An Examination of Block and Integrated Practice Learning Models within Employer Sponsored Pre-Registration Nursing Programmes

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Abstract

United Kingdom [UK] pre-registration nursing programmes [PRNPs] allocate half their curriculum learning hours to practice-based education which predominantly involves supervised workplace experience based on a block and/or integrated practicum model. Nevertheless, remarkably little robust research investigates the relative effectiveness and strengths/shortcomings of these models.

This mixed-methods study examines block and integrated placements within employer-sponsored BSc (Hons) PRNPs provided by a UK-based distance learning university. Beliefs/experiences of the two practicum designs shared by 37 respondents from four stakeholder groups were acquired via semi-structured interviews. Quantitative analysis involving a sample of 460 nursing students was also undertaken to ascertain whether exclusive exposure to one placement type affected withdrawal/achievement rates.

The research question for this investigation was: '*What effect does a sponsor's decision to adopt an integrated or block model of practice learning for those PRNP students whom they employ as non-registrant carers have on the student learning experience and retention/achievement?'.*

Qualitative content analysis of the interviews yielded five common themes. Most importantly, respondents perceived the block model as more effective in promoting affinity, facilitating role transition, and mitigating against perceived difference, although the integrated framework was deemed preferable for services releasing students from their non-registrant carer work. Based on these results, critical situational factors requiring consideration when selecting the most appropriate practicum model are identified.

Subsequent crosstabulation and multinomial logistic regression analyses failed to demonstrate any statistically significant relationship between placement structure and student retention/degree classification. Finally, qualitative study data were re-analysed against the theory of human relatedness [THR]. It is argued that stakeholders may form their view of specific placement models by implicitly evaluating them against criteria akin to the key THR propositions. Improving practicum experiences might, therefore, also necessitate revising learning environment audit tools, challenging stakeholder practicum

design prejudices and changing emphasis within PRNP curricula to better address these propositions.

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A glossary of nursing and nurse education terms

Adult Nursing: A branch of nursing addressing the needs of adults with physical health problems.

American Association of Colleges of Nursing [AACN]: An organisation based in the United States of America which seeks to establish quality standards for nurse education, assists schools of nursing to implement such standards, aims to improve nursing care, and supports nursing research and practice.

Assistant Practitioner [AP]: An NRC with a higher level of assessed clinical knowledge and skill who holds a qualification at Regulated Qualifications Framework Level 5.

Block placement: A traditional practicum model which involves exclusive placement periods within a PRNP, commonly lasting several weeks or months. It is also referred to as a *consecutive*, *contiguous*, *daily*, *full-time*, *intensive*, *inter-semester*, or *uninterrupted* practicum design.

Childrens' Nursing: A branch of nursing addressing the needs of children and young people with physical health problems.

College of Registered Nurses of British Columbia [CRNBC]: The regulatory body for nurses in British Columbia, Canada.

Employer Sponsor: An employer of an NRC who provides an opportunity for this individual to become a nursing student, and ultimately an RN, by providing financial and logistical support in respect of their studies.

Enrolled Nurse [EN]: A second tier of qualified nurse within the healthcare workforce of several nations. Known as a *Licensed Practical Nurse* [LPN] in Canada. EN training was phased out in the United Kingdom [UK] in 1992.

Failing to Fail: A phenomenon describing mentors who avoid failing nursing students even when these learners have not met the required level of proficiency in their practicum.

Future Nurse: An initiative by the NMC to update and future-proof UK PRNP education. Led to the implementation of new educational standards in 2018.

General Nursing Council [GNC]: The first regulatory body for nursing in the UK, which was established in 1919.

Higher Apprenticeship Nursing Associate [HANA]: An apprenticeship-based programme in England leading to a second-tier qualification and entry to the NA part of the NMC register.

Integrated placement: A practicum model, lasting several months or longer, in which nursing students have academic and practice learning in the same week; commonly spending several days in placement and the rest of their weekly programme time in academic study. It is also known as a *blended*, *concurrent*, *continuous*, *day release*, *distributed*, *divided*, *integrative*, *interspersed*, *intra-semester*, *non-block*, *non-consecutive*, *non-intensive*, *parallel*, *part-time*, *protracted*, *simultaneous*, *split*, or *weekly* practicum design.

Internship: A practicum model used to complement a block and/or integrated placement model, or to follow a nursing programme which has only limited practice learning. It commonly consists of a placement, lasting up to a year, which occurs either towards the very end of, or after, the programme and in such cases is normally a prerequisite for nursing students seeking registration with a regulatory nursing body. It is also referred to as a *nurse residency*.

Learning Disabilities Nursing: A branch of nursing addressing the needs of adults, children, and young people with intellectual impairments and learning disabilities.

Learning Environment Audit [LEA]: A tool used by a PRNP provider which assesses the suitability of a clinical service to effectively accommodate and support nursing students.

Mental Health Nursing: A branch of nursing addressing the needs of adults, children, and young people with mental health problems.

Mentor: An RN who is formally responsible for supporting a nursing student in a practicum. Also interchangeably known in different nations as *facilitators*, *instructors*, *practice assessors*, *preceptors,* and *supervisors*.

Newly Qualified Nurse [NQN]: An RN who has been qualified and practising for less than 12 months.

Non-Registrant Carer [NRC]: A generic term to describe all staff delivering nursing care who do not hold a qualification on the register of a nursing regulatory body. NRC titles include *Assistant Practitioner* [AP], *Healthcare Support Worker* [HCSW], *Healthcare*

Assistant [HCA], *Nursing Aide*, *Nursing Assistant*, *Nursing Auxiliary*, or *Support Worker*.

Nurse Educator: An academic involved in the education of nursing students. Also known as a *Nurse Tutor.*

Nursing and Midwifery Council [NMC]: The current UK regulatory body for nursing, which replaced the UKCC in 2002.

Nursing Associate [NA]: A second tier of nursing practitioner who, upon successful completion of a programme recognised by the NMC, can seek entry to a separate section of the nursing register. First recognised by the NMC in 2018.

Nursing Degree Apprenticeship [NDA]: An apprenticeship-based programme in England leading to qualification as an RN and permitting entry to the NMC register.

Nursing Student: A learner commonly on an undergraduate programme leading to qualification as an RN.

Objective Structured Clinical Examination [OSCE]: A test of clinical nursing knowledge and skills, sometimes used in PRNPs, and normally to identify whether an individual meets an expected minimum standard of proficiency.

Post-Registration Nursing Programme: A nursing programme which only existing RNs are entitled to study.

Practice learning: A term describing all nursing education that occurs in a healthcare environment.

Practice Tutor [PT]: A nurse educator who specifically supports nursing students and their mentors during a practicum.

Practicum: A period of supervised and supported clinical learning for a nursing student which is undertaken in a real workplace setting for the purpose of acquiring and developing practice-related knowledge and skills. Also interchangeably known as *fieldwork education*, *placement*, *practice education*, *practice experience*, *practice teaching and learning*, or *rotation*.

Pre-Registration Nursing Programme [PRNP]: A nursing programme leading to qualification as an RN and entitlement to join the register of a regulatory body.

Project 2000: The first set of PRNPs in the UK which, upon successful completion, enabled nursing students to gain registration as an RN and a Diploma in Higher Education.

Registered Nurse [RN]: A qualified nurse entitled to join the register of a nursing regulatory body and practice in this capacity.

Registered Undergraduate Student of Nursing [RUSON]: An Australian initiative in which second year nursing students are offered paid health service employment concurrent to their PRNP studies, under RN supervision.

Regulatory body: An organisation with whom an individual must be registered in order to practise legally as an RN within a specified geographical location.

Royal College of Nursing [RCN]: A professional body and trades union in the UK offering membership to nursing staff.

RCN Institute for Advanced Nursing Education [RCNI]: A former arm of the RCN which offered post-registration nursing programmes. These programmes were transferred to The Open University in 2007.

Temporary Undergraduate Nursing Students [TUNS]: An initiative in Hong Kong which enables nursing students who have completed at least one year of their current PRNP to undertake part-time salaried work as NRCs under RN supervision during weekends and holidays.

Theory Practice Gap: The disjunct between best practice, as identified by nursing research, and the actual practice of many nurses which, it is argued. is founded instead upon a set of shared common-sense understandings.

Undergraduate Nurse Employment Demonstration Project [UNDP]: A Canadian initiative in which third and fourth year nursing students are offered the opportunity for salaried employment at their educational level under the guidance of a nurse who is supernumerary to regular service staffing.

UNISON: A trades union in the UK offering membership to nursing and other healthcare staff.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC]: The UK regulatory body for nursing which replaced the GNC in 1979 and was itself replaced by the NMC in 2002.

Chapter 1. Thesis introduction

In 2016, after six years undertaking more senior management roles for the Faculty of Health & Social Care [now part of the Faculty of Wellbeing, Education & Language Studies], I returned to my substantive post as a Staff Tutor/Senior Lecturer in The Open University [OU] serving the communities of northeast England and Cumbria. Whilst I had been working away in various parts of the UK, my academic colleagues in this locality had helped secure an important Health Education England [HEE] contract to provide both adult and mental health employer sponsored pre-registration nursing programmes [PRNPs] to National Health Service [NHS] Trusts in the region. The programmes were, and continue to be, designed to upskill existing staff who are currently working in non-registrant nursing roles and who may neither possess the entry qualifications commonly required by most UK universities for such programmes, nor be able to bear the costs of engaging in conventional full-time undergraduate study, commonly as mature learners. Hence, this PRNP provision contributes to fulfilling The OU's mission to make higher education accessible to the widest possible audience (The OU 2022a).

Meeting the requirements of the new HEE contract necessitated a concerted effort from all regional staff in the faculty and although I had not previously held any role in The OU nursing programmes [my post was based in the health and social care department, rather than the nursing department], as a mental health nurse and nurse tutor who had maintained his registration with the Nursing & Midwifery Council [NMC], on resuming my local duties I was immediately asked to contribute to their planning and delivery. Becoming acquainted with the operational management, systems, and structures of these PRNPs was a steep learning curve. Nevertheless, I was soon involved in promoting them to NHS and independent sector healthcare organisations.

During a meeting with local employer representatives held only a few weeks after I returned to work in the region, my developing knowledge of The OU PRNPs was put to the test. Having provided an overview of the curricula to this audience, I explained that students on these programmes could undertake their mandatory 2,300 hours of supernumerary practice learning required by the NMC in either block or integrated

placements, depending on employer preference, and explained the difference between the models. After this brief presentation, I was asked by one attendee what initially seemed a simple question, namely *'which works best, a block or integrated practicum?'* To my slight embarrassment, I was unable to answer this question at the time, but I reassured the manager asking it that I would investigate what studies had been undertaken in respect of this matter and provide clarification in due course.

A subsequent search of The OU's nursing research and scholarship archives, however, found nothing which directly addressed the topic and repeated literature searches with increasingly wide parameters still failed to produce any significant body of applicable material. Indeed, it was not until I had called upon the help of a literature search specialist in the Library & Archives Service of the Royal College of Nursing and my searches applied worldwide parameters for English language publications across all health and social care disciplines without any date restrictions that I began to acquire a very modest collection of broadly relevant literature. Even then, none of the identified reports examined the use and value of block and integrated placement models in the context of employer sponsored pre-registration health or social care education programmes.

Several weeks after the meeting with regional employer representatives I concluded that, if it was genuinely the case no studies had been undertaken to address this specific topic, then perhaps I had an academic obligation to try and help rectify the situation. In my OU role, I therefore commenced an investigation with the research question *'what effect does a sponsor's decision to adopt an integrated or block model of practice learning for those pre-registration nursing programme students whom they employ as non-registrant carers have on the student learning experience and retention/achievement?'* The following year this work became the research component of my part-time *Doctorate of Education* with Newcastle University and so the focus of this thesis. The investigation involved collecting data from members of four key stakeholder groups, namely OU nursing students, employer sponsors, registered nurses providing student mentorship in clinical settings, and university practice tutors [several of whom I line managed]. It was therefore necessary to carefully consider both power asymmetry and ways to mitigate this imbalance [see Chapter 8].

I believe I may now finally be getting close to providing a considered and fulsome answer to the original 'simple' question that the employer representative posed during that meeting back in 2016. I never envisaged that arriving at this position would take anywhere near as long. Nonetheless, the investigative process associated with addressing it has immeasurably enhanced my understanding of practice learning experiences, generated multiple academic development opportunities and in so doing allowed me to contribute to a seriously under-researched field of nurse education. I can only thank this manager for asking the original question and apologise to her for my extremely tardy response.

With the exception of the introduction and conclusion [which both include elements of personal reflection], the content of this thesis refers to me, the researcher, in the third person. It should be stressed that this literary style is not used to imply objectivity, since the critical realist philosophy which underpins this investigation dismisses any notion that a researcher is capable of perceiving and describing phenomena objectively [see Chapter 2]. Instead, it is adopted to promote a focus on the content of the writing, rather than the writer (Federation University, 2020; University of Arizona, 2023), and to facilitate the presentation of information *'without getting mixed up in the linguistic nuances of what the writer is explaining, what the reader knows, or what the research is saying'* (La Framboise, 2022, p.1). This strategy also aligns with guidance that use of the first person should normally be restricted to those circumstances when an individual is writing reflectively (University of Hull, 2023) and that, depending on the purpose of a specific document, it may be appropriate to use both the first and third person in different sections (Massey University, 2010).

Chapter 2. A critical realist approach to the study, the research question, and literature search

2.1 Introduction

According to Wainwright (1997, p.1263)*, 'ontology is what exists, epistemology is how we can come to know about it and methodology is the means of acquiring this knowledge.'* Since pre-registration nurse education relocated to the higher education [HE] sector in the United Kingdom [UK], there has inevitably been dramatic growth in research activity (Royal College of Nursing [RCN], 2003) and '*nursing researchers are faced with a smorgasbord of competing methodologies'* (Corry et al., 2018, p.1). To determine whether a philosophical orientation can suitably address a research question, investigators must show they understand it (Dieronitou, 2014; Schiller, 2016) and be able to articulate and justify its use (Scott, 2007).

Because critical realism guided the design and implementation of this study, it is appropriate to detail the origins and key assumptions of this approach, its broad relevance to research within both nursing and nurse education and its specific value as a philosophical basis for this investigation. This chapter therefore seeks to present a critical realist view of the world and describe its associated approach to research before highlighting the appeal of this philosophy to nurse researchers and finally explaining why and how it underpins this study.

2.2 Locating critical realism

Philosophers identify several distinct forms of realism; most notably *historical realism*, *direct realism* [also termed *naïve* or *scientific* realism] and *critical realism*. A researcher adopting an historical realist approach believes *'reality exists outside the mind, but is historically constructed'* (Elshafie, 2013, p.9), the veracity of knowledge is determined by *'its correspondence with the independent reality of the past'* and knowledge of this historical past needs to recognise linguistic and cultural evolution in the same way scientists studying the natural world must consider evolutionary processes (Waites, 2011, p.327). In contrast, direct realism suggests that sensory experiences provide an accurate representation of reality and, therefore, a valid data source; whilst a critical realist

researcher believes such experiences are subjectively mediated and individual accounts cannot necessarily be relied upon to accurately reflect reality, so there is also a need to consider what underlying systems and relationships may affect observed phenomena (Harper, 2011; Saunders & Tosey, 2013). Acknowledging potential unconscious bias within both the accounts and interpretation of human experience [including those of an investigator] may help encourage researchers undertaking a critical realist study, such as this one, to consider ways to mitigate the adverse effect of such partiality. In this instance, various strategies were employed with this goal in mind [see Chapters 8, 9, 10, 11, 18].

Also known as *neomodernism* (Parpio et al., 2013; Reed, 2006), *transcendental*, or *complex realism* (Clark, 2008), critical realism was proposed by British philosophers Roy Bhaskar & Rom Harré in the late twentieth century (Bhaskar, 2008) and primarily developed in the social and health sciences (Clark, 2008). Today, many research studies are founded upon this philosophy (Miller & Tsang, 2010; Ryan, 2018). Critical realist ontology seeks to provide an alternative way to study the social world (Banifatemeh et al., 2018), navigating a course between the ontological extremes of *positivism* and *constructivism* and in so doing challenging these dominant philosophical paradigms (Moore, 2013; Oliver, 2012).

Critical realism has been described as *'a significant meta-theory for the social sciences'* (Hoddy, 2019, p.111) and '*the most appropriate meta-theory to underpin the use of empirical research methods'* (Scott, 2005, p.633). Moreover, it is '*a global movement that transcends disciplines'* (Williams et al., 2016, p.10) and is one that has led to the development of philosophical variants such as s*ocial realism*, now employed in some sociological investigations (Moore, 2013). Over a decade ago, Maxwell (2011, p.15) suggested '*critical realism has been largely unnoticed by most qualitative researchers*.' More recently, however, the critical realist approach has been described as *'steadily gathering support for its unique ways of categorizing, highlighting and interpreting phenomena'* (Schiller, 2016, p.100) and being of great value in nursing and wider healthcare research (Bakhshi et al., 2015; Terry, 2013); perhaps due in part to '*its usefulness and philosophical fortitude'* (Parpio et al., 2013, p.491).

In common with positivism, critical realism offers a common ontology/epistemology for the natural and social sciences (Bergin et al., 2008), recognises the existence of a world independent of a researcher's knowledge of it (McGhee & Grant, 2017; Scotland, 2012)

and regards scientific investigation as providing the most secure source of knowledge (Hammersley, 2002). Unlike positivism, however, it asserts '*the real world operates as a multi-dimensional open system'* (McEvoy & Richards, 2006, p.69) and is '*composed not only of events, states of affairs, experiences, impressions, and discourses but also underlying structures, powers, and tendencies'* (Patomaki & Wight, 2000, p.223), much of which cannot be observed (Angus et al., 2006). Critical realism proposes two dimensions of knowledge; the *intransitive, 'a reality independent of what we think of it'*, and the *transitive*, or *'our thinking of it'* (Wikgren, 2005, p.14). Since it is considered impossible to apprehend reality (McEvoy & Richards, 2006), *'ontology does not depend on epistemology'* (Øgland, 2017, p.6) and science must rely on socially produced theories to enhance understanding of this intransitive dimension (Bergin et al., 2008).

2.3 Central critical realist assumptions

According to critical realism, *'there is not, even in principle, a "God's eye view" that is independent of any particular perspective'* (Maxwell, 2011, p.15). Since *'all human beings gather and understand information through a worldview which includes histories, prospects, narratives, mental models and cultural norms'* (McGhee & Grant, 2017, p.848), it is considered impossible for social science research to ever be neutral and wholly objective. Critical realists assert that *'data do not speak for themselves, that some person is using an interpretive framework to organise them'* and so *'the known will never be more than an increasingly accurate approximation of reality'* (Sprague, 2010, p.85). All knowledge, irrespective of the way it has been acquired, is therefore deemed potentially fallible and so should be examined critically (Bisman, 2010; Miller & Tsang, 2010). Furthermore, by explicitly rejecting epistemological neutrality and striving for enhanced reflexivity, philosophical approaches such as critical realism may demonstrate more robust objectivity than is achieved by adopting positivist research principles (Edwards, 2014; Sweetmore, 2021). Efforts to promote reflexivity and bracketing within this study are detailed later in the thesis [see Chapter 18].

Bhaskar claims reality is differentiated and stratified within three levels. The *empirical* level includes experienced/observed events, the *actual* level describes all events which occur irrespective of whether we experience them, whilst the *causal*, or *real*, level addresses powers, structures and mechanisms which generate events but may not be empirically

measurable (Houston, 2001; Moore, 2013). According to critical realism, observed phenomena do not always reveal the mechanisms causing them (Wainwright, 1997) and may even inhibit a fulsome and accurate understanding of social reality (Banifatemeh et al., 2018). Critical realist research aims to understand potential causal mechanisms or structures leading to observed phenomena (Oltmann & Boughey, 2012; Wand et al., 2010) and, like positivism, establish generalisations but these are based on probabilistic rather than absolute truth (Bisman, 2010). From a critical realist perspective, behaviour is influenced but not controlled by social structures, hence the interplay between agency and structure are central to understanding social reality (Oliver, 2012).

Mingers & Standing (2017) argue that within the organizational world events do not happen by chance but for reasons, so it is incumbent upon researchers to try and explain why these events occur. To establish causative generalisations, critical realist investigators identify and document '*harmonious patterns and themes, and the consistent correspondence, or lack of correspondence, of these themes with underlying theories'* (Bisman, 2010, p.11). Such activity should ultimately enable them to conceptualize potential causative links between the contexts, generative mechanisms, and the outcomes of interest (Mukumbang et al., 2020).

2.4 Data analysis and critical realist goals

Data are normally analysed via two complementary processes known as *abduction* and *retroduction* (Meyer & Lunnay, 2013). Abduction is '*a form of inference that uses emerging empirical observations to generate a hypothesis that will account for those observations*', although critical realists recognise such inferences do not prove a cause-effect relationship (Schiller, 2016, p.92). Retroduction involves researchers seeking to establish the most probable explanation to account for their findings (Clegg, 2001; O'Mahoney & Vincent, 2014) by drawing upon understanding derived from theoretical analysis, since it is this form of knowledge which allows them to question, clarify and challenge the prerequisites or conditions of potential underlying mechanisms or processes which may cause observed phenomena (Reed, 2009; Meyer & Lunnay, 2013). Such processes allow '*theorising to go beyond what is immediately knowable but maintains an obligation to test that theorising in the crucible of real-world experience and against competing theories'* (Oliver, 2012, p.375).

