders are interconnected. The context of environment needs to be linked to leadership in the areas". (Memo following a student focus Group in Regional Site A)

> "There is a need to link potential mentors to clear criteria and the need to integrate policies into the overall system for mentorship. Need to link preparation to be a mentor to support and supervision arrangements, integrating mechanisms to monitor performance. There is a strong need to integrate all aspects of the mentor journey from pre-selection to performance. The need for quality systems to link into and through all areas of the mentor journey". (Memo – 18 following interview with Mentor in Regional Site B)

5.1.3 Nature of Mentor Selection

As can be seen in Figure 20, these three conceptual categories formed the substantive code of mentor selection.

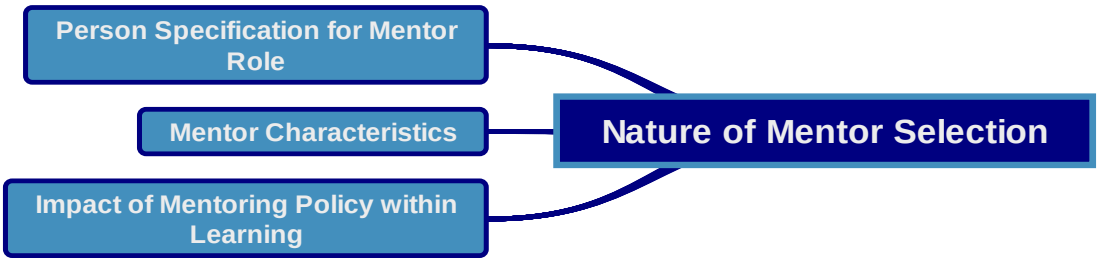


Figure 20 – Substantive code and associated conceptual categories of 'Nature of Mentor Selection'.

Line managers recognised that the perceptions and expectations of potential mentors should be considered before undertaking a programme and as such line managers required to explore the individual's motivations before undertaking further study:

> 'As managers we should have more robust systems in place to ensure potential mentors have had enough development following qualifying but also have satisfactory performance reviews. This is a decision which should be taken at a Senior Management level so all areas within the hospital can have the same standards.' (Regional Site C Focus Group – Managers: p4).

Whilst the changes within healthcare and education are paramount, some managers link this to the promotion of an ethos for lifelong learning and, as such the need to review the criteria for mentor selection. Recommendations from Watson's (2004) research reported the mentorship course should not be required for promotion and that managers should look on mentor preparation as a means in itself. In my study managers expressed the importance of considering the mentor's potential disposition towards the mentorship programme. Becoming a mentor is described as one of the greatest challenges a registered nurse can face (Aston and Molassiotis 2003). However there is little written in relation to the selection and training of mentors (Andrews and Wallis 1999).

Despite the literature on mentors and the mentoring process (ENB 1987, Gray and Smith 1999, 2000, Kramer 1993, Morle 1990) there remains little agreement on the selection of mentors. In fact selection poses particular problems given the lack of criteria and evaluation of effectiveness (Andrews and Chilton 2000). Within this substantive code the need for specific criteria for mentor selection was crucial to ensuring suitable applicants undertaking the mentor role.

The next section presents the findings from the two conceptual categories and the substantive code ‘The impact of Preparation on the Mentor’.

5.2 Mode of Delivery of Mentorship Programme

In two out of three of the Regional sites, namely site A and B, the majority of mentors were prepared through a two day course predominantly held at the Higher Education Institution. In some instances the initial preparation was accompanied with information packs and exercises relating to the practice area as a learning environment. The mode of delivery within the course was mainly face to face with lectures using group work around assessment issues. In addition, in all Regional sites some mentors felt the mode of delivery needed to be re-visited given the wide range of potential mentors, who were at different levels and different degrees of educational awareness.

The main difference was in Regional site C, where some of the mentors were prepared as part of their undergraduate programme. Some students who were being prepared in this way felt the length of time was not enough to cover all aspects of mentorship. The rationale for including mentorship training in the undergraduate programme was driven by a senior management request from the NHS establishment as this was viewed as a way of reducing the release of staff time to attend mentorship training events in the future. Previous research reports the need for effective preparation and support to enable mentors to fulfil their role effectively (Duffy 2000, Luker and Kendrick 1996, Scholes et al., 2004). Indeed inadequately prepared mentors or those not given support when in the role are linked to a reluctance to fail students (Duffy, 2004). Additionally, mentor preparation needs to meet the standards set out by the Nursing Midwifery Council (2006).

Qualified staff who had not trained in the HEI in Regional site C attended a mentorship course. The mode of delivery was mainly by lectures, incorporating exercises around course delivery, assessment and learning and teaching approaches. All the participants, including mentors, link lecturers, practice education facilitators and managers expressed views regarding the lack of consistency in the approach to mentorship courses. This led to recognition for the need to review the content and mode of delivery of all mentor preparation.

5.2.1 Making Sense of Preparation

In Regional site A, some mentors reported on the need for time to reflect following the preparation course for mentorship, and as such needed to actively engage with a team of mentors. Following the mentor course, the majority of mentors felt they would have benefitted from the opportunity to practice questioning skills, and enable them to develop skills in coaching.

Mentors in some of the areas who had recently moved into a relatively new area of clinical practice did identify deficits in their knowledge and skill set. Whilst, the majority of mentors reported feeling skilled regarding psychomotor developments, it was the ability to transfer knowledge and skill acquisition at the same time as providing feedback and reinforcement for students that was a concern. Some of the mentors referred to the difficulty they had in managing student practice under indirect supervision, and having enough opportunity for the student to reflect and process the learning to enhance their knowledge. However, in Regional sites B and C all mentors on completion of the course found trying to bring all the connections together with time for the mentor and student to reflect upon clinical experience was difficult. The majority of mentors felt the need to have an opportunity for students to express what they were learning with their named mentor, so theory could be applied to practice.

The latter was challenging to achieve therefore making connections, and making sense of clinical situations proved difficult. Whilst most of the mentors found the theoretical concepts of learning and teaching to be helpful, it was the application and internalisation of the concepts into their mentor practice that was deemed to be difficult:

> ‘During the phase following preparation, and the time before you get a student allocated was difficult. You need support to apply learning to ensure participation with the students would be enabling.’ (Regional Site B – Christine – Mentor: p10).

Some of the mentors expressed the need for a follow up on completion of the mentor course, so that the course was not seen in isolation and time was given to reflect upon their learning. Spouse (1996) stated that mentors had little or no opportunities for reflection. However, the impact of the preparation courses for mentors has not been the subject of published research (Watson, 2004). This is an area for further research.

In addition from all Regional sites some of the mentors found that from the time of participating in the mentorship preparation course, until they were allocated a student there was a feeling of not been fully aware of any educational changes to the student’s programme. As such, some of the mentors reported the need for the Higher Education Institution, namely the Link Lecturer to check with potential mentors so a learning programme could be developed together. Moreover, there was felt to be a need to bridge the gap between the course and the reality of having a student:

> ‘I felt lost having a student even though I had undertaken a mentorship course. The student documentation was changed and I felt foolish asking the student for clarification.’ (Regional Site C – Jean – Mentor: p6).

5.2.2 The Impact of Preparation on the Mentor

Education preparation for mentorship was found to be in different formats and modes of delivery. However, the impact following mentor preparation required more careful planning and follow up in relation to making connections for implementing learning and teaching approaches. Modes of action required to be considered on how new mentors could work together with previous mentors in a supervisory model to integrate the theoretical component of mentorship to the reality of practice. The impact of mentor preparation encompassed the conceptual codes of the mode of delivery in respect to the mentorship programme and how participants made sense of such preparation as indicated below in Figure 21.

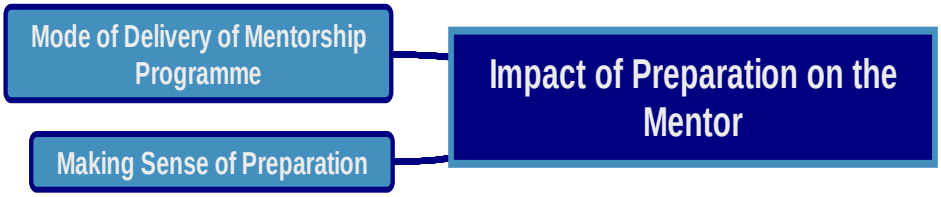


Figure 21 – Substantive code and associated conceptual categories of 'Impact of Preparation on the Mentor'.

The next section presents the findings of the 3 conceptual categories related to the substantive category 'Reality of the Mentor Role'.

5.3 Planning for the Student

Across all three Regional sites, all mentors reported a considerable gap in time between completing the mentor course, and being allocated a student. In most cases the mentor's name was 'starred' as an indication a student would be allocated to them. The majority of mentors reported the day the students arrived very often coincided when they were not on duty perhaps due to holidays or other staff requesting time off. All mentors felt

this lack of planning for the student difficult to manage as the named mentor had to pass the orientation and induction to someone else who was on duty. The difficulty most of the mentors had with this course of action was that this individual may not have completed a mentorship preparation course.

In all instances a learning contract was to be negotiated within a specific timescale, yet if the named mentor or associate mentor were unavailable, the target to achieve a learning contract was not met. The majority of students expressed difficulty if the learning contract was not negotiated, as they felt learning experiences gained were picked up by chance rather than being planned or organised:

> 'You wonder around the first few weeks of the clinical experience trying to find out about the routine of the ward but if a learning contract was available the competencies required for the placement could be linked to the experience required to achieve success.' (Regional Site C Focus Group – Students: p4).

In all three of the sites, most of the mentors felt the Link Lecturer should be actively engaged in all planning aspects of learning.

However, in two sites (A & B) most of the mentors expressed satisfaction with the role of the Link Lecturer, and others viewed the input dependent on the ability of the lecturer to engage and their credibility within the practice area. All sites were satisfied with the timeframe for informing them of student allocation. Students were very appreciative of letters from mentors prior to commencement of their placement with the indication that the student could go to the clinical area prior to the actual placement.

Below is a quote illustrating the negative impact of the absence of such a welcome:

> ‘You arrive in a ward and there is nothing prepared for you. Even if there was a piece of paper with information about the ward this would have helped. At least it would have given the impression you were expected.’ (Regional Site B Focus Group – Students: p7).

It would appear that in some general ward areas there was a lack of information in comparison to speciality environments:

> ‘You can arrive in a speciality area and the experiences are detailed as part of a rotation which reflects the patient journey.’ (Regional Site B Focus Group – Students: p8).

> ‘It is much easier if a practice educator is in a placement area as you can benefit from the educational programme for trained staff’. (Regional Site B Focus Group – Link Lecturers/Practice Educational Facilitators: p11).

Across all three regional sites, all the students reported positively on the clinical areas that had a menu of learning experience available. The consensus view from students was that this reflected areas which were interested in providing learning opportunities, and as such the mentor had been given thought to their role. Neary et al., (1996) reported mentors required support in planning the learning programme. In areas where students did not have a programme of learning, all the students perceived this as an immediate disadvantage:

> ‘When students had a menu of experience and planned opportunities the overall experience was more structured and students are not left wondering around attaching themselves to whoever is on duty.’ (Regional Site C Focus Group – Link Lecturers/Practice Education Facilitators: p3).

This links to Spouse (2001) who viewed effective mentors as able to provide more opportunities to bring theory and practice together. However, despite supernumerary status and planning for learning, student nurses may still be failing to gain a systematic knowledge of practical nursing. It was Corlett et al., (2003) who reported the type of placement students complete may be more important than the sequencing of theory within practice.

Ajiboye (2000) identified the active role students need to take in their own learning but also stressed the importance of the mentor in helping to identify their learning needs. Willis (1997) found that students did not know what they should be doing during placements.

Chaffer (1998) and Rinomhota (1998) highlighted that students felt that they need to be better prepared for placements and that staff should be better prepared to receive them. All students in my study expressed the value of been able to identify areas of curriculum interest to engage with. A mentor's view is expressed in the following quote:

> 'You need to incorporate a learning programme around the multidisciplinary team to capture holistic care. This needs to include specialist input to enhance the student's experience.' (Regional Site A – June – Mentor: p3).

However the quote from Regional Site A June captures a broad view of holistic care from a mentor's perspective yet in some general areas the view of the multidisciplinary team approach for students learning was not seen as a priority:

> 'There is a real issue with students having experience with the multidisciplinary team. It is very apparent students are kept back from these opportunities due to staffing issues.' (Regional Site A Focus Group – Link Lecturers/Practice Education Facilitators: p3).

> ‘In some of the speciality areas students are encouraged to go with members of the multidisciplinary team. The experiences help students with specific skills around exercising following surgical treatments. In order cases students have the opportunity to be engaged in discharge procedures with the social work team. You really need to push in to get the experiences.’ (Regional Site C Focus Group – Students: p8).

Students expressed the value of mentors selecting individual patients or groups of patients to enable the development of skills. Some of the students reported mentors needed to organise experiences as they had expert knowledge of an area, but to also enable students to question practice, so they could develop professionally and personally.

Matching the learning need to learning opportunities was seen as critical for ensuring a programme of learning within the practice area was designed to meet students’ educational needs and the environment promoted learning and teaching opportunities. Surveys by O’Flanagan (2002) and Alderman (2001) have demonstrated that student is very happy if they find themselves in an environment that promotes teaching sessions. The programme of learning, in my study, was reported by all the mentors as an essential activity to discuss the nature of the placement and the learning opportunities available. The following quote captures this:

> ‘The need to discuss the experiences on an individual basis with students is crucial which is necessary for a successful outcome.’ (Regional Site B – Peter – Mentor: p11).

Across all three Regional sites, managers in the majority of cases did not take an active role in planning for the students, as they had a consensus view that this activity should be solely a mentor’s role, as they had knowledge of the curriculum and assessment approaches. Managers had

a consensus perspective that the mentor was the best person to design a programme for learning, due to their knowledge of the clinical area and the client group. All managers agreed that mentors needed to plan experiences for students, but not only in developing competencies, but also confidence. All mentors viewed the need for opportunities to work in a collaborative way to meet the students' learning needs by helping them identify areas of interest. It was also reported by managers that mentors needed to help students' identify their own opportunities as they became more familiar with clinical practice.

5.3.1 Resources to Support Student Learning

In all three Regional sites, most clinical areas had learning packages available relating to the specific field of practice. Students reported the benefit of additional resources, which helped link theory, and they could then transfer knowledge gained into practice. Web based resources were available in some areas. Link Lecturers and Practice Education Facilitators worked jointly to prepare learning resources, which also provided information from the Higher Education Institution to practice. Whilst most of the students reported the benefit, it was felt by students that there was a need to have a uniform practice throughout all areas to ensure consistency of practice. However, in two out of three of the Regional sites emphasis was on the importance of patients and families to support student learning:

> 'It was really good to get feedback from patients and families particularly when the comments were helping to enhance care delivery. This was a great opportunity for students to learn.' (Regional Site B Focus Group – Students: p12).

In addition, some of the managers emphasised to students the resources available within the ward area and in other departments, particularly within the multi-disciplinary team.

5.3.2 Feelings Experienced by the Mentor

All mentors in all sites viewed the experience with students who were competent, confident and organised about their clinical learning, as very rewarding. Mentors who were able to prepare students clinically and theoretically to provide holistic care enhanced the mentor's satisfaction of their role. It was reported by mentors, when the learning environment, learning opportunities and resources were effective, this enabled the student's experience to be meaningful. As a result, all mentors felt in these instances they had made a contribution to the student personally and professionally. In regional sites A, B and C some degrees of apprehension were expressed by the majority of mentors, particularly when students were having difficulties around assessments. Some of the mentors reported negative concerns when students were not interested or had difficulties in assessment, which made some feeling they had failed the students. This is reflected in the following quotes:

> 'You feel awful at not been able to turn things around when there are difficulties as you feel responsible for their success, although this needs to be balanced, ensuring students are 'fit for practice.' (Regional Site A – June – Mentor: p5).

> 'As a mentor you need to assess the student to check if an extension to the practice placement is required. It could be the student needs more time to correct assessment issues or gain more confidence.' (Regional Site A – Peter – Mentor: p7).

Whilst some mentors viewed having a student as a challenging opportunity the satisfaction gained on successful completion of the placement was immensely rewarding. All mentors felt they had made a very positive contribution to the overall support aspects of the student journey. In addition, students were often able to give information from the theoretical content to the mentor.

Some mentors expressed the amount of time it took to engage with students who required extra support and as such there were occasions in which they felt quite strained.

Importance was placed across all Regional sites for mentors working directly with the students and seeing the students' progress from a novice level to demonstrating competence. However, in areas where students were struggling to achieve skills and competencies, it was frustrating for the mentor not being able to provide continuity of supervision. The majority of mentors reported on the lack of infrastructure to support mentors within ward areas. The following quotes captured the need for infrastructure at ward level to enable consistency for students:

> 'It is the lack of continuity of mentorship everyone giving the students different advice. It ends in confusion for the mentor.' (Regional Site B – John – Mentor: p4).

> 'You just feel terrible not able to offer an adequate amount of supervision. As a mentor you have to trust the students to get on with the job, yet you do not know what they are doing or learning.' (Regional Site C – Katrina – Mentor: p7).

> **'**You need to operate a team approach to mentoring to help with continuity so students can progress in a supportive environment. It is different in an environment when the ward manager is positive about having students and values their contribution.' (Regional Site C – John – Mentor: p8).

5.3.3 Reality of the Mentor Role

These conceptual codes were condensed into the substantive code 'The reality of the Mentor role' as illustrated in Figure 22.

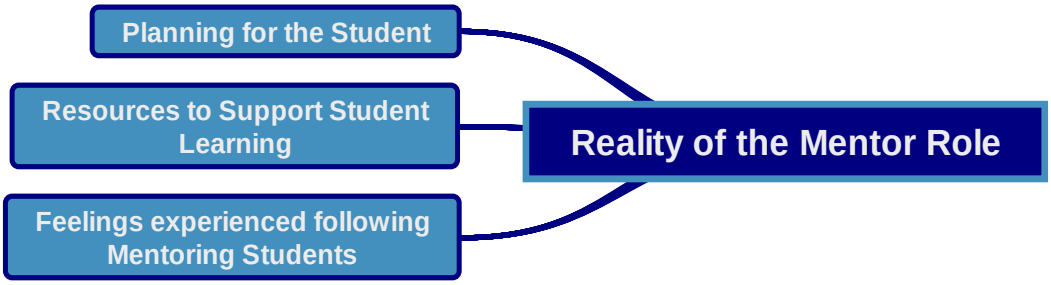


Figure 22 – Substantive code and associated conceptual categories of 'Reality of the Mentor Role'.

Planning for the student experience linked to resources for learning and teaching, generated both positive and negative experiences for the mentor. Creating planning templates to ensure a quality learning experience was critical to enhance the experiences and satisfaction of the mentor. Hallet et al., (1996) demonstrated in order for learning to take place theory and practice need to be closely linked, hence the importance of planning for learning. Mentorship needed to ensure that teaching and learning and the subsequent planning and resourcing of that needed to be integral to care delivery. Previous research findings demonstrated considerable resources have been applied to prepare practitioners to be mentors (Morton-Cooper and Palmer 2000; Chow and Suen 2001).

The student experience required to be planned in relation to the context of the situation with preparations prior to the student arrival. Linking mentorship preparation to the facilitation of learning in practice is crucial as Spouse (2001) viewed planning of activities to meet student needs assisted in the application of theoretical knowledge to practice.

This substantive code is associated with preparing and planning for receiving a student to mentor as well as the feelings generated as a result of mentoring. This is illustrated in Figure 30.

5.3.4 Becoming a Mentor to Facilitate Learning in Practice

Becoming a mentor to facilitate learning in practice became the major category from further condensing of the substantive codes. This major category was conceptualised from the mentors, practice education facilitators, link lecturers, managers and student accounts of their experiences around the challenges of mentorship. Figure 23 overleaf provides an overview which will explored in more depth.

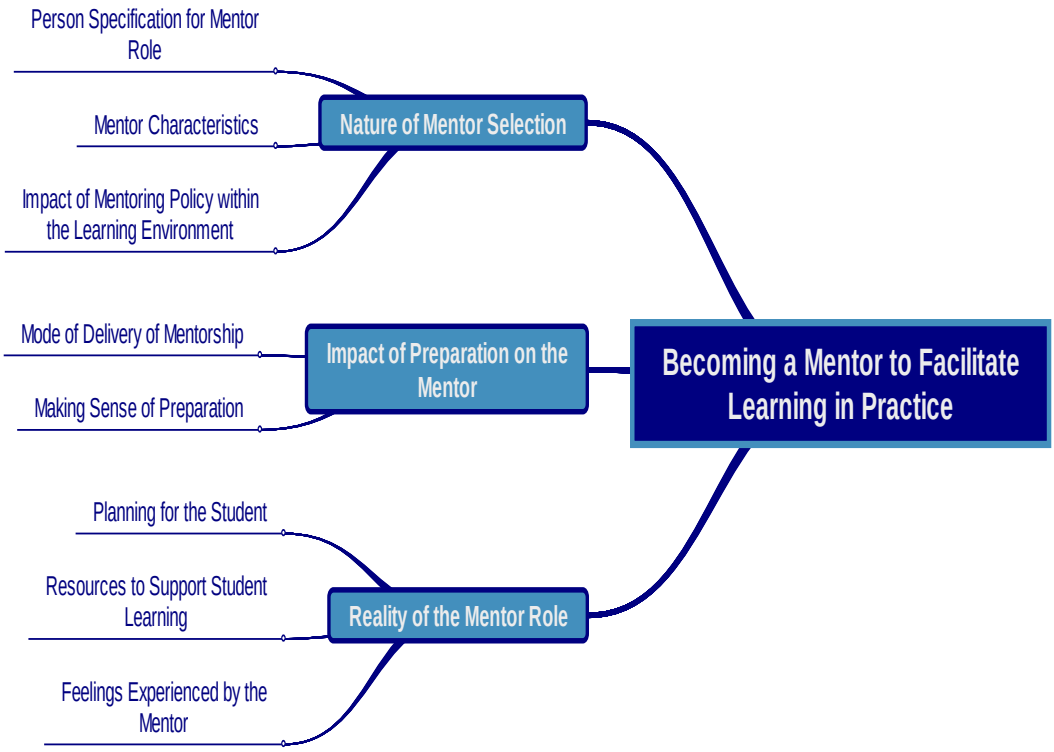


Figure 23 – Conceptual categories and substantive codes to the first major category 'Becoming a mentor to facilitate learning practice'.

All participants excluding students reported on the issues surrounding the need for clear guidelines for the recruitment of mentors, and the need for uniformity in strategies. Providing information and having the opportunity to discuss and shadow a mentor prior to attending the course was highlighted as a significant factor by all mentors in the study.

Whilst, some mentors felt confident when they were selected for the course, others wished to have more time within the clinical area to gain expertise in care delivery in the organisational systems and processes at ward level, so students would get the ultimate benefit. In the majority of

clinical areas, ward managers needed to have mentors prepared to ensure students were supervised, yet the processes for selection of mentors lacked consistency, which often meant those selected for the course were participating out of a sense of duty:

> 'It would help if the Higher Education Institution had guidelines on mentor selection. This differs from ward to ward and even if potential mentors are in the same division of a hospital there are different practices. This can lead to some staff feeling disadvantaged.' (Regional Site B Focus Group – Managers: p5).

> 'I would have felt more confident if my manager had spoken to me as part of a development review rather than finding my name on the list. It would be good to feel you are ready to undertake a mentor role.' (Regional Site A – Susan – Mentor: p2).

The majority of mentors felt the lack of a consistent approach to mentorship selection was attributed to the lack of leadership from senior staff within the practice area. However, in those areas with policies in place, there was still a need to establish a joint approach with the Higher Education Institutions and the National Health Service incorporating senior management at ward level, senior representation from the Higher Education Institution, Link Lecturers and Practice Education Facilitators to review resourcing for mentorship.

Providing appropriate information to ensure there were adequate mentors in place was important, as was ensure planning cycles for mentorship were built into Communication Partnership Forums. Some managers reported the need for a strategic agenda and priorities, linked through practice education facilitators, in order to address the deficit in the areas where the number of mentors prepared is inadequate:

> ‘Some of the ward areas have difficulty with maintaining the number of mentors required for students. In many areas this was due to the high turnover of staff. There needed to be more engagement with Practice Education Facilitators to review the number of mentors and to target the areas of greatest need.’ (Regional Site C Focus Group – Managers: p2).

> ‘It really helped when areas had a Practice Educator on site who has responsibility for the learning environment and ensuring adequate numbers of staff to supervise students.’ (Regional Site A Focus Group – Managers: p11).

Essentially, this would enable managers to plan more productively, and in turn be responsive to the requirement of staff and student ratios.

The majority of mentors expressed their anxiety about attending a mentorship course due to the lack of information received from managers and the Higher Education Institution. However all the mentors received dates of mentorship courses and in the majority of cases an outline programme for the course. Nevertheless, the mentors wished to have more information in advance on the contents of the course and to be able to discuss this directly with the ward manager and the educational link from the Higher Education Institution.

Whilst mentors, practice education facilitators, link lecturers and managers reported on the need for intelligence gathering to review the current establishment of mentors, there was a recognised need to check the overall status of existing mentors in relation to currency of mentors. Managers also reflected on the need for the capacity and capability of potential mentors to enable applicants to have a heightened awareness of the requirements of the role of a mentor. Establishing policies for mentor selection, which was part of an educational infrastructure, would ultimately give more of a focus on quality and the overall effectiveness of the educational programme for mentors. All participants expressed the

benefits of a transitional phase from preparation to undertaking the mentor role, as the mentor developed professionally and personally, however, all the students needed mentors who were dedicated to the role.

Consequently, those participating in the mentoring programme were perceived by some staff as being advantaged over others, as this development opportunity was often seen in certain areas and with some management as criteria for promotion. Becoming a mentor requires a process, which is driven from strategy so policies can be implemented, which are pivotal to the impact of mentorship on facilitating learning in practice.

5.3.5 Summary

Figure 24 overleaf, is presented again by way of a summary. This section focused on the major category ‘Becoming a Mentor to Facilitate Learning in Practice’ and gave accounts of specification, characteristics and policy aspects within the regional sites relating to the nature of mentor selection, which linked to the impact of preparation and the reality of the mentor role.

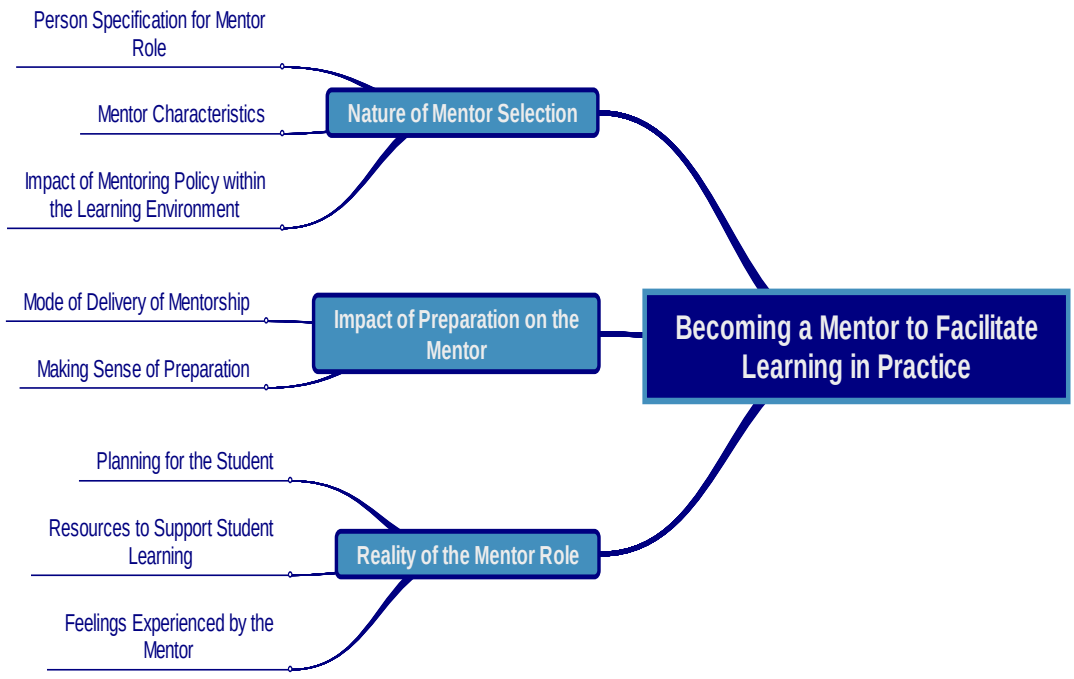


Figure 24 – The conceptual categories and substantive codes to the first major category 'Becoming a Mentor to Facilitate Learning in Practice'.

The next section focuses on the conceptual categories, substantive codes and the second major category. 'Operationalising the facilitation of learning in practice'. See Diagram 3 for an overview.

5.4 Student – Mentor Relationship

Within Regional site (A) the majority of students found out who their mentor was on the first day of practice placement, whilst some students had been invited to the clinical area prior to commencement so the mentor and student could meet. The latter created a welcome to the clinical environment, however there appeared to be no system of allocation by managers for students to match with mentors, with the majority of students feeling managers or delegated staff at ward level should be more

proactive in student allocation. The following quote captures the need for a consistent approach to the allocation of students to mentors:

> 'It tends to be always the lower grade of staff who are mentors. When there are no junior staff to mentor then a sister grade would mentor in some cases it is the newly qualified staff that end up mentoring the students.' (Regional Site A – Link Lecturers/Practice Education Facilitators: p10).

However, in the majority of cases the allocated mentor was not available on the first day or sometimes even the first week of placement, which was similar to Regional site B and C.

The majority of students in Regional site A felt the newly qualified staff were a great deal more effective as mentors, although this was not apparent in site B or C as students favoured mentors with years of experience, which is illustrated in the following quote:

> 'Some students think that someone who is new to the job would do better as they are more inclined to take you and show how you do things because they know what it is like and how it feels and they know how hard it is on the wards, plus you wouldn't pick up bad habits whereas with the older nurse you would.' (Regional Site A Focus Group – Students: p14).

This quote was included as it expressed the strong feeling and perception that new mentors were closer to reality and perhaps had more currency with their skills set. All the students found that the Link Lecturer was able to bring direction and provide clarification around the competencies to be achieved:

> 'The link lecturers brought clarity and focus to the learning contract and helped the mentor. It was great to know the link lecturer would have regular contact with you to help your learning.' (Regional Site A Focus Group – Students: p4).

> ‘It really helped when the link lecturer had taught the students in the university and then linked into the practice areas you felt confident in the information and support which would be given.’ (Regional Site A Focus Group – Students: p5).

Experience for students depended on the continuing professional development of the mentor and their ability to reflect, question the students and have knowledge of the underpinning theory. Spouse (1996) viewed the quality of the relationship between the student and mentor was fundamental to a successful outcome. However, Hallet et al., (1996) claimed students could not take full advantage of clinical experiences as discussions with mentors were often simplistic. In this study, some of the students experienced difficult encounters with their mentors relating to an evidence base for practice. As far back as the nineties the importance of a supervisory relationship between a student and supervisor was crucial for effective clinical learning (Earnshaw 1995; Newton and Smith 1998; Williamson and Webb 2001; Wilkins and Ellis 2004).

The lack of value on theoretical learning was captured in the following:

> ‘Staff who have been trained 20 or 30 years they think this learning thing is a load of nonsense. They claim – oh! Students who come now and they know nothing – they are worse than useless when they come into the ward.’ (Regional Site A Focus group – Link Lecturers/Practice Education Facilitators: p6).

In contrast to this quote the following was expressed:

> ‘Students who come out from the University sometimes need more time for clinical skills particularly if they had not being given that particular experience during their programme. However once they are given the opportunity they pick up skills quickly.’ (Regional Site A Focus Group – Link Lecturers/Practice Education Facilitators: p10).

In addition, in Regional site B all students reported it was very useful to have the testing of their knowledge and particularly the ability to reflect on theory and practice. Cameron-Jones and O'Hara (1996) found students wanted their mentors to be more challenging. However, it was Jackson and Mannix (2001) who reported students needed to feel safe when asking questions, and perceived students were not encouraged to question, but were left on their own to care for patients. The benefit of these experiences happened when mentors knew about the student's programme and students found this was linked to continuing professional development for mentors. Similar findings were expressed in Regional site (B) with, some of the students expressing dissatisfaction relating to the management of allocating a student to a named mentor. Chow and Suen (2001) in a survey found that student's positive perceptions of mentors were associated with the level of satisfaction in the learning relationship. In a study by Lloyd-Jones et al., (2001) students who did not work with a mentor were usually not supported by other staff and as such, the students learning experience was greatly impacted upon, thus affecting subsequent development. Concerns expressed by some students in my study are illustrated below:

> 'Students given a mentor, then they go off sick and no one is allocated. Often the students are left unsupervised due to mentor allocation. It was actually three days before finishing a placement that some students were given a new mentor and that only happened because of constantly asking about the assessment book.' (Regional Site B Focus Group – Students: p8).

This Regional Site B quotation represented strongly the need for back up due to sick leave and annual leave but also to ensure systems were in place around assessment processes. The lack of planning particularly when contingency plans were not in place was an apparent strand that ran throughout some general ward areas in all sites.

As in regional site (A), all the students felt there was no system for mentor – student allocation within the organisation, but names of students were added to off-duty lists, which appeared to be who was available on the day:

> 'Mentors say to the students. Oh! You're with them because it is their turn to take a student so they are doing mentoring out of necessity, why can't they make you feel welcome?' (Regional Site B Focus Group – Students: p11).

All students expressed the need to know their named mentor before going on placement, which was similar to the findings in Regional site A. In Regional site B this would have advantaged the students as they felt the benefit of them knowing who their contact was helped to lessen the anxiety prior to the placement experience. However, on the other hand students' also noticed the disadvantage of this depending on the mentor and placement allocated, which was linked to the reputation of the clinical area:

> 'While it was good to know the mentor, and if you got a letter from the ward prior to the placement this was heartening but if you heard rumours about mentors and wards you felt fearful before even getting to the area. We are in a small area and the grapevine is not good. When there is a lot of negativity and rumour this can dominate your thoughts.' (Regional Site B Focus Group – Students: p14).

Some students reported positive aspects relating to a small geographical area which is captured in the following:

> 'There is benefit when managers mentors and link lecturers knows the clinical areas well and the learning environment is positive. This makes students want to go to that ward and want to return when qualified. The difference a positive learning environment can make is unbelievable particularly when there is a positive view towards learning and staff are doing courses themselves.' (Regional Site B Focus Group – Students: p15).

From Regional site C, the majority of students reported they arrived on wards, and it was whoever was on duty that day took the students. In some areas it was clearly identified on the duty allocation sheet, yet the students may not see that named individual for weeks due to holidays or patterns of working, which was similar in regional site B. In addition, students viewed the need to match a mentor with a student after considering a profile of each individual.

Furthermore, it was perceived by students the importance of considering age profile, previous nursing experience, life experience, family commitments, and specific areas of interest. This would enable a holistic view of the students needs to be considered and matched appropriately. The issue of mentor and student allocation was illustrated in the following quotes:

> 'The managers need to help the mentors plan the allocation of students since they are responsible for the resourcing of their areas. They need to ensure mentors are available for students at the beginning of the placements after all they make up the off duty.' (Regional Site C Focus Group – Link Lecturers/Practice Education Facilitators : p8).

> 'In some areas students are given a choice as to the placement pattern. This works better when the student can have the same off duty as the mentor and follow the mentor on to night duty.' (Regional Site C Focus Group – Link Lecturers/Practice Education Facilitators: p9).

All students in Regional site C expressed positively the philosophy of the need to match students to mentors. Firstly, it was felt this would ensure senior students were linked with appropriate mentors, particularly during the management component. Secondly, it was perceived this would enable the mentor and student to be on the same shift pattern, which would ultimately enable a system of supervision for students. Lastly,

students reported an allocation system of mentor to student which would mean a more efficient use of time and would contribute to the assessment aspect making it more continuous, and not just signing a book.

The benefits of the need for criteria relating to the allocation of students to mentors were captured in the following quotes:

> ‘This was my last placement and my mentor was a newly qualified staff nurse, while the first year student was allocated one of the senior charge nurses who were never really working directly with the student, which meant the student was left working with untrained staff for the majority of the time.’ (Regional Site C Focus Group – Students: p11).

> ‘Mentorship has a huge effect on how you progress through the course, it has a huge benefit on your self confidence and your self belief so it makes an enormous difference.’ (Regional Site C Focus Group – Students: p13).

Similar findings from Regional site C were expressed by students in site A, who felt the time the mentor spent with the student related to the organisation and subsequent planning within that environment. The reality of the experience was captured in Focus Group quotes from Regional site (A):

> ‘We were passed from ‘pillar to post’ everyday, working with a new member of staff with a new mentor signing me off when I only worked with them one day’.

> ‘We just ended up ‘latching’ onto anyone who showed an interest as we felt under their feet. Sometimes mentors did not like us which made the experience unbearable’: p7).

These two quotes portrayed a strength of feeling around the need for planning the student experience:

> ‘When you have a programme and a named mentor and someone who is allocated to cover the mentors’ time off this helps the supervision and security you feel. Most of the speciality areas had you allocated to a staff nurse who may not have been a mentor but knew the area well. This made a difference. Some of the qualified staff in general ward areas were inexperienced in the organisation of the ward and perhaps this made things more difficult for trying to organise for the students.’ (Regional Site B Focus Group - Students: p14).

All students reported that, when the mentor and student time was planned the benefit to both parties was valuable, enhancing the learning opportunities and the invaluable learning experiences the students had.

Hoyles et al., (2000) suggested the need for engagement within clinical areas to enable students to arrive at a deeper more meaningful understanding of the practice of nursing.

The benefits of a planned approach for mentor and student allocation are captured below and illustrate the importance of consistency around the learning experience for students:

> ‘You work with the same person all of the time they know your weaknesses and they know that they need to build on for achievement of competencies. All this creates a good environment for learning’. (Regional Site A Focus Group – Link Lecturers/Practice Education Facilitators: p8).

In the regional site (A) some of the students valued the relationship with the Link Lecturer, while others felt it depended on how knowledgeable the individuals were in the clinical area. Brown et al., (2005) reported students valued the support from Link Lecturers and the need for visits from a lecturer whilst on clinical placement. In this study the Link Lecturer, who engaged with students at the beginning of placements contributed to the planning of the learning experience, and the negotiation of the learning

contract, added valued support. Whilst the first conceptual category focused on the student-mentor relationship, this ultimately linked to the student-link lecturer relationship.

5.4.1 Student – Link Lecturer Relationship

Some of the students had negative encounters with the link lecturers, and did not find the role of the link lecturer in practice placement to add any educational value. Chapple and Aston's (2004) research demonstrated the need for change in the role of the lecturer in practice. As such, the liaison role was inconsistent with a lack of clarity resulting in the role not being valued. The lack of clarity in the role of the lecturer was reported by stakeholders (Day et al., 1998). In this study, some students expressed the view that not all Link Lecturers had suitable qualities to be able to engage. This reflected the findings in Regional site (A), however similarities were apparent within the Regional sites B and C. While some felt the input was minimal and at critical times in the student's journey lecturers were unavailable. Hence the frustration experienced by students resulted in them feeling vulnerable.

Rogers and Lawton (1995) reported the lack of support from HEIs with contact mainly problem orientated. Students in my study had a strong viewpoint as exemplified in the following quote:

> 'When some lecturers can plan their clinical visits for students effectively, the impact of a small minority who are not interested reflects on everyone. They are required, at key points of the student experience, yet they go on holiday and do not provide cover.' (Regional Site B Focus Group – Students: p10).

In my study, the majority of Link Lecturers interviewed wanted clarification on the role of the lecturer across all three regional sites particularly with external monitoring processes. The following captures the expressions

from some Link Lecturers in one regional site and is a particularly strong quote around the leadership required from the Higher Education Institution:

> ‘As link lecturers we need to take more responsibility for student learning in practice as it is half, the programme. However, this aspect of the lecturer’s role requires leadership from the Higher Education Institution.’ (Regional Site B Focus Group – Link Lecturers/Practice Education Facilitators: p12).

Some of the students reported a lack of contact with Link Lecturers on practice placements, and in Regional site C whilst some students indicated there were visits to check how students were progressing within an area this depended on the Lecturer. The majority of the students wanted more regular contact form the Higher Education Institution with input into teaching sessions at ward level. Some students reported that in some areas of clinical practice, mentors found it difficult to engage with the Higher Education Institution as the contacts were mainly by telephone.

This was reinforced by Duffy et al., (2000) who felt more input was required from lecturers at placement level with more effective communication required. As such, some mentors wanted a more systematic approach of engagement with students, from the link lecturers. The following quote captures a consensus from the students:

> ‘The need for more regular contact with lecturers is required as the mentor role has no time allocated. They can be asked to supervise five or six students. How can they adequately supervise, give feedback and at the same time check the assessment criteria. Lecturers need to be present in the wards and have areas, which they are responsible for. It is too much to leave everything for mentors to do as they have other responsibilities.’ (Regional Site C Focus group – Students: p13).

This quote is included to demonstrate the strength of feeling around the role of the lecturer in practice. Whilst there was concern with the numbers of students mentors were to supervise this related to general ward areas and was not apparent in the more specialist environments.

Some students reported that some lecturers had an adaptable, considerate and flexible approach to student learning which ultimately maintained continuity of relationships and focused on the link between education and practice, a finding specifically relating to Regional site A. All the students appreciated the Link Lecturer who was approachable and demonstrated knowledge of contemporary nursing and was seen by the clinical staff as 'role models' in education. Newton and Smith (1998) demonstrated the social aspects of the lecturer role were rated highly along with teaching and tutorial ability. In this study, all the students placed a high value on the credibility the Link Lecturer had with clinical staff, and expressed that this contributed to the overall experience for students in the clinical arena as the Link Lecturer was involved jointly with mentors.

Brennan and Hunt (2001) saw the need for the value of clinical teaching to be re-established. In addition, the majority of students in Regional site A highly valued the engagement of the lecturer in a tripartite collaboration with the assessment in the clinical area. Whilst the Link Lecturer mainly engaged in theoretical aspects relating to portfolio development, the majority of students felt the Link Lecturer provided consistency of contact, and ensured the same criteria was applied to all students, yet some students expressed the lack of uniformity with the portfolios. Maslin Prothero and Owen (2001) found that nurse lecturers needed to develop individualised practice – based roles, with Koh (2002) reinforcing the need

for an educational structure, which supported regular teaching sessions in practice settings.

5.4.2 Student – Practice Education Facilitators Relationship

The student and Practice Education Facilitator relationship and awareness of the role varied across all three regional sites, with some of the students reporting that Practice Education Facilitators in Regional site A were engaged with students, as part of a planned approach for preparation for practice placement. This was linked to an orientation programme for students in acute care areas. The majority of students expressed Practice Education Facilitators came into ward areas to discuss experiences, and some instances acted as arbitrators in areas of conflict or in disputes over assessments. The following quote captures students' perceptions:

> 'The Practice Educator Facilitators are relatively new roles and not everybody knows about them. It would appear they are more effective in some areas and not in others. We have heard the mentors reflecting on the role but there seems to be a lack of clarity given it should be the Link Lecturer who is involved in assessment issues.' (Regional Site A – Students: p14).

This quote is included to demonstrate the lack of clarity around the Practice Education Facilitator role and the need for a strategic approach to ensure consistency across sites. The engagement between the student and practice education facilitators was limited in some instances and as such some of the students questioned the value of the role in Regional site B. In some areas the Practice Education Facilitators contributed to resource folders for students and mentors which was a different role from Regional site A. As such, some students were unclear about the practice education facilitator role in Regional site C and confused this with the role of an educational coordinator or the staff member who was engaged in practice education. However, similar to the other two sites some students

were aware that the Practice Education Facilitator role engaged with ward areas but the functions all differed. In Regional site C, the Practice Education Facilitators were able to harness increased resources to assist with accommodating student numbers and enabling more engagement with the multi-professional team. The latter meant that students were more able to follow the entire patient journey.

5.4.3 Student – Mentor – Link Lecturer Relationship

In two of the Regional sites, a similar model of engagement operated, namely a tripartite system for practice learning, whilst in Regional site C the majority of students reported there was no three way engagement of the student, the mentor and the Link Lecturer. This would only happen in circumstances, which impacted on assessment or complaint issues. This was in contrast to Regional site A, where all the students reported on a tripartite approach involving the mentor and Link Lecturer with input into a learning contract with monitoring on a regular basis linked to the portfolio and assessment of performance.

Papp et al., (2003) viewed a good clinical learning environment as one with cooperation and collaboration between mentors and lecturers. In this study, some of the students valued the Link Lecturer input into assessment, while some students felt the process of engagement was very challenging, and the students felt stressed. This was contributed to the lack of a consistent approach from the Higher Education Institution on the assessment through portfolio. The majority of students valued the ability to reflect on experiences and in particular if the mentor, student and Link Lecturer could do this together. In both Regional sites A and B all students reported a three way approach within the clinical learning environment, which centred around the student experience and performance with the mentor and link lecturer making a judgment on competencies. Wills (1997) found that students valued lecturers'

interpersonal skills, competence, evaluation skills and teaching ability, with the need for Link Lecturers to organise and facilitate learning. Murphy (2000) reported the nurse lecturer could fulfil liaison, teaching, practice and research roles within clinical areas. In my study some students felt some of the lecturers used the time to monitor what mentors were doing.

5.4.4 Models of Relationships for Learning in Practice

Within all regional sites, the practice placement environment was an entity with various models of relationships established to facilitate a supervisory approach to enable students to be able to achieve their competencies. The supervisory relationship between the student and mentor was characterised by the importance of the context for learning and embraced the importance of the atmosphere within the clinical learning environment, the philosophy for learning and the supervisory relationship. Essentially, within the mentor model, there were levels of mentoring relationships, including the 'star mentor', associate roles and the team mentoring approach:

> 'I was given the 'star mentor' role which meant I had experience to be able to guide and direct other mentors. I felt proud of this as my work with students was recognised.' (Regional Site A – Lyn – Mentor: p2).

The ward atmosphere and the ward manager linked closely to the leadership style within the environment, and this either enhanced or hindered the student journey within clinical practice:

> 'The style of leadership was so important as to whether students were encouraged. If the experience was planned and supervision arrangements were in place plus time for reviews and assessment learning was enhanced as the whole experience was planned. The learning environment was positive for students.' (Regional Site B Focus Group – Students: p9).

> ‘In an environment where the ward manager was not visibly leading the ward team and creating a conductive environment being haphazard for students the learning opportunities were hindered and in many cases morale of staff was lowered.’ (Regional Site C Focus Group – Link Lecturers/ Practice Education Facilitators: p10).

Hence, the leadership approach to establishing the clinical environment as a learning environment was closely linked to the philosophy of care delivery aligned to planned learning situations within the ward. Whilst the mentor relationship was key to ensuring continuity of experience the connection with the Link Lecturer and Practice Education Facilitator were considered important in contributing to the quality of the clinical learning environment and supervision. It was evident in areas where the Link Lecturer placed strong value on clinical education, underpinned by an implemented educational philosophy, that this created a structured support for students in practice placement:

> ‘We loved the placements when the Link Lecturer was considered to be part of the team and was seen as a key figure in the educational experience for the students. We felt there was a stronger academic element to practice and we were questioned about conditions and treatments.’ (Regional Site A Focus Group – Students : p3).

Practice Education Facilitators had engagement with some students prior to placement allocation, ultimately, creating a link with the University and the practice arena. Essentially, this enabled continuity of communication, and thus provided students with relevant information on the clinical area. The value of the tripartite collaboration in some areas between the student, mentor and link lecturer provided a mechanism to optimise the teaching and learning process in a structure of engagement, hence, nurturing and influencing students’ satisfaction with their placements. The variety of relationships for practice learning in the four conceptual

categories associated with the substantive code ‘Models of relationship for learning in practice’ are illustrated in Figure 25.