For critical realists, the goal of research is not to formulate universal laws but develop existing levels of explanation and understanding (McEvoy & Richards, 2006). The methodology of critical realism involves the construction of theory but does so by offering insights into causal mechanisms (Frecknall-Hughes, 2016), testing explanations of underlying structures/mechanisms, capturing observable relationships between variables, and establishing *'empirical evidence regarding intervening and countervailing mechanisms'* (Miller & Tsang, 2010, p.145). Indeed, causal explanation is considered much more important than description (Wilson & McCormack, 2006). In short, the key focus of any investigation founded upon critical realism is to identify how certain causal mechanisms operating in particular circumstances create specific changes (McCormack et al., 2007).

Critical realism also suggests there are logical criteria against which some theories can be deemed better than others (Wikgren, 2005) and *'the best explanations are those that are identified as having the greatest explanatory power'* (Parpio et al., 2013, p.491). Such explanatory power is largely determined by the robustness of the processes used to produce new knowledge (Moore, 2013). More controversially, based upon explicit evidence and a clear rationale, critical realist researchers not only take a position within a debate (Edgley et al., 2016) but may also make value judgements about the way things should be (Corry et al., 2018; O'Mahoney & Vincent, 2014).

2.5 A realist synthesis

A critical realist literature review, also termed a *realist synthesis* (Wong et al., 2013), should be evaluative rather than simply descriptive (Hastings, 2021) and strive '*to enable the identification of the key contextual characteristics and mechanisms'* associated with the topic under investigation (Harris et al., 2022, p.7). It should also seek '*to determine the extent to which previous research has contributed to the critical realist goals of description and explanation'* (Ranyard, 2014, p.5). The author is expected to present a case which leads the reader through their arguments based on the supporting literature (Edgley et al., 2016) and thereby readily facilitates third-party evaluation of their assertions and conclusions.

A traditional systematic review, which is based on positivist philosophy, emphasises the number of 'quality' studies that support or challenge a hypothesis and prioritises

randomised controlled trials (Greenhalgh et al., 2018). It commonly addresses '*very narrowly focused questions that rarely reflect the complexity of the context in which interventions are operationalized*' (McCormack et al., 2007, p.7). In contrast, a critical realist review is more flexible; aiming to present a coherent argument through the identification and organisation of ideas, theories, and logic (Armstrong, 2018; Jones & Gatrell, 2014) as well as highlighting areas worthy of further investigation (O'Mahoney & Vincent, 2014). This is because its fundamental purpose is not to provide answers but to stimulate further questions (Edgley et al., 2016). A realist synthesis involves '*an inherently iterative, non-linear approach'* often requiring multiple literature searches (Harris et al., 2022, p.7) and '*adopts an open-door policy on evidence',* drawing in, and on, '*studies using any of a wide range of research and evaluation approaches'* (Pawson et al., 2004, p.40). *'In order to produce research consistent with its ontological and epistemological assumptions'*, studies based on critical realism '*often find it necessary to review and integrate a large body of abstract philosophical literature*' (Wynn & Williams, 2012, p.788).

2.6 Data collection

Within a critical realist study, data collection methods should be determined by the nature of the research problem (McEvoy & Richards, 2006), although the investigation should always ultimately provide a *'theoretical description of mechanisms and structures, in order to hypothesize how the observed events can be explained'* (Bygstad & Munkvold, 2011, p.3). Such studies may draw upon a diverse range of expert opinion, as well as quantitative and qualitative evidence to better understand the phenomena being studied (Gray, 2018; Jones-Devitt et al., 2017). Indeed, not only are qualitative and quantitative methodologies considered appropriate but using both approaches may enhance understanding (Miller & Tsang, 2010; Roberts, 2014) and enable triangulation of research findings (Parpio et al., 2013; Williams et al., 2016). Some critical realist researchers, however, are sceptical regarding the use of quantitative methods (Hastings, 2021; Kirby, 2013; Zachariadis et al., 2010), perceiving their role as primarily descriptive *'since quantitative summaries and correlations between variables alone cannot uncover evidence on the causal mechanisms that generate the actual events we observe or predict future incidents'* (Zachariadis et al., 2013, p.862). Furthermore, rather than being linear, such research adopts an iterative

process (O'Mahoney & Vincent, 2014); hence the destination of the research cannot be known until it is reached (Edgley et al., 2016).

2.7 Critical realism and nursing

Positivism commonly regards *'qualitative data as "handmaiden" or "second best" to the quantitative data'* (Hesse-Biber, 2010, p.457); yet in much nursing research the former may be of greater importance than the latter in establishing the intransitive powers, structures and mechanisms which shape human experience. Indeed, a positivist approach has been described as less appropriate for studying the social world (Hammersley, 2001); not least because of its inability to capture many unobservable and non-measurable concepts (Wilson & McCormack, 2006); hence *'many social and healthcare researchers have abandoned it in favour of paradigms that they believe better incorporate the experiences, needs and aspirations of human subjects'* (Corry et al., 2018, p.9). In contrast, critical realism reconciles differences between quantitative and qualitative methodologies (Rolfe, 2006a; Ryan, 2016) and is regarded as superior to positivism within nursing research (Wainwright, 1997).

Modern nursing practice and, by implication nurse education, is *'embedded within complex social situations'* (Williams et al., 2016, p.1). Similarly, clinical placements are widely regarded as complex, multi-dimensional, socio-cultural entities (Bergjan & Hertel, 2013; Dafogianni et al., 2015, Thomas et al., 2015, Tomietto et al., 2014a). Critical realism searches for, and embraces, complexity (Clark et al., 2007) and for nursing researchers is deemed to offer a more comprehensive approach that is '*congruent with their disciplinary perspective as well as with the inter-disciplinary world they inhabit*' (Reed, 2006, p.36); offering a way forward in respect of *'a philosophical debate that has challenged nursing science for centuries'* (Parpio et al., 2013, p.490).

Critical realism supports intensive academic enquiry (Reed, 2009), seeks to provide deep explanations rather than surface descriptions (Saunders & Tosey, 2013; Shajimon & Soon-Chean, 2018) and *'judge the situation under investigation'* (Sayer, 1997, p.484). Investigations founded on critical realist principles also have the ultimate goals of promoting emancipation (Dammak, 2015; Øgland, 2017, Wilson & McCormack, 2006) by providing new knowledge to overcome unjust or oppressive systems, structures, or

behaviours (Reed, 2006; Wise, 2019) and facilitate transformative interventions (Sweetmore, 2021). This philosophy is perhaps best reflected, therefore, in Anton Chekhov's assertion that *'knowledge is of no value unless you put it into practice'* (Leung, 2014, p.1).

2.8 The research question and the rationale for addressing it from a critical realist perspective

The research question for this study is:

What effect does a sponsor's decision to adopt an integrated or block model of practice learning for those pre-registration nursing programme students whom they employ as non-registrant carers have on the student learning experience and retention/achievement?

Drawing upon various psychosocial theories, the pragmatic aim of the investigation is to identify features within both models which may affect student learning and retention/achievement; ultimately to allow future placements to be designed and delivered in a way that recognises these causative factors and best accommodates individual circumstances to promote optimal practice learning conditions. The investigation is therefore located within a complex social and professional context, seeks to establish causative mechanisms which cannot be empirically measured, uses multiple data sources and mixed methods, and has emancipatory aspirations. A critical realist approach therefore appears the most appropriate philosophical foundation for the study.

2.9 Limitations and cautions of adopting a critical realist approach

The eclectic, values-based approach of critical realism has been condemned by positivists as *'advocating subjectivism, irresponsible relativism and lack of standards which work against conducting proper research'* (Patomaki & Wight, 2000, p.213). Bisman (2010), however, identifies various techniques available to reduce bias, termed '*critical multiplism'*, within critical realist research. These include implementing different data collection methods, using multiple sources of data, and underpinning a study with several theoretical perspectives.

Whilst positivism and critical realism share some common ontological/epistemological assumptions, critical realism appears to offer a more appropriate philosophical framework

and related methodology upon which to address many research questions within nursing and nurse education. Nevertheless, it remains important to recognise challenges regarding a critical realist approach, including the lack of detailed guidance on translating this philosophy into applied research methods (Miller & Tsang, 2010; Oliver, 2012), how realistic it may be to identify and separate complex and interwoven generative mechanisms (Reed, 2009) and how to deal with conflicting study data (Rolfe, 2006a). Hammersley (2009, p.7) also argues '*social scientists, whether realists or non-realists, have no distinctive expertise to determine what is good or bad about the situations they seek to describe and explain.'* Arguably, it is therefore of utmost importance that value judgements derived from critical realist research are founded on extensive and varied evidence and robust arguments. In this study, the researcher strived to ensure any emergent value judgements complied with these requirements.

2.10 The literature search and discussion

Congruent with a critical realist approach, the study provides a comprehensive, thematically structured realist synthesis to both contextualise the investigation and examine key issues which may affect the practice learning experiences of Open University [OU] pre-registration nursing students. The first chapter of this realist synthesis outlines the historical, cultural, political, and organisational development of nursing and nurse education. It briefly describes educational changes perceived to have exacerbated the *theory-practice gap*, the creation of Healthcare Assistant and Assistant Practitioner roles [posts which most OU nursing students occupy prior to programme entry], the tensions between the clinical skills set of these staff and nursing students, efforts to address a long-term and worsening shortage of nurses by widening the entry gate to nurse education and providing more flexible modes of study, and the specific problems non-registrant carers may face in a nursing student role. The thesis then concentrates on the distinctive features of OU study, the development, structure, and delivery of its nursing programmes, the atypical student population of these courses, differing views regarding learners undertaking paid work concurrent with pre-registration healthcare education, and efforts in the UK to promote a more diverse discipline.

The review continues by identifying extensive international evidence associated with the wider challenges of being a nursing student, particularly in respect of stress arising from

practice learning experiences and the detrimental behaviour of some clinicians and nurse educators towards such learners. It also identifies additional problems faced by mature students and those on part-time university courses [key issues related to this study, given that OU nursing students are almost exclusively mature learners and have concurrent employment as non-registrant carers] and highlights some practices which may reduce nursing student stress. Research associated with practicum quality and capacity is also examined, including the tensions between universities and placement providers, the features which appear to increase the probability of positive practice learning and those which inhibit such experiences. Worryingly, various studies identify nursing students on placements being ignored, harassed, bullied, criticised in the presence of patients, used as unpaid labour to complete menial tasks, and exposed to discrimination.

Finally, the literature review explores the comparatively modest number of English language studies published internationally which either directly review the implementation of initiatives providing supplementary work experiences for nursing/midwifery students that are similar to the conditions faced by some learners on The OU nursing programmes, or the use of block and integrated practicum models in other courses. In summary, this final chapter of the realist synthesis notes that existing evidence fails to conclusively support either model as the most appropriate design for practice learning. As noted earlier, a realist synthesis often requires multiple searches and draws upon a broad range of literature. The complex and multifactorial nature of the topic examined within this thesis therefore inevitably displays these features.

Literature searches drew upon the library services of Newcastle University, the RCN, and The OU, and utilised databases including *Academic Search Complete*, *BioMed Central*, the British Library *EThOS* resource, *CINAHL with Full Text*, the *Directory of Open Access Journals*, *Emerald Premier*, *Google*, *Google Scholar*, *Internurse*, *OvidSP Journals*, *PubMed*, *Sage Journals Online* and *Taylor & Francis Journals Online*. Regular *Nursing Times* news updates were also examined and alerts regarding published work of potential interest, provided by *Academia.edu* and *Google Scholar*, considered. Additionally, a literature search specialist in the RCN Library & Archives Service sought out publications specifically addressing block and integrated placement models within nurse education.

At various stages of the literature searches, lemmatization, field options and Boolean operators were employed to focus or extend its parameters. Nevertheless, only a limited amount of published material directly relevant to this research was evident. Indeed, no previous work exploring block and integrated practicum designs within employer sponsored pre-registration health or social care education programmes was identified, although a relatively small number of studies with transferable relevance were located, described, and evaluated.

Chapter 3. Realist Synthesis – the development of nurse education and nursing recruitment/retention issues

3.1 Introduction

Nurses have been described as '*the backbone of health service delivery worldwide'* (Kabanga et al., 2018, p.134). In the United Kingdom [UK] most physical and mental health nursing care for adults is provided by two practitioner groups who receive different professional training and hold qualifications located on separate parts of the nurse register. *Adult* [or *general*] nurses primarily offer physical healthcare, whilst *mental health* [or *psychiatric*] nurses largely address an individual's psychological health problems (Nursing & Midwifery Council [NMC], 2010).

The establishment of modern adult nursing is commonly attributed to nineteenth century innovators such as Florence Nightingale and Ethel Bedford-Fenwick who introduced improved standards of discipline, hygiene, and hospital organisation (Lloyd Jones, 2012; Sellman, 2010). In contrast, mental health nursing developed from the *moral treatment* movement of the late eighteenth and early nineteenth century, led by pioneers such as William Tuke and Phillippe Pinel (Nolan, 2022; Norman & Ryrie, 2013). Indeed, training for adult and mental health nursing students was entirely separate until the late twentieth century (Nolan, 2012), although UK nurse education is now based on generic and specialism-specific competences (NMC, 2023b). For many years, nurse education in the UK has also included dedicated pre-registration pathways for learning disability and children and young people nursing (Royal College of Nursing [RCN], 2017a).

The development of distinct nursing disciplines, roles, and recruitment challenges provide important context to this research study and so are examined here. More specifically, this chapter of the thesis highlights numerous tensions within the discipline, such as stereotyping and prejudice associated with different nursing specialisms, contrasting views about an all-graduate profession, concerns that transition of nurse education to the higher education sector has exacerbated the theory-practice gap, mixed views about male nurses, and shortages of registered nurses [RNs]. Clearly, these are all factors which may

potentially impact on nursing student practice learning experiences – the focus of this investigation.

3.2 Eclecticism in nursing and the early development of nurse education

Eclecticism has been defined as '*the fusional synthesis of different philosophies'* and within contemporary nurse education there is significant demand for such fusion based upon a recognition that *'no philosophy is complete in itself and therefore cannot be applied in all situations'* (Venkatesan & Joshi, 2015, p.25). The positivist biomedical model of illness, based on the principles of biological abnormality, diagnosis, treatment and cure has dominated healthcare for over a century (Hemingway, 2016; Nairn, 2012; Wade & Halligan, 2004) and although much adult nursing practice may still be driven by this model (Gould, 2011; Mazzotta, 2016; Szabo Hart et al., 2016), it has also long been argued that nursing is founded upon theoretical eclecticism and holism (Brossett Garner, 2014; Hektor Dunphy, 2015; McEwan & Willis, 2022; Power, 2016). Indeed, Cody (1996) suggests that, in addition to its own, nursing draws upon the theoretical and research knowledge base of eleven other disciplines; namely epidemiology, management science, medicine, nutrition, pathophysiology, pharmacology, physiology, psychiatry, psychology, social psychology and sociology, and that such diversity helps promote innovation within the discipline.

Arguably, eclecticism within nursing may originate from the diverse roots of nurse education and practice within its four main specialist fields. The first institution providing formal nurse education was established by the Lutheran Order of Deaconesses under the direction of Pastor Theodor Fleidner in Kaizerwerth, Germany, in 1836 and, following her experiences of treating soldiers injured during the Crimean War and visiting Kaizerwerth (Hill & Stephens Howlet, 2013), in 1860 Florence Nightingale set up the first UK School of Nursing in London, which continues today as part of Kings College London (Rafferty 2020). This course, based on an apprenticeship model of learning, emphasised the importance of appropriate nurse conduct (Ousey, 2011; RCN, 2017b); a philosophy which continued to shape UK nurse education until the 1990s (Buchan et al., 2008).

Requiring a demonstrable level of applicant maturity, such courses normally only accepted entrants aged 23 years or older (Quin & Kilkenny, 2018). Nightingale's philosophy of nurse education was founded on the nineteenth century social more that individuals should

display *'conformity with the orders of those with purported greater knowledge'* (Sellman, 2010, p.130) and, since physicians were deemed to be the ultimate healthcare experts, the nurse's role was limited to accurately carrying out medical directives, most of which focused on the physical needs of the patient (Hilton, 1997). Since the Nightingale era there has been an ongoing struggle for nursing to acquire professional status (Purssell & McCrae, 2021), although whether this innovator's actions promoted, or inhibited, acquisition of such status remains debatable.

The first UK specialist course for *sick children's* [now known as *paediatric* or *children and young people*] nursing commenced in 1878 (Clarke, 2017) and the first dedicated course to prepare individuals to become *mental deficiency* [later termed *mental subnormality* and known today as *learning disability*] nurses began in 1919 (Blair, 2019). It was developed by the Medico Psychological Association [MPA] (Royal College of Psychiatrists, 2020). The MPA had earlier launched the first dedicated training for *asylum* [then *psychiatric* and now more commonly *mental health*] nurses in 1890 (Brimblecombe, 2006). A rival training scheme provided by the General Nursing Council [GNC] was launched in 1920 and the two programmes ran concurrently until the MPA course was discontinued in 1948 (Nolan, 2012).

3.3 Higher Education and UK professional, statutory, and regulatory bodies

In 1893, the world's first university-based nursing programme was launched within the United States of America [USA] at the School of Medicine, Howard University, Washington DC and the first degree in nursing was provided by the University of Minnesota, USA, in 1909 (Hood, 2014). Nevertheless, it was not until 1926 that the first post-registration higher education [HE] Diploma in Nursing became available in the UK through the University of London (Green, 2003), and it took until 1969 for the University of Manchester to become the first UK academic institution to provide a degree in nursing (University of Manchester, 2012). Indeed, Petit dit Dariel et al (2014) comment that, globally, most nurse education has only gradually transitioned from vocational training into post-secondary or higher education since the middle of the twentieth century.

To date, nursing in the UK has had three professional, statutory, and regulatory bodies. The *Nurses Registration Act 1919* established UK nursing's first regulator, the GNC, which

created and maintained a register of all qualified nurses (Ousey, 2011). Alongside the RN, a second-tier practitioner who trained for two years instead of three, originally known as an *Assistant Nurse* and later an *Enrolled Nurse* [EN], was introduced in 1943 (Shuttleworth, 2018). Following the *Nurses Act 1949*, both men and women were entered on the same general section of the GNC Register (Hargreaves, 2019); although *'whether men are suitable within the profession continues to be a divided issue'* (Christensen & Knight, 2014, p.95) and the World Health Organization [WHO] (2020, p.21) claim *'biased perceptions of women's role in caregiving and social gender norms make recruitment of male students an ongoing challenge.'* In 1979, the GNC was superseded by the UK Central Council for Nursing, Midwifery & Health Visiting [UKCC] (Arton, 1998), which was itself replaced by the Nursing & Midwifery Council [NMC] in 2002 (Ousey, 2011).

UK pre-registration nursing programmes [PRNPs] did not routinely offer an academic and a professional qualification until the implementation of the UKCC *Project 2000* initiative, which '*radically transformed the way student nurses were prepared and educated*' (Fulbrook et al., 2000, p.350). Launched in 1989, Project 2000 resulted in all UK PRNPs becoming university-based and nursing students successfully completing such courses were awarded a Diploma in HE in Nursing Studies alongside an entitlement to join the register (UKCC, 1986). The movement of nurse education from hospital-based schools of nursing into university faculties, however, separated service areas used for practice placements and the academic learning environment, so may have exacerbated the *theory-practice gap* (Aston et al., 2000; Buhat-Mendoza et al., 2014). This concept captures the longstanding and commonly held belief within nursing that there is a continuing disjunct between best practice, as identified by nursing research, and the actual practice of many nurses, which is founded instead upon a set of shared common-sense understandings (Brossett Garner, 2014; Newton et al, 2009a; Oducado et al., 2019) and is one that remains '*the subject of study and debate throughout the global nursing community'* (Booth et al., 2007, p.946).

Project 2000 also introduced a new non-registrant role, originally referred to as a nursing *Aide* and later a *Healthcare Assistant* [HCA] who possessed a competence-based, *National Vocational Qualification* [NVQ] located at level two or three of the *Regulated Qualifications Framework* [RQF], to support the RN (Bach et al., 2005). Furthermore, this model of HE-

based nurse education led to EN training being phased out in 1992 (Seccombe et al., 1997). More recently, however, a *Nursing Associate* role, requiring successful completion of a training programme lasting two years and leading to a level five award on the RQF and entry to a new section of the NMC register, was introduced. This role, '*marketed as bridging the gap between Senior Healthcare Assistants and qualified nursing staff*' (Sprott, 2017), displays clear similarities with the old EN duties and position within the nursing hierarchy (Purssell & McCrae, 2021).

In 2009, the NMC announced that nursing would become an all-graduate profession (RCN, 2017b); hence all UK nursing students successfully completing a PRNP after 2013 would also achieve at least a Batchelors degree in nursing. This development, however, was not unanimously supported. Stacey et al (2016, p.184) comment that '*a significant proportion of the public, other healthcare professions and nursing itself, maintained that degree level study was not required to fulfil the role of the nurse'* and *'those who are academically able are less skilled and less interested in the "basic" aspects in the provision of nursing care'*; an assertion reflected in the pejorative statements *"too posh to wash"* and *"too clever to care".* Harden (1999, p.200) claims downgrading nursing in this way '*has its origins in the Western tradition of valuing the theoretical and abstract over the practical.'*

Following an NMC (2017a, 2017b) consultation process, further changes to the *Standards of Proficiency for Registered Nurses* within the *Future Nurse* initiative (NMC, 2018a) and revised *Standards framework for nursing and midwifery education* (NMC, 2023a), as well as new *Standards for Student Supervision and Assessment* (NMC, 2018b), were introduced. These standards are designed to *'give nurses a greater understanding across all four fields of nursing practice'*, increase '*the emphasis on teamwork and leadership'*, give nurses *'greater responsibilities in the area of public health'* and equip them with *'the skills to train as prescribers immediately after qualifying'* (NMC, 2018c).