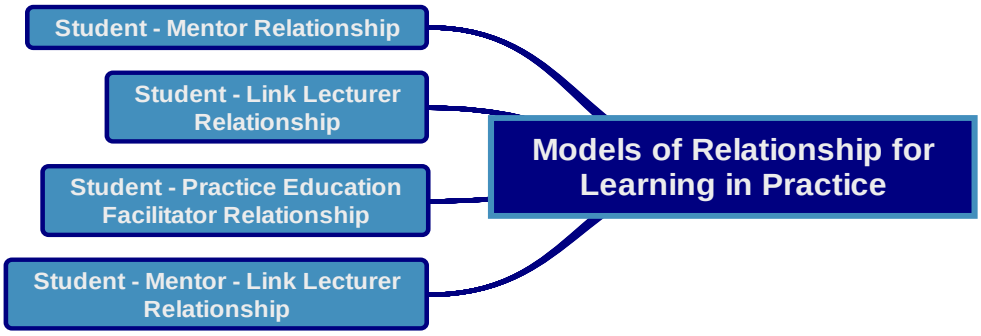


Figure 25 – Substantive code and associated conceptual categories of ‘models of relationship for learning in practice’.

The next section presents findings from the 2 conceptual categories associated with the substantive code ‘Influences of Partnership Relationships’.

5.5 Reactive Encounters between Higher Education Institutions and National Health Service Establishments

All regional sites reported reactive encounters had recurrent themes with a focus on complaints, crisis situations and assessment issues. In Regional site A, some managers reported the only HEI engagement occurred was when evaluations were not of a satisfactory standard or when there was a particular student issue or some area of complaint. Collaborations between the HEI and NHS establishments in Regional site B were reported by some managers as occurring when there was a particular crisis, mostly surrounding assessment issues.

Whilst Practice Education Facilitators primarily supported mentors, some of the areas of focus related to concerns around student assessment or

fitness for practice issues especially within Regional site A. With a similar focus in Regional site B as Practice Education Facilitators linked closely with some managers and mentors, yet it was reported in some of the cases the contact was related to solving numbers of students to practice placement availability.

Whilst the majority of managers in two out of three Regional sites reported contact with Link Lecturers was the result for areas of concern, which primarily were issues from students. Link lecturers engaged in the majority of cases to resolve issues, answer areas of concern and in particular conflict over assessments. All managers reported the culture for engagement was problem orientated rather than a reflection on developments around curriculum issues, which could lead to an enhancement for student learning and a more conducive environment. Moreover, the lack of a proactive engagement in all three sites meant that discussions from some of the managers took place at the request of individuals who were experiencing difficulty with processes relating to students. In addition, types of engagement focused on numbers of students per placement area. Difficulties with student allocation were addressed however, these were not linked into policies which could have helped in the decision making process.

5.5.1 Proactive Encounters between Higher Education Institutions and National Health Service Establishments

Proactive encounters within Regional site A, reported that all the ward managers saw the benefit of conducive relationships and engagements, which were sustainable with key individuals from the Higher Education Institution. It was reported the continuity of the relationships were important, therefore enhancing the ethos of collaborative engagement. However, the expansion to include Practice Education Facilitators was seen by some of the managers to be a helpful addition enabling

information exchanges between Higher Education Institution and the staff in the National Health Service. All managers viewed updating on curriculum issues, as extremely positive, and reported the value of Link Lecturers and Practice Education Facilitators actively engaging in workshops with mentors, which in some of the cases involved students:

> 'Initially, as managers we had real-doubts about practice education facilitators. There was a lack of clarity around their roles. We thought they would be working directly with the students.' (Regional Site B Focus Group – Managers: p11).

This quote is presented to illustrate a sense of confusion and direction around the Practice Education Facilitator role which demonstrated the need for clear direction from management.

However, some of the managers expressed the need for more input from Link Lecturers relating to communications regarding changes in Higher Education and different course changes. Practice Education Facilitators were viewed by some of the managers as a bridge to getting information, and enabling a system of facilitating forums for discussion which was also found in Regional site C. All the managers viewed the need for key individuals from the Higher Education Institution and the National Health Service to regularly engage in formal forums to discuss educational issues impacting on supervision for students.

This was particularly reflected in Regional site C with all the managers reporting on the need for forums to be established on a regular basis involving key staff, who are engaged in the preparation of students for the nursing register.

Some managers reported the benefit of Practice Education Facilitators linking directly with education co-coordinators within units to explore

supervision strategies and programmes for students, which was particularly evident in regional site C. The next section links to reactive encounters between Higher Education Institution and National Health Service Establishments.

5.5.2 Influences of Partnership Relationships

The nature of partnership relationships ultimately aimed to provide learning experiences however, more importantly was the approach to the operationalising of the partnerships. Thus, the active involvement with stakeholders consequently required sharing between the different parties to improve the quality of learning and teaching. In fact, the approach to partnership relationships needed interactive mechanisms so the collaboration between the Higher Education Institution and the National Health Service Establishments did not adopt passive modes to engagement. Strategies for partnership relationships required to make connections for learning in practice, therefore moving away from a problem orientated relationship, reactionary models of engagement to planned approaches, with all stakeholders in the process. The substantive code and associated conceptual categories can be seen in Figure 26.

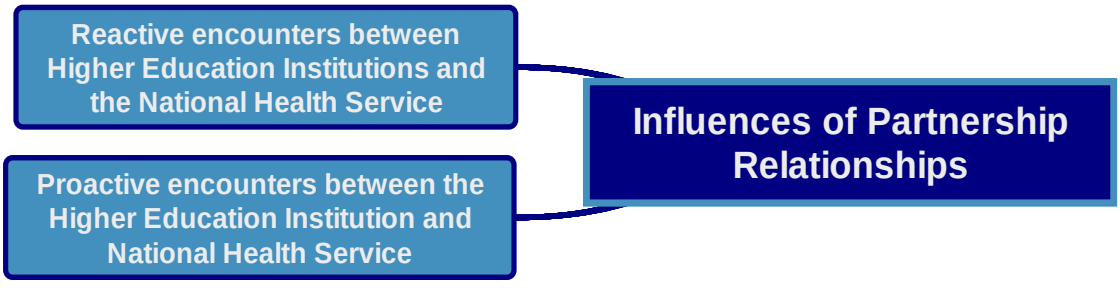


Figure 26 – Substantive code and associated conceptual categories of 'influences of partnership relationship'.

The conceptual category ‘Proactive encounters between Higher Education Institution and National Health Service that are associated with the substantive code ‘Impact of Mentoring Culture on Learning in Practice will now be explored.

5.5.3 Influences Impacting Student Satisfaction in the Learning Environment

In all Regional sites, all the students felt supported in a learning environment where the mentor had an interest in teaching, however the majority of students expressed feeling an inconvenience:

> ‘You were often left on your own and sent for a coffee break on your own. You did not feel included as all the trained staff had tea together. While this did not happen in all areas you felt you were intruding.’ (Regional Site C Focus Group – Students: p11).

In Regional Site B some of the students expressed the following:

> ‘You can feel a part of the team when the educational and social climate is brought together and students are embraced as part of the team.’ (Regional Site B Focus Group – Students: p14).

The students felt the need to have mentors who were well motivated was perceived to be critical for learning in practice. The majority of students felt mentors should want to take on the role and not feel pressurised. Those who saw mentorship as an integral part of their job profile had less difficulty with the aspect of mentoring students (Atkins and Williams 1995). Across all three regional sites the majority of students felt they were left unsupervised, and were left shadowing a clinical support worker rather than a mentor.

The following quotes illustrate the point:

> ‘Sometimes people are allocated a student and they are not really qualified enough to have a student, they are not focused and they are not very mature to teach you, they don’t want to take the responsibility of having students.’ (Regional Site A Focus Group – Students: p3).

> ‘The ward leader says work with such and such but they are not a qualified member of staff, however you do not mind that when you are starting out you can learn from the clinical support workers, especially if you have never been in that role yourself, but as you progress, you need supervision. Your status as a student nurse is compromised, you are not learning, but just another pair of hands to complete the work.’ (Regional Site A Focus Group – Students: p4).

These two quotes are included to demonstrate the strength of feeling around the need for supervision from qualified mentors for student nurses.

Some students expressed the vulnerability they felt when staff kept referring to the style of training and were disregarding of the current system of nursing education as illustrated in the following quote:

> ‘In my day you would be doing this and in my day you would be doing that. You felt vulnerable, which made you lose confidence, which impacted on your competence.’ (Regional Site A Focus Group – Students: p10).

As a result, some students felt unsure as the impressions given by some mentors the experiences students had were lacking and not up to the standard. All students felt some mentors increased their vulnerability, depending on their levels of ability to effectively engage in supervision. The following quotes capture the strength of feeling around supervision and were included to demonstrate the depth of the concern.

> ‘You are carrying out a procedure and you are shaking like a leaf because they have totally made you feel useless which makes you lose confidence.’ (Regional Site A Focus Group – Students: p5).
>
> ‘I have been in a position where I followed the mentor from the preparation room into the patient’s room and asked ten questions and got one word answers, made it completely clear she was unwilling to involve me in what was going on.’ (Regional Site B Focus Group – Students: p8).
>
> ‘If you need something to do, away and look in the cupboards and drawers so that you can find things later. Then you find skills are going on in the ward and you are not included.’ (Regional Site C Focus Group – Students: p11).
>
> ‘In other areas students were left with one trained nurse and we felt vulnerable. While being able to contribute to care delivery, we were left to get on with the work allocation, and not really having the supervision required. It was a bit scary, you can feel very lost.’ (Regional Site B Focus Group – Students: p12).

In all three Regional sites, the majority of students expressed the active role they had to play in the learning environment with the majority of planning coming from the students. When learning was structured, the opportunities and experiences were broad incorporating the multidisciplinary team.

Research by Cahill (1996) on student nurses’ experience of mentorship in practice revealed that teaching and learning activities were seen as taking place after the ‘work’ (patient care) was completed. Hence, the separation of learning and patient care, thus dividing the time for direct contact with patients and that of student learning. However, Cahill’s (1996) research could suggest that students were unable to perceive they were learning practically. In this study, the research also focused on the mentor’s perspective, in that mentors may fail to make connections between clinical nursing knowledge with academic knowledge, theories and research. Students were seen as part of the workforce and not in the

capacity as ‘learners’. The majority of the students reported this reflected the main areas of student experience including medical, surgical and elderly care environments. In contrast, students who had experienced in specialty locations expressed a marked advantage relating to supervision, support and time for learning:

> ‘We are an extra pair of hands in general ward areas, but in theatre it was totally different they have so much time for you – so much support you feel able to enjoy the experience.’ (Regional Site C Focus Group – Students: p11).

Other students had a different view:

> ‘We did not feel we were an extra pair of hands in some general ward areas as you could be allocated to a team and then had the support of a group of staff. This was better than wandering around.’ (Regional Site C Focus Group – Students: p14).

In all the Regional sites, students expressed dissatisfaction with the impact on supernumerary status, which was never addressed by the Higher Education Institution, or at ward management level despite students expressing concern they were being treated as a member of staff.

This reference to being counted in the workforce numbers at ward level meant that they were allocated duties as a member of staff and not as a student who had learning needs. Wilson – Barnett et al., (1995) reported some students viewed supernumerary status positively yet also expressed the lack of clarity around supernumerary status caused confusion and disillusionment. Whilst supernumerary status has been around since the 1950’s, and adopted by nurse education with the implementation of Project 2000 (Gray and Smith 1999) with the original intention to free

student nurses, so they would not be counted in the numbers (McGowan and McCormack 2003) as members of the ward team.

Therefore, in my study, the system of allocating duties left a lack of engagement with the mentor and the student in order to plan learning experiences in line with the learning contract and competencies to be achieved. Hence, students were left attaching themselves to healthcare assistants, as the ethos was very much on the completion of the workload, and not in the overall learning programme for students. Most of the students reflected on their disillusionment and felt annoyed that their learning outcomes were not planned or structured in relation to the care delivery at ward level:

> 'You can work like an auxiliary for the whole of the placement, but you want a balance in the learning experiences. You are there to learn not to support poor staffing levels.' (Regional Site B Focus Group – Students: p11).

> 'Whilst it is important to be part of the ward team you need to have opportunities to gain new experiences when mentors facilitate this it can be much better.' (Regional Site B Focus Group – Students: p13).

Students had very clear views of their hopes and expectations of practice learning, which included being able to enjoy clinical placements. Students found the learning environment where they were encouraged to learn and supported in that learning enhanced the overall experience. The students contrasted the approachable and dependable mentor to the one who had a lack of interest and enthusiasm for the role:

> 'It was awful when the mentor had no interest in having students, you felt frustrated and knew this person would be writing a report on your progress.' (Regional Site C Focus Group – Students : p6).

Positive environments enabled the student to engage in learning even though they had limited experiences within a new practice area. Students expressed a great sense of achievement and the confidence felt when they knew what to do, and the fear of getting in the way and disrupting the mentor was reduced:

> ‘Once you knew the routine of the ward and in particular how to do dressings when you were in a surgical ward. Once you knew the treatments you felt confident to use your initiative which meant you did not need to keep going back to the mentor. It felt good to be involved in decisions once you felt confident and you knew were able to achieve: p10).

In Regional site B, the majority of students discussed the vulnerability around performing clinical skills. The uncertainty of clinical procedures and the fear of getting aspects of the skill wrong clouded the overall experience for the student however, mentors who praised and encouraged the students increased their confidence. In contrast, the mentors who would dismiss the students and demonstrate skills so fast, resulting in feelings of despair and the fear of doing something wrong due to the time not being taken to break the skill into components in order for the students to demonstrate competence.

Jones et al., (2001) demonstrated the failure of mentor and student to connect could be down to poor organisation and the absence of management to plan mentor’s days off. As such, management was seen both as a managerial and educational issue. The majority of students reported supernumerary status was not only influenced at ward level, but was impacted upon by senior management.

The quotes around supernumerary status are included as they spanned all three focus groups with students indicating the importance this issue was for them:

> ‘Managers are coming down everyday checking how many students are on duty and taking auxiliary staff away so you are solely left working as an auxiliary. In some wards you are told at the beginning of the placement, supernumerary status will be compromised.’ (Regional Site A Focus Group – Students : p6).

> ‘Even when you are participating in a learning event you get phoned or taken out because they are an auxiliary short.’ (Regional Site B Focus Group – Students: p9).

> ‘There is a real issue with supernumerary status you are counted in the numbers of staff on duty at ward level yet you are a student trying to gain experience.’ (Regional Site C Focus Group – Students: p11).

In addition, in Regional site C some of the students expressed the lack of support given, when there were issues of conflict around supernumerary status, and as such contributed the impact to both a NHS establishment and a HEI problem which needed to be addressed. While some students did make their views regarding supernumerary status clear to the University the outcome of that was perceived to be negative for the group of students, as this extract illustrates:

> ‘Having engaged the University the challenge came from the trained staff, one in particular who confronted the students in front of other nurses and some patients, challenging us as to whether we were professional and taking nursing seriously. One of the students burst into tears but the sister just kept going at the one student saying you will be going to the bed managers meeting and speak to all the staff and tell them why you are refusing to do auxiliary work.’ (Regional Site C Focus Group – Students: p12).

This quote demonstrated a strength of concern, however students in Regional Site C Focus Group felt managers did not have adequate staffing resources so frustrations were often passed to students.

Students clarified the issue about auxilliary work in the following quote:

> 'We help with basic nursing care, comfort and cleanliness duties, giving meals but we need to be competent at organising care, delivering care, documentation and decision making. We need to be able to engage in team meetings. We need to be given time to administer medicines and feel confident. It is not that we do not want to contribute to auxiliary duties.' (Regional Site C Focus Group – Students: p13).

The desire to learn more than that of an auxiliary nurse is also a finding noted by Gray (1997)

All students expressed strong views regarding workforce planning and the need for managers to ensure ward areas had the correct grade of staff for the care delivery needed. There was a particular issue in general ward areas in comparison to the more specialist environments, which appeared to have better staffing compliments. Even though the HEIs support supernumerary status for students, the structure within the NHS Management Systems still counts students in the overall staffing numbers. Lankshear (1998) highlighted the concept of supernumerary status led to differences in interpretation, which influenced learning opportunities.

As a result, in some instances staff have interpreted supernumerary status as meaning students were only there to observe (Downes 2001, O'Callaghan and Slevin 2003).

The following quote captures the students view in my study:

> ‘Regardless of what they say we are counted in the numbers otherwise the bed manager would not be checking the numbers of staff, their grades with particular emphasis regarding the numbers of students on duty. Our learning experiences are compromised as it depends on the duty rota whether you can accompany a patient to see a procedure even though you have been caring for the patient. We cannot say anything otherwise we would be treated horribly for the rest of the placement, so you just have to keep your mouth shut and get on with it.’ (Regional Site C Focus Group – Students: p8).

The next conceptual category ‘Ward Manager Relationship in the learning environment’ will be discussed.

5.6 Ward Manager Relationship in the Learning Environment

The ward manager role required more engagement with mentors, lecturers, practice education facilitators and students to provide leadership for teaching within practice. This reflected all the views from all the regional sites, as there was a need for a culture of engagement to manage the learning environment.

> ‘I think the ward manager sets the tone for the working environment, and that has a direct impact on their staff. I think the ward manager has a huge influence on what experience you leave the ward with. If it is not a positive environment then it obviously has a knock on effect on any students.’ (Regional Site A Focus Group – Students: p15).

All students across all regional sites expressed strong views into the role of the ward manager claiming the best placements were when the leadership from a senior individual within the ward area was proactive leading to engagement of staff, ultimately changing the whole ethos of the environment. This links to the importance of effective ward management which was highlighted with early studies in the eighties discussing the

importance of effective leadership within the clinical environment (Fretwell 1980; 1983). Furthermore, studies in the nineties confirmed the importance of effective ward management (Wilson-Barnett et al., 1995; Levec and Jones 1996). However Pulsford et al., (2002) reported the lack of support from managers for learning in practice. The expectation for a learning environment was set by the manager in which an interest was taken in staff for development. Students viewed this as important as the learning opportunities and experiences gained had an impact on staff and ultimately the learning environment:

> 'I had some experiences where the manager would look at you, not speak to you, this feeds down to your learning experience. Leadership is so important no matter what level and whoever is in the ward in a senior position sets the scene for everything underneath.' (Regional Site B Focus Group – Students: p16).

> 'The manager just walks past you, they do not know you are working on the ward. She does not know who I am or the fact that I am in her ward caring for her patients. If the one at the top decides she does not care then she is not going to encourage her staff to care.' (Regional Site C Focus Group – Students: p9).

> 'When the manager is working with staff, students and patients then there is a sense of a team and students feel the manager knows who they are. It is much better if the ward manager engages rather than being perceived as a figure head with not much engagement with students. It is not only the students but also the patients.' (Regional Site C Focus Group – Students: p11).

Some students had positive views of the ward manager:

> ‘The ward manager in some areas worked directly with patients and families particularly in the rehabilitation areas. There was a real sense of teamwork and not the same divide between trained and untrained staff. There was a sense that every member of the ward team was important but this was the result of leadership at ward level.’
> (Regional Site C – Focus Group – Students: p12).

In addition, in Regional site C, ward managers were viewed by students as key to the learning experience and creating a learning culture. However, ward managers in many areas did not have much engagement with students, and in many instances it appeared their activities were very much managerial involving administration and meeting targets. While the role of ward manager has changed over the years there is a pivotal role for a key individual within the learning environment. Saarikoski and Leino-Kilpi (2002) supports the role of the ward manager as key to establishing the ward atmosphere. The ward manager sets the scene for effective learning, however the role of the mentor replaced the pivotal engagement of a senior figure at ward level with the mentor taking on the pedagogical role and the supervisor of student nurses (Booth 1992; Gray 1997; Willis 1997; Newton and Smith 1998).

Andrews and Roberts (2003) identified a role for senior nurses, who could help students reconcile the academic demands and ritualistic practices. Senior nurses could also provide challenge for students and be the link between mentors and academic teachers. Andrews and Roberts (2003) viewed the role of senior nurses as an alternative approach to help address the perception of ineffective mentoring. Yassin (1994) viewed the experience and attitude of the ward manager influenced how concepts were interpreted and applied at a local level. In this study, all the students reported that in areas where the ward manager demonstrated a leadership role in teaching, the experience of the students was enhanced as the

learning culture was lead from a senior level. The following quote illustrates the point:

> 'In areas where the ward manager was a role model for the rest of the staff the learning opportunities were well planned for the students. You felt learning was important – you wanted to take all the opportunities. You felt appreciated and part of the team, where people mattered.' (Regional Site C Focus Group – Student: p11).

5.6.1 Impact of Mentoring Culture on Learning in Practice

The conceptual categories discussed above are with the substantive code 'Impact of Mentoring Culture on Learning Practice (Figure 27).

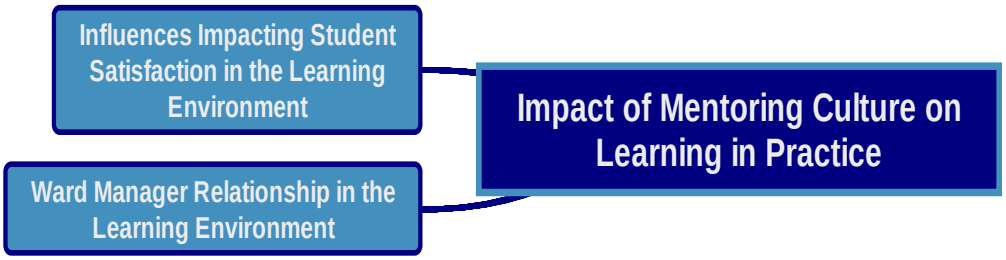


Figure 27 – Substantive code and associated conceptual categories of 'Impact of Mentoring Culture on Learning in Practice'.

The culture set within the clinical learning environment was crucial for learning in practice and required a system which impacted on student nurse supervision in clinical practice, but also enabled engagement with all parties involved with the student journey. The leadership style in the ward area was instrumental for the pedagogical atmosphere on the ward to enable a supervisory relationship to be established. O'Flanagan (2002) demonstrated the role of the ward manager was essential in creating the environment for learning; nevertheless the emphasis was placed on all the members of the team who were responsible for maintaining an effective

learning environment. In my study the impact of a supervisory mechanism that was not planned for students created negative accounts, and as such created an atmosphere where meaningful learning situations for students were insufficient. Chan (2004) supported the need to focus on the students learning in relation to the social climate of the clinical learning environment. Hence the leadership within the learning environment needed to give direction to ensure the learning goals were effectively operationalised, so the clinical team could support learning in practice. Neary (2000) reported that students were often left on their own to carry out care and perform new procedures. Without planned support for students, Spouse (2001) found they had difficulty with the psychomotor components of nursing. In my study within the conceptual categories there were challenges to student supervision creating clinical areas which were perceived as not good learning environments and thus impacted on supernumerary status of the student, which ultimately influenced the opportunities for planned student learning in practice.

The conceptual categories linked to the substantive code – impact of mentoring culture on learning in practice is illustrated in the figure below:

The next section links to the first conceptual category relating to the substantive code.

5.7 Summary

The second major category – Operationalising the Facilitation of Learning in Practice involved three substantive codes and eight conceptual categories (See Figure 28 below). The nature of the relationships developed and sustained between HEIs and NHS establishments are crucial to the quality of the students' learning experience. In particular, a proactive approach to partnership working and ward managers adopting a student-focused approach are fundamental to both influencing the nature of partnerships but also their impact on the clinical learning environment.

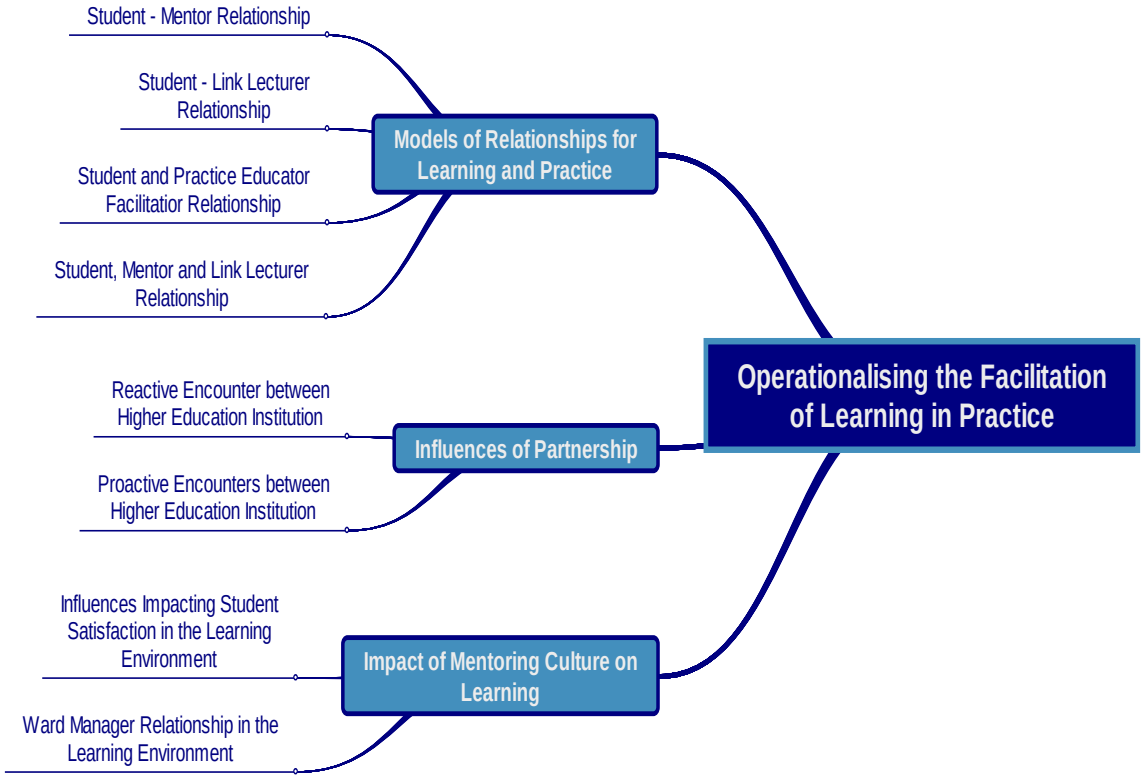


Figure 28 – The conceptual categories and substantive codes to the second major category 'Operationalising the Facilitation of learning in Practice.

The next section presents the findings from the 2 conceptual codes related to the conceptual category ‘Challenges to Student Performance’.

5.8 Reality of Assessment Process

In all Regional sites the level of knowledge of mentors in relation to signing off competences concerned the majority of students, however it was felt in areas of specialism the mentors were highly knowledgeable within their practice field, and as such students felt confident with them assessing performance. The majority of students expressed that because of their mentor’s lack of understanding of assessment documentation, forms were signed off without the knowledge of the implications. This aspect is reflected in the following quote:

> ‘They end up signing you off anyway. There is a lack of knowledge of the assessment tool they tell you that means nothing to me.’ (Regional Site A Focus Group – Students: p11).

Other students argued and brought in a different perspective:

> ‘Some mentors have a good knowledge of the assessment tool as they have recently completed a mentor course. The new mentors who have recently qualified have a good knowledge of the tool and can bring in your reflections on care given.’ (Regional Site A Focus Group – Students: p13).

The majority of the students found the assessment aspect of the mentor role to be difficult due to an apparent lack of knowledge of what was expected of them within the assessment. The content of mentor preparation should include the assessment of pre-registration nursing students to improve reliability in processes (Atkins and Williams 1995, Duffy et al., 2000, Spouse 1998, Watson 2000).

In this study, there were issues for the students on how the mentors made judgments regarding their performance, which was coupled with a lack of understanding of the assessment documentation. Ultimately, some of the students questioned the mentor's ability to undertake the role following a mentorship course as many appeared to be unable to group the requirements in order to fulfil the role. In some instances assessment documentation was just signed mainly based on ability to be part of the team, the ability to contribute to care delivery, the interpersonal components however, the theoretical underpinning of competencies were not high in the assessment process.

In two out of three Regional sites it was reported that the assessment of students was often rushed at the end of the placement with the majority of students expressing the need for a more continuous process, which would be coupled with an assessment of performance following supervised practice. Students reported that mentors just signed the learning outcomes when there was meant to be discussion. From the Higher Education Institution perspective the researcher was told that the mentors met with students to discuss their learning plan, yet students reported that in reality this never really happens. The impact of assessment was capture in the following quote:

> 'They complete your whole assessment book and never discuss any of it with you. It comes back all signed and you wonder how did they know what they were signing – they did not observe you, supervise you or ask you questions. How do they know you had any knowledge or skill? You never get a chance to discuss, it is not fair because some of the mentors are intentionally doing it.' (Regional Site C Focus Group – Students: p7).

Whilst mentors are expected to be responsible for student assessment, they are not given the time to do so properly or any remuneration for taking on the role. Pulsford et al.'s study (2002) found there was no

difficulty with the time aspect of mentoring. However, some students felt remuneration should only be given to satisfactory performing mentors. Students indicated that assessment documentation could be made easier and not presented in massive books. This latter finding is supported by Turner et al., (2003) who reported the need for well – designed clinical practice documents. The following quotes capture two students' views from my study:

> 'Now I am focusing on the experience to be gained in the ward and much less focus on completing the book. The mentors are trying their best and are struggling against the limitations of trying to fit us in.' (Regional Site B Focus Group – Students: p13).

> 'It is the documentation that is the issue and can spoil the learning experience but you have to complete the book – if not you do not pass. You become very reliant on the ward staff.' (Regional Site B Focus Group – Students: p13).

The importance of theoretical underpinnings in the assessment process was seen as important in Regional site B. Theoretical knowledge gained prior to placement helped students engage with staff and contribute to tutorials and study sessions which were held in some areas. As a result the majority of students felt confident in this knowledge base. Some of the students felt the knowledge they had was much better than trained staff. This reflected in students answering questions and is captured in the following quotes:

> 'We were just amazed at how trained staff had limited physiological knowledge and how we could really start to analyse what was happening. You had to have the knowledge to do so.' (Regional Site B Focus Group – Students: p8).

> ‘We loved going with the specialist nurses as they had in depth knowledge and expertise. This make you want to ask questions. Staff were not defensive in their responses.’ (Regional Site B Focus Group – Students: p9).

Limited physiological knowledge was also found to be a factor in Scholes et al., s (2004) evaluation of the Making a Difference curriculum in England. In my study, all students conveyed the lack of understanding surrounding the assessment documentation yet mentors rely on students to interpret the meaning of an outcome. As well as the assessment book, students also had to get their mentor to initial their skills passport.

The following quotes illustrate a potential issue with the skills passport:

> ‘Who is to know who signs the passport? It could be anyone, who is going to know? My mentor has the same surname as me so I don’t know whether they will be questioning that or no one may notice.’ (Regional Site C Focus Group – Students)

> ‘I think the University are trying to put checks in place to ensure no one slips through.’ (Regional Site C Focus Group – Students)

In some of the placement areas time is made available for the mentor and student to review the learning outcomes and having worked directly with the student this ultimately makes the assessment process more reliable. Mentors who can organise their time and make it as part of the ward’s organisation, enabling students to feel a part of what is going on, places value on learning in practice and the student experience within the clinical learning environment. This system of working facilitates a supportive structure for learning in practice. In addition, the majority of students expressed the fitting into the ward routine and contributing to the overall aspects associated with care delivery, resulting in the majority of mentors feeling they are performing well.

The findings suggest assessment was driven by student's ability to work and display appropriate interpersonal skills. However the theoretical components were not high on the learning agenda. This issue again relates to the lack of theoretical challenge which is reflected in the following quotes:

> 'I think if they think you are competent with your abilities to go out and be doing they are more or less happy to sign anything.' (Regional Site C Focus Group – Students: p7).

> 'It is good to be able to express the knowledge you have gained and it would be nice to have the opportunity to share the theory you had at the University.' (Regional Site C Focus Group – Students: p8).

In two out of three of the regional sites placement staff were unwilling to give reflection time to enable students to complete documentation and build up a portfolio of evidence. As illustrated by the following comments:

> 'Reflection is a bit of a skive but necessary and some were unwilling to give you the time. They did not reflect themselves and did not see any value in linking theory and practice.' (Regional Site A Focus Group – Students: p7).

> 'It was good to get away from the chaos of the ward and feel you had time to reflect. Your confidence increases but it would be so much better if other mentors could do the same, on the other hand you are expected to manage your placement learning yet you are getting to practice without supervision.' (Regional Site C Focus Group – Students: p10).

In two of the Regional sites students reported that their level of knowledge facilitated a change in their behaviour associated with increased confidence. Furthermore on reflection some students could track this back to the beginning of the branch programme and linked this to requirement of providing of evidence in their portfolio. However all the

students wanted more assessment of practical skills, and not just the assessment of their portfolios. The majority of students felt the mentors did not work with students enough to assess their level of competencies, yet just signed the documentation at the end of the placement. This aspect was illustrated in the following quote and was included to highlight the issue with the process of assessment:

> 'The assessment book is signed, sometimes as a student you are present, other times not. You are not often questioned on the competencies as the understanding by the mentor is limited. You end up feeling not very confident in the processes.' (Regional Site B Focus Group – Students: p14).

In contrast to this quote ward managers reported:

> 'We ensure mentors have time to complete assessment documents and build this into the duty rota. This correlates with the student and we encourage a dialogue between mentor and student before signing the assessment book.' (Regional Site B Focus Group – Ward Managers: p11).

5.8.1 Impact of Evaluation Systems

In Regional site A, whilst evaluations were completed, nevertheless students felt the feedback of evaluations were ignored by the staff at ward level as nothing happened to areas which required improvement. Consequently, students questioned the value of completing these forms, since the mechanisms for closing the loop with the system of evaluations was felt to be inadequate as hearing through the grapevine that the same behaviours continued.

The following quotes are included to demonstrate the depth of the concern around the need to ensure follow up actions are in place to complete the evaluation process:

> 'Ward areas have been reported time after time with areas being identified where there was a lot of bullying going on. Students have been reduced to tears on a number of occasions due to bullying techniques and nothing gets done about it.' (Regional Site A Focus Group – Students: p10).

> 'I think there is a lack of support and I think because the NHS are the provider of placements, there is a need for the HEI to place the student somewhere so the issue of poor learning experiences can be put down to personality clashes and the students are just left thinking what is the point of expressing views in evaluations. Nothing happens.' (Regional Site A Focus Group – Link Lecturers/Practice Education Facilitators: p14).

> 'Staff within some of the environments they just say 'I don't know' about evaluations. The Higher Education Institution needs to be more proactive and link lecturers need to link with ward management. The practice education facilitators need to work collaboratively with all the stakeholders.' (Regional Site A Focus Group – Students: p9).

> 'Nothing ever gets done, you get no back up from the University to help address poor learning environments, students are afraid to create an under current so you are seen as a trouble maker. There seems it be an unspoken agreement if you are a good student you will get through the course regardless.' (Regional Site B Focus Group – Students: p10).

Interestingly in two out of three of the Regional sites (A and B), the majority of Link Lecturers reported on the value students place on evaluations and the importance attached to giving feedback. Whilst some of the evaluations regarding practice placements were less favourable, this in turn enabled a constructive dialogue to take place with managers and Practice Education Facilitators.

As such this reiterated to students there was a result from participating in the evaluation process. There was a consensus view around the transparency of the evaluation process from Link Lecturers, although Practice Education Facilitators reported that at ward level the transparency was not consistent across areas. In some of the ward areas evaluation forms remained with the ward managers and were not shared with mentors. In all Regional sites, management systems for evaluations systems and processes for managing evaluation at ward level appeared to be disjointed and haphazard within the clinical learning environment. This gave rise in some of the situations to managers keeping them at their level with the majority of mentors not actively engaged in reviewing and discussing the contents of the student evaluations.

In two out of three of the Regional sites (B & C) both Practice Education Facilitators and Link Lecturers reported on the value of evaluations, both parties felt in some instances students did not see the impact of improvements to areas. An avenue was in place from the Higher Education Institution to ensure student evaluations were completed and feedback given to ward managers. All the Practice Education Facilitators had a role in communicating the outcome of student evaluations to clinical areas. Although mechanisms were in place for evaluations, the consistency for dealing with these at ward level required more action, with a more formal approach between the Higher Education Institution and the National Health Service.

These views were expressed in the following quotes and included to demonstrate the need to close the loop around processes:

> ‘While the practice education facilitators had a avenue to be involved in the evaluation system, yet it would help if the approaches could be linked formally with the educational audit and be part of an educational forum for discussion.’ (Regional Site B Focus Group – Link Lecturers/Practice Education Facilitators: p11).

> ‘As link lecturers with responsibilities for areas of practice, we see the need for a forum to openly engage in discussion over the positive effects in the learning environment and the hindrances which link to the whole system of evaluation, not just the students.’ (Regional Site B Focus Group – Link Lecturers/Practice Education Facilitators: p13).

While students reported filling out evaluation forms there was no real impact at ward level, with students expressing ‘what is the point’ particularly if staffing levels are not changing and the supervision aspects of the student experience are not enhanced. Some of the students felt it would be useful for a formal reporting system of the actions taken as a result of evaluations, so the mechanism for evaluations is not seen as a paper exercise:

> ‘Evaluations should give feedback to ward staff on the positive aspects not just complaints.’ (Regional Site C Focus Group – Link Lecturers/Practice Education Facilitators: p12).

> ‘Evaluations should be about sharing good practice.’ (Regional Site C Focus Group – Link Lecturers/Practice Education Facilitators: p13).

Some of the students never saw evaluations coming back to ward level and never heard them discussed. Students expressed the need for senior managers within the National Health Service and the University to review the evaluation systems for students but also mentors and managers.

Feedback to clinical areas following student evaluation was patchy in many areas.

Pulsford et al., (2002) expressed the need for more information regarding students' placements with more feedback, from the Higher Education Institution as to students' progress, but also evaluations of placement experiences. In my study, some of the Link Lecturers expressed the view that the reporting back system for evaluations to ward areas needed to be improved. The majority of practice education facilitators wanted a much closer link between the Higher Education Institution and the National Health Service to deal formally with evaluations of students. As such, Link Lecturers and Practice Education Facilitators all expressed the need for a proactive approach to the management of ward areas that required more input into creating a conducive climate for practice learning. Implications of students giving feedback in Regional site B lead them to question the value:

> 'You go to a hospital placement and give feedback and they are trying to work out who it was that had something bad to say. Oh! It must be her, she didn't like the ward, it was dead obvious.' (Regional Site B Focus Group – Students: p13).

This quote is included to demonstrate the need for confidentiality when student give feedback particularly in small geographical areas.

All the students expressed concern over evaluations and how the impact of expressing views could be known throughout the hospital:

> 'Oh watch out for her she was a trouble maker and she will be coming to your ward.' (Regional Site B Focus Group – Students: p7).

More importantly for students in Regional site B there was a lack of sharing evaluations with the ward team, however in some of the community based areas evaluations were displayed on a notice board.

Students viewed this as a useful means of communicating with all staff as the evaluations were all very positive. While students reported filling out evaluation forms there was no real impact at ward level, with students expressing what 'is the point'. This related in particular to staffing levels not changing and the supervision aspects of the student experience are not enhanced. Some of the students felt it would be useful for a formal reporting system of the actions taken as a result of evaluations, so the mechanism for evaluations was not seen as a paper exercise.

All the managers expressed informing staff about evaluations and in some instances these were displayed on a notice board or other cases evaluations were placed in folders.

The conceptual categories discussed above are associated with the conceptual category 'Challenges to Student Performance'.

5.8.2 Challenges to Student Performance

Challenges associated with the student performance related to the assessment processes and the need for proactive engagement from mentors to ensure consistency in process. Processes for assessment were often hindered due to the lack of planning for the event, but also due to apparent time constraints, which were detrimental for student and mentor engagement. As such the assessment of student performance was seen in many instances as a documentation exercise, without any direct supervision of competencies.

> 'You are not supervised so the competence is never checked. You just go on and on and no one gives feedback on how to improve.' (Regional Site A Focus Group – Students: p11).

The specialist nurses supervise students which are captured in the following quotes and bring a more positive focus to supervision and assessment of students:

> ‘The specialist nurse supervised us when doing wound care which gave us confidence around building up our skills. The respiratory nurse specialist supervised us when giving medication and helped us with health promotion activities when working with asthma patients.’ (Regional Site B Focus Group – Students: p9).

Therefore, some student experiences involved completing placements with little or no feedback on performance, resulting in the process of assessment been called into question. Whilst the assessment process was a component of the overall experience in practice, the aspect of reflecting on that experience gave particular challenges, which were in some instances not followed up in a proactive way. The systems and processes for the impact of evaluations presented areas requiring improvement particularly relating to dissemination of results following student evaluation. Ultimately, the structures required streamlining to ensure there was a proactive system between the Higher Education Institution and the National Health Service, enabling operational systems to be put in place for student evaluation. Quality criteria for effective learning environments needed to be ensured, which linked into educational audit, to ensure placement areas for students were quality assured, and were monitored against criteria.

Therefore, the feedback from student evaluations required to be part of the monitoring process for clinical areas. The need to explore models for systematic and continuous processes for evaluation between the Higher Education Institution and the National Health Service required being part of a planning cycle, so intelligence gathering from evaluations could be effectively shared and acted upon. Figure 29 illustrates the substantive

code and associated conceptual categories of 'Challenges to Student Performance'.

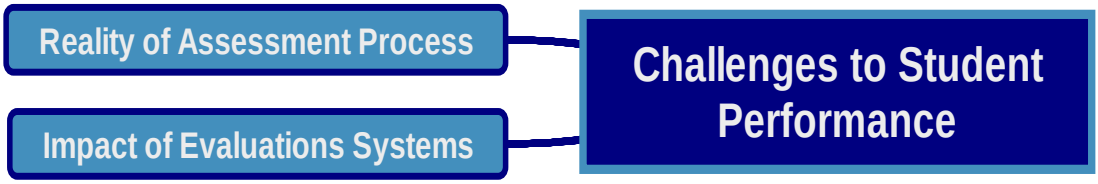


Figure 29 – Substantive code and associated conceptual categories of 'Challenges to Student Performance'.

The next section will explore the 2 conceptual categories making up the substantive code 'Policy to Enhance Mentor Performance'.

5.9 Nature and Quality of Mentor Feedback Systems

In Regional Sites A and B all the mentors reported the need for systems to enable feedback to Link Lecturers following a student experience but also having a forum to give feedback to managers. As such, the system gathers data from students, but all the mentors wished for a wider engagement for feedback:

> 'It would be useful to have focus groups for mentors to enable a sharing of experiences. Feedback systems need to include managers and staff from the Higher Education Institutions.' (Regional Site C – Jane – Mentor: p4).

Within Regional site B, the majority of the mentors wished to have a mechanism for reporting their experiences, relating to the level of knowledge students had on commencement of placement and their ability to make an application from theory to practice:

> 'It would be useful if the mentors and students had a forum to discuss experiences so students could apply theory into the clinical situation. It would be useful for mentors to have planned teaching sessions to link theory and practice.' (Regional Site B Focus Group – Students: p10).

Whilst it was reported by all the mentors this linked into the student competencies, the ability to give feedback to the Higher Education Institution in a structured way would have closed the audit loop. In addition, in all sites mentors would have appreciated feedback formally and informally particularly during difficult situations. All the mentors reported the need for feedback going to the Higher Education Institution, and in particular the Link Lecturer, rather than just student evaluations. Some of the mentors reported having the opportunity to give feedback to the Higher Education institution, but also indicated once the feedback was given; the closing of the loop backward did not appear to happen.

The majority of mentors wished to have a formal mechanism for feedback on their learning and teaching areas and in particular learning packages and resources which had been prepared.

5.9.1 Impact of Managers on Mentor Quality

In two out of three regional sites the majority of mentors reported managers feedback to them was very limited. As a result, mentors continued having students with no feedback on the performance. All the mentors assumed since no feedback was given the presumption was made that all the parties were satisfied. However, in all three regional sites some of the mentors only had feedback if there was a complaint made about an area. All the mentors felt the engagement was reactive, and as such mentors needed to receive positive feedback as well as areas of concern. In Regional site B mentors did get engagement from managers as part of the appraisal system, but in some cases this was seen as a part of the process which was just added on. Link Lecturers had limited engagement in giving feedback to mentors. In addition, in regional site C, all the mentors felt their role as mentors was not part of any appraisal system or staff development activity. Therefore, many of the mentors reported feeling this important activity of mentorship was not

highly valued in all areas of the establishment. Contact from managers to mentors was a reactive approach to student concerns and complaints coming through the Higher Education Institution systems, and not linked to any systematic approach for an enhancement on quality:

> 'The only time you get spoken to is if there is a complaint or negative evaluation. Why can't they give praise and constructive criticism? This would add to a culture of enhancement and make you want to continue being a mentor.' (Regional Site C – Andrea – Mentor: p7).

> 'I had areas pointed out that I could be better at. As a result I did a practice education module which helped me develop learning plans and be more effective with portfolios and reflective learning.' (Regional Site C – Susan – Mentor: p6).

The next section links to the substantive code 'Policy to Enhance Mentor Performance'.

5.9.2 Policy to Enhance Mentor Performance

Systems required to be in place to give feedback to mentors from a management perspective and also to enable the process to be embedded within the appraisal mechanism. Processes for quality assurance are needed to incorporate opportunities for mentors to gain feedback on their development and performance as a mentor. The need to take account of the mentors' understanding of questioning skills required to facilitate critical thinking skills in the students is key to ensuring that they are fit for purpose (McCarty and Higgins 2003). It has been suggested that the questioning skills of mentors tend to focus on lower order questions (Phillips and Duke 2001, Scholes et al., 2004). This points to the need for polices which focus on enhancements of the mentor performance required systems, which could be part of a joint strategic approach between Higher Education and the National Health Service. The Figure below illustrates the substantive code and the associated conceptual categories.

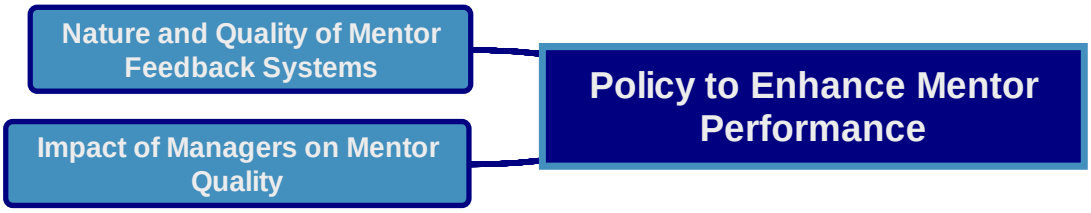


Figure 30 – Substantive code and associated conceptual categories of 'Policy to enhance mentor performance'.

The next section presents the 2 conceptual codes linked to the substantive code 'Levels of Enhanced Relationship Drivers'.

5.10 Strategic Engagement for Quality Clinical Learning

Some of the mentors across all three Regional sites reported in areas where the senior nurses valued clinical learning, the impact on the local implementation of learning and teaching strategies for student learning was seen as an integrated part of the engagement. Some of the mentors viewed the need for senior managers to give feedback to ward areas on the collaboration with the Higher Education Institution, which needed to be part of a structured engagement:

> 'There needs to be a formal reporting system so Higher Education Institutions can update Senior Managers on curriculum changes and enhancements to clinical learning.' (Regional Site B Focus Group – Link Lecturers/Practice Education Facilitators: p11).