3.4 Nursing disciplines and stereotypes

Beyond historical variations in the origins and development of nurse education related to the four main nursing specialisms, there are also well-reported cultural differences affecting the way nurses interact with one another, different professional groups, those receiving care and other stakeholders. RNs working outside the adult nursing discipline are

often not regarded as *real* or *proper* nurses (Harries, 2013; Ramsay, 2015; Shepley, 2016; Vishakha, 2013) and are deemed inferior by colleagues in adult nursing (Sabella & Fay-Hiller, 2014). For example, mental health nurses have been portrayed as lazy; avoiding hard work by chatting to patients (Holland, 2018; Sercu et al., 2015) and performing a role that is primarily custodial (de Carlo, 2007; Freshwater et al., 2014) and founded on little more than common sense (Holmes, 2001). Sabella & Fay-Hiller, (2014) even report overhearing adult nurses saying colleagues in mental health are crazy. Furthermore, Brimblecombe (2006) suggests similar derogatory comments have been made about such practitioners by general hospital trained nurses for over 120 years.

Adult nursing is also subject to negative stereotyping; nurses in this discipline being commonly portrayed as little more than the doctor's helper or handmaiden (Anthony et al., 2019; Gambacorta, 2017; Matziou et al., 2014), treating the care recipient as a diagnosis rather than an individual, being task oriented and obsessed with physical care and aseptic orderliness (McCrae et al., 2014; Pearson et al., 2005). Research by Sercu et al (2015) explored the reasons mental health nurses in two Belgian hospitals gave for entering the specialism. Congruent with these stereotypes, they cited the requirement for adult nurses to unquestioningly comply with the physician's instructions and were concerned such nurses fail to provide personalised care and focus almost exclusively on the disorder rather than the care recipient.

3.5 Nurse shortages, inter-disciplinary education, and incentivisation

Since the early twentieth century, concerns have regularly been expressed regarding a national shortage of qualified nurses; perhaps the first notable instance occurring prior to the start of the Great War in 1914 (Quin & Kilkenny, 2018). More recently, it has been widely recognised that there are significant and worsening shortages of such practitioners in all specialisms within the UK (Coghill, 2018a; Collins, 2019; NHS Improvement, 2019) and one recent national nursing survey found '*a clear picture of unsustainable staffing levels in health and care services*' (Castro-Ayala et al., 2022, p.8). Similar deficiencies have been reported in nations within Africa (Msiska et al., 2014; Roziers & Ramugondo, 2014; Salifu et al., 2022), Asia (Fawaz et al., 2018; Haron et al., 2014; Tang, 2021; Tseng et al., 2013), Australasia (New Zealand Nurses Organisation, 2021; Nisbet et al., 2011), the European Union [EU] (Carlson & Idvall, 2014; Jokelainen et al., 2011; Kukkonen et al., 2016), North

America (Buchan et al., 2018; Shearer & Lasonen, 2018; Stewart, 2022) and beyond (Ambusaidi & Almaskari, 2021; Chuan & Barnett, 2012; Lamont et al., 2015; Wong et al., 2018). Indeed, the WHO (2020) reported there was a global shortage of 5.9 million nurses in 2018.

In 2019, the National Health Service [NHS] had between 40,000 (RCN, 2019) and 43,000 reported nursing vacancies in England alone; meaning 12% of full-time equivalent RN posts were vacant (Mitchell, 2019). By 2020, this figure had increased to 50,000 and *'workforce burnout was described by many as the highest in the history of the NHS'* (House of Commons Health & Social Care Committee [HCHSCC], 2021, p.4). One year later, NHS vacancies in England were reported to have increased by a further 12% (Ford, 2021c). Some NHS Trusts were said to be *'looking to fill nursing roles, including some senior positions, even if the candidate was not qualified as a nurse'* (Campbell, 2021a) and, in the financial year 2021/22, NHS spending on agency nursing staff rose by 20% (Triggle et al., 2022). It was also reported government efforts to recruit 50,000 more nurses by 2024 had so far failed to impact on vacancies (Baines, 2022) and that, even if this goal was achieved, the NHS in England could still face a shortfall of 38,000 nurses by 2023/24 (The Health Foundation, 2022). The Government's workforce planning and development in this field has therefore been rated '*inadequate'* (HCHSCC, 2022).

Data also indicates that between April 2021 and March 2022, more nurses left the NMC professional register than during the same period in the previous two years; stress and poor mental health being the third most common identified reason (NMC, 2022). Nursing shortages in mental health, a discipline which historically recruits higher numbers of mature students (House of Commons Health Committee [HCHC], 2018), are almost 42% higher than for adult nursing (Public Health England, 2017) and therefore particularly troubling. This situation has been largely attributed to mental health practitioners feeling overworked, undervalued and poorly paid (Migration Advisory Committee, 2016; HCHC, 2018; RCN, 2018a) and, more recently, has been exacerbated by the COVID-19 pandemic which has left an estimated 8 million people in England unable to access specialist mental health services (Campbell, 2021b).

Even before the Coronavirus pandemic, which commenced in 2019/20, demand for NHS services had grown so much that for each additional nurse employed by acute NHS trusts

in England since 2013/14, there have been 157 extra hospital admissions (Nursing in Practice, 2019). It is argued that NHS recruitment of nurses from overseas '*will have to be a major contributor if the goals on increasing nurse numbers are to be met*' (Palmer et al., 2021, p.37) but there has been a '*reduction in the number of nurses from the EU wanting to work in the UK following the Brexit referendum'* (Holt et al., 2018, p.57). Worse still, it is forecast that, globally, one in six practising nurses will retire by the year 2030 (WHO, 2020), and without radical action the current deficit of UK nurses could increase to 108,000 by 2029 (The Open University [OU], 2019a).

Understandably, therefore, improving nursing recruitment and retention are now priorities for healthcare services (McLaughlin et al., 2009); not least because failing to effectively address them may inevitably have a detrimental effect on care quality (Flott & Linden, 2016). More recent UK efforts to address the problems have included a government decision to ring-fence another 5,000 places for '*students studying nursing or allied health courses'* and the exemption of mature learners from student number controls (Reid, 2020, p.1). Nevertheless, the NMC (2022, p.3) reported that 48% of practitioners registering in the financial year 2021/22 had trained overseas; 66% in India or the Philippines and acknowledged that the UK was becoming *'more reliant than ever on internationally trained professionals joining our register.'*

Hood et al (2014b, p.97) suggest *'interprofessional education is viewed as necessary for students in disciplines such as medicine, nursing and allied health in preparation for the real world of collaborative practice*.' Their Australian survey of 746 students in six pre-registration healthcare courses found respondents were both enthusiastic about interdisciplinary learning and that such opportunities help them better understand the roles and practices of others. Further work by Hood et al (2014a, p.109) using a satisfaction survey and focus groups involving 23 nursing and medical students to evaluate experiences on an interprofessional learning programme discovered '*ward-based interprofessional clinical placements offer senior students authentic ideal clinical experiences.'* Similarly, research by Higgins et al (2010) identified increased interdisciplinary/multidisciplinary education as one of the top priorities for 129 co-ordinators/directors of mental health learning programmes in the Republic of Ireland.

Nyatanga (1998, p.175), however, argues *'professional ethnocentrism derived from professional identity and socialisation'* is a key barrier to interprofessional education. As a result, there have been calls for interprofessional learning to be *'embedded in educational programmes and their support structures to normalise interprofessional working'* (Williamson et al., 2011a, p.2306) and for all UK PRNPs to be fully integrated (HCHC, 2018, Naylor et al., 2016); thereby providing a generic learning experience equipping nurses to practice in all healthcare fields. Although the Nursing Associate standards of proficiency (NMC, 2018d) and programme standards (NMC, 2018e) do indeed expect these practitioners to care for people of all ages with any health need, the most recent changes to RN education (NMC, 2018a; NMC, 2023a), however, have ignored such calls; instead retaining specialist nursing branches and separate professional qualifications. This restrained response to serious recruitment and retention issues may have been influenced by awareness that introducing a fully integrated PRNP curriculum in Australasia and North America, in which children and young people, learning disability and mental health nursing have become post-graduate specialisms, appears to have greatly increased recruitment problems to fields such as mental health nursing (Hazelton et al., 2011; Molloy et al., 2016; Ng et al., 2010).

From April 2017, revised funding arrangements for PRNP degrees arising from the UK Government's 2015 Comprehensive Spending Review means tuition fees for these courses in England are now borne by the student, rather than the NHS, and so commonly involve funding from the *Student Loans Company* (Council of Deans Health, 2015); leaving such individuals substantially worse off before and after graduation (London Economics, 2016) and having a disproportionately large adverse effect on mature entrants (HCHC, 2018). Some health service providers in England choose to offer employees alternative entry to such programmes as part of a *Nursing Degree Apprenticeship* route, normally funded via an organisation's contribution to the apprenticeship levy (Department of Health & Social Care [DHSC], 2016); since, also from April 2017, all employers with annual salary costs of more than £3 million have had to pay an apprenticeship levy of 0.5% of these costs to Her Majesty's Revenue & Customs (Nielson, 2016). This was part of the Government's wider goal to have three million apprenticeships commence by 2020 (Kellett & Clifton, 2017). Such providers, however, are not permitted to use levy resources to fund staff backfill

(National Health Executive, 2018) and, unlike a traditional nursing degree, are required to set aside 20% of the apprentice's paid employment for off-the-job learning (Department for Education, 2019); meaning that these secondments are still a comparatively expensive training/development commitment for employer sponsors.

Following the implementation of new funding arrangements, applications for entry to PRNP degrees in England during the academic year 2017/18 fell by 19% (Universities & Colleges Admissions Service [UCAS], 2017), compared to a 2.6% reduction in all undergraduate subjects (Buchan et al., 2019) and then by 12% in 2018/19; leading to an overall UK reduction in nursing student numbers of 16,580 in the first two years since the funding regime changed (RCN, 2018b). Similarly, NHS Improvement (2019) report a 31% decrease in applications for nursing and midwifery courses between 2016 and 2018*;* whilst Savage (2019) highlights a slightly higher reduction of 32%. Buchan et al (2019, p.24) therefore argue '*the inescapable conclusion is that the change in funding arrangements in England, combined with the demographic drop in the population of 18-year-olds, has resulted in a decrease in the number of nursing students*.' Furthermore, London Economics (2016) conclude that, given existing NHS workforce shortages, any decline in education commissioning and student numbers will significantly increase future staff shortages.

In 2020, the UK government introduced an annual maintenance grant of £5,000 for all nursing students to help with living costs (DHSC, 2019) but this initiative had no immediate positive effect upon applicant numbers. UK nursing programme applications commencing in the autumn of 2021, however, rose by 32% compared to 2020; returning to a level last achieved in 2016 (UCAS, 2021). Nevertheless, this increase was attributed to individuals being inspired by the work of nurses during the COVID-19 pandemic rather than the new financial changes (Council of Deans Health, 2021) and ultimately generated only a 5% increase in nursing students (Ford, 2021a). This assertion is supported by data which indicated a subsequent 10.5% reduction in applications to UK nursing programmes in 2022 (Ford, 2022) and a further 18.5% reduction in respect of those commencing in 2023 (Ford, 2023). News that the government was to consult on plans to *'lower the student loan repayment threshold to £25,000 and increase the repayment period from 30 to 40 years'* led the RCN (2022a) to highlight that nursing graduates would be amongst those hit hardest by any such change.

The RCN (2021a, 2022a) has continued lobbying the government to meet student tuition fees in full if the discipline is to secure the future number of nurses it requires. Moreover, despite its call for a 12.5% pay-rise for nurses in 2021, the UK government submitted a recommendation to the NHS Pay Review Body for only a 1% increase (Ford, 2021b); an action described as making many nurses feel undervalued and which may cause them to leave the discipline in greater numbers (RCN, 2021b). This recommendation was later raised to 3% (DHSC, 2021) but was still below the rate of inflation (RCN, 2021c). More recently, the DHSC announced a 4% pay increase for NHS nurses in England during the financial year 2022/23, although the RCN argued this award was a pay cut in real terms and would be balloting its members on industrial action (RCN, 2022b). This ballot led to the first UK-wide nursing strike by RCN members in its 106-year history (Triggle, 2022).

3.6 Upskilling non-registrant carers and widening the entry gate to PRNPs

HCAs are a third of the caring workforce in UK hospitals and '*there are over 1.3 million unregistered healthcare assistants and support workers working on the frontline of care'* (Cavendish, 2013, p.14). Their role, however, varies in different organisations and healthcare settings. Additionally, use of in-service training to develop their clinical skills occasionally means these staff have a wider scope of practice in some areas than may be the case for even an experienced nursing student on placement in the same setting. This is particularly true of Assistant Practitioners; non-registrant carers [NRCs] who have undertaken further training to RQF Level 5, normally as part of a Foundation Degree or HE Diploma located outside the NMC's regulatory control. It has been argued prior work experience as an NRC may more effectively prepare an individual for the practice demands imposed upon both nursing students and RNs (Gould et al., 2004; Urwin et al., 2010) and that, given the *'very high drop-out rates on university nursing courses for students entering straight after A-Levels, there is a strong case for improving access to nursing courses for experienced carers'* (Cavendish, 2013, p.58).

Inevitably, experienced NRCs considering entry to PRNPs are often mature learners and it has been argued that many developed nations, such as the UK, are '*increasingly reliant on older women nurse students to maintain the future graduate nursing workforce'* (Andrew et al., 2022, p.1). The precise definition of a mature learner varies but is commonly described as 21 years or older on course commencement (James & Beck, 2016; Reid, 2020).

Research by McVitty & Morris, (2012) found mature students in HE often come from lower socio-economic backgrounds than their younger peers. Butcher (2015) states such learners are often risk-averse and so reluctant to take on a loan to fund their studies. Following HE tuition fee increases in 2012, the HE Funding Council for England [HEFCE] (2013) reported that university acceptances among applicants aged 20 and over fell by 7.1% and that debt aversion was greatest amongst lower income social groups.

In 2021, the median full-time annual salary for a UK employee was £31,772 (Office for National Statistics, 2022) but in 2022/23, an experienced HCA working in the NHS [Band 3] on the maximum salary point received only £21,777 per annum (NHS Employers, 2022). Although the upskilling of NRCs to become qualified nurses might be regarded as a logical method by which to increase the number of RNs, especially given international nursing shortages are likely to severely limit the effectiveness of UK efforts to recruit nurses from other nations, concerns have been expressed that requiring a student to take out a loan in order to study a nursing degree would most discourage older applicants and those from lower socio-economic groups, such as many HCAs, from considering such a career move (Holt et al., 2018). The legitimacy of this concern is perhaps supported by evidence that between 2016 and 2018, the proportion of PRNP applicants in the UK aged 21 to 25 years fell by 13%, whilst applications from those over 25 years fell by 6% (Buchan et al., 2019).

The American Association of Colleges of Nursing (2006, p.4) argue a *'continuous supply of well-educated nurses is critical'* and so '*new strategies for recruiting and retaining bright young men and women from diverse educational and cultural backgrounds into nursing must be developed and tested.'* Similarly, the NMC (2017b, p.5) stress the need for *'an approach to nurse and midwife education that allows education institutions and their practice placement partners to deliver programmes in creative and innovative ways that offers a range of full time and flexible modes of study.'* Fuller et al (2008, p.6) argue barriers to HE participation are commonly classified as *''situational' (e.g. costs, time, geographical accessibility of the provision and factors which are relevant to an individual's circumstances); 'institutional' (e.g. flexibility with regard to mode of attendance, time-tabling, and admissions procedures and requirements); and 'dispositional', relating to individual motivation and attitudes to learning (often reflecting previous educational experiences)''*. Qualitative research exploring barriers to UK university study for older

learners supports the relevance of such categorisation (James & Beck, 2016) and it is argued that for most HCAs, financial, social, and academic constraints make conventional full-time PRNPs inaccessible (Culley, 2004; Gould et al., 2004; The OU, 2019a).

As a result, since the start of the new millennium there have been growing efforts to widen PRNP access (Cavendish, 2013; Mayne, 2007; NHS Improvement, 2019; RCN, 2008a). Secondment by an HCA's employer (Gould et al., 2004), the removal of requirements not stipulated by the NMC from university programme entry criteria (The OU, 2019c) and use of blended learning with online components (NHS Improvement, 2019) may be the most effective means by which to improve such access. Part-time PRNPs are also regarded as an important way to extend the RN workforce (Parish, 2004; Cavendish, 2013). McDaid (2009, p.61), however, comments that students on her part-time PRNP received '*negative remarks from staff about their part-time status'* and some felt '*undervalued by team members.'* Similarly, research by O'Driscoll et al (2009, p.210) found many part-time nursing students '*felt that they had a relatively low status'* and some even considered themselves to be a *'second class citizen'* within the practice setting.

Although there has been only limited research in the field (Draper et al., 2014), several studies suggest HCAs seconded to PRNPs also struggle with transitioning to a nursing student role. Research by Wood (2006, p.37) found this transition '*appeared to be delayed because of the pre-existing views of mentors about the HCAs' level of competency and, to an extent, the student's reluctance to be proactive in the clinical assessment of their knowledge and skills.'* Such reluctance was attributed to the internalised expectation that, as HCAs, they should be passive and compliant. Roberts (2006, pp.44-45) suggested seconded students with less experience than their peers *'lacked self-confidence associated with the amount of time they had spent in practice before starting the programme'*, whilst more experienced respondents felt *'the first year of the programme was largely spent going over what they felt they already knew.'* This researcher therefore concluded that academics may need to change emphasis within the PRNP curriculum for seconded students to ensure they regard the programme as relevant and that it better develops their existing knowledge.

Focus group interviews by Brennan & McSherry (2007) involving 14 nursing students with previous HCA experience found their professional socialisation brought about a significant

culture shock, not least in respect of accountability. Questionnaires completed by 7 former HCAs on a PRNP who subsequently attended a focus group highlighted participants found the transition daunting and believed their roles blurred in placement, adversely affecting their student status (Mayne, 2007). More recent research by Arrowsmith (2016) involving a survey of 297 nursing students who had previously been employed as HCAs discovered that their prior experience did not always effectively equip them for their placements, triggering role change shock. Similarly, Adair (2017) used semi-structured interviews to explore the experiences of six nursing students who had worked as HCAs and found that although all respondents felt the role undertaken in their first PRNP placement was very similar, the knowledge underpinning their practice was different and they struggled with the concept of accountability and delegating duties. The study therefore recommended such learners may need additional support during the first year of their programme to facilitate a smooth transition to a nursing student role.

Comparable experiences have also been reported in other courses designed to upskill nursing staff. In Australia, interviews with 10 students who had previously trained as ENs on a nursing degree programme described their transition to student status as stressful, several commenting that it was ignored in some placements and that staff simply took advantage of their existing expertise (Rapley et al., 2006). More concerningly, research in Canada by Gordon et al (2013, pp.6-7) employing focus groups to explore the experiences of 27 second level Licensed Practical Nurses [LPNs] undertaking a programme leading to an RN qualification found participants felt they *'were not respected, that their nursing knowledge as LPNs was not acknowledged, and that it was challenging for them to feel a sense of belonging with the RN community.'*

3.7 Conclusion

Despite numerous initiatives to promote entry to PRNPs, nurse shortages are a growing concern in both the UK and beyond; particularly in fields such as mental health. Tensions, which may be partly attributable to differences in culture and history, exist between the nursing specialisms, but calls in the UK for PRNPs to produce a generic nurse have largely been ignored; perhaps because the introduction of similar change in some other nations appears to have exacerbated staffing problems in certain clinical areas. Widening PRNP applications by reducing entry qualifications, offering part-time courses, and encouraging

NRCs to upskill have been proposed as ways to increase the RN population. In the UK, the transition to all PRNPs offering at least a bachelor's degree, the reported negative experiences of part-time nursing students, the introduction of new funding arrangements which leave undergraduates substantially worse off, and the reluctance of low-income earners, such as HCAs, to take out student loans, however, have done little to improve recruitment conditions.

As identified earlier in this chapter, various remedial strategies have been proposed to address widespread international problems associated with recruiting PRNP students and then retaining these learners throughout their studies and into practice as qualified nurses. The OU, the academic institution in which this research study is located, is one example of an education provider striving to create a more diverse nursing population. Seeking to do so, however, means their PRNPs do not reflect mainstream provision, hence the next chapter of this thesis details the distinctive features of the university and its nurse education portfolio to locate the investigation more clearly.

Chapter 4. Realist Synthesis - The Open University and its nursing programmes

4.1 Introduction

The employer-sponsored pre-registration nursing programmes [PRNPs] upon which this research is based are atypical provision in terms of their entry requirements, modes of delivery, geographical provision, and student population. This chapter therefore outlines The Open University [OU] mission, its nationwide provision, uncommon selection criteria and the distinctive structure of its nursing programmes to better locate the reflections, views, and experiences of stakeholder participants within this study and explain the application of practice learning models within The OU PRNPs.

4.2 The OU - origins, mission, and educational provision

The OU received its Royal Charter on 23 April 1969 (The OU, 2022a) and its first 24,000 undergraduates were registered in 1971 (The OU, 2022b). It has provided Higher Education [HE] opportunities to more than two million students in 157 countries (The OU, 2020a). With over 205,000 students, it is one of the biggest universities in Europe (The OU 2022a) and the largest in the UK (The OU, 2020a). It continues to be the only UK university dedicated to distance learning and to have a significant presence in all four UK nations (The OU, 2022b). Unlike conventional university programmes, distance education is characterised by the provision of self-instructional teaching materials (Holmberg, 2011; Ranganathan & Rajkumar, 2020).