While the managers reported on the need for established forums to engage with senior staff from the NHS establishments and the HEIs to develop approaches to implement policies from Government and the Nursing and Midwifery Council, this required a strategy to drive policy implementation. It has been argued by Castledine (2005) that service providers might suggest that universities give more support to the practice arena for their students. There was a consensus view for Link Lecturers

and nominated Practice Education Facilitators to be part of a group, which linked into ward managers before and after student placements to enable a reflective account to take place of the factors, which enhanced or hindered the learning environment:

> 'Having a forum to engage with Managers to update on curriculum issues and changes around assessment would encourage a proactive dialogue rather than reacting to situations. Changes could be made following a student experience which could enhance the environment for future learning.' (Regional Site B Focus Group – Link Lecturers/Practice Education Facilitators: p14).

All mentors viewed the need for more formalised systems to join together the links between education and practice, which needed to be driven and focused on from senior managers. Whilst Practice Education Facilitators were seen as linking education and practice all the mentors were aware of the levels of engagement to ensure quality learning. Most of the mentors referred to the need for joint systems of working, so all the stakeholders can be aware of each other's organisational challenges and in particular 'hot spots' within the National Health Service, which could impinge on student opportunities and learning:

> 'Higher Education Institutions need to be aware of changes within the clinical area which could impinge on student learning and in particular closure of wards, changes and situations which cause a reduced impact on activity.' (Regional Site C Focus Groups – Managers : p13).

5.10.1 Operational Engagement to Implement Quality Clinical Learning

In Regional site A, it was apparent from the mentors, there was a need to ensure that systems and processes which impacted on the student journey required to be implemented. All the mentors wanted consistency across all areas with defined guidelines from the Higher Education Institution on the role of the lecturer in supporting students in practice. The impact of Practice Education Facilitators across the three Regional sites required to be re-visited and in the majority of mentors cases the need for clarity and purpose on the role, with models of working to enhance and support learning in practice.

In all Regional sites, it was reported by mentors and managers the need for a consistent model for Practice Education Facilitators with clearly defined remits to enable similar systems across directorates to be put in place. In two out of three Regional sites (B and C) the need for educational audit and mentorship to be tied together to ensure the quality within the care environment was maintained with mentorship delivered in line with standards.

> 'The audit should reflect the number of mentors prepared and how many students can be supported in the clinical environment. The number of sign off mentors need to be part of the audit process to ensure standards are maintained for monitoring purposes.' (Regional Site A Focus Group – Link Lecturers/Practice Education Facilitators: p11).

In addition, all managers in all the sites reported the need for operational manuals for all processes surrounding the students with name contacts in each institution, so they were not left unable to make connections. In two out of three Regional sites (A and B) mentors viewed the use of a notice board to update staff on the curriculum, assessment issues, attendance criteria, patterns of working for the student, reflection guidelines and

information on the requirements for portfolios as a useful way to display and disseminate information to staff.

The next section reviews the substantive code 'Levels of Enhanced Relationship Drivers'.

5.10.2 Levels of Enhanced Relationship Drivers

Partnership engagement for learning in practice was driven by the need for a joined up strategy between the Higher Education institution and the National Health Service. Hence the need was apparent for senior staff to engage in requirements related to the student journey, which were driven by the need for quality systems. These findings reinforced earlier research that partnerships were considered effective when there were systems in place which enhanced communication between education and service (Eraut et al., 1995; Davis et al., 1995). In addition supporting learning in practice is the responsibility of the educational and service providers working in partnership to develop mechanisms to support learning (DoH 2001; QAA 2001; NBS 1999).

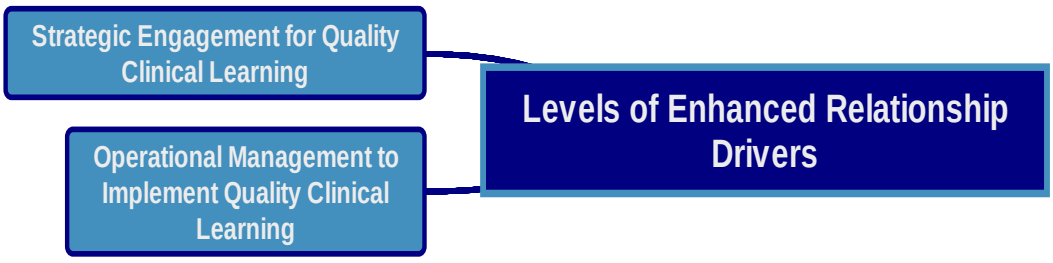


Figure 31 – Substantive code and associated conceptual categories of 'Levels of enhanced relationship drivers'.

Returning o Diagram 3, the reader can see that the previously discussed conceptual categories and substantive codes are linked to the third major category ‘Quality Infrastructure Optimising Learning in Practice’.

5.10.3 Quality Infrastructure Optimising Learning in Practice

To be able to optimise learning in practice an infrastructure to engage at a strategic and operational level was required with representation from the Higher Education Institution and National Health Service establishments. As such, the need for named individuals who could take a strategy for learning in practice and operationalise policies for assessment processes for students was required. Evaluation systems required to have impact in the clinical areas with the need for feedback systems for dissemination to all ward staff. The challenge of an infrastructure was to ensure evaluations were acted upon with subsequent action plans to optimise learning in practice. To enhance mentor performance, feedback systems as part of an infrastructure needed processes, for the Link Lecturer and manager to give feedback, therefore enabling and facilitating mentor success. Quality infrastructures to optimise student and mentor performance ensuring students achieved competencies and therefore were fit for practice needed a support structure to ensure all learning situations were fully optimised. ‘Quality infrastructure optimizing learning in practice’ is discussed within the context of three substantive codes and six conceptual categories and is illustrated in Figure 32.

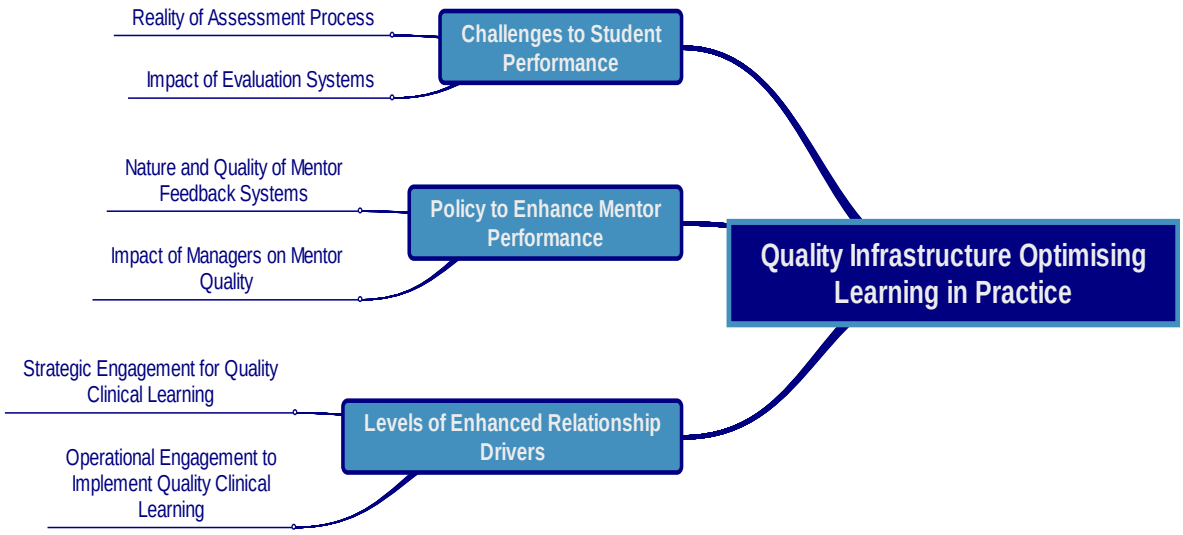


Figure 32 –The conceptual categories and substantive codes to the major category 'Quality infrastructure optimizing learning in practice'.

Engaging in infrastructure to optimise learning in practice was pivotal to impact on experiences for students, managers, mentors, link lecturers and practice education facilitators within the clinical learning environment.

5.11 Summary

This section has reviewed the major category 'Quality Infrastructure Optimising Learning in Practice' which focused on challenges and policies to enhance performance of the student and mentor, incorporating drivers influencing relationships within practice learning. As such, the impact of systems and processes for quality in assessment, evaluation systems and engagement at a strategic and operational level were detailed. The next chapter will focus on the core category – Strategic Engagement for a Quality Learning Experience in Practice and an explanation of the tentative emerging theory.

Chapter Six

Strategic Engagement for a Quality Learning Experience in Practice: Core Category in Relation to the Emerging Theory

6.0 Introduction

This chapter will introduce the core category 'Strategic Engagement for a Quality Learning Experience in Practice'. The core category embraces the themes of vision, values and commitment that run through each of the three major categories and, therefore have integrative and explanatory power, which in turn has relevancy for all the participants in the research study. The chapter concludes and discusses the main findings in relation to a theoretical framework for the emerging tentative theory. The contribution to knowledge provides a possible way forward to enhance the quality of student learning within practice through closing the gap between strategic and operational processes using an active collaborative partnership approach.

6.1 Emergence of the Core Category: Strategic Engagement for a Quality Learning Experience in Practice

Glaser (1978:93) stated that the criterion for a grounded theory study is to develop theory from the data, which 'accounts for a pattern of behaviour', and which is relevant for those involved. Within the core category, the behaviour and patterns, which emerge give meaning and substance to what is happening. Explanatory power therefore gives an account of the relationship between the major categories which occurred towards the end of the research (Cutcliffe 2000).

In order to facilitate the discussion, the core category will be discussed in the first instance as this reflects the 'funnel down' approach advocated by Glaser (1978). The conceptual processes underpinning the emergence of the core category around the vision, values and commitment are discussed and how these contributed to the development of the emergent tentative theory. The categories will be viewed in relation to theoretically sampled literature. In accordance with Glaser and Strauss (1967:23) the goal is to produce 'theoretical abstraction about what is going on in the areas studied'.
The major categories, substantive codes and conceptual categories bring together the processes as perceived by mentors, practice education facilitators, link lecturers, managers and students regarding the strategic implementation of practice based learning, through the infrastructure to enable operational processes with the ultimate impact on the quality of the learning environment.

The core category of strategic engagement for a quality learning experience in practice involves, firstly, the vision from senior managers within the National Health Service establishments and the Higher Education Institutions; secondly, the component relating to the values within both organisations contributing to mentoring relationships to enhance learning in practice and lastly, the commitment as the result of joint partnership working to implement policies and establish systems and processes with engagement from managers, link lecturers, Practice Education Facilitators (PEFs) and mentors. Therefore, the core category includes all these and links all categories.

Substantive codes and conceptual categories are the processes that mentors, link lecturers, PEFs, managers and students perceived on their experiences for learning in practice. As such, the processes involved for the emergence of the core category had stages and phases, which link to the development of a basic social psychological process (Glaser, 1978). Glaser (2001) viewed the conceptualisation of the data as core in grounded theory and, therefore views individuals as developing meanings in order to bring interpretation into their worlds, hence determining the core category. The use of memos, narrative accounts and sampled literature from analysis of the data enabled the researcher to be theoretically sensitive.

6.1.1 Explanation of the Tentative Emerging Theory

The development of theory can be classified at three distinct levels. Theory development at the highest level includes formal theory, with substantive theory at an intermediate level and tentative theory at the lower level of the classification (Parahoo 2006; McCann and Clarke 2003). The highest level of theory can be classified as 'Grounded Formal Theory' which offers a broad conceptualization of the phenomenon under study and involves synthesis of ideas (Parahoo 1997). The most common form of theory to emerge from grounded theory methodology is around the middle-ranged theories (Burns and Grove 2001) which support the view that the knowledge derived is relevant to the real world.

Glaser and Strauss (1967) and Strauss and Corbin (1990) suggest four criteria for assessing the quality of the theory developed. The theory should: fit well with the phenomena being researched; provide understanding to participants in the study as well as others involved in the area; provide generality (applicability to a wide variety of

contexts); and provide control (clarity of under what conditions the theory is applicable and providing a basis for action).

My study was not subject to wider critique as I was not able to test out the credibility and trustworthiness of the study with other people. The data generated went through constant comparative method which is integral with grounded theory analysis, however if data had been collected in other fields of practice learning (for example in community areas) my findings would not have been fully saturated. Thus from my research study an emerging 'tentative theory' evolved. Burns and Grove (2007) state that 'tentative theory' occurs when the theory has not been subject to any substantial testing and has had a reduced exposure from the academic community.

Glaser and Strauss (1967) suggest two main criteria for judging the adequacy of an emerging theory: it should fit the situation and should help those involved in the situation make sense of their experience and provide suggestions on how to manage the situation better.

6.1.2 Tentative Emerging Theory– Closing the Strategic and Operational Gap to ensure a Quality Learning Experience in Practice

Chamberlain (1999) suggests two important strategies in the development of theory: the use of memos and diagrams as these require the researcher to engage with the data in order to critically examine the properties of emerging categories and the nature of the inter-relationships. I used both throughout my study and will present examples of these to reflect the processes involved in developing my tentative emerging theory.

The emerging tentative theory generated is the gap between strategy and its operational implementation within the practice setting. Whilst the title of the research study is the strategic engagement for a quality learning experience in practice, it is the operational transfer of strategic policies into learning in practice for mentors and students which forms the basis of the emerging tentative theory.

The core category explained the relationships between the major categories, substantive codes and conceptual categories (see Diagram 3 for overview) and became the title of the thesis (Glaser 1992). The series of steps suggested by Burns and Grove (2007) were adopted in the process of developing a framework to underpin the tentative emerging theory. Burns and Grove (2005) suggest selecting and defining concepts; developing statements that relate to the concepts; expressing these statements in a hierarchical fashion and developing a conceptual map that expresses the framework.

During data analysis, concepts emerged which were significant for mentors, managers, link lecturers, practice education facilitators and students. Towards the end of the research I began to realise that the tentative emerging theory was developing in that it became increasingly clear that while there were well developed strategies which were owned in partnership between the NHS and HEIs, there was a gap between the vision, values and commitment espoused in the strategy and how this was actually operationalised in the practice setting. A framework is presented to illustrate the influences of partnership between the HEIs and the NHS (Diagram 4).

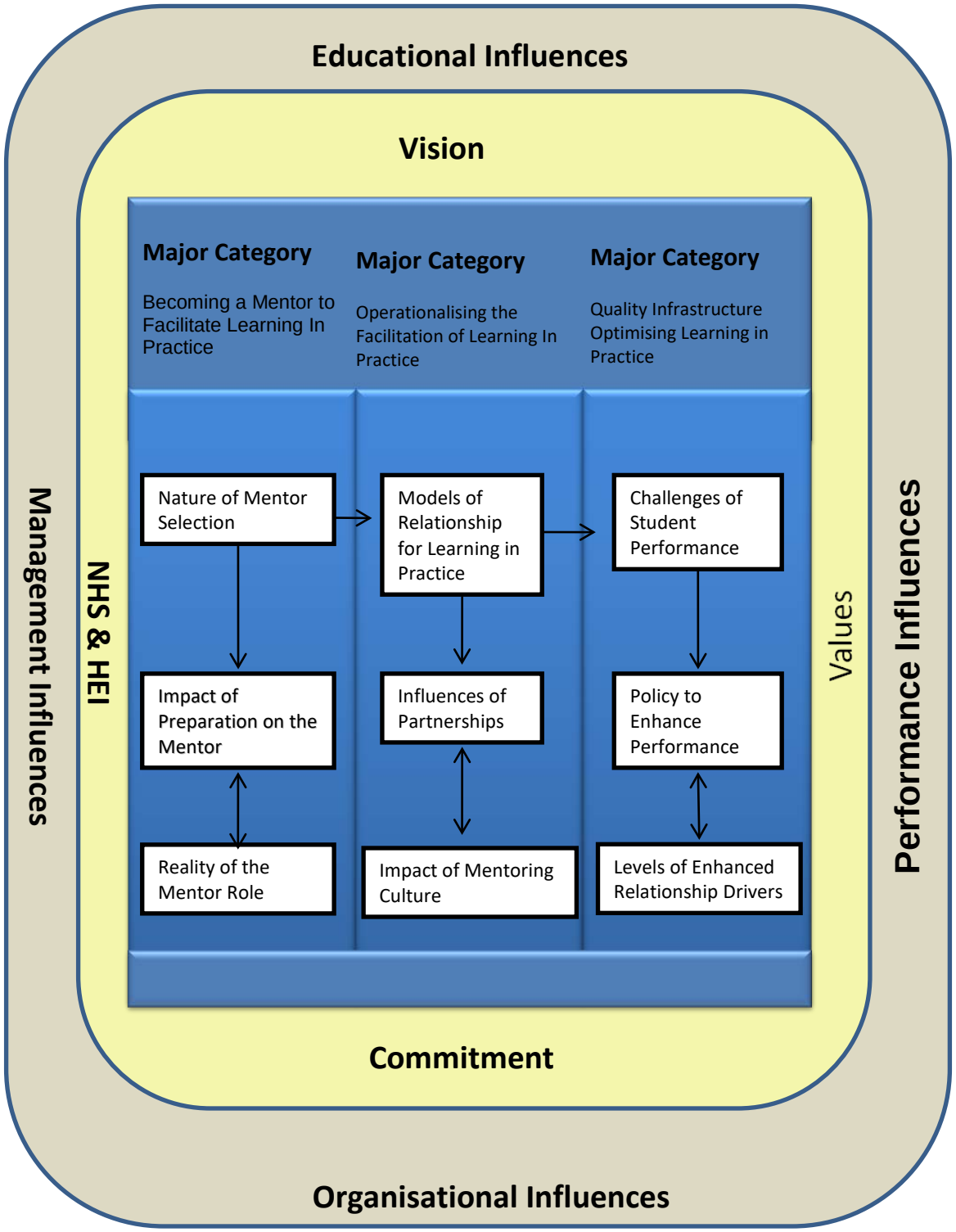


Diagram 4 – Framework to consider the influences on Partnership between the Higher Education Institution and the National Health Service.

The outer ring of Diagram 4 represents the educational, managerial, organisational and performance influences that pervade the partnership between HEIs and the NHS. The next ring reflects the three linked processes involved in the core category and the inner blue ring incorporates the 3 major categories with their substantive codes.

The process involved in developing the framework illustrated in Diagram 4 heralded the beginning of identifying the nature of the gaps between strategy and its operationalisation. The commitment, vision and values related to the strategy for providing a quality learning experience for students in practice from the perspective of the senior management in the HEIs and NHS lacked clarity in respect to how components of the strategy would influence and guide how these should actually be implemented. It is appears that the strategy which is jointly owned by NHS and HEI partners stands alone without a supporting operational action plan. Thus again from the business world, Henderson et al., (2006) note there is a distinct gap between senior management focusing on strategy and those in practice attempting to make things happen. From the research findings, the factors influencing the production of the strategic – operationalisation gap are presented in Diagram 5. This diagram highlights the disconnect between those responsible for strategic and operational management.

From the strategic side of the gap, three factors have been identified: a lack of systems and processes; a lack of monitoring and evaluation and a lack of clearly defined and measurable standards.

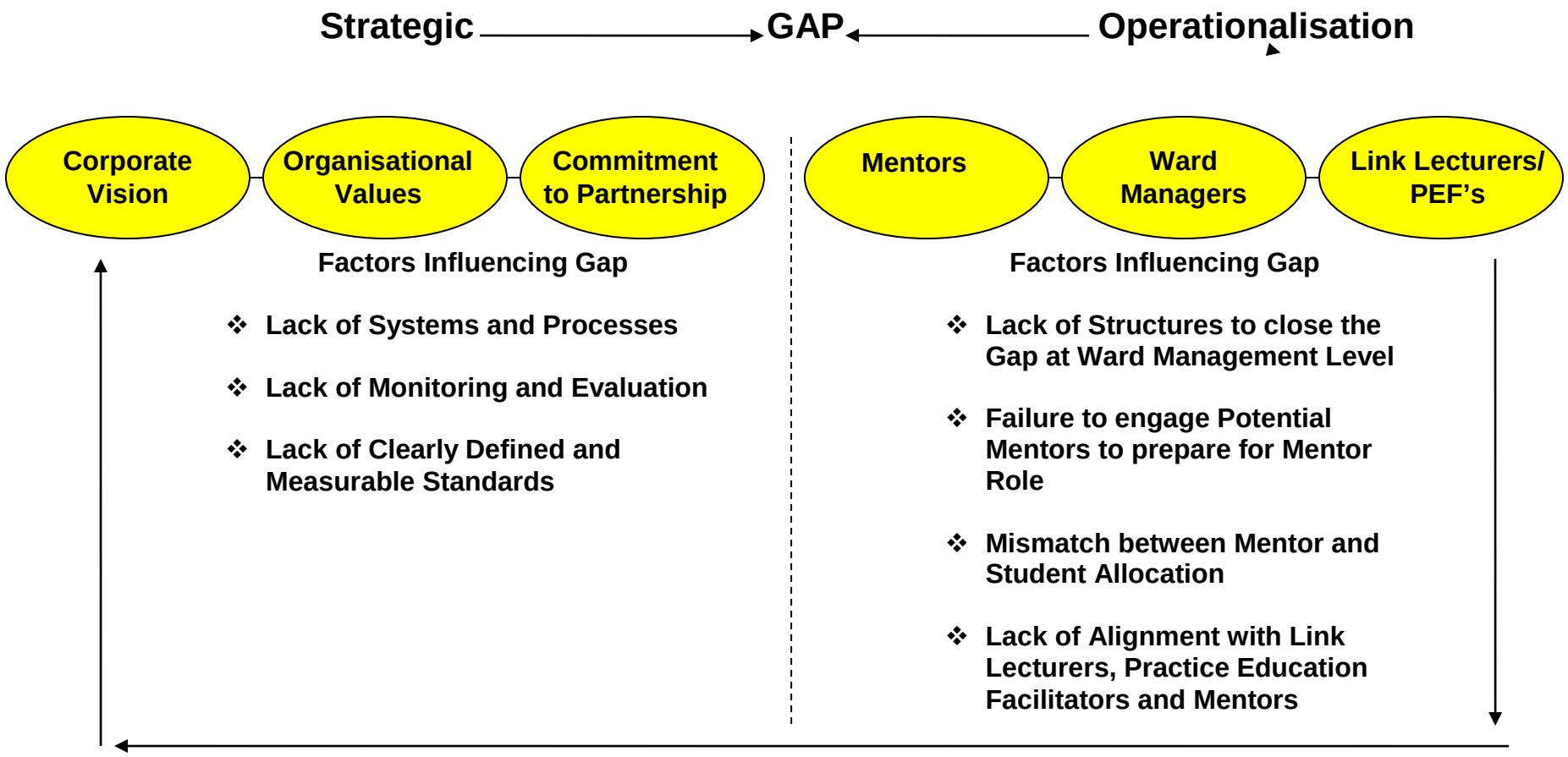


Diagram 5 – Factors influencing the Strategic and Operational Gap

Findings indicate that mentor selection and the support required in undertaking the role, requires a clearer alignment between policies and processes so that deliverable goals can be identified and agreed in order to support the strategic direction (McAdam et al. 2008) required by the partnership. NES (2007) in the National Approach to Mentor Preparation for Nurses and Midwives requires that mentors have recorded that at least 40% of a student's time must be spent being supervised (directly or indirectly by a mentor) has obvious implications for the management of resources in practice. McAdam et al. (2008: 832) assert that leadership is:

> '... essential through both strategic and translational levels, where leaders need to span both levels in terms of authority and knowledge, thus providing continuity across the strategic-operational space'.

Although making reference to a strategic–operational divide in Total Quality Management, McAdam et al.'s (2008) assertions are applicable to this tentative emerging theory of the strategic-operational gap.

My research findings illustrated a lack of consistency in monitoring and evaluating the important processes required to offer a quality learning environment for students. Managers reported a lack of any formal mechanisms to provide feedback to mentors or to address any performance management issues. Students reported that their voice was seldom heard when they completed their evaluation of placement forms – in other words they received no feedback on what happened as a result of their comments. The guiding principles from the NES (2007) core curriculum framework for a national approach to mentor preparation and the NMC (2008) standards to support learning and assessment in practice are required to be incorporated into an agreed monitoring and evaluation plan.