The OU promotes educational opportunity and social justice by seeking to make high-quality university education available to all, irrespective of an individual's geographical location, previous qualification level, or disability/additional requirements (The OU, 2022b). Indeed, 23% of OU undergraduates reside in the 25% most deprived areas of the UK and 32% of these students have one 'A' Level or a lower qualification before commencing their degree. The university is the largest UK educational provider for those with disabilities (The OU, 2022a) and 76% of OU students are already in employment prior to commencing their learning programme (Kellett & Clifton, 2017). In contrast to the

composition of the student population in most UK universities, the majority of OU undergraduates are mature learners, although the proportion of younger students has been increasing for several decades and 34% are now under 25 years of age (The OU, 2022c).

The University has a longstanding partnership with the British Broadcasting Corporation; co-producing up to 25 television and radio series each year (The OU, 2022d). In addition to its more conventional offer of undergraduate and postgraduate accredited programmes, it also provides free, non-accredited, online courses. Following a start-up donation of $4.45 million from the William & Flora Hewlett Foundation [WFHF] in 2007, The OU launched *OpenLearn* and the platform now offers over 1000 free HE-level courses (The OU, 2022e; WFHF, 2020) which have been accessed by more than 100 million users worldwide (Grimmette, 2022).

4.3 The development, range, and scale of OU nursing programmes

The OU has provided supported and open distance learning courses and study materials related to nursing and other health and social care disciplines for over 30 years (The OU, 2022f). Although the effectiveness of nurse education via distance and online programmes has been questioned (Molzahn et al., 2009; Salisu et al., 2019), demand for learning delivered in these ways is increasing (Fawaz et al., 2018; Maria et al., 2019; McIntyre et al., 2013). Responding to such demand, the university has offered PRNPs in partnership with healthcare employers since 2002. Its model of PRNP provision, however, is atypical within UK nurse education since it can be undertaken part-time over four years [rather than only being available as a full-time course commonly lasting three years] and requires all applicants to be non-registrant carers [NRCs], often Healthcare Assistants [HCAs], who normally hold a vocational qualification [VQ] at Regulated Qualifications Framework [RQF] Level two or three, or Assistant Practitioners [APs] who possess a VQ at RQF Level five. As a result, applicants already have experience in delivering nursing care but must also have the support of their employer to join the programme (The OU, 2019b).

Such experience may greatly facilitate learning, especially during the early stages of the programmes. Evidence suggests *'values, beliefs, and expectations begin to form before students enter academia'* (MacLellan et al., 2011, p.40) and can influence whether nursing

students continue their studies (Tawash et al., 2012). PRNP students may begin their professional education having been exposed to negative images of nursing (Tseng et al., 2013) largely acquired from inaccurate media representations of the discipline (Tawash et al., 2012; van Iresel et al., 2016); hence the earlier work experiences of NRCs entering a nursing programme may mitigate the adverse effect of such images and so lessen the risk of student withdrawal.

Historically, initiatives in the UK which enable and promote concurrent NRC employment for nursing students have been rare and the notion of undertaking such work alongside an undergraduate nursing programme condemned as an additional commitment which may harm academic achievement (Castledine, 2009; Hasson et al., 2013; Rochford et al., 2009). In other nations such as Australia, Canada, Hong Kong, and the United States of America, however, models that provide scope for paid care work concurrent with nurse education as a means to '*better prepare and retain new graduates for actual practice'* (Law & Chan, 2016, p.1) have been designed, implemented, and positively evaluated (Chan, 2014; Gamroth et al., 2006; Law, 2015; Stout et al., 2015). Indeed, Kenny et al (2020, p.202) assert that *'for more than two decades, benefits of nursing students working in healthcare settings while completing their studies have been highlighted.'*

OU learners undertake their PRNP undergraduate studies whilst continuing in their substantive posts so, in addition to the academic and practice learning challenges within all such programmes, must concurrently manage the different expectations associated with their roles as an NRC and nursing student. Employer support is a programme entry condition because of the staff backfill costs associated with supernumerary student practice learning and because the employer must agree to arrange both the stipulated clinical learning opportunities and provide appropriately qualified and experienced mentors [recently re-termed *Practice Assessors*]; registered nurses [RNs] based in these settings to support the student and assess their practice competence. On the conventional OU PRNP degree, academic study is undertaken in the student's own time and their employer need not provide them with any study leave (The OU, 2016). Employers supporting such students within the Nursing Degree Apprenticeship [NDA] framework, however, are required to ring-fence 20% of the apprentice's paid employment for off-the-job [OTJ] learning (Department for Education, 2019).

Over 1,700 NRCs have qualified as RNs via these OU programmes and more than 1,400 nursing students are studying with the university across the UK (The OU, 2019b). To place this latter figure in some context, during 2019 the total number of students accepting a place on a nursing course in England was 23,630 (Maguire, 2021). Congruent with The OU's mission, its nursing programmes help to promote a more diverse nursing student population (Koch et al., 2015) and ensure that staff in the healthcare workforce better *'reflect the communities they care for in terms of factors such as age, ethnicity, and socioeconomic status'* (Holt et al., 2018, p.57).

Such diversity is important given the assertion that nursing has historically been a predominantly female mono-cultural group (Heath, 2002) and imposed implicit entry barriers for individuals from different social classes or ethnic minority backgrounds (Clayton-Hathway et al., 2020). Although 91% of UK universities require three 'A' levels at grade 'C' or higher [or equivalent qualification] to enter their PRNPs, the Nursing & Midwifery Council [NMC], the profession's regulatory body, only require entrants to possess the equivalent of RQF Level 2 mathematics and English and to be of good health and character; hence, to widen access to such learning opportunities, these are also the entry criteria set by The OU for their PRNP degrees (The OU, 2019b).

Originally, OU PRNPs led to nurse registration and award of either a Diploma in HE in Adult or Mental Health Nursing (The OU, 2008). From 2012, in accordance with NMC policy changes, The OU PRNPs began offering nurse registration and a BSc (Hons) degree in both fields (The OU, 2013). A post-registration BSc (Hons) Nursing Practice programme was also available for RNs who were not graduates to acquire a degree in nursing (Jones & Dawson, 2007) and this continued until reduced applications led to a final cohort in 2018 (Reeds, 2018).

In 2018, The OU launched NDAs in adult and mental health nursing in England alongside its existing PRNP degrees to allow acquisition of a nursing degree and entry to the NMC register within an apprenticeship framework and so funded via an employer's apprenticeship levy contribution (The OU, 2018a). The annual programme entry points were also increased, allowing students to commence their studies in the early autumn or late winter (The OU, 2018b). In the same year, the university launched a Higher Apprenticeship Nursing Associate programme (The OU, 2018c). Two years later, it received

NMC approval to deliver two more PRNP BSc (Hons) degrees in the fields of Learning Disability and Children and Young People Nursing and to provide a three-year, full-time route as well as the existing four-year, part-time route (Messenger & Webb, 2020).

4.4 Performance measures

Despite undergraduate attrition generally being much higher for distance learning courses (Simpson, 2013) and The OU setting such modest PRNP entry requirements, its student retention rates are amongst the best in the UK. The average retention rate for nursing students in England is 76% (The Health Foundation, 2019) but 92% of these learners studying with The OU successfully complete their programme (Grimmette, 2019). This situation may be partly attributable to student demographics. Although Koch et al (2015) identified that mature nursing students, of which the population of the OU PRNPs is almost entirely comprised, had less positive clinical experiences which in some cases increased attrition, Lassche et al (2013) report mature learners worry less than younger students and reduced anxiety can have a beneficial effect on learning. Furthermore, it is argued many nursing students only have a limited and inaccurate understanding of the discipline when they commence their studies (van Iersel et al., 2018); whereas OU PRNP students enter their programme with experience of delivering nursing care in an NRC role and so may be better prepared for the reality of service provision.

According to the UK-wide *National Student Survey*, The OU has an 86% overall satisfaction rating, compared to a UK average of 74% and, amongst 175 degree-awarding providers, is ranked sixth (The OU, 2022i). The most recent *Research Excellence Framework* recognised 82% of its research as *world-leading* or *internationally excellent* (The OU, 2022j) and, amongst HE institutions in the UK, it was ranked 62/129 for research quality (Grove, 2022). Moreover, studies involving both alumni and employers suggests The OU programmes effectively equip newly qualified nurses to fulfil their professional duties (Draper et al., 2014). Nevertheless, funding changes introduced to PRNPs in England from April 2017 and the subsequent move towards many existing employees in this nation undertaking such studies with The OU as part of an NDA, with its additional financial burden on employer sponsors, means the university must provide an even more compelling argument that staff upskilling is a sound investment for healthcare providers; not least because

accommodating PRNP students on conventional courses provided by other academic institutions is much less costly for these services.

4.5 Collaborative working

The OU has long worked in partnership with trades unions and professional bodies associated with nursing; most notably UNISON and the Royal College of Nursing [RCN]. The OU and UNISON partnership was established in 1997 with a shared goal to increase access to HE for individuals who, historically, may not have engaged with such provision (UNISON, 2020). The partnership agreement was reaffirmed in 2017 and over 7,000 UNISON members have so far studied an OU accredited course; many taking advantage of a UNISON bursary scheme that provides financial support to members undertaking undergraduate study (Unionlearn, 2017).

In 2007, The OU and RCN initiated a strategic alliance, seeking to be a stronger combined force for positive change in health and social care education and practice. This alliance saw both staff and programmes within the RCN Institute for Advanced Nursing Education [RCNI], the body's educational arm, transferred to the university. These RCNI programmes included a MSc in Nursing course and so extended OU nursing provision into the postgraduate domain (Jones & Dawson, 2007). Such provision was subsequently widened to include a Postgraduate Certificate, Diploma and MSc in Advancing Healthcare Practice (RCN & The OU, 2008) and more recently a postgraduate Certificate in Non-Medical Prescribing (The OU, 2019c), MSc in Advanced Clinical Practice (The OU, 2019d) and a Doctorate in Health and Social Care (The OU, 2019e).

4.6 OU PRNP degree delivery

To ensure OU PRNP students are equipped for undergraduate learning, modules during their first year include various study skills development activities; some of which are included in formative and summative assessment tasks (The OU, 2020b). For nursing applicants holding existing HE qualifications which may have already addressed key elements of PRNP content at a comparable level, the university offers a free credit transfer service to enable submission of a case for accreditation of prior learning and thereby avoid duplicating study and reduce the time taken to become an RN (The OU, 2022h).

OU PRNP students undertake their academic study via distance learning, which draws upon various educational resources, including service user and carer accounts, practitioner facilitated discussions, self-assessment questions, video and audio materials, reference texts, computer-aided learning packages, printed and web-based resources, asynchronous forums [where interaction need not take place in real time], and synchronous tutorials [i.e., in real time within a face-to-face or online environment]. As in other universities, students also have access to an extensive library with librarian support, which is available online, a student support team, who offer information, advice, and guidance related to OU study, a careers guidance service, and a computing helpdesk (The OU, 2020b).

Academic study within each PRNP module is supported by a module tutor; normally a part-time associate lecturer appointed for their subject expertise. This tutor assists students to engage with module materials, monitors their progress, provides study skills support, facilitates tutorials, moderates online forums, advises on assignment writing and assesses and provides feedback on student work. Academic support for students is provided through individual and small group tuition (The OU 2020b) and is available both synchronously and asynchronously (The OU, 2014).

Module tutors are normally assigned approximately twenty PRNP students in their group. Since all or most of their work is undertaken at a distance and UK PRNP education is standardised, however, they may be allocated students anywhere in the UK (The OU, 2020c). This flexible student allocation provides more consistent employment for module tutors [since a reduction in student registrations on a module in one area of the UK at a given time is often offset by an increase elsewhere], enables students to interact with a more diverse peer group, and means it is virtually unknown for a module presentation to be cancelled [since delivering it nationwide means that even if student numbers are greatly reduced for a presentation, it is still viable to run; albeit with a smaller number of tutor groups].

Clinical learning within The OU PRNPs is supported by practice tutors, now termed *Academic Assessors* by the NMC (2018b). These staff are commonly part-time associate lecturers who are also RNs. They quality assure practice learning environments in which students gain experience, monitor learner achievement of the required experiences and support student production of evidence to demonstrate achievement of NMC

proficiencies. Practice tutors also normally participate in face-to-face tripartite meetings with learners and their mentor/practice assessor [RNs based in a practice learning environment who determine student competence in accordance with NMC standards] and provide students with information about any further support they require (The OU, 2020c).

Practice tutor groups are much smaller than module tutor groups, being comprised of approximately five students (The OU, 2020b). This tutor-student ratio makes it easier to create viable geographical groups [given practice tutors normally hold regular face-to-face tripartite meetings] and accommodate the needs of healthcare providers who may only be able to release very small numbers of staff to study the PRNP at any one time. It also means some employer sponsors, such as general practice surgeries, wanting to upskill a single NRC whom they employ and who could not be accommodated in a conventional PRNP can still be offered an opportunity to become an RN via The OU's educational provision.

Staff tutors are responsible for the line management and development of an associate lecturer group [including module tutors and practice tutors] and are based in all four UK nations. They act as the interface between the faculty for whom they work and The OU's student support team, providing a bridge between production of academic material and its delivery to students. Staff tutors also have external engagement responsibilities; liaising with employers, sector skills councils, trades unions, professional bodies, and other stakeholders in the location they serve. Furthermore, they undertake a role within module teams. These teams are largely comprised of academic colleagues located at The OU's campus at Milton Keynes, but staff tutors contribute to their work in developing teaching, learning and assessment design and online pedagogy (Nations & Regions Workload Norms Task & Finish Group, 2013; Roy, 2022).

4.7 OU PRNP placement structure

The clinical experiences of OU PRNP students are structured on one of two placement designs, the integrated or the block model. In the integrated model an employee fulfils the responsibilities of their substantive NRC post for part of their working week alongside approximately 15 hours of supernumerary practice learning as a nursing student for the remaining time. Since the working day/shift commonly varies between 7½ and 12 hours, this means a student would normally be in a practicum for one or two days per week. In

contrast, the block model involves an employee completing their supernumerary practice learning hours in shorter full-time blocks that equate to the same total number of practice learning hours which feature in the integrated model, returning to their substantive NRC post outside these blocks. It is the nursing student's employer who chooses the practice learning model and, so long as any placement plan proposed by this sponsor is compliant with NMC requirements, it receives OU approval.

4.8 Organisational change

In 2015, the university implemented a *Locations Analysis Project* to determine the optimal future configuration of OU centres in the UK (The OU, 2015a). This project led to the closure of seven regional centres in Birmingham, Bristol, Cambridge, Gateshead, Leeds, London, and Oxford, whilst retaining the campus at Milton Keynes and expanding centres in Belfast, Cardiff, Edinburgh, Manchester, and Nottingham (Havergal, 2015). To maintain local presence and responsiveness, over 130 staff tutors based in the regional centres scheduled for closure were offered continued employment as home-based workers (The OU, 2015b) and, in the spring of 2017, the decommissioning of these centres was completed (The OU, 2017). In 2016, the seven OU faculties were reconfigured into four new units and the Faculty of Health & Social Care [where nursing programmes were located] merged with the Faculty of Education & Language Studies to become the Faculty of Wellbeing, Education & Language Studies (The OU, 2015c). These changes did not directly affect associate lecturer work.

4.8 Conclusion

The OU's atypical philosophy and approach to delivering HE is perhaps inevitably reflected in its PRNP provision. Despite concerns about offering nurse education via distance learning, the university has created programmes based on this model which fully comply with NMC requirements and achieve levels of student retention and satisfaction that are amongst the highest in the UK. Nevertheless, the additional financial and logistical pressures imposed on the employer sponsors of OU PRNP students may, particularly during periods of economic pressure, make this model of nurse education harder for such employers to perceive as a sound investment.

Moreover, from a research perspective, the different design of such programmes clearly restricts the extent to which results from investigations based on this provision are transferable to conventional PRNPs offered by other academic institutions. The OU, however, has historically been one of the few UK PRNP providers to accommodate both block and integrated practicum designs; meaning it also offers a rare opportunity to explore the effect such placement models may have on student learning experiences in this nation. Indeed, given recent growth in both virtual learning environments and NDAs [with their requirement for OTJ learning], it seems likely that knowledge derived from such exploration may have greater future relevance to a wider range of academic institutions.

Despite wide variation in PRNP curricula, international evidence regarding the challenges faced by nursing students displays a high degree of commonality; hence it is probable such findings are relevant to those OU nursing undergraduates whose practice learning experiences are a central feature of this research study. The next chapter of the thesis therefore examines work from across the globe exploring the prevalence of excessive PRNP student stress, key stressors for such learners and strategies which may best facilitate their stress reduction and promote wellbeing.

Chapter 5. Realist Synthesis - nursing student challenges

5.1 Introduction

This chapter describes the common challenges faced by students within their pre-registration nursing programmes [PRNPs] internationally. High levels of student stress [often attributed to negative practice learning experiences] and worrying withdrawal rates are identified. A range of specific problems for nursing students who are also mature learners, studying part-time and/or upskilling from a non-registrant carer [NRC] role [all key characteristics applicable to virtually every nursing student featuring in this study] are reported. Given this investigation focuses on the impact of different practice learning models upon the workplace experiences and programme retention/achievement of mature nursing students who study part-time and have a work background as NRCs, such information is extremely pertinent to the investigation.

5.2 The prevalence of nursing student stress and associated attrition

Becoming a nurse is globally recognised as a complex and stressful process for which many students feel inadequately prepared (Alzayyat & Al-Gamal, 2014; Jonsson et al., 2014, Muleya et al., 2015; Ntho et al., 2020; Rafati et al., 2020). It is argued modern nursing programmes expose students to more pressure (Timmins et al., 2011), so new curricula must better facilitate positive stress management as well as effectively prepare students to enter the nursing workforce (Fornés-Vives et al., 2016). The transitional challenge faced by students on their path to becoming qualified practitioners is not unique to nursing (Hamshire et al., 2013). For example, similar difficulties have been described in law (Evans et al., 2017; Jenkin, 2019), medicine (Kuhlmann et al., 2016; Rahman et al., 2014; Weurlander et al., 2018), occupational therapy (Golos & Tekuzener, 2019; Govender et al., 2015), paramedic practice (Kennedy et al., 2015; Lucas et al., 2013), physiotherapy (Higuchi & Echigo, 2016; Siddiqui et al., 2019; Tambag & Can, 2018) and teaching in both primary and secondary education (Malderez et al., 2007; Ord & Nuttall, 2016; Stricklin & Tingle, 2016).

Nevertheless, research in the United States of America [USA] found *'nursing students reported higher stress scores on academic and external stresses'* than those on dentistry,

medicine, pharmacy, or physical therapy courses (Stecker, 2004, p.469). It continues to be argued such students experience significantly higher levels of stress than learners in other disciplines (Rafati et al., 2017; Yan, 2019) and may even set aside their own physical and mental health needs in order to provide effective patient care (Sheeba & Gracia, 2017). Indeed, in 2016, 10% of nursing students at one university in Wales '*asked for support with anxiety, stress or depression'* (Munn, 2017, p.12) and a survey of 753 military and civilian nursing students in Indonesia reported extremely high levels of student stress in both groups (Pertiwi et al., 2020). Moreover, the culture within this discipline may itself exacerbate student stress; given *'the old nursing adage that nursing eats its young'* (Peters, 2014, p.223).

Over a decade ago, research by the Royal College of Nursing [RCN] (2008a; 2008b) suggested between 39% and 42% of nursing students in the United Kingdom [UK] had considered leaving their PRNP. A more recent survey of 107 nursing undergraduates in Jamaica suggested 31% of respondents intended to leave the discipline on graduation (Pusey-Murray & Onyefulu, 2018). Similarly, it has been reported that '*in Taiwan nearly one third of newly graduated nurses quit their first nursing job within 3 months and many never return to nursing'* (Jiang et al., 2012, p.152). Research at a university in England also suggests PRNP students still commonly think about withdrawing from their studies; citing stress, concerns regarding the competing demands of academic workload and clinical placements, frustration, and a sense of inadequacy as factors associated with such thoughts (Cust, 2020).

Evaluation of a new university-based curriculum in France suggested student *'attrition from nursing, which has already been observed internationally, may have been amplified*' by implementation of this curriculum (Petit dit Dariel et al., 2014, p.99). A UK survey involving 130 final year students and recently qualified nurses and midwives who were clinically active during the COVID-19 pandemic found '*60% of those in work said the pressures had made them consider leaving their jobs already, while 62% of respondents reported anxiety and stress as a result of their roles'* (Parry, 2021). A survey involving over 20,000 UK nursing staff recently identified that 75% of shifts lacked their agreed registered nurse [RN] allocation, only 18% of respondents believed they had '*enough time to provide the level of care they would like'* and 81% felt patient care was compromised by a lack of

nurses (Castro-Ayala et al., 2022, p.8). Furthermore, the NHS experienced an 18% increase in RN sick leave in May 2021 compared to May 2019 and a 31% increase in absences taken for mental health reasons (Ford, 2021d).

Preventing academic failure is a priority for Higher Education Institutions (Ryan, 2016). Although there is '*no central record of student nurse attrition in the UK and no standardised method of recording it*' (Urwin et al., 2010, p.203), it has been estimated the average UK nursing student attrition rate is 24% (The Health Foundation, 2019) and research by Buchan et al (2019) reported PRNP student attrition was as high as 50% in some UK universities, but as low as 5% in others. Longitudinal research following 1,702 nursing students in Sweden throughout their PRNP found study burnout increased from 30% in the first year to 41% by the third year and levels of exhaustion and disengagement also showed a statistically significant increase as the students' course progressed. The researchers therefore concluded that burnout may have adversely affected student learning and psychological well-being (Rudman & Gustavsson, 2012). In addition, evidence indicates RNs often leave the discipline within a year of qualification due to excessive stress and burnout (Flott & Linden, 2016; Tsang et al., 2016; Wong et al., 2018); a phenomenon first recognised over four decades ago and originally referred to as *reality shock* but now more commonly termed *role transition* (Sparacino, 2015; Tastan et al., 2015; Wakefield, 2018).

5.3 Practice learning and stress

By enabling students to develop and apply essential clinical skills, the practicum has been described as a critical component of all PRNPs (Chan et al., 2018; Jestico & Finlay, 2017; Madhavanpraphakaran et al., 2014). Nursing students, however, commonly regard clinical learning as one of the most stressful parts of their professional education (Andrew et al., 2022; Priest, 2005; Timmins et al., 2011). Given some PRNP student placements may only last between two and four weeks and it may take the learner at least the first week to settle into the experience, the importance of familiarising students with the practice learning environment before the practicum commences has been emphasised (Tam et al., 2020; van der Riet et al., 2018).

A survey in the Republic of Ireland involving a convenience sample of 52 third year PRNP students '*showed that examinations, the level and intensity of academic workload, the*

theory-practice gap and poor relationships with clinical staff were the leading stressors' for such learners (Evans & Kelly, 2004, p.473). These findings are supported by a systematic review examining nursing student stress, which identified that relations in the clinical environment, caring for patients and families, and academic demands were the highest reported stressors (Alzayyat & Al-Gamal, 2014). A quantitative study by Burnard et al (2008a), which generated data from 1,707 PRNP students based in five countries, noted nursing stress was evident in all these nations but reported variation in whether the clinical or academic demands of a nursing programme were deemed most stressful. Students in Albania, the Czech Republic and Wales reported both programme elements were equally challenging, whilst those in Brunei and Malta found the academic study more demanding.

A further comparative investigation of stress amongst 547 nursing students in Greece, Nigeria, and the Philippines also highlighted variation in the nature and degree of learner stress. Nevertheless, respondents from all three nations still ranked academic work, faculty and staff demands and the clinical environment as amongst the overall highest stressors (Labrague et al., 2018). Research involving 348 nursing students in the Republic of Ireland using a questionnaire similarly found *'many students experience programme-related stressors'* and '*more than one-third also reported stressors related to relationships with clinical staff and clinical assessment of competence'* (Timmins et al., 2011, p.758).

In Jordan, a self-reported questionnaire completed by 181 second year undergraduates at two universities rated assignment work and clinical experiences as the most stressful components of their PRNP. Specifically, respondents cited over-assessment and an excessive study workload as problematic, but the authors added that placements often seemed neither welcoming nor desirable locations for learners (Shaban et al., 2012). Additionally, a survey in the Philippines involving 61 third and fourth-year nursing students found assignments and workload to be the greatest stressors but, specifically, perceived incompetency was a major source of practicum stress (Labrague, 2013).

Using focus groups to examine the learning experiences of 90 baccalaureate PRNP students in Iran, Sharif & Masoumi (2005, p.1) found *'nursing students were not satisfied with the clinical component of their education'* and '*experienced anxiety as a result of feeling incompetent';* emotions exacerbated by a perceived theory-practice gap. Learners said the initial period of a practicum was the most worrying element of each clinical experience,

partly due to their fear of making mistakes. In-depth interviews with 21 final year nursing students in Macau explored their experiences on clinical placements. The results highlighted students' own perceived lack of competency, strained relationships with preceptors, heavy workload, and associated separation from their normal sources of support, led some to experience decreased social health and a loss of belonging within a wider social context (Tam et al., 2020).

A survey involving 125 nursing students in Saudi Arabia highlighted moving clinical placements and limited professional knowledge/skills as significant stressors. The researchers also identified learner relationships with teachers and hospital nursing staff as stress-provoking factors (Waled & Badria, 2019). In China, a cross-sectional study involving 474 PRNP students following completion of a general hospital sub-internship lasting six months found '*the nursing students' level of role stress at the end of the first sub-internship was high'* and most felt they had been given unnecessary work that was inconsistent with their role (Sun et al., 2016, p.1).

In Australia, a study by Nolan (1998, p.625) involving data derived from focus groups attended by a purposive sample of six second year PRNP students noted that *'while students are familiarizing themselves with new settings, routines and staff, they can think of little else'* and so concluded there is an '*argument for exposing the student to fewer clinical venues in the programme and maximizing the length of individual placements in order to maximize learning time.'* More recently, using mixed methods research involving 51 paediatric and mental health PRNP students in Scotland, Millar et al (2017, p.47) also identified *'the process of moving between different placement areas can make students feel unsettled, thereby compromising their learning*.' Similarly, a web-based questionnaire completed by 1,903 nursing students in Cyprus, Belgium, England, Finland, the Republic of Ireland, Italy, the Netherlands, Spain, and Sweden found learners acquired a better understanding of the RN role during a longer practicum (Warne et al., 2010).

5.4 Power dynamics and the hidden curriculum

Within nursing, power and autonomy have been shown to greatly affect job satisfaction (MacLellan et al., 2011). MacMillan (in Eggertson, 2013, p.24) suggests the stress PRNP students experience is exacerbated by a *hidden curriculum* they commonly encounter in

clinical placements. Instead of being treated as healthcare team partners, she argues those responsible for supervising and supporting such students during placements *'often silence them when they raise issues or questions about something they have observed in a patient's care'*; hence they '*receive an unspoken message: their job is to follow orders and procedure, not try to change the status quo.'* MacMillan's claims in respect of Canadian nurse education were made without supporting empirical evidence, but in an earlier paper, Priest (2005) asserts there is both research and anecdotal data from nursing students in this nation to support them and more recent research by Mitchell et al (2021) contributes to this body of evidence.

Moreover, the phenomenon may be evident in the learning experiences of PRNP students in other countries. An ethnographic case study in England by Allan et al (2011, p.847) suggested two key elements of the hidden curriculum in practice learning are the expectations of trained staff that PRNP students, despite their supernumerary status, should '*work while they learn and that on registration, they are expected to be competent to work immediately as registered nurses.'* Semi-structured interviews involving 20 Bruneian student nurses found their low status within the healthcare hierarchy caused them practice-related stress (Burnard et al., 2007). Furthermore, in a systematic review and meta-synthesis of qualitative literature related to nursing student experiences in UK adult hospital settings, Thomas et al (2012) identified a notable minority of PRNP students do not have nurturing and caring placements and experience less than positive relationships with clinicians.

5.5 Nurse educators and student stress

Nurse educators may help to prevent, or at least challenge, the hidden curriculum in clinical settings and in so doing reduce the theory-practice gap (Carson & Carnwell, 2007). A scoping review of supervisor experiences within undergraduate nursing and paramedicine programmes in rural services found *'a recurring enabler of effective clinical supervision was perceived to be the quality of the relationship between the organisation and the university'* (Trede et al., 2014, p.785). A survey in Italy involving 250 newcomer nurses which explored clinical learning in nurse education also concluded a '*synergic link between nursing education institutions and health care settings in providing clinical*

placements for nursing students is useful to both educational and health care organizations' (Tomietto et al., 2014b, p.6).

Holmberg (2003) maintains the relationship between nurse teachers and their students may be one of the greatest influences upon learner motivation, satisfaction, and retention. A survey in Scotland by Price et al (2011, p.782) involving 389 PRNP undergraduates found '*fifty four percent of students felt that a visit in clinical placement from a lecturer was important or very important to them.'* Learners believed such interaction facilitated more detailed feedback on their clinical performance and provided them with increased emotional support. Indeed, Ryan (2016) claims that effective nurse educators can facilitate changes in student behaviour and thereby promote better learning experiences. A systematic review of professional socialisation among PRNP students by Salisu et al (2019, p.1295) suggests this could be achieved by nurse educators '*creating a conducive and supportive environment and by not expecting so much or burdening students with unachievable goals.'*

In Malaysia, a survey involving 142 student nurses, 54 RNs and 8 Nurse Tutors found learners regarded supervision as the most beneficial component of a practicum (Chuan & Barnett, 2012), whilst a survey of 63 nursing students in the West Indies showed most respondents regarded having a clinical instructor in their placement as important (Prescott-Carter & Onuoha, 2016). A longitudinal study in Australia involving interviews, a survey and field work observations with 28 second and third year PRNP students, 25 RNs, 6 Nurse Unit Managers and 4 Directors of Nursing also identified the value of effective clinical teachers. Indeed, student respondents often *'recounted positive interactions where the teacher engaged them in various activities and explained practices in detail'* (Newton et al., 2009a, p.323). Additionally, a survey involving 310 nursing students in Oman showed interpersonal relationships with clinical teachers was a key dimension of their satisfaction with a practice learning environment (D'Souza et al., 2015).

It has been argued, however, that '*nurse educators have multiple roles and responsibilities*', and the broad expectations associated with their work may increase levels of job dissatisfaction and burnout (Sarmiento et al., 2004, p.142). Mixed methods research in England by Aston et al (2000) involving 131 students on an adult nursing programme, 76 lecturers and 46 practitioners found although there was widespread agreement academics

should be involved in practice placement support, more than half of the lecturers participating in this study said they had received no preparation before being expected to provide such support and that it was simply assumed being an RN meant they could function effectively as a practice teacher. Student participants also believed lecturers regarded supporting nursing students in placements as a low priority. More recent work in Oman continues to identify concerns that novice nurse educators may be overwhelmed by the demands of their new role (Ambusaidi & Almaskari, 2021).

A study by Andrews et al (2006) involving a focus group of 7 nursing students and interviews with 30 ex-students from two English universities discovered contact between learners and link tutors [academics with a remit to facilitate placement learning] was surprisingly limited. Similarly, in a qualitative investigation using two world-café events involving a purposive sample of 51 South African PRNP students, participants reported *'a lack of support from nurse educators'* and '*no communication between the stakeholders involved (i.e., peer-mentors, peer-mentees, and nurse educators)'* (Ntho et al., 2020, p.4). Quantitative research in Italy examining the placement experiences of 597 nursing undergraduates found wide variation in the reported quality of the relationship between nurse teachers and students (Tomietto et al., 2014a). Moreover, in Jordan, semi-structured interviews with 30 PRNP students identified that clinical instructors often seem to have received inadequate preparation for their role, failed to individualise student support and displayed limited evidence of communicating effectively with other academic staff to ensure consistency of educational provision during the programme (Saifan et al., 2015).

Worse still, more recent evidence suggests nurse educators may even contribute to student stress. A survey of 100 nursing students in Saudi Arabia identified '*teachers and nursing staff*' as the second highest source of stress for respondents after '*assignments and workload'* (Hamaideh et al., 2017, p.200). In-depth interviews of 14 nursing students in Turkey by Arkan et al (2018) found not only were teaching staff infrequent visitors to the clinical environment, but their high expectations led some students to become demotivated and emotionally exhausted. A study in Spain involving 69 PRNP students and using a nursing stressors questionnaire also highlighted relationships with tutors as one of the most powerful stressors experienced by learners both at the beginning and end of their programme (Gorostidi et al., 2007).

More recently, a survey of 430 nursing students in Iran who had successfully completed at least one clinical training unit discovered the limited competence and inappropriate conduct of clinical instructors were the most common causes of student stress. Learners believed some of these educators lacked relevant/current clinical knowledge and skills, were inattentive to their needs, over-emphasised theoretical learning at the expense of clinical education, had unrealistically high expectations of student performance, failed to provide adequate feedback and displayed unsupportive behaviour in response to their mistakes (Rafati et al., 2020). Meanwhile, Ghanaian focus groups involving 40 nursing students and 15 nurses suggested nurse educators were commonly angry, domineering, displayed poor communication skills and were disrespectful to students, thereby hampering practical nursing skills acquisition (Salifu et al., 2022).

5.6 Particularly challenging programme periods

A survey of 275 nursing students in the Czech Republic and Slovakia found experienced nursing students reported higher stress levels than novice ones and that such stress was mainly associated with clinical experiences (Gurková & Zeleníková, 2018). Similarly, longitudinal quantitative research involving 112 PRNP students in Wales over the duration of their programme found levels of self-reported stress and self-esteem were different at various stages of nurse training. Stress was greatest at the start of the third year, levels of self-esteem were lowest at the end of the programme and when these students had completed their studies and were applying for jobs, their stress reduced (Edwards et al., 2010). Although the researchers did not attribute these findings to any specific cause, they acknowledged the view that nursing students in their final year of training may be exposed to greater pressures and struggle to regard themselves as sufficiently well-prepared to shortly qualify.

These observations are supported by research indicating final year PRNP students in Spain attribute much of their stress to a perceived lack of competence (Gorostidi et al., 2007). Furthermore, research in Israel involving 892 second, third and fourth year PRNP students found learners attributed their stress to feeling they had received inadequate training and lacked crucial nursing knowledge, although the researchers noted stress levels were highest amongst second year students (Admi et al., 2018).

5.7 Mature and part-time nursing student stress

Since 1980, the number of mature students engaged in UK higher education [HE] has increased from approximately 10% to nearly 33% (McVitty & Morris, 2012). Nevertheless, James & Beck (2016) argue older learners are largely ignored in HE debates. In the UK, part-time undergraduate demographics are markedly different to the full-time student population. Over 79% of these learners are more than 25 years old [compared with 13% of full-time undergraduates], 64% are female [compared with 56% of full-time learners] and 66% have family commitments [when most full-time undergraduates are single and childless]. Part-time HE students are also more likely to study subjects allied to medicine (Callender et al., 2010a; Callender et al., 2010b; UK Commission for Employment & Skills, 2011).

Evidence suggests part-time study, such as that provided by Open University [OU] PRNPs in which mature learners are the most common participants, can have further negative social and psychological consequences. In the UK, completion rates for part-time HE courses are significantly lower than those for full-time programmes (Universities UK, 2013). Butcher (2015, p.54) reports some part-time undergraduates with concurrent employment must radically change their lifestyle to accommodate the extra demands that study makes on their time. In addition, these students describe concurrently working and studying as *'like having two different personalities'* and often seek to hide their student status from work colleagues. Given that McDaid (2009) discloses she and some of her colleagues received negative remarks from staff about their status on a part-time PRNP HE Diploma programme, leading them to feel undervalued, such behaviour is understandable.

A descriptive correlational design involving 20 part-time graduate nursing students in Jamaica found over 73% of respondents reported a moderate or high level of stress during their programme (Brown et al., 2016). In Hong Kong, Tak-Ying Shiu (1999) identified that, amongst 20 public health nurses who completed a diary of experiences for 7 days, the 9 nurses in this sample undertaking a part-time degree programme in their specialist field engaged in fewer family-related activities than their non-student peers and those students who also had children experienced greater role strain. Mixed methods research in England by Carnwell (1998) involving an initial questionnaire and follow-up ethnographic interviews with 96 community nursing students undertaking part-time distance learning

modules to access a degree course identified that some respondents experienced problems in balancing their family life and study commitments.

A survey in Scotland involving 113 third-year adult nursing students found some of the greatest reported barriers preventing HE Diploma students from considering a transfer to a degree programme were *'the combined pressures of work, study and family stress'* (Sheward, 2005, p.153). Similarly, via a questionnaire completed by 111 nursing undergraduates at a Brazilian university, respondents reported their main stressors were inadequate time with family members and for leisure activities (de Souza et al., 2016). Given mature students have been encouraged to go to university as part of the UK widening participation agenda and 25% are parents (White, 2012), it seems reasonable to conclude such tensions may be commonplace within the PRNP student population in many universities; especially for those completing part-time undergraduate study.

A survey by Nicholl & Timmins (2005) involving 70 part-time nursing students in the Republic of Ireland found balancing study and workplace commitments was rated as their highest educational stressor. Further research in this nation by Evans et al (2007) employing a questionnaire completed by 132 respondents undertaking a part-time degree course for qualified nurses in two academic institutions identified this challenge as the second highest mean stressor after preparing assignments. On a part-time PRNP HE Diploma programme in England, O'Driscoll et al (2009, p.213) also discovered *'placements were identified by students as a time when tension between home, student and employment roles may become particularly high.'* Stephens (in Parish 2004, p.13), however, argues some part-time PRNP learners fail to understand the commitment such study requires and suggests many '*have unrealistic expectations of how a part time course could run'*; for example, failing to appreciate their programme will be significantly longer than a full-time course and that they will still be expected to have practice learning during unsocial hours.

Qualitative research by Draper et al (2014, p.1308) involving semi-structured telephone interviews with 17 alumni of the part-time OU PRNPs, all of whom were therefore NRCs, also termed *Healthcare Support Workers* [HCSWs], concurrent with their nursing student role highlighted there were *'challenges associated with the stages of transition from HCSW to student to registered practice.'* Respondents identified dealing with resentment and

jealousy from non-registrant staff with whom the newly qualified nurses had earlier been peers, managing the frustration of moving between a student and HCSW role [since the skills they were permitted to use in each varied] and asserting their need for supernumerary practice learning as nursing students to be the most significant challenges they encountered. Overall, these alumni believed becoming RNs via this PRNP course was harder than doing so through a conventional programme because it demanded more self-discipline, self-management, and self-motivation. In respect of part-time nursing programmes, it is therefore argued *'managers and nurses need to work together to devise flexible working options that will maintain organizational goals while facilitating nurses to study'* (Timmins & Nicholl, 2005, p.481); whilst nurse educators need to help their students to manage stressors more effectively (Alzayyat & Al-Gamal, 2014).

5.8 Stress reduction

The physical and emotional demands associated with providing nursing care may cause some practitioners to adopt inappropriate coping strategies, thereby having adverse consequences for their health and wellbeing (Labrague, 2013; Shaban et al., 2012). Indeed, whilst nursing students are at high risk of experiencing mental health problems, it is rare for them to seek professional psychological help (Pumpuang et al., 2018). Whilst avoidance behaviour is a stress management technique (McGrath et al., 2003), undertaking a survey of 171 final year nursing students in Northern Ireland, Gibbons (2010) found such behaviour was a strong predictor of burn-out, even when it was only used occasionally. Of equal concern, a study by Timmins et al (2011) in the Republic of Ireland found 10% of PRNP students reported using alcohol or drugs to relieve stress and less than 69% of respondents rated their mental health as *good* or better.

A systematic review of ways to reduce workplace stress in nursing, concluded it was *'not possible to recommend any particular approach for practical implementation because the number of studies is too small to determine it'* (Mimura & Griffiths, 2003, p.14). Nevertheless, there is now some empirical evidence identifying factors which may mitigate against burn-out in nursing and promote healthy or positive stress, termed *eustress*. For example, a survey in the USA involving 1,296 members of the National Student Nurses Association found a strong sense of belonging in placements had a positive impact on learning, motivation, and confidence (Grobecker, 2016).

In-depth semi-structured interviews with 18 nursing students in Australia and the UK found *'belonging is a prerequisite for clinical learning'* and so should be actively promoted (Levett-Jones & Lathlean, 2008, p.103). A study in the Republic of Ireland identified talking things through with family members or friends was the most common and desirable stress management technique employed by nursing students (Timmins et al., 2011). Furthermore, research in Thailand using self-reported questionnaires completed by 343 nursing students suggested universities should focus their efforts on promoting positive attitudes regarding professional psychological assistance, create a more supportive culture within the nursing campus and provide better information related to psychological help for peers, student families, and academic instructors (Pumpuang et al., 2018).

In the UK, universities, the National Health Service, private, voluntary, and independent sector healthcare providers have stressed the importance of adequate pre-placement preparation for nursing students (Sherratt et al., 2013) and Karimollahi (2012, p.743) claims *'orientation sessions before clinical placement can help students develop self-confidence in coping with the stress inherent in a clinical setting.*' Results from a Canadian study support the value of such intervention. The College of Registered Nurses of British Columbia and Thompson Rivers University found providing a workshop for PRNP students to prepare them for their first practicum, which included advice about how to engage with practitioners in the clinical setting, was found to be effective in reducing student stress, promoting retention, and developing nursing skills (Priest, 2005). Quantitative research involving 100 baccalaureate paediatric nursing students in the USA found although *'student nursing preparation for the clinical environment emphasizes the mastery of psychomotor skills'*, evidence suggests *'greater emphasis should also be placed on the affective domain.'* Hence, alongside the acquisition of skills, such as undertaking assessments, nursing students should be better equipped to cope with the psychological challenges of practice learning, such as fear of clinical interventions causing patients pain (Lassche et al., 2013, p.52).

In Norway, quantitative secondary data analysis of 446 nursing student questionnaires, originally completed to explore the extent to which learners believed they had acquired different nursing knowledge and skills, concluded '*the development of nursing students' reflective skills and facilitating their theoretical understanding in initial nursing education*

might enhance nursing students' ability to perceive coherence between theory and practice' and thereby reduce the tensions commonly experienced in practice learning (Hatlevik, 2012, p.876). Since Mikkonen et al (2016, p.93) highlight '*the powerful potential of the student's own role in influencing his or her learning in a clinical environment*', perhaps such development activities are effective because they help learners to appropriately utilise and target this potential.

Focus groups involving 185 students and early, mid, and late career nurses in Canada found participants believed *'ongoing training, education and professional development facilitate transition to practice for students and new graduates and also help to ensure competency and quality patient care throughout the span of nurses' careers.'* Additionally, the researchers observed *'healthy work environments were identified by nurses across all career stage cohorts as those that invested in continuing professional development opportunities'* (Price & Reichert, 2017, p.10). Similarly, Pattillo (2012, p.2) claims *'reports show that new nurse graduates benefit from nurse managers who provide clear expectations, create a healthy work environment, and recognize educational needs.'* A mixed methods study in England by Halpin (2015) using questionnaires and semi-structured interviews with 288 newly qualified nurses [NQNs] in four phases over a twelve-month period from their point of qualification also supports this assertion; finding active support from approachable, accessible, and constructive managers, together with a sense that the individual was working in a 'good' team, were important features which helped to reduce stress.