The factors influencing the gap from the operationalisation perspective relate to a lack of formalised structures and processes at ward level; a lack of a mentor selection policy, a mismatch between mentor and student allocation and a lack of alignment of working practices between Link Lecturers, PEFs and Mentors.

6.1.3 Managing the Interface to Close the Gap

There needs to be a clear and agreed action plan to close the strategic-operational gap. The model in Diagram 6 (overleaf) provides a conceptual overview of the four factors required in closing the gap. The diagram is modified from the work of Leonard and McAdam (2002a). Leonard and McAdam (2002a) conducted a grounded theory study of 19 organisations with the aim of exploring how the Business Excellence Model (BEM) is used and how its use could be enhanced to derive maximum benefit to the organisation. They identified the importance of having a mechanism to structure and deliver strategy in order for it to be operationalised. There are therefore close parallels with the emerging tentative theory from my study. While the literature reveals the use of Leonard and McAdam's (2002a) model in business settings (Leonard and McAdam 2002b; 2002c; McAdam et al. 2008), there is no literature that makes reference to its use in an educational setting. Leonard and McAdam's model was modified to suit the content of my study around the Strategic and Operational aspects between the Higher Education Institutions and the National Health Service establishments.

The reader will see that it is proposed that in order to close the strategic-operational gap there needs to be a continual interplay between structures, planning, performance and professional practices. This requires managers which strategic and operational responsibility to work collaboratively to set targets, plan the logistics of how strategies can be effectively and efficiently implemented as well as how these should be

monitored and evaluated from both a performance and professional perspective.

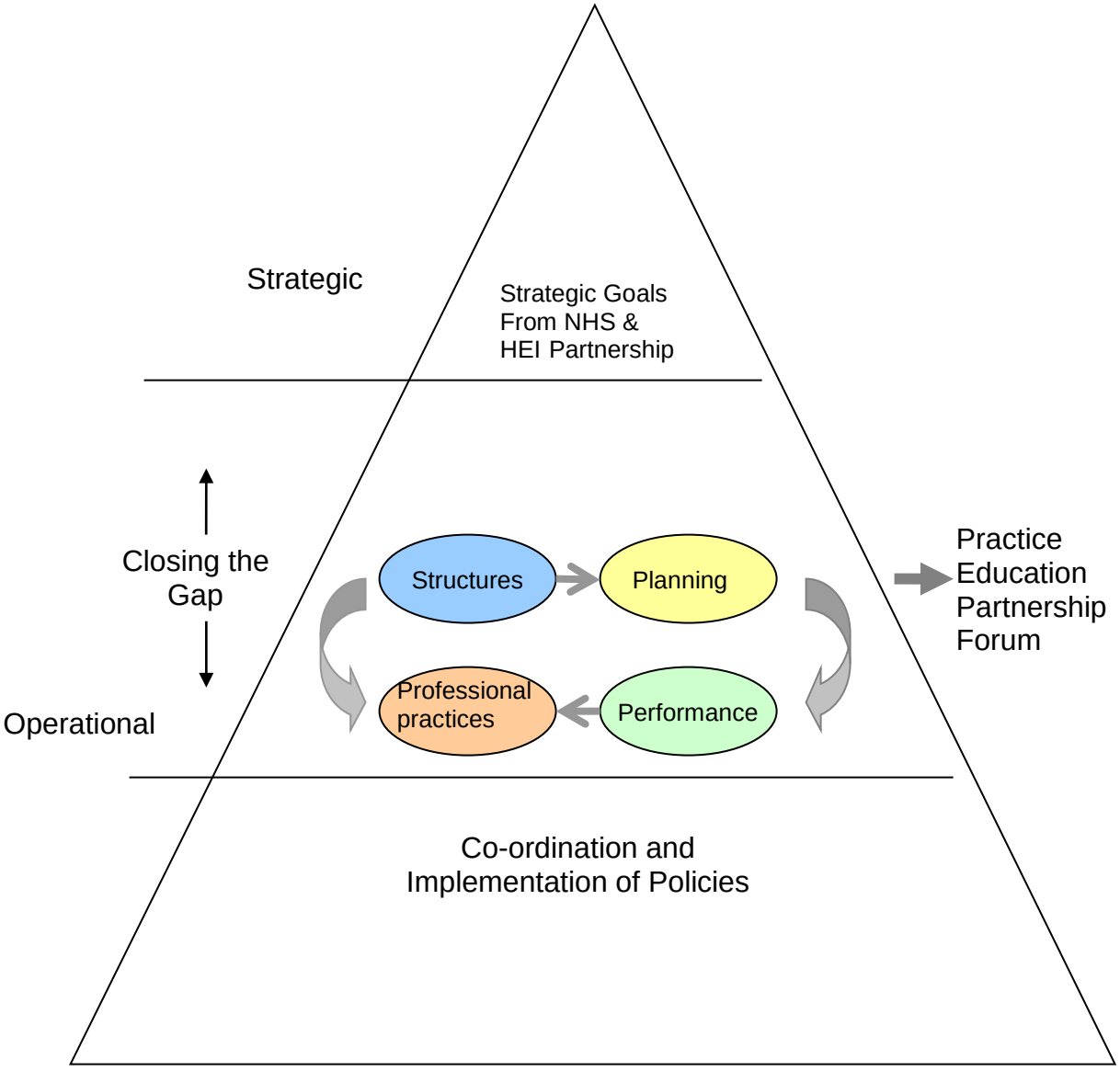


Diagram 6 – Model to illustrate the strategic and operational gap (modified from Leonard and McAdam 2002).

In their recent report ‘From Ward to Board: identifying good practice in the business of caring’, Machell et al. (2009) identify eleven factors which are deemed vital to enabling NHS Boards to engage effectively in clinical quality. One of these factors could be easily applicable in managing the interface in order to close the strategic-operational gap. The factor is described as having the right building blocks in place. Machell et al., (2009: 1) state that:

> ‘we have identified three key building blocks: the right information; recognition of the importance of relationships combined with robust governance arrangements; and strong clinical leadership and clinical engagement. The absence of any of these will prevent boards from focusing effectively on the business of caring.

The three building blocks above clearly link to measures already suggested in managing the interface in order to close the strategic – operational gap. In particular robust partnership relationships have been argued as being key as well as a commitment for managers responsible for strategy and operational matters to work together to facilitate the continuous interplay between structures, planning, performance and professional practice.

It is proposed that creation of a Practice Education Partnership Forum would support more effective management of the interface in order to close the gap (see Diagram 6). A Practice Education Partnership Forum could provide a focus on strategic and operational issues relating to Scottish Government Policy, Nursing Midwifery Council Standards and Guidelines and local, regional and national policy. The forum could provide an opportunity to facilitate learning in practice and reflect all aspects of the student journey. Representation from the Higher Education Institution and the National Health Service Establishment at a senior level would aim to plan the resources required for quality enhancement of

practice learning to close the gap between strategic and operational matters. There should also be representation from mentors, link lecturers, ward managers and PEFs to reflect on the impact of preparation on the mentor and the support required in the mentor role. Consideration should also be given to student representation.

The Forum could provide an opportunity for an active partnership engagement which has a clear vision for a quality learning experience for students in practice. The vision should incorporate the values and commitments required to operationalise and optimise learning in practice and give direction to the management, educational, performance and organisational influences required to be addressed to facilitate learning in practice. Link lecturers, mentors, PEFs and student representation could facilitate the closure of the strategic–operational gap as the Forum would focus on quality enhancement for the student journey. Only further research will tell whether using this suggested model would close the strategic and operational gap. In my own region of employment it is the intention to set up a Practice Education Partnership Forum as described in and a commitment has been gained for this Practice Education Partnership Forum to evaluate the effect of this strategy has had on minimising the strategic-operational gap after one year of operation.

Chapter 7

Conclusions and Recommendations

7.1 Strengths and Limitations of the Study

This mixed method study aimed to explore the impact of the strategic arrangements and mechanisms to implement and support practice based learning, investigate the selection processes, preparation, support and evaluation of mentors and explore the impact of mentorship from the viewpoint of mentors, students, managers and educational links within the clinical learning environment. Through addressing the research questions, there was a particular focus on strategic and operational issues. Whilst the participants were from three different regions across Scotland, these were across the central belt of Scotland. It therefore cannot be claimed that the findings will have transferability to other Regions in Scotland. However, saturation of all categories did emerge through data collection and it is maybe likely that some of the findings will have resonance in other areas of Scotland, but this would need to be tested.

A key strength of my research study was the different characteristics of the areas incorporating rural and city localities reflecting different sizes of undergraduate contracts. The wide range of practitioners, senior mangers and students across the hierarchy added to the richness of data generated.

The sample was small for this research study although the data generated was rich which illuminated the categories. Since the sample was small the views may not be representative of other mentors and students. However, I was reasonably confident that within the study sample saturation had taken place however if I had gone to rural localities the picture may well have been different. Further research of this would be required.

Whilst the use of focus groups as a data collection method has strengths they also have limitations. Their strengths lie in that they are relatively

straightforward to organise and can be used to focus on key issues as well as permitting the opportunity to probe areas uncovering the deeper meaning behind comments. The limitations of focus groups include the requirement of the researcher to be skilled in facilitating the discussion ensuring that all participants have the opportunity to have their voice heard. Whilst I conducted test focus groups, there were times when I had to remind myself of the inherent danger of researcher bias. Researcher bias is also inherent in coding and data analysis of qualitative data. This limitation was off-set through robust supervisory sessions where I was challenged on my interpretations of the data. The use of my reflexive diary, field notes immediately post data collection and memos further helped me to take a step back from being immersed in the data and to be reflexive. My supervisors independently read the interview transcripts and whilst there was concordance with my analysis, the process evoked a great deal of discussion which provided an avenue for further refinement.

In this study, a limitation could be that I did not employ respondent validation as I decided I would not want any possibility of re-interpreting the emerging findings. In the literature there is some debate over the use of respondent checking in qualitative research (Mays and Pope 2000). Those advocating it believe it to be useful in gathering participants' perceptions of the emerging findings. Others assert that undertaking respondent validation can lead to collusion and can also cause participant distress through reading an account of their contribution to the research (Barbour 2000). The latter is more likely to occur when the research topic is of a sensitive nature. The core category, Strategic Engagement for a Quality Learning experience in practice embraced the themes of strategy, vision values and commitment that ran through each of the major categories discussed in Chapter 5. The tentative recommendations are structured around the core category and its constituent parts as well as the emergent tentative theory.

7.2 Recommendations about Strategic Engagement for a Quality Learning Experience in Practice

- There needs to be consideration to managing the interface between the strategic vision and the operational functioning of learning in practice by closing the gap through the Practice Education Partnership Forum.

- It is tentatively recommended that there should be an overarching strategy with a focus on the preparation of a competent nursing workforce with the Higher Education Institutions and the National Health Service Establishments demonstrating a commitment to achieving excellence within the Clinical Learning Environment for students.

- From sections 5.4; 5.4.1; 5.4.2; and 5.4.3 which centred on the student-mentor relationship, student-Link-Lecturer relationship, student-Practice Education Facilitator relationships and student-mentor and Link Lecturer relationships there is a need to develop a jointly operationalised practice learning strategy indicating the responsibilities of mentors, Link Lecturers and Practice Education Facilitators. It is tentatively recommended that this is encompassed within the overall strategy reflecting partnership working between HEIs and NHS establishments.

- Through the establishment of support mechanisms for mentors there is a need to establish Practice Education Partnership Forums to provide an avenue to have mentoring experiences and sharing areas of good practice. It is tentatively recommended that leadership at a senior level within both HEIs and NHS establishments develop a strategy of active engagement to support

mentors which would necessitate through its operationalisation, improved communication and support mechanisms being in place.

- There is also the need for managers in both HEI's and NHS to ensure mentors are prepared for student supervision, which needs to be linked to a current mentor register and database to check currency of mentors.

- It is tentatively recommended that a coherent strategy for mentor development, performance and performance management is established, linked to personal development is evaluated on an annual basis.

7.2.1 Recommendations about Becoming a Mentor to Facilitate Learning in Practice

- From the data presented in the section 5.3.4 'Becoming a mentor to facilitate learning in practice', it was evident that the participants had issues around recruitment of mentors and the need for uniformity in the criteria for selection of mentors. Therefore, there is a tentative recommendation around the need for strategic and operational strategies to be implemented jointly between the Higher Education Institution and National Health Service Establishments to establish agreed role specifications, which would be transparent for potential mentors.

- The first major category 'Becoming a mentor to facilitate learning in practice' produced evidence that indicated the need for a mentoring policy, which included dialogue and discussion with potential mentors as part of ongoing development. To enhance the operationalising of such a strategy a tentative recommendation

would be to engage the manager from the National Health Service at ward level, and the Higher Education Institution, namely the Link Lecturer in a pre-selection discussion to ensure potential recruits were aware of the role specifications required to be a mentor. A tentative recommendation would also include information packs on mentor recruitment (including role requirements and person specification), course detail, and statement of support from managers and evidence of continuing professional development linked to personal development planning.

- In section 5.2.1 'Making Sense of Preparation' the development of a formalised system between the National Health Service and the Higher Education Institution is recommended to engage with new mentors on completion of the preparation programme in order to reflect and plan for students. This would provide a mechanism to link the theoretical preparation for mentorship with the reality in practice. The tentative recommendation would also include the adoption of a tripartite approach to mentor support to include the mentor, the link lecturer and the practice education facilitator for new mentors following mentor preparation.

7.2.2 Recommendations about Operationalising the Facilitation of Learning in Practice

The establishment of formal partnership forums with representation from both organisations is also tentatively recommended arising from the tentative emerging theory. These partnership forums must reflect all aspects of the student journey, to enable stakeholders to contribute and link

into an infrastructure for quality learning in practice. Processes needed to be in place for the following;

- Student evaluation of the practice environment, the effectiveness of their learning and mechanisms to inform students of changes made as a result of their feedback.

- Mechanisms and processes to address quality issues related to identified shortfalls through the evaluation.

- Mechanisms for mentor-student allocation at ward level to ensure mentor availability.

A tentative recommendation to improve the learning environment would be the establishment of Practice Education Partnership Forums for ward managers/ charge nurses to discuss educational philosophy, educational audit, role of managers in support of mentors and the systems and processes for external quality arrangements with Health and Life Science Partnership, (agents for the Nursing and Midwifery Council), which needs to be linked to partnership forums.

Section 5.3 highlighted the need for mentors to link with students prior to commencing placements. Therefore it is recommended that the provision of information from the mentor to students is recommended as a means of an introduction to the placement area. This could be achieved by creating a proforma, which could be e-mailed to the Higher Education Institutions and given to the students by the Link Lecturers. Mechanisms should also be put in place for the arrangement of membership of those Practice Education Partnership Forums would reflect the tripartite arrangement to facilitate learning in practice.

7.2.3 Recommendations about Quality Infrastructure Optimising Learning in Practice

- In respect of support of learning and assessment in practice, there is a need to clearly identify the mentor's understanding of the criteria for assessment. A tentative recommendation includes the need for structured learning opportunities to be matched to the competencies required for students to achieve. This also includes the need for the mentor to engage with the Link Lecturer on issues regarding student progress.

- In section 5.6, the impact of the mentoring culture on learning in practice was highlighted, particularly, the role of the ward manager. The tentative recommendation to improve the leadership and management at ward level requires a revisiting of the role of ward manager/ charge nurse to stress the responsibility for the learning environment as part of the objectives for managers.

- The need to establish formal mechanisms for student, mentor and manager evaluations of Learning in Practice, which is linked into partnership forums and senior management.

- The need to revisit the operationalising of supernumerary status, linked to a supervision strategy for student nurses, which needs to be incorporate within the Higher Education Institutions and National Health Service Establishment joint strategy.

- The importance of assessment of student nurses needs a critical review of supervision arrangements to assess performance and complete documentation, linked to the HEI and NHS Establishment Strategy.

Following on from the tentative recommendations the implications for Policy and Practice are discussed.

7.3 Recommendations for Policy and Practice

This study provided a valuable insight into the strategic implementation of practice based learning and should provide some direction for quality enhancement in both Higher Education Institutions and National Health Service Establishments. The core category of 'strategic engagement' has implications for the future management of learning in practice through the development of a vision and the need for policies at both strategic and operational levels. To ensure consistency in interpretation and implementation it is paramount that these policies are devised collaboratively between HEIs and NHS establishments.

The incorporation of criteria for mentorship linked to planning for a quality learning experience for students should prepare them to achieve their potential. This has implications for policies relating to mentor selection, preparation, support and evaluation. The strategic engagement with stakeholders to create a joint partnership approach for a conducive learning environment will possibly enable the processes and outcomes of mentoring relationships to be recognised, nurtured and incorporated into operationalised systems.

Both the Higher Education Institutions and the National Health Service Establishments have an impact on the relationships in the clinical learning environment and there is a need to use this tentative theory of engagement to impact on the relationships to enhance learning.

7.4 Recommendations for Further Research

The following are suggested areas worthy of future research:

- The testing of the emerging tentative theory across Scotland to include, urban, rural localities, hospital and community areas.

- The need to evaluate the impact of strategic engagements between the HEI's and NHS establishments.

- Further investigation into the formal evaluation of the role of the mentor.

- The need to evaluate how the Link Lecturer and Practice Education Facilitators can work together to enhance the clinical learning environment. Recommendations around Practice Education Facilitators were not reported in my study as there was a National study which was reporting.

- Further investigation surrounding student evaluations of learning in practice to incorporate mentors and managers and auditable feedback mechanisms.

- The need to evaluate the impact of Practice Education Partnership Forum.

- The role and impact of Practice Education Facilitators within the clinical learning environment as a means to close the gap between the strategic and the operational.

References

Abbott, P., Sapsford, R. (1998). *Research Methods for Nurses and the Caring Professions.* (2nd Ed) Buckingham: Open University Press.

Acton, L., Gough, P., McCormack, B. (1992). The Clinical Nurse Tutor Debate. *Nursing Times* 88 (32), pp. 38–41.

Ajiboye, P. (2000). Learning Partners. *Nursing Standard* 14 (51), p.53.

Alasuutar, P., Bickman, L., Brannen, J. (2008). *The Sage Handbook of Social Research Methods.* London. Sage.

Alderman, C. (1998). Clinical Placements. *Nursing Standard* 12 (40), pp. 22-4.

Alderman, C. (2001). Best Placed... The Problem of Clinical Placements. *Nursing Standard* 15 (29), pp. 14-15.

Alderson, P. (1995). Consent to Research: The Role of the Nurse. *Nursing Standard* 36 (9), pp. 28-31.

Andrews, M., Chilton, F. (2000). Student and Mentor Perceptions of Mentoring and Effectiveness. *Nurse Education Today*. 20 (7), pp. 555-562.

Andrews, M., Roberts, D. (2003). Supporting Student Nurses Learning in and Through Clinical Practice: The Role of the Clinical Guide. *Nurse Education Today.* 23 (7), pp 474-481.

Andrews, M., Wallis, M. (1999). Mentorship in Nursing: A Literature Review. *Journal of Advanced Nursing*. 29 (1), pp. 201-207.

Annells, M. (1996). Grounded Theory Method: Philosophical, Perspectives, Paradigm of Inquiry and Postmodernism. *Qualitative Health Research*. 6 (3), pp. 379-393.

Artininian, B.M. (1998). Grounded Theory Research: It's Value for Nursing. *Nursing Science Quarterly.* 11 (1), pp. 5-6.

Aston, L., Mallik, M., Day, C. (2001). An Exploration into the Role of the Teacher/Lecturer in Practice: Findings from a Case Study in Adult Nursing. *Nurse Education Today*. 20 (3), pp. 178-88.

Aston, L., Molassiotis, A., (2003). Supervising and Supporting Student Nurses in Clinical Placements: The Peer Support Initiative. *Nurse Education Today.* 23 (3), pp.202–210.

Atkins, S., Williams, A. (1995). Registered Nurses' Experiences of Mentoring Undergraduate Nursing Students. *Journal of Advanced Nursing.* 24 (4), pp. 791-799.

Atkinson, F. I. (2000). *Survey Design and Sampling*. Oxford. Blackwell Science.

Baillie, L. (1994). Nurse Teachers' Feelings about Participating In Clinical Practice: An Exploratory Study. *Journal of Advanced Nursing.* 20 (1), pp.150-159.

Barbour, R.S. (2000). Checklists for Improving Rigour in Qualitative Research: A Case of the Tail Wagging Dog? *British Medical Journal*. 322pp. 1115-1117.

Barriball, K.L., White, A. (1994). Collecting Data Using a Semi-Structured Interview. *Journal of Advanced Nursing.* 19 (2), pp. 328-335.

Beauchamp, T.L., Childress, J.F. (2009). *Principles of Biomedical Ethics*. (5th Ed). Oxford, Oxford University Press.

Nursing Standard. 8 (8), pp. 25-27.

Benton, D. (2000). Grounded Theory. In: Cormack, D. (Ed) *The Research Process In Nursing.* Oxford: Blackwell Science.

Benzies, K.M., Allen, M.N. (2001). Symbolic Interactionism as a Theoretical Perspective for Multiple Method Research. *Journal of Advanced Nursing* 33 (4), pp. 543-547.

Bewley, C. (1995). Clinical Teaching in Midwifery; an Exploration of Meanings. *Nurse Education Today* 15 (2), pp. 129-135.

Beyea, S.C., Nicoll L.H. (1997). Qualitative and Quantitative Approaches to Nursing Research. *AORN Journal* 66 (2), pp. 323-325.

Birks, M., Chapman, Y., Francis, K. (2008). Memoing in Qualitative Research: Probing Data and Processes. *Journal of Research in Nursing.* 13, P*. 68.*

Blumer, H. (1937). Social Psychology. In: Schmidt, E.P. (Ed.), *Man and Society*. Prentice-Hall, Englewood Cliffs, NJ: Prentice-Hall.

Blumer, H. (1969). *Symbolic Interactionism: Perspective And Method* Englewood Cliffs, N.J: Prentice-Hall.

Bloor, M. (2001). *Focus Groups in Social Research*, London, Sage Publications.

Booth, B. (1992). Ward Sisters: Someone to Believe in. *Nursing Times* 88 (15), pp. 36-37.

Bowers, B.J. (1988). Grounded Theory. In Sarter, B. (Eds) *Paths to Knowledge. Innovative Research Methods for Nursing*. New York, National League for Nurses.

Bowling, A. (2002). *Research Methods in Health: Investigating Health and Health Services.2nd Ed.* Buckingham; Philadelphia: Open University Press.

Boyd, C. (2001). Philosophical Foundations of Qualitative Research. In Munhall, P. (Ed.), *Nursing Research; A Qualitative Perspective*. Sudbury, Jones & Bartlett.

Brennan, A., Hunt, R. (2001). The Challenges and Conflicts of Facilitating Learning in Practice: The Experiences of Two Clinical Nurse Educators. *Nurse Education in Practice.* 1, pp. 181–188.

Britten, N. (1995). Qualitative Research: Qualitative Interviews in Medical Research. *British Medical Journal*. 311, pp. 251-253.

Brown, L., Herd, K., Humphries, G., Paton, M., (2005). The Role of the Lecturer in Practice Placements:….What Do Students Think? *Nurse Education in Practice.* 5, pp. 84-90.

Bryman, A. (2004). Qualitative Research on Leadership: A Critical but Appreciative Review. *The Leadership Quarterly* 15, pp. 729–769.

Bryman, A. (2008). Editorial *Qualitative Research*. 6 (1), pp. 5-7.

Bryman, A. (2008). Social Research Methods (3rd Ed). London Oxford University Press.

Burgess, R.G. (1984). In The Field: An Introduction to Field Research *International Journal of Nursing Studies.* 31 (6), pp. 499-510.

Burns, N., Grove, S.K. (2001). *The Practice of Nursing Research: Conduct, Critique & Utilisation.* 4th Ed. London, Saunders.

Burns, N., Grove, S.K. (2007). *Understanding Nursing Research.* 4th Ed. London. Saunders.

Cahill, H., A. (1996). A Qualitative Analysis of Student Nurses' Experience of Mentorship. *Journal of Advanced Nursing*. 24 (4), pp. 791-799.