A qualitative case study exploring NQN support in an English hospital by Whitehead et al (2015) suggests receiving effective individualised preceptorship from carefully selected, well-prepared and experienced nurses given ring-fenced time to work with their preceptee could enhance confidence and competence, improve job satisfaction, reduce stress and anxiety, and increase staff retention. Arguably, RNs who feel valued and less stressed are more likely to provide positive learning experiences for those nursing students whom they support. Furthermore, a survey of third year PRNP students in Northern Ireland highlighted positive placement experiences can *be 'an important source of stress likely to lead to eustress'* (Gibbons, 2010, p.1299); perhaps because constructive work-based learning

'engages the learner in problem solving and enhances the skills of inquiry, networking and creativity' (Moore, 2007, p.161), thereby developing confidence.

5.9 Conclusion

Evidence suggests nursing student stress is an enduring, complex, worldwide phenomenon affected by a range of educational, social, environmental, intrapersonal, and interpersonal variables. Specifically, such variables include pre-entry guidance and applicant programme understanding, the mode of nursing study undertaken, the academic and placement expectations of the course, competing family, programme and work demands, the support RNs receive which may affect student clinical experiences, the learner's self-concept and perceived preparedness for future practice, tensions between professional learning and delivering nursing care, a student's sense of belonging within a practicum, their relationship with clinical and teaching staff and transitional challenges. Similarly, various interventions have been identified as effective in reducing such stress, although most appear to focus on organisational, rather than individual, remedies.

As is evident in this part of the thesis, many nursing student stressors are associated with practice learning - the focus of this investigation – and so this literature ultimately assisted in the analysis and discussion of qualitative data derived from respondent experiences of different placement models. The next chapter more closely examines literature addressing the numerous problems directly related to practicum delivery and those characteristics which may be associated with positive placement experiences.

Chapter 6. Realist Synthesis - placement quality and capacity

6.1 Introduction

High-quality pre-registration nursing programmes [PRNPs] are critical if nurses are to effectively address contemporary healthcare challenges (Jyothi & Shalini, 2019). *Practice learning*, a term describing all nurse education that occurs in a healthcare environment (Royal College of Nursing, 2017c), is globally recognised as a fundamental component of such provision (Abuosi et al., 2022; Carmody et al., 2020; Kim, 2022; Morley et al., 2017; Woo et al., 2020). Although the language describing allocation of a student to a real workplace for the purpose of professional learning varies across different nations and disciplines, such activity is commonly and interchangeably known as *fieldwork education*, *placement, practice education*, *practice experience, practice teaching and learning*, a *practicum,* or *rotation* (Asare, 2017; Imms et al., 2017; Vassos et al., 2019; Woods, 2021).

Exposing students to varied clinical environments and different patient needs may improve educational outcomes (Ohaja, 2010; Taylor et al., 2012; Vatansever & Akansel, 2016), enables application of classroom learning to care delivery (Dimitriadou et al., 2014) and facilitates professional identity and socialisation (Baglin & Rugg, 2010; Bonello, 2001a; Msiska et al., 2014). In common with many other nations (Asare, 2017; Tang, 2021; Warne et al., 2010), PRNPs in the UK allocate half of their curriculum learning hours to practice-based education (Nursing & Midwifery Council, 2023b). Inevitably, however, practice learning environments vary both in their core functions and the quality of educational experience they offer (Bisholt et al., 2014; Cooper et al., 2020).

This chapter of the thesis identifies the characteristics of effective practice learning environments, the challenges related to securing appropriate placements and features associated with both positive and negative practicum experiences for PRNP students. All these topics are therefore inextricably linked to the goals of this research study.

6.2 Providing effective and positive nursing placements

Clinical placements have been described as hectic, complex, multifaceted, socio-cultural entities offering opportunities for nursing students to either engage or disengage in

practice learning (Bergjan & Hertel, 2013; Dafogianni et al., 2015; Thomas et al., 2015). Concerns regarding the adequacy of clinical education within PRNPs have escalated since such provision moved to the Higher Education [HE] sector (Baldwin et al., 2014; Ousey & Gallagher, 2010; Phillips et al., 2012). Historically, nurse training has primarily been determined by hospital, rather than educational, needs (Keleher et al., 2007) and so tensions may inevitably exist between universities and the healthcare agencies approached to offer practicum experiences. Whilst educational organisations '*have a major interest in ensuring that their students have effective and productive placement experiences'*, service providers must *'ensure a sustainable workforce for the delivery of quality, safe and timely healthcare that meets efficiency and productivity indicators*' (Trede et al., 2014, p.784). Care services already struggling to manage their budgets in a perceived climate of under-resourcing may therefore regard assigning precious staffing to support students as a commitment they can ill-afford.

Billett et al (2016, p.1) suggest *'universities often have to identify and secure placement opportunities through engaging with private and public sector institutions that provide these experiences in a variety of ways, durations and kinds of engagements.'* In the specific context of nurse education, Hutchings & Sanders (2001) highlight widespread evidence of the difficulties in providing practice learning experiences that accommodate the needs of patients, employers, students, and academic institutions; whilst van der Riet et al (2018) claim there are long-standing multidimensional problems related to providing effective clinical placements.

Specifically, concerns have been expressed regarding a lack of sufficiently high-quality practicum opportunities (Kaliyangile & Ngoma, 2020; Salifu et al., 2022; Vanson & Bidey, 2019) and an increasing student population (Hooper et al., 2020; Kessler et al., 2021; Schwartz, 2019). These challenges are worsened by widespread shortages of qualified practitioners (Castro-Ayala et al., 2022; Collins, 2019; Zimmer et al 2014), adverse economic conditions (Fawaz et al., 2018; Papastavrou et al., 2016; Public Health England, 2017) and greater demand for health services (Bøe & Debesay, 2021; House of Commons Health Committee, 2018; Quail et al., 2016). Reimer Kirkham et al (2007) therefore highlight a need for detailed examination of how PRNP students engage in practice learning and the development and implementation of innovative practicum models. Such

activities may be particularly important given claims that practicum experiences may affect a nursing student's future employment decisions (Andrews et al., 2005) and negative placements increase attrition, exacerbate recruitment problems, and ultimately lead fewer new graduates to enter the workforce (Chuan & Barnett, 2012).

Healthcare services are difficult environments for nursing students to negotiate (Newton et al., 2009b); being unpredictable, stressful, and occasionally confusing for these learners (Baraz et al., 2015; Esmaeili et al., 2014). Whilst placements may be challenging and demanding, they also provide potentially rewarding experiences (Greenstock & Brooks, 2014; Mikkonen, 2005). Various factors affect the quality of clinical education within placements and hence the nature and extent of student learning in the practice setting (Stephenson, 2016) and it is recognised that healthcare organisations often do not readily encourage new learning (Henderson et al., 2011). Research in Hong Kong by Lee et al (2018, p.103) involving semi-structured interviews with 16 fourth year nursing students and 4 registered nurses [RNs] found nursing students' clinical education was affected by *'interpersonal, socio-cultural, instructional, environmental, emotional and physical factors'* and placement experiences had a profound effect on whether these students chose to continue their programme; an assertion supported by more recent research in Israel (Suliman & Warshawski, 2022).

Although *'it is essential that students are treated with equity and consistency throughout their education'* and receive *'high-quality structured learning experiences in a supportive environment'* (Hutchings & Sanders, 2001, p.41), it has been argued some education providers are now so desperate to find clinical placements for PRNP students they adopt a laissez-faire approach to practicum planning which ignores the requirement for such experiences to be clinically relevant (Schwartz, 2019). Critically, even what constitutes a positive practice learning experience for a nursing student is unclear. Levett-Jones et al., (2012, p.16) maintain '*there is little robust contemporary evidence to support many of the practices related to clinical placements for nursing students*' and observe that '*in the nursing literature, opinions are divided concerning the optimal duration and structure of placements as well as their impact on students' experiences.'*

Indeed, it continues to be argued that *'despite a considerable body of literature exploring placement learning within health professionals' education, there is limited evidence*

available on what exactly makes a good placement' (Jack et al., 2018, p.930). Similarly, Vance & Burford (2018, p.28) note that, regarding models of placement learning, there is a *'dearth of robust evaluation data in the literature, with, most frequently, low quality evidence from pilot studies.'* Perhaps of equal concern, however, is that an integrative literature review of 22 studies addressing practicum satisfaction found most concluded nursing students wanted more positive placements than they reported experiencing (Phillips et al., 2017). More recently, a questionnaire exploring practicum experiences completed by 301 final-year PRNP students in Singapore found respondents were moderately satisfied with their placements but desired a degree of autonomy in their clinical learning which was commonly unavailable. The researchers also discovered clinical teachers often failed to provide the creative and innovative practice-based learning activities which would most effectively engage students (Woo & Li, 2020).

6.3 Characteristics of a positive practicum

A survey of 150 final-year PRNP students in Australia by Doyle et al (2017) found learners regarded working with welcoming staff who were favourably disposed towards providing learning opportunities was the most positive influence on their level of placement satisfaction. Reflective accounts from 10 second-year nursing students in Namibia identified that good interpersonal relationships in a practice setting enhanced their learning and were associated with these individuals feeling welcome, supported, and recognised as a member of the clinical team (Nuuyoma & Ashipala, 2018). Using focus groups involving 14 third-year nursing undergraduates in Australia, van der Riet et al (2018) also concluded positive student evaluation of placements could be attributed to these learners being expected, welcomed and familiar with the setting, staff, policies, and procedures.

Quantitative research in Egypt drawing on the experiences of 127 third and fourth grade PRNP students by Mostafa (2017) suggests a positive practice learning environment is characterised by open communication, shared learning experiences and trust, and is never the product of chance but instead created by educators who fully appreciate the varied needs of adult learners; a view supported by other researchers (Bisholt et al., 2014; Carter et al., 2015). Similarly, a literature review and national stakeholder consultation undertaken on behalf of the Australian Government identified clinical placement

experiences were improved in those settings which displayed '*a culture for quality'*, provided effective supervision, offered learning opportunities which enabled '*participation in direct patient care'*, exhibited '*effective communication and collaboration between students, academic institutions, and placement* sites', and received sufficient resourcing for practicum activities. Conversely, placement quality was adversely affected by '*occupational stress which induces states of anxiety that inhibit learning, impair performance, and compromise health and wellbeing'* and *'workplace incivility and aggression which threatens the socio-emotional and physical safety of students in the placement environment'* (Siggins Miller, 2012, p.v).

Appropriate preparation of those RNs involved in supporting PRNP students is central to creating a welcoming atmosphere (Hutchings & Sanders, 2001); not least because such clinicians have power over these learners (Mansour, 2013; Hemberg & Sjoblom, 2018) and are likely to have the most profound influence on student learning during clinical placements (Levett-Jones et al., 2012). Experimental research in South Korea by Kim et al (2013) involving 52 junior PRNP students found a practicum which involved greater integrated educational provision from academics and clinicians was the most effective means by which to increase both teaching quality and student proficiency. Henderson et al (2011) also claim successful practice learning relies on good partnerships between healthcare providers and academic institutions.

Within nursing, the process of professionalization has been widely examined (MacLellan et al., 2011) and the student's sense of belonging as a team member within a clinical learning experience is recognised as inextricably linked to their receptiveness to new learning. Aitkenhead et al (2015) argue that, within a practicum, staff and students need to work together constructively and Woo & Li (2020, p.7) assert '*a positive collegial relationship is essential to a clinical learning environment that promotes effective apprenticeship-based learning and professional socialization for nursing students.*' In-depth semi-structured interviews with 18 third year PRNP students in Australia and England found *'positive staff-student relationships are crucial for students to feel accepted, included and valued*' and that feeling part of a practitioner *group 'influences choices about staying in the 'profession' over the longer term and the development of students' sense of identity as a nurse'* (Levett-Jones et al., 2009a, p.323). A survey involving a convenience

sample of 310 undergraduate nursing students in Oman also suggested *'being recognized as part of the nursing team and participation in patient care created positive student learning'* (D'Souza et al., 2015, p.838), whilst the results of a survey involving 147 PRNP students in Northern Ireland confirmed '*the importance of personalisation and sense of belonging and acceptance for nursing students to be a key factor in the clinical learning environment'* (Shivers et al., 2017, p.63).

Interviewing 10 final-year nursing students in England regarding their practice learning experiences, Phillips (2017) found every respondent described a strong desire to be accepted by the clinical team within which they undertook their placement and strived to become a valued member. Data from focus groups comprised of 12 final-year PRNP students in Australia also *'highlighted the importance to their learning of belonging to a team where their skills and knowledge could be constructively improved'* (Nash et al., 2009, p.55). Focus group responses from 17 undergraduate midwifery students, also in Australia, similarly highlighted the importance of acquiring a sense of belonging in the clinical team but noted the respondents' efforts to 'fit in' sometimes required them to set aside their learning needs for fear that asserting them would jeopardise their positive working relationships (Gilmour et al., 2013). More concerningly, interviews involving a purposive sample of 30 third and fourth-year undergraduate nursing students in Malawi found '*unfairness and lack of objectivity during the evaluation of the clinical performance of nursing students'* which, recognising the effect the quality of their relationships could have upon the clinical grades they received, led these learners to become *'preoccupied with building relationships with qualified nurses'* (Msiska et al., 2015, p.470).

6.4 Student support on placements

In Iran, 90 baccalaureate nursing students in focus groups said the initial period of a practicum was the most anxiety-provoking component of each clinical experience, partly due to a fear of their making mistakes in delivering nursing care. Participants in this study also suggested there were tensions between themselves and RNs regarding the work they were assigned; since this often involved very basic nursing tasks which they believed would have been better delegated to non-registrant carers (Sharif & Masoumi, 2005). Such accounts do not therefore appear to reflect the need, articulated by several writers, for nursing practice placements to be flexible, varied and provide individualised student

learning opportunities (Hutchings & Sanders, 2001; Thomas & Westwood, 2016). Semi-structured interviews with 7 second and third-year adult PRNP students commencing an Emergency Department placement in Scotland also indicated most felt terrified and were concerned at being ill-prepared and unable to meet the expectations of clinicians in the setting but ultimately believed they became a member of the team (Hunter, 2010).

Interviews, surveys, and fieldwork observations involving 29 second and third year PRNP students in Australia by Newton et al (2009b) suggested it was only by contributing to the work of a ward team that students gradually gained acceptance and moved beyond their initial status as a peripheral team member. Earlier work in the same nation by Nolan (1998) using semi-structured interviews with a purposive sample of 6 second year PRNP students found that, until these learners felt accepted within their placement, learning could not proceed. Moreover, unstructured interviews with a convenience sample of 6 nursing students in England found participants '*expressed a lack of confidence and self-criticality in their performance'* (Ryan, 2016, p.68); whilst a systematic review of professional socialisation among undergraduate nursing students reported such learners commonly face discrimination, disrespect and isolation in practice environments and that these experiences can lead individuals to feel vulnerable, burdensome, lack confidence and become withdrawn and demotivated (Salisu et al., 2019). It is perhaps unsurprising, therefore, that research involving the completion of a qualitative questionnaire by 77 nursing students in Finland concluded an invitation to participate in care delivery is the cornerstone of effective student supervision and being excluded from mainstream staff activity in a practicum can cause the learner to acquire a permanent negative professional self-image which they retain as an RN (Hemberg & Sjoblom, 2018).

Newton et al (2009b) recognise nursing students may have to navigate various cliques and affiliations within the unfamiliar clinical environments in which their placements occur. Evidence does indeed suggest many such learners encounter social and interpersonal complexities within practice settings. A case study, undertaken in Australia, involving 7 nursing students at different stages of their programme all of whom were assigned to a rural clinical practicum, noted that *'professional relationships in this rural setting crossed into participants personal worlds'* (Pront et al., 2013, p.284), whilst Doyle et al (2017) discovered the culture within a practice learning environment, most notably how clinicians

acted towards their colleagues, was regarded by students as the best indicator of their likely success in a placement.

Clinical staff have traditionally been assigned to provide learning support for students on placements (Ohaja, 2010). Internationally, different terms are used to describe an RN who is formally responsible for supporting a nursing student in a practicum; such practitioners being variously referred to as *facilitators* (Ford et al., 2016), *instructors* Flott & Linden, 2016), *mentors* (Hunt et al., 2016), *practice assessors* (Nursing & Midwifery Council, 2018c), *preceptors* (Happell et al., 2015) and *supervisors* (Prescott-Carter & Onuoha, 2016) and these titles are often used interchangeably (Sandy, 2014). Mentoring has been described as enabling nursing students to both work with, and emulate, experienced qualified nurses and in so doing develop their clinical competence and help them link theory to practice. The mentor role is also regarded as central to making nursing students feel a valued member of the clinical team and may be one of the most important influences upon the socialisation process in nursing, the acquisition of ethical decision-making skills, and the individual's delivery of high-quality care (Baldwin et al., 2014; Muleya et al., 2015; Skela-Savič & Kiger, 2015).

A survey by Carlson & Idvall (2014) involving 260 nursing students in Sweden found the supervisory relationship had the strongest impact upon their perception of the clinical learning environment, whilst a focus group discussion involving 7 nursing students in the United Arab Emirates '*indicated that their training was dependent on their preceptor and their willingness to guide the student*' (Hooper et al., 2020, p.66). Correspondingly, a questionnaire completed by 178 nursing undergraduates, 22 clinical facilitators and 163 supervising RNs in Australia discovered '*relationships between supervising ward nurses and undergraduates were important influences on the placement experience'* and affected how confident learners felt in seeking advice and support. Indeed, on those occasions when a nurse made it clear they were unwilling to help students, respondents reported feeling *'nervous and incompetent'* (Courtney-Pratt et al., 2011, p.1386). Furthermore, a survey of 357 second-year nursing students in Cyprus reported '*the dimension "supervisory relationship (mentor)", as well as the frequency of individualized supervision meetings, were found to be important variables in the students' clinical learning'* and that effective

supervisors not only helped meet individual learning needs but also enabled students to gain a sense of professional identity (Dimitriadou et al., 2014, p.236).

A subsequent quantitative research study in Cyprus involving 463 nursing undergraduates found '*the supervisory relationship was evaluated by the students as the most influential factor in their satisfaction with the clinical learning environment*', that '*students who had a named mentor reported being more satisfied*' but that satisfaction levels decreased as these learners progressed within the programme (Papastavrou et al., 2016, p.1). Focus groups involving 100 nursing students in Saudi Arabia also identified the importance learners attached to having instructors who were good communicators, empathic, supportive, motivating, competent and professional role models (Allari & Farag, 2017). Moreover, a comparative study of two models of supervision in Australia involving 159 PRNP students found respondents overwhelmingly regarded the quality of supervisory support they received as the most important influence on their practice learning experience (Walker et al., 2013); whilst in Canada, interviews with 26 preceptors and 23 nursing students located in rural settings discovered a positive relationship between the student and preceptor could significantly affect recruitment to vacancies in rural services (Yonge et al., 2006).

6.5 Problematic mentor preparation, beliefs, and conduct

A review by Henderson et al (2012) of six studies from three different nations employing the same clinical learning environment survey indicated that, although PRNP students generally reported feeling a sense of affiliation within their placements, their opportunities for one-to-one interaction with practitioners were much more limited. In Malawi, data from 126 questionnaires completed by student nurses and midwives and follow-up focus group discussions involving 30 of these participants identified inadequate support from their clinical teachers. It also found the poor communication of qualified nurses often robbed students of their dignity and reduced their confidence to develop clinical skills during a practicum (Mbakaya et al., 2020). Semi-structured interviews with 17 nursing students in Iran by Esmaeili et al (2014) identified instructor friendliness and expertise were key components of a positive student learning experience, that delegation of tasks increased learners' self-confidence and sense of accountability but that, once again,

negative mentor behaviours, such as criticism of a student in the presence of patients, adversely affected learner self-confidence and motivation.

A review by Atakro & Gross (2016, p.3) suggests the benefits of a supervisory relationship in a clinical setting may also be limited; concluding *'there is no evidence to support the notion that preceptorship provides students with the opportunity to develop critical thinking.'* Arguably, various studies may provide an explanation for this limitation. In Israel, a questionnaire completed by 200 RNs working as preceptors in both community and hospital settings found many preceptors felt inadequately prepared for their role (Natan et al., 2014); whilst a mixed methods case study in England highlighted that although mentors primarily lead nursing student learning on a day-to-day basis, they do not always have the necessary support, training, or capacity to do so effectively (O'Driscoll et al., 2010).

Quantitative research in Slovakia involving a questionnaire completed by 143 mentors similarly discovered respondents *'tended to lack a career development plan, had low work time spent on research and insufficiently participated in education and training activities'* (Skela-Savič & Kiger, 2015, p.1044). Henderson et al (2011) argue nurses often feel they have insufficient time to interact with students and research in Sweden by Carlson et al (2010) involving observation of 13 RNs and focus groups attended by 16 preceptors reported that these practitioners often felt stressed and inadequate due to the limited time they could assign to providing student support. Further research has also highlighted that RNs providing placement education have the most influential effect on nursing student learning but are often too busy to engage in clinical teaching (Anderson et al., 2020; Lee et al., 2018; Madhavanpraphakaran et al., 2014).

Nurses working within rural settings in Canada were concerned as to whether the currency of their nursing knowledge was adequate for them to be an effective preceptor and those holding lower academic qualifications than the students whom they would be supporting sought to acquire were less willing to undertake such a role. Additionally, those who were already preceptors expressed concern about a lack of engagement with, and support from, the university providing the PRNP programme (Yonge et al., 2006). Similarly, a survey involving 34 RNs in Australia indicated '*that university involvement in preparation of preceptors is scant'* and *'resource provision and communication from universities to*

preceptors is considered problematic' (Broadbent et al., 2014, p.403). Furthermore, interviews with 18 undergraduate nursing students in Iran identified instructors commonly had inadequate theoretical and practical competence and the researchers concluded that the existing arrangements for practice learning were failing to effectively meet nursing student needs (Baraz et al., 2015).

Davey (2002, p.194) claims '*students on clinical practicum are often placed with dissatisfied nurses who continue to express their discontent and endeavour to discourage students from fulfilling their potential.'* More objective evidence appears to support some of these concerns. In Australia, Enrolled Nurse students described receiving inadequate placement supervision (Schwartz, 2019) and research in England involving unstructured interviews and non-participant observation of 15 nursing students, 15 mentors, 8 ward managers, a practice development co-ordinator, and a senior nurse responsible for clinical development found learners often felt they were treated like non-registrant carers rather than nursing students (Ousey, 2007). In the West Indies, a semi-structured questionnaire completed by 103 PRNP students noted supervisors use them as *'an extra pair of hands'*, *'get tired of helping when they have to do other things'* and some were *'ignoring students when they come on the ward'* (Prescott-Carter & Onuoha, 2016, p.1046).

In Jamaica, a questionnaire completed by 107 undergraduates on a four year PRNP degree identified almost 18% of respondents described their relationships with preceptors as '*difficult'* or *'very difficult'* (Pusey-Murray & Onyefulu, 2018); whilst a survey of 113 nursing students from 11 universities in South Korea found over 67% believed they were assigned chores to complete in the practice setting, reported being frequently asked to undertake non-nursing tasks and felt that their practicum schedule was often determined by the needs of the service rather than to fulfil their learning objectives (Park & Nam, 2016). In France, an evaluation of a new PRNP curriculum using documentary analysis, on-site observations, in-depth interviews, and focus groups involving nursing students, newly qualified RNs, nurse educators and clinical placement co-ordinators found nursing students received little sympathy or support from their mentors. Indeed, it was suggested '*student nurses from the new program who were insufficiently prepared to perform clinical skills were often perceived as burdens to staff nurses who passed them around like "hot potatoes"'* (Petit dit Dariel et al., 2014, p.96).

Interviews with 30 third and fourth-year nursing students in Malawi suggested learners found their relationship with clinical supervisors as one of the most stressful within their programme; regarding them as critical observers who policed their practice (Msiska et al., 2014). Of even greater concern, more recent research in South Africa using two world-café sessions involving a purposive sample of 51 male and female PRNP mentees suggested mentors commonly absented themselves from the practice setting for part of the working day and, when available, were often '*unapproachable, autocratic and displayed undesirable attitudes towards undergraduate nursing students'*; being '*more interested in having intimate relationships with them rather than mentoring them'* (Ntho et al., 2020, p.5).

Roxburgh (2014) claims many students report feeling they are no more than visitors to their clinical placement and do not 'belong' there. Research by Levett-Jones et al (2009a) supports this assertion, highlighting some nursing students felt excluded from the clinical team during their placement, were alienated and regarded as an impediment to effective service delivery. Indeed, based on these student reflections, the researchers suggested staff made little effort to hide the impatience and frustration they experienced when having to support learners and their negativity diminished student confidence and enthusiasm for learning.

Semi-structured interviews with 30 nursing and midwifery students in Ghana identified poor interpersonal relationships between learners and staff during clinical placements; respondents being humiliated by placement staff if they made mistakes. Moreover, *'some staff nurses and midwives had their favourite students and if a student was not a favourite of any staff, he or she was not taught by any nurse or midwife'* (Atakro, 2017, p.7). In the UK, focus groups and interviews involving 41 students on adult nursing, dietetics, midwifery, paramedic, occupational therapy, physiotherapy, and podiatry programmes indicated most respondents felt they were well supported in placements. Nevertheless, students commonly cited examples of placement staff displaying unsupportive behaviour and negative attitudes towards learners (Williamson et al., 2011b).

In an online survey completed by 159 undergraduate nursing students in Australia, '*many participants commented on what they perceived to be a lack of interest from staff to which they were assigned and this made them feel like they were a burden'*; hence the

researchers concluded such negative experiences may adversely affect both a learner's view of nursing and the construction of their professional identity (Walker et al., 2014, p.106). More recent research in England involving a survey of 1,425 PRNP students and follow-up unstructured interviews with 22 learners generated comparable findings. Although respondents were eager to acquire a sense of belonging, in some placements they felt unsupported, ignored, treated merely as unpaid labour, and even bullied (Jack et al., 2018).

Similarly, a cross-sectional survey involving 888 Australian nursing undergraduates found just over 50% of respondents had experienced bullying and/or harassment during a clinical placement and the perpetrator was most commonly an RN based in this clinical setting (Budden et al., 2017). Furthermore, a survey of 296 PRNP students in New Zealand found such learners *'experience a significant amount of uncivil behaviour while on clinical placement',* including being ignored, excluded from nursing activities, sexually harassed, delegated menial tasks, and told they were worthless (Minton & Birks, 2019, p.15). Such evidence may also help to explain the results of a survey in Saudi Arabia which identified a strong preference amongst 110 nursing students for a preceptorship model involving a Clinical Teaching Assistant from the college of nursing rather than a hospital-employed RN (Omer et al., 2013).

6.6 Educational culture

In terms of both learning and student satisfaction, the clinical service provided by a placement may be less important than its educational culture. Doyle et al (2017) found whether students had been assigned a specialist or generalist practicum had no effect on reported levels of satisfaction with their experience. In Sweden, quantitative research by Bisholt et al (2014, p.308) involving a questionnaire completed by a convenience sample of 185 third-year nursing students undertaking their last programme placement in either a hospital, nursing home, community nursing team, primary healthcare setting or mental health service '*showed that they experienced more meaningful and multi-dimensional learning situations in hospitals than in other clinical settings*.' It was suggested, however, that this difference may have been the result of the leadership style of service managers, the level of co-operation between nurse teachers and clinicians and varying levels of patient contact affecting opportunities for practice learning, rather than the nature of

service provided. Using a multiple case study to explore nursing student placements in four units of an urban health centre in Canada, Hegenbarth et al (2015, p.307) discovered units develop a culture associated with hosting nursing students and the ideal learning environment is characterized by openness, taking students 'under their wing' and structuring learning experiences to meet their goals.

6.7 Practicum length

Several studies suggest the amount of PRNP student time in a placement may also affect practice learning, although the most desirable model is a matter of greater debate. Hudson & Weston (2014) claim healthcare student placements have historically involved short-term experiences that provide little scope for students to develop relationships with patients and which prevent learners from fully appreciating the continuity of care. In contrast, Newton et al (2009b, p.633) argue a structure where PRNP students return to the same organisation for placements in the second and third years of their programme enables learners to acquire *'a sense of attachment and familiarity with the workplace, including knowledge of the hospital sites, and relevant policies and procedures.'*

Mixed methods research in Australia and England involving 362 third year PRNP students in three universities concluded longer placements involving *'a consolidated period of practice for students to 'settle in' and establish collegial relationships is an important influence on their experience of belonging and a necessary precursor to their active and participative learning'* (Levett-Jones et al., 2008, p.8). Work by Lee et al (2018, p.108) also found longer practice learning experiences could enable students to establish a better rapport with clinicians in the setting but cautioned *'a longer clinical placement guarantees neither positive interpersonal relationships between nurses and nursing students, nor the students' positive learning experiences.'*

There is also some evidence to suggest that unexpected benefits may arise from shorter practice learning periods. For example, a longitudinal study in Australia involving 429 graduates from 12 health disciplines, including nursing, found that students given rural placements of four weeks or less in their training were more likely to take up professional employment in rural settings on qualification. The researchers attributed this finding to shorter placements minimising problems that were not directly practicum-related but

could adversely affect the impression students gained in respect of rural practice, such as extra travel and social dislocation (Playford et al., 2006). It should be noted, however, that these findings differ to those of several comparable studies in medical education, which have indicated the value of extended placements ultimately encouraging students to take up rural practice as physicians (Hudson & Croker, 2017; McDonnel Smedts & Lowe, 2008; Poncelet & Hudson, 2015).

6.8 Individual and student group characteristics

In seeking to determine the effectiveness of the practicum, one should not overlook the influence of individual and student group characteristics on the learning experience. In Oman, a survey involving 76 nurse preceptors highlighted problems with a lack of student motivation and commitment (Madhavanpraphakaran et al., 2014); whilst in Australia, supervising ward nurses similarly identified difficulties when learners appeared to lack enthusiasm or drive (Courtney-Pratt et al., 2011). More recently, focus groups involving 40 Ghanaian nursing students found some learners appeared not to take their training seriously, were unwilling to learn, often absent from placements and that such negative attitudes and behaviour adversely affected development of their clinical competence (Salifu et al., 2022).

A systematic review of undergraduate nursing students' socialisation reported that self-motivation is a key factor affecting an individual's ability to cope effectively with challenges during their programme (Salisu et al., 2019). Research in Oman by D'Souza et al (2015) found receptiveness to learning opportunities was affected by the PRNP student's socio-economic status, culture, customs and values and that older learners and those with a history of higher academic performance were more likely to report satisfaction with their clinical learning experiences. In addition, a survey in Norway involving 184 nursing students discovered older respondents reported more positive perceptions of the learning environment and speculated that such students *'may be more motivated when they finally enter nursing education'* and possess a greater level of emotional and experiential maturity '*which makes it easier to tackle the varied challenges in different placement settings'* (Bjork et al., 2014, p.6).

In the UK, a focus group and eleven subsequent in-depth interviews of mature students undertaking adult and mental health PRNPs found learners were exposed to various competing demands affecting both their academic and practice-based learning and participants not only valued peer support highly but saw this as critical to their success (Brigham & Smith, 2008). In Australia, an evaluative study of an innovative model of PRNP student support, teaching, and learning, also reported learners valued working with their peers in the practice setting, since doing so generated a sense of camaraderie, provided mutual support, allowed workload to be shared and afforded better opportunities to discuss clinical experiences. Nevertheless, students also noted such working arrangements created competition between learners for more limited practice opportunities (Bourgeois et al., 2011).

In Norway, a survey involving 23 nursing students experiencing a new model of placement support discovered peer learning enhanced collaboration and support (Vae et al., 2017); whilst research in Sweden involving 17 patient interviews to evaluate a model of practice learning, in which nursing students learn through supervision in pairs, was reported to enhance care provision (Strömwall et al., 2018). Correspondingly, in England a study examining factors associated with nursing student success found the value of peer support was repeatedly highlighted by participants (Ryan, 2016). Additionally, a survey in Malaysia involving 142 student nurses reported that interaction with peers during a placement was regarded as a valuable resource, providing informal help and emotional support, and thereby contributed to better conditions for clinical learning. The researchers concluded, however, that students '*also need to have a positive attitude towards their own learning in order to make best use of the learning opportunities available to them whilst on placement*' (Chuan & Barnett, 2012, p.196).

6.9 Assessment problems

Gupta et al (2017, p.74) claim *'it is evident assessment drives learning, and what is not assessed is not learnt.'* Effectively evaluating the clinical performance of students is highlighted as a specific challenge in nurse education and inconsistencies in the assessment of nursing undergraduates may prevent some individuals from acquiring the necessary skills for RN practice (Sandy, 2014). The use of traditional tools to determine the extent of learning, for example portfolios and multiple-choice questions (McMullan, 2008;

Siegel, 2015), and measuring teacher effectiveness based on the test performance of students (Kantar, 2014; Lum, 2016; Oermann & Gaberson, 2017) have also been accused of exacerbating assessment-driven behaviour within PRNPs.

Moreover, it is argued portfolios are not always satisfactorily standardised, valid, and objective (Aswani, 2019; Joshi et al., 2015; Moniz et al., 2015) and that mentor 'sign-off' of nursing student competence at the end of a placement increases the risk that learners displaying unsatisfactory clinical performance are treated as if they are proficient (Hunt et al., 2016); a phenomenon commonly referred to as *failing to fail* (Bachmann et al., 2019). In Malawi, an investigation by Mbakaya et al (2020) also discovered clinical assessments which students undertake within their PRNP are commonly re-scheduled for the convenience of assessors, leaving learners with multiple assessments in short periods and increasing their stress. Such conditions may be of particular concern given the assertion that the frequency and intensity of clinical assessments to which nursing students are exposed can adversely affect the process of clinical learning (Nelwati et al., 2013).

Research by Ryan (2016, p.64) suggests nursing undergraduates seek '*to understand the context of the programme and career rather than just see things as a 'single' assessment*.' In contrast, a study in Hong Kong by Tiwari et al (2005) using focus groups attended by a purposive sample of 38 second, third, and fourth year PRNP students and RNs found what students learned during placements appeared to be restricted to those knowledge and skills directly associated with programme assessments. Correspondingly, focus groups involving 15 medical students during their first clinical year in Australia highlighted that their *'preoccupation with a narrow professionalisation goal and summative assessment to get there'* inhibited wider teamworking and professional acculturation (Greenstock & Brooks 2014, p.107). Furthermore, a study by Ousey (2007) suggested nursing students believed questioning practices within a placement could adversely affect their mentor's judgement as to whether they had successfully completed all expected competences during the practicum and so was behaviour that was best avoided. It seems, therefore, that just as educators may risk *teaching to the test* to enhance academic outcomes for a group of learners (O'Donovan et al., 2019), so nursing students may be inclined to simply *learn for the test* and avoid appearing challenging during a practicum with a similar personal goal in mind.

6.10 Conclusion

Providing effective PRNP placements is an enduring, multi-faceted challenge for nurse educators worldwide. Practice learning experiences are affected by a range of social, environmental, educational, intrapersonal, and interpersonal variables. Specifically, such variables include student preparedness for the practicum, the emphasis assigned to achieving programme assessment tasks, the learning culture of a service, the quality of support and guidance offered to placement providers by the academic institution delivering the nursing programme and the student's contribution to, and sense of belonging within, the nursing team. Practicum experiences are also affected by the time a supporting nurse can devote to learner support, mentor expertise, the relationship between the preceptor and student, the nature and availability of peer support amongst learners and the impact of individual student characteristics on the practice learning experience. Given the wide range of international evidence indicating negative PRNP student experiences during placements, it appears nursing still has much to do if it is to create the clinical learning conditions necessary to improve retention on such programmes, enhance student satisfaction, ensure practicum experiences help to create confident and skilled nurses and in so doing more effectively tackle staffing shortages.

Nevertheless, the realist synthesis undertaken within this chapter of the thesis provides both useful findings against which to assess some of the results of this study [see Chapters 10, 12 &, 15] and support subsequent arguments regarding recommendations to improve nursing student practice learning experiences [see Chapters 11, 13 & 16]. In the next chapter, those relatively modest number of investigations examining either student experiences comparable to an integrated practicum, or which evaluate the use of block and/or integrated placement models [the focus of this research study] within various disciplines, are described and appraised.

Chapter 7. Realist Synthesis - practicum models

7.1 Introduction

Whilst practice learning is of considerable importance in the development of nursing skills (Bergjan & Hertel, 2013) and direct workplace experiences are by far the most frequently adopted approach to the clinical education of pre-registration nursing programme [PRNP] students, there continues to be no identified model on which to structure such learning that is demonstrably superior (Bhagwat et al., 2018; Bourgeois et al., 2011; Rohatinsky et al., 2017). '*Many of the bodies that set standards for pre-registration health and social care professional education specify a minimum total duration for practice education but do not specify how this ought to be achieved*' (Beveridge & Pentland, 2020, p.488). As a result, practicum experiences both for nursing students (Levett-Jones et al., 2012; Yan, 2019) and the wider undergraduate population (Rambe, 2018; Robinson & Walters, 2016; Smith, 2021) vary greatly in terms of duration and intensity.

Eskilsson et al (2014) claim numerous research studies have explored learning in clinical practice. Nevertheless, some authors argue there is still a lack of high-quality evidence evaluating differing placement designs (Millington et al., 2019; Schuijers et al., 2013) and McAllister et al (2018) highlight a paucity of evidence evaluating quality improvements in clinical placements. Happell (2008, p.850) adds that studies in this field have *'not attempted to identify and measure the extent to which students' perceptions of clinical experience can be influenced by factors such as time spent in the clinical environment.'* Similarly, Ryan (2016) asserts there is little literature focusing upon those environmental factors within PRNPs that can be modified to optimise student success and Nyoni et al (2021) draw attention to a shortage of work addressing the longitudinal effect of different practicum designs.

Although increased attention is now being given to alternative placement models (Patterson et al., 2017), more than 180 years since the first formal nurse education programme was established (Hill & Stephens Howlet, 2013) there is still only limited evidence available regarding exactly what creates a good practicum (Jack et al., 2018). This may be partly attributable to the historical status of workplace learning, which has been

deemed inferior, rather than different, to that provided within academic institutions (Billett, 2008). As a result, within nursing (Chan et al., 2018; Gonzalez-García et al., 2021; Papastavrou et al., 2016) and other health and social care disciplines (Fairbrother et al., 2016; Hemy et al., 2016; Vance & Burford, 2018) there have been calls for research not merely to explore placement experiences but identify the most effective practice learning models.

This final chapter of the realist synthesis underpinning this research summarises and reviews work of direct relevance to the research question. It does so by focusing upon investigations which either describe and evaluate workplace learning experiences comparable to use of an integrated practicum design, or which consider implementation of block and/or integrated placements within academic programmes. From a critical realist perspective, a study with a single area of interest, such as this investigation, must commonly *'go beyond its disciplinary boundaries to achieve adequate understanding'* (Danermark, 2019, p.368). To gain such understanding within a topic lacking an extensive knowledge base, the literature reviewed in this chapter therefore comes from a wide range of disciplines.

7.2 Models of practice learning

Various terms are used to describe practicum experiences and supervisory practices in clinical education literature (Sheepway et al., 2011). Uys & Gwele (2005), however, argue there are essentially only three core models employed to structure practice learning within PRNPs, namely the *block*, *integrated* and *internship* approaches. Nevertheless, numerous sub-variants, such as the *block and dedicated education unit* (Donnelly, 2012), *hub and spoke* (McClimens & Brewster, 2017), *pathway* (Stacey et al., 2012), *developing and learning care unit* (Strömwall et al., 2018) and *rotational* models (Venkatesan & Joshi, 2015) are evident.

Stephenson (2016) suggests the clinical education framework is one of three key factors affecting placement learning experiences, the other two being the specific characteristics of the practice learning environment and the quality of student supervision. Many practice learning models described and evaluated in nursing literature, for example the *clinical education unit* (Jayasekara et al., 2018), *clinical partnership* (MacLean et al., 2018), *cluster*

(Bourgeois et al., 2011), *collaborative learning unit* (Marcellus et al., 2022) and *team preceptorship* (Cooper Brathwaite & Lemonde, 2011) models, however, focus solely on the supervisory practices of clinicians and educators, failing to consider the influence of practicum duration and intensity on the nature of student learning. As Cleak & Zuchowski (2019) comment, quality supervision can be present or absent in practice education within any placement model. Since practicum structure may affect student performance and learning outcome achievement (Baglin & Rugg, 2010; Happell et al., 2015), it is arguably just as important, therefore, to examine placement design as the model of supervisory support to which students are exposed.

7.3 The Block model

The block model is a traditional practicum design (Humphries et al., 2020, Terry et al., 2022) and the most commonly used placement framework within professional healthcare programmes (Coleman et al., 2017). It is also referred to as the *consecutive* (Sederevičiūtė-Pačiauskienė & Vainorytė, 2015; Van Nuland et al., 2021), *contiguous* (California State University San Bernardino, 2022; Luther College, 2018), *daily* (Adistana et al., 2020; Colorado College, 2022), *full-time* (Langørgen & Magnus, 2020; Smith et al., 2019), *intensive* (Dobkin & Hassed, 2016; Jaspher & Kavichelvi, 2021), *inter-semester* (Adam, 2018; Kwashie, 2019), or *uninterrupted* (Archer, 2016; Gao et al., 2021) approach. The model provides exclusive placement periods within a programme (Levett-Jones et al., 2018; University of Southern Queensland, 2021), commonly lasting several weeks or months (Humphries et al., 2020).

Advocates claim this design offers continuous and coherent learning (Meyer-Smith & Mitchell, 2005), is *'more conducive and in tune with the pursuit of intellectually and professionally stimulating tasks'* (Gulalia, 2020, p.10) and gives the student in-depth experience of a workplace (Newcastle University, 2022; Sunirose, 2013). It may also provide greater opportunity for learners to witness and participate in the whole service user journey (Radey et al., 2019) and to become acculturated in a setting (Anastas, 2010). Furthermore, it is argued the block model enables learners to focus entirely on practice learning without the competing demands of concurrent academic studies, promotes a richer appreciation of practitioner roles and makes placement scheduling easier for the educational institution and service provider (Uys & Gwele, 2005).

Nonetheless, using a block model has some potential disadvantages. For example, it may increase the risk that academic learning is given insufficient emphasis and becomes crammed between placements, whilst having separate periods of classroom and clinical learning can make the application of theory to practice harder (Aged Care Services Australia, 2020; Dhemba, 2012). In addition, it is claimed learners on short, intensive, block placements can struggle to acquire a sense of belonging within a clinical team, practice learning experiences risk being regarded by both students and clinicians as work rather than education, and learners may even find themselves used simply to offset staffing shortages (Coghill, 2018b; Kevin et al., 2010; Uys & Gwele, 2005).