Cahill, H.A. (1997). What Should Nurse Teachers Be Doing? A Preliminary Study. *Journal of Advanced Nursing.* 26 (1), pp.146-153.

Cameron-Jones, M., O'Hara, P. (1996). Three Decisions about Nurse Mentoring. *Journal of Nursing Management.* 4 (4), pp. 225-230.

***Carlisle, C*., Kirk, S., Luker, KA. (1997).** The Clinical Role Of Nurse Teachers Within A Project 2000 Course Framework. Journal Of *Advanced Nursing* 25 (2) pp. 386-95.

Castledine, G. (2005). Poor Standard Assessment-Putting Patients At Risk. *British Journal of Nursing*. 14 (14), p.793.

Cerinus, M. (2001). The Ethics of Research. *Nurse Researcher.* 8 (3), pp. 72-89.

Chaffer, D. (1998). Places Please. *Nursing Standard.* 12 (40), p.25.

Chamberlain, K. (1999). Using Grounded Theory in Health Psychology. In Murray, M. And Chamberlain, K (Eds.) *Qualitative Health Psychology; Theories and Methods*. London: Sage.

Chan, D. (2002). Development of the Clinical Learning Environment Inventory: Using the Theoretical Framework of Learning Environment Studies to Assess Nursing Students Perceptions of the Hospital as a Learning Environment. *Journal of Nursing Education.* 41 (2), pp. 69-75.

Chan, D.S.K. (2004). The Relationship between Student Learning Outcomes from Their Clinical Placement and Their Perceptions of the Social Climate of the Clinical Learning Environment. *Contemporary Nurse.* 17 (12), pp. 149-158.

Chapple, M., Aston, E.S. (2004). Practice Learning Teams: A Partnership Approach to Supporting Students' Clinical Learning. *Nurse Education in Practice*. 4, pp. 143-149.

Charmaz, K. (1990). Grounded Theory Objectivist and Constructivist Methods. In Denzin, N.K., Lincoln, Y.S. (Eds) *Handbook of Qualitative Research*, Second Edition, Thousand Oaks, Sage.

Charmaz, K. (1994). Discovering Chronic Illness: Using Grounded Theory. In *More Grounded Theory Methodology: A Reader* (Glaser B., Ed.), Sociology Press, Mill Valley, CA.

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist Methods. In *Handbook of Qualitative Research*, 2nd Ed. (Denzin N. & Lincoln Y., Eds), Sage, Thousand Oaks, CA.

Charmaz, K. (2006). *Constructing Grounded Theory*. *A Practical Guide through Qualitative Research*. London; Sage.

Chenitz, W.C., Swanson, J.M. (1986). F*rom Practice to Grounded Theory: Qualitative Research in Nursing.* California, Addison-Wesley.

Chesser-Smythe, P.A. (2005). The Lived Experience of General Student Nurses on Their First Clinical Placement. *Nurse Education in Practice.* 5, pp. 320-327.

Chow, F.L.W., Suen, L.K.P. (2001). Clinical Staff as Mentors in Pre-Registration Undergraduate Nursing Education, Students' Perceptions of the Mentors' Roles and Responsibilities. *Nurse Education Today.* 21 (2), pp. 350-358.

Clifford, C. (1997). *Qualitative Research Methodology in Nursing and Health Care.* New York, Churchill, Livingstone.

Clutterbuck, D. (2001). *Everyone Needs A Mentor; Fostering Talent on Your Organisation, 3rd Ed.* Chartered Institute of Personnel and Development (CIPD).

Colaizzi, P.F. (1978). Psychological Research As the Phenomenologist Views It. In Valle, R & King, M (Eds.) *Existential Phenomenological Alternatives For Psychology.* New York, Oxford University Press.

Corlett, J. (2000). The Perceptions of Nurse Teachers, Student Nurses and Preceptors of the Theory-Practice Gap in Nurse Education. *Nurse Education Today*. 20 (6), pp. 499-505.

Corlett, J., Palfreyman, J.W., Staines, H.J., Marr, H. (2003). Factors Influencing Theoretical Knowledge And Practical Skill Acquisition In Student Nurses: An Empirical Experiment. *Nurse Education Today*. 23 (3), pp.183-190.

Cormack, D. (2000). *The Research Process in Nursing.* (4th Ed) Oxford: Blackwell Publishing.

Council of Deans and Heads of UK University Faculties of Nursing, Midwifery and Health Visiting. (1999). Developing a Clinical Academic Career for Nurses and Midwives: *A Consultation Paper*.

Creswell, J.W., Miller, D.L.(2000). Determining Validity in Qualitative Inquiry*. Theory into Practice.* 39 (3), pp124-130.
Crotty, M. (1992). The Perceptions of Nurse Teachers Regarding the Preparation for Their Role in Project 2000 Programmes. *Nurse Education Today*. 12(5), pp. 350-356.
Crooks, D.L. (2001). The Importance of Symbolic Interaction in Grounded Theory Research on Women's Health. *Health Care for Women International.* 22. pp. 460-464.
Curtis, E., Redmond, R. (2007). Focus Groups in Nursing Research. *Nurse Researcher.*14 (2), pp. 25-37.
Cutcliffe, J.R. (2000). Methodological Issues in Grounded Theory. *Journal of Advanced Nursing.* 31 (6), pp. 1476-1484.
Cuthbertson, P. (1996). Attitudes to Project 2000: A Survey of Qualified Nurses. *Nursing Standard*. 11, pp. 38-41.
Czaja, R., Blair, J. (1996). *Designing Surveys*. London, Pineforge Press.
Dale, A.E. (1994). The Theory-Theory Gap: The Challenge for Nurse Teachers. *Journal of Advanced Nursing*. 20 (3), Pp. 521-524.
Darling, W.L. (1984). What Do Nurses Want In A Mentor? *Journal Of Nursing Administration*. 14 (10), pp. 42–44.
Darling, L.A.W. (1985). What Do Nurses Want In A Mentor? *Nurse Educator* .10 (1), pp. 18-20.
Davies, W.B., Neary, M., Phillips, R.P. (1994). *The Practitioner – Teacher: A Study in the Introduction of Mentors in the Pre-Registration Nurse Education Programme in Wales.* University Of Wales, Cardiff.
Davies S. Shepherd B., Thomson A. And Whittaker K. (1995). *An Investigation into the Changing Educational Needs of Community Nurses, Midwives And Health Visitors in Relation to the Teaching, Supervising And Assessing of Pre-and Post-Registration Students.* English National Board for Nursing, Midwifery and Health Visiting. Research Report Series Number 13. ENB. London.
Day C., Fraser D., Mallik M., Aston L. (1998). *The Role of the Teacher/Lecturer in Practice.* ENB Research Report. Series No 8. English National Board for Nursing, Midwifery and Health Visiting, London.
Denzin, N.K. (1989). *The Research Act: A Theoretical Introduction to Sociological Methods,* 3rd Edition. Englewood Cliffs, N.J. Prentice Hall.
Denzin, N.K., Lincoln, Y.S. (2003). *Strategies of Qualitative Inquiry.* Thousand Oaks, California, Sage.
Department Of Health, (2001). *Practice Placements*: *A Discussion Paper*. Department of Health, London.
Downes, M. (2001). Support For Student Training: A New Role As Demonstrators. *Nursing Times*. 97 (7), pp 39.

Duffy, M.E. (2000). Conceptual Analysis in Compliance. *Journal of Clinical Nursing.* 9 (1), pp. 5-12.

Duffy, K., Docherty, C., Cardnuff, L., White, M., Winters, G., Greig, J. (2000). The Nurse Lecturer's Role in Mentoring the Mentors. *Nursing Standard*. 15 (6), pp. 35-38.

Duffy, K., Ferguson, D., Watson, H. (2004). Data Collecting in Grounded Theory Some Practical Issues. *Nurse Researcher*. 11 (4), pp. 67-78.

Duffy, K. (2004). Mentors Need More Support to Fail Incompetent Students*. British Journal of Nursing.* 13 (10), P.582.

Dunn, S.V., Hansford, B. (1997). Undergraduate Nursing Students' Perceptions of Their Clinical Learning Environment. *Journal of Advanced Nursing.* 25, pp. 1299-1306.

Earnshaw, G.T. (1995). Mentorship: The Students' Views. *Nurse Education Today.* 15 (4), pp. 274-279.

Edwards, P., Roberts, I., Clarke, M., Diguiseppi, C., Pratap, S., Wentz, R., Kwan, I., (2002). Increasing Response Rates to Postal Questionnaires: Systematic Review. *British Medical Journal.* 2002. 324, pp.1183-1186.

Elcock, K.S., Curtis, P., Sharples, K., (2007). Supernumerary Status – An Unrealised Ideal. *Nurse Education in Practice.* 7, pp. 4-10.

Elkan, Robinson, J. (1993). Project 2000: The Gap Between Theory And Practice. *Nurse Education Today* .13, pp. 295-298.

English National Board (1987). *Institutional and Course Approval/ Reapproval Process. Information Required, Criteria And Guidelines*. ENB, London.

English National Board (2001). *Preparation of Mentors and Teachers. A New Framework of Guidance.* ENB, London.

Eraut, M., Alderton, J., Boylan, A., Wraight. A., (1995). *Learning To Use Scientific Knowledge in Education and Practice. Settings. L*ondon, ENB.

Field, P.A., Morse, J.M. (1985). *Nursing Research: The Application of Qualitative Methods*. London, Croon, Helm.

Field, P.A., Morse, J.M. (1995). *Qualitative Research Methods for Health Professionals*, Thousand Oaks, CA: Sage.

Fielding, N.G. (1994). *Qualitative Data Analysis with a Computer: Recent Developments.* Social Research Update, University Of Surrey.

Freshwater, D., Rolfe, G. (2001). Critical Reflexivity: A Politically And Ethically Engaged Research Method For Nursing. *Nursing Times Research*. 6 (1), pp. 526-550.

Fretwell, J.E. (1980). An Inquiry into the Ward Learning Environment*. Nursing Times*. 76 (26), pp.69-75.

Fretwell, J.E. (1983). *Ward Teaching and Learning*. London, RCN.

Garity, J. (1995). Ethics In Research. In Talbot, LA (Ed) (1995). *Principles and Practice of Nursing Research.* St Louis, Mosby.
Gelling, L. (1999). Ethical Principles in Healthcare Research. *Nursing Standard.* 13 (36), pp. 39-42.
Gerrish, C.A. (1990). An Analysis of the Educational Role of the Ward Sister (Implications for Nurse Educators). *Nurse Education Today.* 10 (3), pp. 198-205.
Gillespie, (2002). Student-Teacher Connection in Clinical Nursing Education**.** *Journal of Advanced Nursing.* 37 (6), P. 566*.*
Gilbert, T. (2006). Mixed Methods And Mixed Methodologies: The Practical, The Technical And The Political. *Journal of Research in Nursing*. 11, pp. 205-216.
Glaser, B.G., Strauss, A. (1965). *Awareness of Dying***.** Chicago, Aldine.
Glaser, B., Strauss, A. (1967). *The Discovery of Grounded Theory Strategies for Qualitative Research*. Chicago, Aldine.
Glaser, B. (1978). *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory.* Mill Valley, the Sociology Press.
Glaser, B.G. (1992). Constructivist Grounded Theory Forum for Qualitative Socialization. 3 (3) *Http://www.Qualitative* Research.Net/Fqs-Eng.Htm).
Glaser, B. (2001). *The Grounded Theory Perspective*: *Conceptualisation Contrasted With Description*. Mill Valley: Sociology Press.
Glaser, (2004). *Remodelling Grounded Theory*. Forum: Qualitative Social Research (On-Line Journal) 3, (3). Http://Www.Qualitative-Research.Net/Fqs.
Glover, P. (2000). Third Year Nursing Students' Perceptions and Use of Feedback in the Clinical Setting. *International Journal of Nursing Practice.*6 (5), pp. 247-252.
Graneheim, U.H., Lundman, B. (2003). Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to Achieve Trustworthiness. *Nurse Education Today*. 24, pp 105-112.
Graziano, A.M., Raulin, M.L., (2007). *Research Methods: A* P*rocess of Inquiry* (6th Ed). London, Boston, Mass.
Gray, M. (1994). Personal Experience of Conducting Unstructured Interviews. *Nurse Researcher.* 3, pp.65-71
Gray, M.A. (1997). *The Professional Socialisation Of Project 2000 Student Nurses: A Longitudinal Qualitative Investigation Into The Effect(S) Of Supernumerary Status And Mentorship On Student Nurses*. Unpublished Ph.D. Thesis, Department Of Nursing and Midwifery, Faculty of Medicine, University Of Glasgow.
Gray, M.A., Smith, L. (1999). The Professional Socialisation of Diploma of Higher Education in Nursing Students (Project 2000): A

Longitudinal Qualitative Study. *Journal of Advanced Nursing 29* (3), pp. 639-647.

Gray, M.A., Smith, L. (2000). The Qualities of an Effective Mentor from the Student Nurses' Perspective; Findings from a Longitudinal Qualitative Study. *Journal of Advanced Nursing.* 32 (6), pp. 1542-1549.

Guba, E.G., Lincoln, Y.S. (1989). *Judging the Quality of Fourth Generation Evaluation*. In Guba, E Lincoln (Eds) Fourth Generation Evaluation. California: Sage Publications.

Gubrium, J.F., Holstein, J.A. (Eds.), (2002). *Handbook of Interview Research: Context and Method*. Thousand Oaks, CA: Sage.

Haber, J. (1994). *Nursing Research: Methods, Critical Appraisal, and Utilization*. (3rd Ed) St. Louis, Mosby.

Hall, W.A., Callery, P. (2001). Enhancing the Rigor of Grounded Theory: Incorporating Reflexivity and Relationality. *Qualitative Health Research*. 11 (2), pp. 257-272.

Hallet, C., Williams, A., Butterworth, T. (1996). The Learning Career in Community Nursing a Phenomenological Study of the Project 2000 Placement. *Journal of Advanced Nursing.* 23, pp. 578-586.

Hammersley, M. (1989). *Ethnography: Principles in Practice*. London, Routledge.

Hand, H. (2003). The Mentor's Tale: A Reflexive Account of Semi-Structured Interviews. *Nurse Researcher*. 10 (3), pp.15-27.

Hardey, M. (1994). Qualitative Research and Nursing. In Hardey, M., Munhall, A. *Nursing Research Theory and Practice*, London. Chapman & Hall.

Hay, J. (1995). *Transformation*, Mentoring: *Creating Development Alliances for Changing Organization Cultures.* New York: Mcgraw-Hill.

Heath, H., Cowley, S. (2004). Developing a Grounded Theory Approach; a Comparison of Glaser and Strauss. *International Journal of Nursing Studies.* 41, Pp. 141-150.

Henderson, J., McAdam, R., Leonard, D. (2006) Reflecting on a TQM Based University/Industry Partnership. *Management Decision.* 44 (10), 1422-1440.

Hickey, G. (1997). The Use of Literature in Grounded Theory. *Nursing Times Research.* 2 (5), pp. 371-378.

Hinds, P.S., Chaves, D.E., Cypess, S.M. (1992). Context as a Source of Meaning and Understanding. *Qualitative Health Research.* 2 (1), 61-74.

Holland, K. (2001). Editorial. *Nurse Education in Practice.*1 (4) Pp. 173-174.

Holloway, I., Fulbrook, P. (2001). Revisiting Qualitative Inquiry: Interviewing in Nursing and Midwifery Research. *Nursing Times Research.* 6, pp. 539-550.

Holloway, I., Todres, L. (2006). Grounded Theory In Gerrish, K., Lacey, A. (Eds) *The Research Process In Nursing* 5th Ed. Oxford, Blackwell.

Holloway, I., Wheeler, S. (2002). *Qualitative Research in Nursing.* (2nd Ed) Oxford; Blackwell Science.

Horsburgh, D. (2003). Evaluation of Qualitative Research. *Journal of Clinical Nursing.*12, pp. 307-312.

Houser, J. (2008). *Nursing Research: Reading, Using, and Creating Evidence*. Sudbury, Mass: Jones and Bartlett.

Hoyles, A., Pollard, C., Lees, S. (2000). Nursing Students' Early Exposure to Clinical Practice: An Innovation in Curriculum Development. *Nurse Education Today*. 20 (6), pp. 490-498.

Howatson-Jones IL. (2007). Dilemmas of Focus Group Recruitment and Implementation: A Pilot Perspective. *Nurse Researcher*. 14 (2), pp.7-17.

Huberman, A. M., Myles, M. B. (1994). Data Management and Analysis Methods. In Denzin, N.K., Lincoln, Y.S. (Eds) *Handbook Of Qualitative Research (*2nd Ed). Thousand Oaks, Sage

Hutchings, A., Williamson, G. R., Humphreys, A. (2005) Supporting Learners in Clinical Practice: Capacity Issues. *Journal of Clinical Nursing*. 14(8), pp.945-955.

Hutchinson, S. (1993). *Journal of Grounded Theory: The Method*. In Munhall, P., Boyd, O. (Eds) (1993) *Nursing Research: A Qualitative* Perspective. York, National League for Nursing Press.

Jackson, D., Mannix, J. (2001). Clinical Nurses as Teachers: Insights from Students of Nursing in Their First Semester of Study. *Journal of Clinical Nursing.10, pp. 270-277.*

Jeffree C.A. (1991). A Broken Link in the Chain. *Senior Nurse.* 11 (3), pp. 4-6.

Jinks, A.M., Williams, R.H. (1994). Evaluation of A Community Staff Preparation Strategy for the Teaching, Assessing and Mentorship of Project 2000 Diploma Students. *Nurse Education Today.* 14, pp. 44-51.

Johnstone, P. (2004). Mixed Methods, Mixed Methodology Health Services. Research in Practice. *Qualitative Health Research*. 14 (2), pp. 259-271.

Jones, M.L., Walters, S., Akehurst, R. (2001). The Implications of Contact with the Mentor for Pre-Registration Nursing and Midwifery Students. *Journal of Advanced Nursing.* 35 (2), pp. 151–160.

Jones, R.A. (2005). Prioritising To Safeguard the Integrity of Nurse Education. *Nursing Times.* 101 (34), pp. 26-27

Jowett, S., Walton, I., Payne, S. (1994). *Challenges and Changes in Nurse Education*; *A Study of the Implementation of Project 2000*. Slough, National Foundation for Educational Research.

Kevern J., Webb C. (2001). Focus Groups as a Tool for Critical Social Research in Nurse Education. *Nurse Education Today*. 21 (4), pp.323-33.

Kilcullen, N. (2007). The Impact of Mentorship on Clinical Learning. *Nursing Forum*. 42 (2), pp. 95-104.

Koch T., Harrington A. (1998). Reconceptualising Rigour: The Case for Reflexivity. *Journal of Advanced Nursing*. 28(4), pp.882-890.

Koch, T. (1994). Establishing Rigor in Qualitative Research: The Decision Trail. *Journal of Advanced Nursing.* 19, pp. 976-986.

Koch, T. (1998). Story Telling: Is It Really Research? *Journal of Advanced Nursing.* 28 (6), pp. 1182-1190.

Koh, L. (2002). The Perceptions of Nursing Students of Practice Based Teaching. *Nurse Education in Practice.* 2, pp. 35-43.

Kramer, N. (1993). Preceptorship Policy: A Tool for Success. *Journal of Continuing Education in Nursing*. 24 (6) Pp. 274-6.

Krueger, **R. A. (1994).** Focus Groups: A Practical Guide for Applied Research. Thousand Oaks, CA: Sage Publications.

Krueger, **R. A., Casey**, **M. A. (2000).** Focus Groups*. Practical Guide for Applied Research* (3rd Edition). Thousand Oaks, CA: Sage Publications.

Lankshear, A. (1998). Helping Students Find A Place in the Team. *Nursing Times*. 94 (29), pp.64-65.

Lauder, W., Watson, R., Topping, K., Holland, K., Johnston, M., Porter, M., Roxburgh, M., Behr, A. (2008). An Evaluation of Fitness for Practice Curricula: Self-Efficacy, Support and Self-Reported Competence in Preregistration Student Nurses and Midwives. *Journal of Clinical Nursing*. 17 (14), pp. 1858-1867.

Le Compte, M.D., Preissle, J., Tesch, R. (1993). *Ethnography and Qualitative Design in Educational Research*. London, Academic Press.

Leonard. D., McAdam, R. (2002a). The Role of the Business Excellence Model in Making Operational and Strategic Decision Making. *Management Decision.* 40 (1), 17-25.

Leonard, D.*, McAdam, R. (2002b).* The Corporate Strategic-Operational Divide and TQM*. Measuring Business Excellence. 6 (1), 5-14.*

Leonard, D.*, McAdam, R. (2002c).* The Strategic Dynamics of Quality Management: A Grounded Theory Research Study. *The Total Quality Management Journal. 9 (1), 50-62.*

Lee, D.T. (1996). The Clinical Role of the Nurse Teacher: A Review of the Dispute. *Journal of Advanced Nursing*. 23(6), pp.1127-1134.

Leininger M (1994) Evaluation Criteria and Critique of Qualitative Research Studies. In: Morse JM, (Ed). *Critical Issues In Qualitative Research Methods*. Thousand Oaks, Sage.

Le Var, R.M. (1996). Nvqs in Nursing, Midwifery and Health Visiting: A Question of Assessment and Learning. *Nurse Education Today*. 16 (2), pp. 85-93.

Levec, M.L., Jones, C.B. (1996). The Nursing Practice Environment, Staff Retention, and Quality of Care. *Research in Nursing & Health.* 19 (4), pp. 331-343.

Lewin (2007) Clinical Learning Environments For Student Nurses: Key Indices From Two Studies Compared Over A 25 Year Period. Nurse Education in Practice 7, pp 238-246.

Lincoln, Y.S., Guba, E.G. (1985). *Naturalistic Inquiry*. London, Sage.

Lindsay, B. (2007). *Understanding Research and Evidence-Based Practice*. Devon. Deer Park Productions.

Lloyd, Jones, M., Walters, S., Akehurst, R. (2001). The Implications of Contact with the Mentor for Pre-Registration Nursing and Midwifery Students. *Journal of Advanced Nursing.* 35 (2), pp. 151-160.

Lomborg, K., Kirkevold, M. (2003). Truth and Validity In Grounded Theory. *Nursing Philosophy.* 4 (3) Pp. 189-200.

Lowenberg, J.S. (1993). Interpretive Research Methodology: Broadening the Dialogue. *Advances in Nursing Science*. 16 (2), pp. 57-69.

Luker, K.A., Kendrick, M. (1996). An Exploration of the Influence of Managerial Factors on Research Utilisation in District Nursing Practice. *Journal of Advanced Nursing.* 23 (4), pp. 697-704.

McAdam, R., Leonard, D., Henderson, J., Hazlett, S.A. (2008). A Grounded Theory Research Approach to Building and Testing TQM Theory in Operations Management. *Omega* 36, 825-837,

McCann, T., Clark, E. (2003). *Grounded Theory in Nursing Research* Methodology *Nurse Researcher*. 47 (3), pp. 279-286.

McCarty, M. Higgins, A. (2003). Moving To An All Graduate Profession: Preparing Preceptors For Their Role. *Nurse Education Today*. 23 (2), pp. 89-95.

McGibbon, G. (1997). How to Make a Questionnaire Work*. Nursing Times.* 93 (23), pp. 46-48.

McGowan B., McCormack B. (2003). Supernumerary Status: Definition, Operationalisation and Its Effect in Practice. *Intensive & Critical Care Nursing*. 19 (5), pp. 308-317.

McGowan, B. (2004) *A Realistic Evaluation of Undergraduate Perceptions of the Definition, Operationalisation and Effect of Supernumerary Status.* University Of Ulster, Newton Abbey.

McHale, C. (1991). Job Mobility among Nurse Teachers. *Nursing Standard*. 6 (1), pp. 30-32.

McLafferty, I. (2004). Focus Group Interviews as a Data Collection Strategy. *Journal of Advanced Nursing.* 48 (2), pp 187-194.
Maclean, L.M., Mayer, M., Estable, A. (2004). Improving Accuracy of Transcripts in Qualitative Research. *Qualitative Health Research*. 14 (10), pp. 113-123.
Macleod Clark, J., Maben, J., James, (1997). Project 2000 Perceptions of the Philosophy and Practice of Nursing; Preparation for Practice. *Journal of Advanced Nursing.* 26, pp. 246-256.
Macleod Clark J., Maben, J., Jones, K. (1996) The Use of Focus Group Interviews In Nursing Research. *NT Research* 1 (2): Pp.143-153
Machell, S., Gough, P., Stewart, K. (2009). *From Ward to Board: Identifying Good Practice in the Business of Caring*. London, Kings Fund and Burdett Trust for Nursing.
Mallik, M., Aylott, E. (2005) Facilitating Practice Learning In Pre-Registration Nursing Programmes – A Comparative Review of the Bournemouth Collaborative Model And Australian Models. *Nurse Education in Practice*. 5, pp. 152-160.
Mallik, M., McGowan, B., (2006) Issues in Practice Based Learning in Nursing in the United Kingdom and the Republic of Ireland. *Nurse Education Today*. 27, (1), 52 – 59.
Mannix, J., Jackson, D. (2001). Clinical Nurses as Teachers: Insights from Students of Nursing in Their First Semester of Study. *Journal of Clinical Nursing*. 10, (2). Pp. 270-277.
Mansell, I., Bennett, G., Northway, R., Mead, D., Moseley, L. (2004). The Learning Curve: The Advantages and Disadvantages in the Use of Focus Groups as a Method of Data Collection. *Nurse Researcher*. 11(4), pp. 79-88.
Marriot, A. (1991) The Support, Supervision and Instruction of Nurse Learners in Clinical Areas: A Literature Review. *Nurse Education Today.*11 (4), pp.261- 269.
Maslin-Prothero, S.E., and S. Owen (2001). Enhancing Your Clinical Links and Credibility: The Role of Nurse Lecturers and Teachers in Clinical Practice. *Nurse Education in Practice.* 1 (4), pp. 189-195.
May, N., Veitch, L., McIntosh, J., Alexander, M. (1997). *Preparation for Practice: Evaluation of Nurse and Midwife Education in Scotland 1992 Programmes. Final Report to the National Board for Scotland.* Glasgow Caledonian University, Glasgow.
May, N., (1994). *Qualitative Research in Healthcare*. London, Stanley Thornes.
May, T. (2001). *Social Research: Issues, Methods and Process*. Buckingham: University Press
Mays, N., Pope, C. (2000). Assessing Quality in Qualitative Research. *British Medical Journal*. 320, pp.50-52.

Mead, G (1934) *Mind, Self, and Society*. Chicago, IL: University Of Chicago

Mead, G (1962) *Mind, Self, and Society.* Chicago, IL: University Of Chicago

Mead, D. (1993). Personal Experiences of Designing Questionnaires. *Nurse Researcher.* 1 (2), pp. 62-70.

Meade, C.D. (1994). Improving and Understanding of the Informed Consent Process and Document. *Oncology Nursing*. 15 (2), pp. 124-137.

Melia, K. (1983) Students' Views of Nursing. Discussion of Method... Insights into Social Science Research... *Nursing Times.* 79 (20) Pp. 24-5.

Morle, K. (1990). Mentorship – Is It a Case of the Emperor's New Clothes or a Rose by another Name? *Nurse Education Today.* 10, pp. 66-69.

Morgan, P.J. (2002) Comparison between Medical Students' Experience, Confidence and Competence. *Medical Education*. 3, (66), pp. 534-539.

Morrison, R.S. (1993). Scientific Integrity in Research. *Journal Neuroscience Nursing.* 25 (5), pp. 321-325.

Morse, J.M., Field, P.A. (1991). *Nursing Research*. London, Stanley Thornes.

Morse, J.M., Field, P.A. (1996). *Nursing Research*. The Application of Qualitative Approaches (2nd Edition). Glasgow, Chapman & Hall.

Morse, J. M., & Field, P. A. (2002). *Nursing Research: The Application of Qualitative Approaches* (2nd Ed.). Cheltenham, UK: Nelson Thornes.

Morse, J.M. (2001). Situating Grounded Theory Within Qualitative Inquiry. In Schreiber, R.S, Stern, P.N. (Eds) (2001) *Using Grounded Theory in Nursing*. New York Springer Publishing Company.

Morse, J.M. (2002). *Nursing Research: The Application of Qualitative Approaches* (2nd Ed). Cheltenham.

Moseley, L., Davies, L. (2007). What Do Mentors Find Difficult? *Journal of Clinical Nursing*. 17, pp. 1627-1634.

Morton-Copper, A., Palmer, A. (2000). *Mentoring, Preceptorship and Clinical Supervision*. London, Blackwell Science.

Munhall, P. (2007). Nursing Research: A Qualitative Perspective (4th Edition). London Sudbury, Mass.

Murray, P. (1999). Fundamental Issues in Questionnaire Design. *Accident and Emergency Nursing.* 7, pp. 148-153.

Murphy, F. (2000). Collaborating With Practitioners in Teaching and Research: A Model for Developing the Role of the Nurse Lecturer in Practice Areas. *Journal Advanced Nursing*. 31 (3), pp. 704-714. **Myers, DG. (2004)** *Intuition: Its Powers and Perils.* New Haven. Yale University Press.

Myall, M., Levett-Jones, T., Lathlean, J. (2008) Mentorship in Contemporary Practice: The Experiences of Nursing Students and Practice Mentors. *Journal of Clinical Nursing. 17, pp*. *1834-1842*

Neary, M., Davies, B., Phillips, R. (1996). The Introduction of Mentorship to Project 2000 in Wales. *Nursing Standard*. 10 (25), pp. 37-39.

Neary, M., (1997). Project 2000 Students' Survival Kit: A Return to the Practical Room. *Nursing Education Today.* 17, pp. 46-52.

Neary, M. (2000). Supporting Students' Learning and Professional Development through the Process of Continuous Assessment and Mentorship. *Nurse Education Today*. 20 (6), pp. 463-74.

Nettleton, P., Bray, L. (2008) Current Mentorship Schemes Might Be Doing Our Students A Disservice. *Nurse Education in Practice*. 8, pp. 205-212.

Newell, R., Burnard, P. (2006). *Research for Evidence-Based Practice*. Oxford, Blackwell Publishing.

Newton, A., Smith, LN. (1998). Practice Placement Supervision: The Role of the Personal Tutor. *Nurse Education Today*. 18(6), pp. 496-504.

NHS Education for Scotland (2007). *National Approach to Mentor Preparation for Nurses and Midwives*. Edinburgh: NHS Education for Scotland.

Nolan, C. (1998). Learning on Clinical Placement: The Experience of Six Australian Student Nurses. *Nurse Education Today* 18, pp. 622-629.

Nursing and Midwifery Council (2008). *Standards to Support Learning and Assessment in Practice*. London, NMC.

Nully, D.N. (2008). The Adequacy Of Response Rates To Online And Paper Surveys: What Can Be Done? *Assessment & Evaluation in Higher Education.* 33 (3), pp. 301-314.

O'Callaghan, N., Slevin, E. (2003). An Investigation of the Lived Experiences of Registered Nurses Facilitating Supernumerary Nursing Students. *Nurse Education Today*. 23 (2), pp. 123-130.

O'Flanagan, S. (2002). Students' Views on Clinical Placements. *Nursing Times.* 98 (6), pp. 32-33.

Ogier, M.E. (1982). *An Ideal Sister?* London, Royal College Of Nursing.

Olesen, W.K. (1994). Researcher as Enabler: An Alternative Model for Research in Public Health. *Critical Public Health*. 5 (3) Pp. 5-14.

O'Neil, E., Morrison, H., McEwen, A. (1993). *Professional Socialisation and Nursing Education: An Evaluation Executive Summary*. Queens University, Belfast.

Oppenheim, A.N. (1992). *Questionnaire Design and Attitude Measurement.* London, Heinemann.

Orton, H. (1981). *Ward Learning Climate.* Royal College Of Nursing. London.

Orton, H., Prowse, J. (1993). *Charting the Way to Excellence*. Sheffield Hallam University, Sheffield.

Osbourne, R. (1991). Blinkered Judgements. *Nursing Standard*. 6 (48), pp. 48.

Owen, S. (1993). Identifying a Role for the Nurse Teacher in the Clinical Area. *Journal of Advanced Nursing*. 18(5), pp. 816-825.

Papp, I., Markkanen, M., Von, Bonsdorff, M. (2003). Clinical Environment as a Learning Environment: Student Nurses' Perceptions Concerning Clinical Learning Experiences. *Nurse Education Today*. 23(4), pp. 262-268.

Parahoo, K. (1992). The Reality of Supernumerary Status. *Nursing Standard.* 6(51), pp. 37-40

Parahoo, K. (2006). *Nursing Research; Principles, Process and Issues.* (2nd Ed) London. Macmillan Press

Parsloe, E. (1992). *Coaching, Mentoring and Assessing: A Practical Guide to Developing Competence*. London: Kogan Page.

Parsons, M., Greenwood, J. (2000). A Guide to the Use of Focus Groups in Health Care Research. *Contemporary Nurse*. 9 (2), pp. 169-180.

Patton, M. (1990). *Qualitative Evaluation and Research Methods*. Newbury Park, Sage.

Payne, GC., Gray, PA. (1991). An Innovative Method For Evaluating Means To Award Placement Credit In A Baccalaureate Nursing Program For RN Students. *Journal of Nursing Education*. 30 (7), pp. 326-327.

Pembrey, S.E.M. (1980). *The Ward Sister – Key to Nursing*. London, Royal College Of Nursing.

Philips R.M., Davies W.B & Neary, M. (1996a). The Practitioner Teacher: A Study in the Introduction of Mentors in the Pre-Registration Nurse Education Programme in Wales. Part 1. Journal of Advanced Nursing 23, 1037-1044.

Phillips, R.M., Davies, W.B., Neary, M. (1996b). The Practitioner Teacher, a Study in the Pre-Registration Nurse Education Programme In Wales Part 2. *Journal of Advanced Nursing.* 23 (6), pp. 1080-1088.

Phillips, N., Duke, M. (2001). The Questioning Skills of Clinical Teachers and Preceptors: A Comparative Study. *Journal of Advanced Nursing*. 33 (4), pp. 523-529.

Phillips, T., Schostak, J., Tyler, J. (2000). *Practice and Assessment in Nursing and Midwifery: Doing It For Real*. The English National Board for Nursing, Midwifery and Health Visiting, London.

Polit, D.F., Beck, C.T. (2004). *Nursing Research Principles and Methods*. Philadelphia, Lippincott.

Polit-O'Hara, D., Beck, C.T. (2006). *Essentials of Nursing Research*: *Methods, Appraisal and Utilization*. (6th Ed). Philadelphia, Lippincott.

Polit-O'Hara, D., Beck, C.T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. (8th Ed) Philadelphia, Kluwer.

Polit, D.F., Hungler, B. (1995). *Nursing Research: Principles, Process and Issues.* Basingstoke, Macmillan Press.

Polit, D.F., Hungler, B.P. (1999). *Essentials of Nursing Research: Methods, Appraisal and Utilization* (6th Ed). Philadelphia, Lippincott.

Polit, D.F., Hungler, B.P. (2001). *Essentials of Nursing Research.* Philadelphia, Lippincott-Raven.

Polit, D.F., Hungler, B.P. (2008). *Nursing Research: Principles and Methods*. 6th Ed. Philadelphia, Lippincott-Raven.

Pontin, D. (2000). Interviews. In Cormack, D. (Ed) (2000) *The Research Process In Nursing*. Oxford. Blackwell Science.

Porter, S. (1993). Nursing Research Conventions: Objectivity or Obfuscation? *Journal of Advanced Nursing*. 18 (1), pp. 137-143.

Porter, S. (1996). Qualitative Research. In Cormack, D.F.S. (Ed) *The Research Process In Nursing*. Oxford, Blackwell Science.

Porter, S. (2000). *Qualitative Research and Qualitative Analysis*. In: Cormack, D. (Ed) (2000) *The Research Process In Nursing.* Oxford. Blackwell Science.

Pulsford, D., Boit, K., Owen, S. (2002). Are Mentors Ready To Make A Difference? A Survey of Mentors' Attitudes towards Nurse Education. *Nurse Education Today*. 22(6), pp. 439-446.

QAA (2001). *Code of Practice for the Assurance of Academic Quality Standards in Higher Education*: Placement Learning. London, QAA

Research Governance Framework for Health and Community Care (2006). Scottish Executive Health Department. 2nd Ed.

Reed, J. (2005). Using Action Research in Nursing Practice with Older People: Democratizing Knowledge*. Journal of Clinical Nursing.* 14 (5), pp. 594-600.

Rinomhota, A.S. (1998). Staff Attitudes to Clinical Placements. *Nursing Management.* 5 (2), pp.12-13.

Ritchie, J., Lewis, J. (Eds.), (2003). Qualitative Research Practice. London, Sage.

Robinson, M. J. (1992). Mixed Feelings. *Nursing Times.* 88 (40), pp. 28-29.

Robson, C. (1993). *Real World Research: A Resource for Social Scientists and Practitioner Researchers*. London, Blackwell.

Rogers, P., Lawton, C. (1995). Self-Assessment of Project 2000 Supervision. *Nursing Times*. 91 (39), pp. 42-45.

Rolfe, G. (1996). *Closing the Theory Practice Gap; a New Paradigm for Nursing*. London, Butterworth-Heinemann.

Rubin, H.J., Rubin, I.S. (1995). *Qualitative Interviewing: The Art of Hearing Data.* Newbury Park, Sage.

Saarikoski, M., Leino-Kilpi, H. (2002). The Clinical Learning Environment and Supervision by Staff Nurses: Developing the Instrument. *International Journal of Nursing Studies*. 39 (3), pp. 259-267.

Sandelowski, M. (1986). The Problem of Rigor in Qualitative Research *Advances in Nursing Science*. 8 (3), pp. 27-37.

Sandelowski, M., Barroso, J. (2007). *Handbook for Synthesizing Qualitative Research.* New York : Springer Pub. Co.

Scholes, J., Freeman, M., Gray, M., Wallis, B., Robinson, D., Matthews-Smith, G., Miller, C. (2004). *Evaluation of Nurse Education Partnership.* Department Of Health.

Schneider, Z. (2003). Nursing Research; Methods, Critical Appraisal and Utilization. Marrickville, Mosby.

Schneider, Z., **Elliott, D., Lobiondo-Wood, G. (2003).** *Nursing Research Methods, Critical Appraisal and Utilisation.* Sydney, Mosby.

Schneider, J.K., Deenan, A. (2004). Reducing Quantitative Data Errors: Tips For Clinical Researchers. *Applied Nursing Research*. 17 (2), pp.125-129.

Schreiber, R.S., Stern, P. N. (2001). *Using Grounded Theory In Nursing*. New York. Springer Publishing Company.

Schwandt, T.A. (2000). Constructivist, Interpretivist Approaches to Human Inquiry. In Denzin, N. and Lincoln, Y.S. (2000) *Handbook Of Qualitative Research*. Thousand Oaks: Sage Publications.

Seaman, C.H.C. (1987). *Research Methods, Principles, Practice and Theory for Nursing*. Connecticut, Appleton and Lange.

Shields, E. (1995). Reflection and Learning in Student Nurses. *Nurse Education Today*. 15 (6), pp. 452-458.

Silverman, D. (2004). Qualitative Research: Theory, Method and Practice (2nd Ed). London, Sage.

Silverman, D. (2005). Doing Qualitative Research: A Practical Handbook (2nd Ed). London, Sage.

Sim, J. (1998). Collecting And Analysing Qualitative Data: Issues Rose By The Focus Group. *Journal of Advanced Nursing* 28 (2), pp. 345-352.

Simons, L. (2007). Moving From Collision To Integration: Reflecting On The Experience Of Mixed Methods. *Journal of Research in Nursing.* 12:73.

Smith, M.J. (1992). Enhancing Aesthetic Knowledge: A Teaching Strategy. *Advances in Nursing Science*. 14(3), pp. 52-59.

Smith, K.V. (1996). Ethical Decision-Making by Staff Nurses. *Nursing Ethics*. 3 (1), pp. 17-25.

Smith, K., Strauss (1998). Understanding Grounded Theory: Principles and Evaluation. *Nurse Researcher.* 4 (3), pp. 17-30.

Sphinx Survey (2006). Questionnaire Design and Analysis. Lexica Edition.

Spouse, J. (1996). The Effective Mentor: A Role Model for Student-Centred Learning. *Nursing Times* 92 (3), pp. 32-35.
Spouse, J. (1998). Scaffolding Student Learning In Clinical Practice. Nurse Education Today. 18 (4). Pp 259-266.
Spouse, J. (2001). Bridging Theory and Practice in the Supervisory Relationship: A Sociocultural Perspective. *Journal of Advanced Nursing.* 33 (4) Pp.512-522.
SPSS (2007). SPSS Base, User's Guide. Chicago, SPSS.
Stake, R.E. (1994). Case Studies. In Denzin, N.K., Lincoln, Y.S. (Eds) *Handbook of Qualitative Research*. Thousand Oaks, Sage Publications.
Stern, P.N. (1980). Grounded Theory Methodology: Its Uses and Processes. *Image* 12 (1), pp. 20-23.
Stern, P. (1985). Using a Grounded Theory Method in Nursing Research. In Leninger, M. (Ed) *Qualitative Research Methods in Nursing*. Orland's F.L., Grune And Stratton.
Stevens, P., Schade, A., Chalk, B., Sleven, O.D.A. (1993). *Understanding Research.* London, Champion Press.
Stodulski, A.H. (1984). Disseminating Nursing Research Information in the UK. *International Journal of Nursing Studies.* 19 (4), pp. 231-236.
Strauss, A.L. (1987). *Qualitative Analysis for Social Scientists*. Cambridge, Cambridge University Press.
Strauss, A., Corbin, J. (1990). *Basics of Qualitative Research* (1st Edition). London, Sage Publications.
Strauss, A., Corbin, J. (1994). Grounded Theory Methodology. In *Handbook of Qualitative Research in* (Denzin, N.L. & Lincoln, Y.S. Eds). London, Sage Publications.
Strauss, A., Corbin, J. (1998). Basics of Qualitative Research: Techniques *and Procedures for Developing Grounded Theory*, 2nd Ed. Sage, Thousand Oaks, CA.
Streubert, H.J., Carpenter, D. R. (1999). *Qualitative Research In Nursing: Advancing The Humanistic Imperative* 2nd Edn. Philadelphia: Lippincott.
Talbot, L. (1995). *Principles and Practice of Nursing Research*. St Louis, Mosby.
Tarling, M., Crofts, L. (2002). *The Essential Researcher's Handbook for Nurses and Health Care Professionals.* Edinburgh: Bailliere Tindall.
Tesch, R. (1990). *Qualitative Research; Analysis Types and Software* Tools. Basingstoke. The Falmer Press.
Tingle, A., Marsland, L. (2001). The Importance Of Pilot Work To Ensure Questions Have Meaning To Participants. *Nursing Times Research.* 6 (4), pp. 759-769.

Topping, A. (2006). The Quantitative – Qualitative Continuum. In Gerrish, K. Lacey, A. *The Research Process in Nursing.* 5th Edition. Oxford. Blackwell Publishing.

Turner, P., Doyle, C., Hunt, L. (2003). Integrating Practice into Theory in the New Nursing Curriculum. *Nurse Education in Practice*. 3 (4), pp. 228-235.

Turner, P. (2001). Peach, Practice Placements and Partnership; an Initiative to Support Clinical Placements in Nursing Curriculum. *Journal of Nursing Management.* 9 (6), pp. 325-329.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) Code of Professional Conduct. London, UKCC

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999). Fitness for Practice. London, UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2000). Advisory Standards for Mentors and Mentorship**.** London UKCC.

United States Government Printing Office (1949). *Trials of War Criminals Before the Nuremberg Military Tribunals Order Control Council Law*. Washington DC, US Government Printing Office.

Van Eps, M. A., Cooke, M., Creedy, D. K., & Walker, R. (2006). Student Evaluations of a Year- Long Mentorship Program: A Quality Improvement Initiative. *Nurse Education Today*, 26 Pp. 519-524.

Veitch, L., May, N., McIntosh, J. (1997). The Practice Based Context of Educational Innovation. Nurses and Midwives Preparation in Scotland. *Journal of Advanced Nursing.* 25, pp. 191-198.

Verpeet, E., De Casterle, B.D., Van Der Arend, A., Gastmans, CAE. (2005). Nurses' Views on Ethical Codes: A Focus Group Study. *Journal of Advanced Nursing*. 51 (2), pp. 188-195.

Wainwright, S. (1994). Analysing Data Using Grounded Theory. *Nurse Researcher*. 1 (3), pp. 43-49.

Walsh, P., Jones, K. (2005). An Exploration of Tripartite Collaboration in Developing a Strategic Approach to the Facilitation of Practice Learning. *Nurse Education in Practice.* 5, pp. 49-52.

Watkins, M. (2000). Competency for Nursing Practice. *Journal of Clinical Nursing*. 9 (3), pp. 338-346.

Watson, N.A. (1999). Mentoring Today – The Student's Views. An Investigative Case Study of Pre-Registration Nursing Students' Experiences and Perceptions of Mentoring in One Theory/Practice Module of the Common Foundation Programme on a Project 2000 Course. *Journal of Advanced Nursing.* 29 (1), pp. 254-262.

Watson, S. (2000). The Support that Mentors Receives in the Clinical Setting. *Nurse Education Today.* 20 (7), pp. 585-592.

Watson, S. (2004). Mentor Preparation: Reasons for Understanding the Courses and Expectations of the Candidates. *Nurse Education Today*. 24, pp. 30-40.

Webb, C. (1992). What Is Nursing? *British Journal of Nursing.* 1 (11), pp. 567-568.

Wellard, S., McKenna, L. (2001). Turning Tapes into Text: Issues Surrounding the Transcription of Interviews. *Contemporary Nurse.* 11(2/3), pp. 180-186.

White, E., Riley, E., Davies, Twinn, S. (1993). *A Detailed Study Of The Relationship Between Teaching, Support, Supervision And Role Modelling In The Clinical Areas Within The Context Of Project 2000 Courses*. English National Board for Nursing, Midwifery and Health Visiting.

Wilkins, A.M., Ellis, G. (2004). Enhancing Learning Environments by Maximising Support to Mentors. *Nursing Times.* 10 (26), pp. 36-38.

Wilkinson, S. (1998). Focus Groups in Health Research: Exploring the Meanings of Health and Illness. *Journal of Health Psychology* 3 (3), pp. 329-348.

Williams, A. (1997). Pitfalls on the Road to Ethical Approval. *Nurse Researcher* 5 (1), pp. 15-22.

Williamson, G.R. (2001) Does Nursing Need an Ethical Code for Research. *Nursing Times Research.* 4 (4), pp. 785-789.

Williamson G.R., Webb, C. (2001). Supporting Students in Practice. *Journal of Clinical Nursing*. 10, pp. 284–292.

Wilson, H.S., Hutchinson, S.A. (1996). Methodological Mistakes in Grounded Theory*. Nursing Research*. 45 (2), pp. 122-124.

Wills, M. (1997) Link Teacher Behaviours: Student Nurses' Perceptions. *Nurse Education Today*. 17(3), pp. 232-246.

Wilson-Barnett, J., Butterworth, T., White, E., Twinn, S., Davies, S., Riley, L. (1995). Clinical Support and the Project 2000 Nursing Student: Factors Influencing the Process. *Journal of Advanced Nursing.* 21 (1), pp.152-1158.

Wimpenny, P. Gass, J. (2000). Interviewing In Phenomenology and Grounded Theory: Is There a Difference? *Journal of Advanced Nursing*. 31 (6), pp. 1485-1492.

World Medical Association (1964). World Medical Association Declaration of Helsinki: Ethical Principles of Medical Research Involving Human Subjects.

Yassin, T. (1994). Exacerbation of a Perennial Problem. The Theory Practice Gap and Changes in Nurse Education. *Professional Nurse*. 10 (3), pp. 183-187.