7.4 The Integrated model

The integrated model is also variously known as the *blended* (Amponsah et al., 2022; Christou et al., 2017), *concurrent* (Bogo et al., 2017; Guin, 2019), *continuous* (Antonio, 2012; McKenna et al., 2013), *day release* (Coghill, 2018a; Malaysian Qualifications Agency, 2015), *distributed* (Arnott et al., 2022; Mayer et al., 2017), *divided* (Indiana University, 2022; Tyndale University, 2022), *integrative* (Rasheed, 2017; Sterenberg & O'Connor, 2014), *interspersed* (Cavaye & Watts, 2014; Grenier, 2015), *intra-semester* (Anim-Boamah, 2021; Ziba et al., 2021), *non-block* (Perry et al., 2016; Rohatinsky et al., 2017), *non-consecutive* (Mesquita, 2018; Radey et al., 2019), *non-intensive* (Brayden Bursaw, 2012; Northwestern University, 2014), *parallel* (Hall et al., 2022; Naidoo & D'warte, 2017), *part-time* (Pridham et al., 2013; Sala-Hamrick, 2019), *protracted* (Ahmed, 2017; Boardman et al., 2019), *simultaneous* (Pearson & Hensley, 2019; Bradley University, 2022), *split* (North Notts College, 2022; University of Nottingham, 2022) or *weekly* (Beck Dallaghan et al., 2022; University of Lincoln, 2023) placement. Students assigned an integrated practicum have academic and practice learning in the same week; commonly spending several days in placement and the rest of their weekly programme time in academic study (Arnott et al., 2022; Sunirose, 2013). To provide a significant and meaningful experience, an integrated practicum often lasts several months or longer (Jagadish, 2015).

The advantages of the integrated model are said to include the potential for greater assimilation of theory and practice via the opportunity it affords students to reflect upon experiences, incorporate new learning and then immediately apply such learning to practice (Belur et al., 2019; Kaszuba, 2018; Rasheed, 2017). The framework also offers

learners *'an opportunity to gradually acquaint themselves with the profession'* (Gulalia, 2020, p.9) and provides increased scope for the same teaching staff to contribute to both academic and practice activities, further integrating student learning (Uys & Gwele, 2005). Use of an integrated practicum may help optimise placement capacity and so be more time and resource efficient (Boardman et al., 2019; Van Dort, 2005). Moreover, it can provide a learning experience that permits an individual to better understand, and work with, service users who require support over longer periods (Mohinuddin, 2020) as well as more fully appreciate everyday routines in the workplace (White & Forgasz, 2016).

An integrated framework, however, may make placements harder to schedule (Uys & Gwele, 2005), especially if the same number of hours are to be achieved as would be the case in an alternative block practicum, and can impair continuity within the practice learning experience (Fuggle, 1999). Integrated placements may be impractical if distant from the location in which classroom-based teaching occurs (Dhemba, 2012; Harris & Myers, 2013; Usher et al., 2022) and students with paid employment can find it more difficult to accommodate practice learning based on this design (Mohinuddin, 2020). Furthermore, concurrent exposure to practice and academic learning may generate additional competing programme demands and in so doing adversely affect student performance (Kirk, 2018; Reinke, 2018).

7.5 The Internship model

The internship model, also referred to as *nurse residency* (Wildermuth et al., 2020), which is designed to facilitate *clinical immersion* (Keiffer et al., 2020; Saxton & Nauser, 2020), can be used to complement a block and/or integrated placement model, or to follow a nursing programme which has only limited practice learning. It commonly consists of a practicum lasting up to a year (Dinç, 2014; Janowicz, 2022) which occurs either towards the very end of, or after, the formal programme and in such courses is normally a pre-requisite for graduates seeking professional registration (Salifu et al., 2022; West et al., 2020). It is claimed an internship *'allows students to learn new knowledge and skills by being completely immersed and engaged in the prescribed activity'* (Aloweni et al., 2017, p.267), permits learners to develop a rich understanding of the practice setting, form stronger working relationships with clinical staff (Bridge & Carmichael, 2014) and promotes more effective interprofessional working (Zomorodi et al., 2017). In addition, such placements

can expose students to new clinical experiences, help them integrate theory and practice, accelerate their learning, and facilitate a more effective transition to a registered nurse [RN] role (Doerner & Swenty, 2019; Neal-Boylan, 2019).

Funding an internship, however, can be problematic (Kumm et al., 2016) and some research within medical education brings into question the claims such immersive experiences necessarily enhance student skills and confidence (Rudland et al., 2011). Perhaps most importantly, since internships are only a supplementary feature of many PRNPs, this review focuses on the block and integrated placement models as the dominant foundations of practice learning within these curricula.

7.6 Practicum design – a limited evidence base, subjective selection, and opaque goals

Although '*it is important to combine theoretical and practical education in such a manner that they support each other in preparing students for the nursing profession'* (Tastan et al., 2015, p.142), Donnelly & Wiechula (2012, p.873) suggest the various practice learning models identified, described, and evaluated within nursing publications indicate *'curriculum designers and clinical venues are yet to find an optimum model of education*' to complement theoretical learning. Phillips (2017) argues very little literature considers the ideal placement length for PRNP students; whilst Rohatinsky et al (2017, p.152) similarly maintain *'little evidence is available to guide curricular planners in determining the appropriate and effective use of different clinical models in nursing education.'* Indeed, it is claimed placement models have largely been based on traditional wisdom (Sheepway et al., 2014), evolved through custom and practice, and been driven by both industry/professional expectation (National Nursing & Nursing Education Taskforce, 2006) and '*practical and financial factors rather than pedagogical needs'* (Birks et al., 2017, p.17). Helping to address the current paucity of research comparing PRNP block and integrated models of practice learning is a primary motivation which underpins this investigation.

Many publications within both nursing (Bjork et al., 2014; Carlson & Idvall, 2014; Gonzalez-García et al., 2021; Sandy, 2014; Saukkoriipi et al., 2020; Schwartz, 2019) and other disciplines (Brandon, 2015; Chan, 2013; Faez & Valeo, 2012; Hudson & Weston, 2014; Whatman & MacDonald, 2017) recommend longer practicum experiences for students. Nevertheless, it is seldom clear whether such work is advocating bigger block placements

with an increased number of hours, akin to the *longitudinal integrated clerkship* increasingly used in medical education (Poncelot & Hudson, 2015), or the same practice learning hours distributed over an extended timeframe [i.e., use of an integrated placement model]. Arguably, this lack of clarity masks a more fundamental uncertainty regarding the specific benefits of a longer placement and what mechanisms best enable these benefits to be realised.

For example, if a longer practicum is proposed as a means to promote greater student integration within the healthcare team, and in so doing strengthen the learner's clinical confidence and competence, then this may indeed necessitate a block placement with extra practice learning hours. If, however, the main goals of providing a longer placement are to better facilitate student reflection on practice and consolidate and assimilate academic and practice learning, then this might instead be more efficiently achieved by an integrated model using the same number of practice learning hours within a placement undertaken over an extended period. Given the reminder by Spence et al (2019, p.464) that '*clinical education is a critical, yet time and resource intensive aspect of nursing education'*, such clarification has both important economic and pedagogical implications.

7.7 Research generating transferable findings

Although not identical to use of an integrated practicum model within The Open University [OU] PRNPs [where all students undertake paid employment outside, but concurrent with, their academic studies on the course] initiatives providing paid nursing employment to undergraduate student nurses commonly reflect similar characteristics to this model. For example, in Canada, Gamroth et al (2006) evaluated an *Undergraduate Nurse Employment Demonstration Project* [UNDP] in which third and fourth year PRNP students were offered the opportunity for salaried employment at their educational level under the guidance of a nurse who was supernumerary to regular service staffing; some undertaking this work concurrent to their nursing studies throughout the year. The quasi-experimental outcome evaluation, which involved 173 new nursing graduates, 40 RNs and 7 faculty members involved in the project, found the UNDP improved the practice performance of many participants, increased confidence and, upon qualification, reduced the transitional period required for them to effectively fulfil their new responsibilities as a nurse. Since there was no evaluation of the initiative's impact on academic performance and some students were

offered UNDP employment in a block during their summer break or a combination of summer block plus extra hours rather than concurrent work, however, extrapolation of these findings to help establish the value of an integrated model of practice learning is inevitably limited.

In Australia, McLachlan et al (2011) evaluated a midwifery employment model in which students on a Bachelor of Nursing/Midwifery dual qualification programme who were also eligible for Enrolled Nurse registration could apply for salaried employment in postnatal wards. This work was undertaken in addition to their university studies but occurred outside programme placements. The evaluation involved 47 midwives and 9 students who participated in the scheme and most reported it strengthened working relationships between hospitals, universities, and students, enabled learners to acquire a clearer identity within a midwifery team and would more effectively facilitate their transition to a midwife role. Nevertheless, since this employment was not concurrent with student placement experiences it does not fully correspond with an integrated model of practice learning.

Originally launched in 2003, the *Temporary Undergraduate Nursing Students* [TUNS] initiative enables students in Hong Kong who have completed at least one year of their current PRNP to undertake part-time salaried work as non-registrant carers [NRCs] under RN supervision during weekends and holidays (Law, 2015). Using a purposive sample of 20 undergraduate and master of nursing students who attended one of six focus groups, some of whom had been employed as TUNS, Chan (2014) explored '*the meanings of intra-personal development and nursing leadership in nursing education and the clinical setting*' (p.425). The investigator's findings '*suggested that working as TUNS in clinical settings further allows students to demonstrate competence in self-management through prioritizing their duties on their own'* (p.429). This study, however, did not distinguish when those respondents with TUNS experience undertook this work, hence any comparison with an integrated practicum is impaired.

In the United States of America [USA], Del Sol Medical Center [DSMC] and the University of Texas at El Paso [UTEP] developed a nurse residency programme. Undergraduate PRNP students were invited to apply, and be interviewed, for such residency during their final semester. Successful applicants received a stipend of $3,500 for three weekly shifts, each

of 12 hours duration, over the semester. These shifts were undertaken within DSMC services and supported by a preceptor. Upon successful completion of their degree and the nurse residency programme, participants could become hospital employees. Those who failed to complete the programme and/or work as an RN within DSMC for at least one year beyond graduation, however, were required to repay the stipend in full. UTEP reconfigured the academic elements of the PRNP curriculum during this semester to accommodate the nurse residency, so teaching sessions were delivered over one rather than two days per week. Evaluation of the initiative suggested it both accelerated and improved competence acquisition, reduced expenditure associated with nurse orientation within DSMC, and was well-received by participants (Stout et al., 2015). It did not, however, examine whether the nurse residency programme affected undergraduate academic performance.

Kenny et al (2019) used mixed methods research to evaluate a *Registered Undergraduate Student of Nursing* [RUSON] initiative in which second year PRNP students in Australia were offered paid health service employment over ten months for at least 7½ hours per week [although all participants actually worked 15-20 weekly hours], concurrent to their programme studies, under RN supervision. The evaluation involved 56 staff and 39 RUSONs in asynchronous focus groups, surveys involving 80 clients, 61 staff and 16 RUSONs and monthly health service surveys of client outcomes and costs. Although RUSONs reported greater practice confidence, acquiring an ability to 'hit the ground running' and feeling part of their clinical team, the concurrent demands of study and employment left some feeling exhausted. Others reported frustration that, as a RUSON, they could not utilise all the skills they had developed as nursing students and experienced difficulty returning to this role after PRNP placement time. The researchers therefore wondered whether learners might have been more effectively employed as NRCs, rather than RUSONs, since doing so may have offered them a broader practice role.

More recently, Kenny et al (2020) evaluated implementation of the RUSON model in 12 rural health services, all located in the state of Victoria, Australia. Data collection involved RUSONs and other staff involved in the pilot study completing monthly online surveys over a 10-month period, use of a closed weblog site for RUSONs and a further one for staff engaging with them, service user surveys and focus groups/individual interviews with

RUSONs and other participating staff. Rostering shifts for RUSONs whilst accommodating the students' clinical placements and university attendance was described as problematic and some RUSONs missed timetabled university activities due to clashes with their paid shifts. Again, concerns were expressed regarding the scope of the RUSON role. Nonetheless, service users evaluated the model very positively and students regarded such healthcare work as much more beneficial to their professional development than alternative salaried employment.

7.8 Directly relevant research – no clear practicum model advantage/preference

A small number of studies have directly addressed the effectiveness of block and/or integrated practice learning models within higher education programmes, but their findings are inconsistent. In the United Kingdom [UK], an early survey by Carter (1997, p.16) compared the quality of supervision for adult branch PRNP students offered by either practice nurses or health visitors in a primary care placement lasting 10 days. The study involved 19 students and found no clear preference for a block or distributed [integrated] placement model amongst facilitators. The researcher found some respondents *'would have preferred a block placement while others would have liked the days distributed over a longer period'* and *'there was no distribution pattern that seemed to be suitable for everyone.'*

In the USA, Theriot et al (2006, p.215) compared the impact of block and concurrent [integrated] placements by analysis of data from a short survey and four standardised scales measuring professional competence and changes in a learner's assertiveness, self-esteem, and features of depression. The research involved 68 students and their field instructors on an undergraduate social work programme. Results showed no statistically significant difference in student performance and emotional wellbeing between learners undertaking placements based on either practicum design. The study also found undergraduates choosing block placements reported a desire to graduate early as the primary reason for this selection, whilst those having concurrent practice learning indicated their choice was largely due to family and work commitments. The researchers concluded that further work was required to evaluate the complete value and efficacy of both models and thereby adopt the best approach to field education.

Rush et al (2009, p.314) used a background questionnaire and an '*investigator generated perceptions of self in the clinical practice culture scale'* to compare the extent to which a convenience sample of 38 final year PRNP students from southeast USA felt they were assimilated into the culture of a practice setting. Learners either experienced a one day per week [integrated] practicum over 15 weeks or a full-time [block] summer externship lasting 6 weeks. Results showed no statistically significant difference in acculturation. The researchers, however, acknowledged that the small sample size may have reduced the power to identify any significant differences in the two placement experiences.

Hunter & Hollis (2013, p.1) surveyed learning organisations providing 228 accredited social work programmes in the USA *'to determine best practices for developing international placements.'* They found 51 programmes offered such placements and although these were commonly based on a block model, some used a concurrent [integrated] design. Programme representatives suggested block placements provided greater flexibility, an immersive practice experience and reduced student learning expenses. Nevertheless, it was acknowledged that a shorter, more intensive, block practicum could adversely affect cultural understanding. In contrast, a concurrent placement was seen as providing improved connections between field work and academic learning, as well as more time for orientation and practice preparation, but might be too long to easily integrate within the curriculum and restrict student interaction. The researchers suggested that, overall, international placement experiences were beneficial irrespective of their structure.

Gilmour et al (2013) undertook qualitative research using focus groups involving 17 midwifery undergraduates at an Australian university to compare the effect of an integrated placement model [involving two days of practice learning per week] versus a block design [lasting between two and four weeks]. Respondents identified a stronger sense of belonging within a clinical team during a block placement. The researchers, however, found students assigned integrated placements in one health authority were often moved between hospitals; hence a reduced sense of belonging for such learners might have been attributable to movement between different teams, rather than exposure to integrated practice learning. The minority of students who experienced both placement types highlighted strengths and weaknesses within each framework; regarding the block model as more effective in consolidating skills, whilst an integrated structure prevented

prolonged periods without practicum experience. The authors concluded neither practicum type was favoured, both models had benefits and disadvantages, and continuity when working with midwives was potentially a more significant influence on the quality of practice learning.

In the USA, Curl & Cary (2014) acquired qualitative and quantitative survey data from 103 students and 84 field instructors to investigate views of block and concurrent [integrated] placements on a post-graduate social work programme. The researchers found respondents in both groups identified advantages to field education based on block and concurrent formats. Field instructors suggested the block model better prepared students for social work practice and a higher proportion were willing to take such learners if they undertook this type of practicum. Students indicated the block model allowed placements to be completed faster, offered a more authentic work experience which enabled them to follow the client journey, and provided an opportunity to set aside the demands of academic study during these periods. Nonetheless, both stakeholder groups recognised the concurrent model may better accommodate a learner's other commitments and promote greater integration of theory and practice. Additionally, field instructors believed this model provided regular time to focus on other aspects of their work when the student was not present.

A factor analysis of 18 self-reported items featuring in a survey completed by 1,499 respondents from nine universities in Australia examined whether undertaking a full-time [block] or part-time [integrated] placement affected self-appraisal of employability (Smith et al., 2014). Of these participants, 91% were registered on an undergraduate qualification. Respondents' study was classified as being located in one of ten academic disciplines and 17% of this sample were identified as completing *health* programmes, although this category was not further defined. The researchers reported that, across the sample, the intensity of placement exposure had no significant effect on the students' perceived employability.

Research, also in Australia, by Sheepway et al (2014, p.200) involved quantitative analysis of student competency-based ratings and placement information associated with 56 third year undergraduates on a speech pathology degree to examine the impact of block and weekly [integrated] placements on competency development. The results indicated

student learning increased with each successive placement to the same extent irrespective of the intensity of a practicum [i.e., the specific model of practice learning to which learners were exposed], the undergraduate's caseload or the practice setting. The researchers therefore concluded *'it is the gaining of the experience itself, rather than the intensity of gaining this experience that is important for competency development.'*

Quantitative research in Canada by Perry et al (2016) involving 130 second year PRNP undergraduates sought to evaluate the effect of block and non-block [integrated] placement models on student learning perceptions via a questionnaire. Although the results of this pilot study indicated respondents perceived block placements as slightly more positive learning experiences than those based on a non-block framework, this difference was not statistically significant. Further investigation of the two practicum designs to ensure valuable but limited clinical time within practice learning environments is used to best educational effect was therefore recommended.

A study at an Australian university used focus groups involving 13 preceptors for third year nursing students to evaluate implementation of an *Integrated Clinical Learning Model* [ICLM] for mental health practice. Rather than a block mental health practicum lasting 4 weeks normally featuring in the course, learners received a protracted [integrated] placement over 16 weeks during which they concurrently studied a mental health theory unit. Respondents felt it provided a more realistic practice experience, reduced levels of learner absenteeism and provided greater opportunity for students to work alongside staff who had different skills, experience, and teaching styles. Nevertheless, respondents also expressed concern that this model reduced continuity for students, made it more difficult for learners to engage with clients, delayed student development of positive working relationships with clinical staff and complicated the preceptor's role in evaluating performance. The researchers therefore concluded preceptors held mixed views about the implementation of this alternative practicum model (Boardman et al., 2018).

Research by Kerthu & Nuuyoma (2019) explored learning in classroom and clinical environments, capturing the views of 10 nursing students at either level one or level two of their programme within two focus groups at a Namibian university. Participants reported their two-week block placement in a clinical setting was neither enough time for them to achieve the specified learning objectives, nor build a rapport with clinical staff.

They also complained at being expected to prepare for theory classes and tests planned for the next academic study period during a practicum. The work, however, did not explicitly state participants wanted an alternative integrated placement, so they may have just been seeking a longer block practicum.

Smith et al (2019, p.15) examined *'the relative importance of work-integrated learning placement quality, structure (whether part-time or full-time), and duration (in weeks), for producing employability outcomes'*, drawing upon responses from 220 undergraduates who experienced part-time [integrated] placements and 178 allocated full-time [block] placements from nine universities in Australia. Using survey data and inferential statistical analysis, they found the reported quality of practicum experiences was a much stronger predictor of employability outcomes than whether placements were full-time or part-time. Unfortunately, the study did not identify the specific programmes in which the student placements featured.

At an Indonesian university, Suhirman (2020) undertook quasi-experimental research involving second year undergraduates within the Elementary Education Department and fourth year students from the Natural Science Education Department. A total of 66 learners were randomly exposed to either a single block practicum of 10 days or one placement day per week over 10 weeks [an integrated model] to see if such exposure affected their practicum test and report scores. Employing assessment, questionnaire, and interview data, the researcher found whilst most participants expressed a preference for an integrated placement, there was no significant difference between test and report scores under both conditions.

7.9 Directly relevant research – block model advantage/preference

In Malta, Bonello (2001b, p.21) undertook semi-structured interviews with 18 newly qualified Occupational Therapists who, as students, either attended hospital placements between one and three days per week [depending on their year of the programme] over an average three-month period [an integrated practicum] or *'were placed in hospitals for one-month periods and had to attend on a daily basis'* [a block placement]. The researcher found respondents experiencing integrated practice learning *'stated that the way that placements were interspersed between their lectures was conflicting to the 'gestalt' of their*

experiences.' Indeed, whilst block placements were regarded as effective and meaningful clinical learning opportunities, during the integrated periods of practice learning interviewees felt 'r*ather than seeing the wholeness of a treatment programme, they experienced fragmented and disjointed treatment sessions'* and this fragmentation '*seemed to highlight the difference between the theoretical and practical worlds'* they encountered within their course.

Chittleborough et al (2010, p.21) explored the learning experiences of 17 Bachelor of Science/Bachelor of Teaching undergraduates at an Australian university during their first 8 months of study. Qualitative data included interviews with pre-service teachers [PSTs], supervising teachers, school, and university staff, as well as university lecturer field notes. The researchers found *'nearly all students and teachers preferred a block model of practicum*.' Respondents believed '*one day per week* [an integrated placement] *did not provide time to develop curriculum or learn about policy and procedure'* and it required more intensive co-working and communication between the supervising teacher and PST to be effective.

Rock & Ring (2010) evaluated block placements within an undergraduate social work degree in Barbados via focus groups and individual interviews with students, field instructors, and a field placement co-ordinator, as well as questionnaires completed by social workers. This practicum design was deemed to promote continuity, enable students to be engaged in client cases from start to finish and offer better opportunities to apply their professional knowledge and skills. Moreover, the block model appeared to enhance student supervision, enable learners to develop greater awareness of the service culture in which the placement occurred and have a beneficial effect on intra- and inter-agency interactions. Some students, however, expressed concern about the adverse financial impact of a block practicum, since this greatly reduced their scope to undertake other paid employment, as well as the demands of completing academic work alongside their placements during the final year of the programme. Nonetheless, the researchers concluded that, overall, application of this practicum framework was seen by most respondents as more beneficial to practice learning than the continuous [integrated] placement design it replaced. It should be noted, however, that when the study concluded

it had been 9 years since the continuous practicum structure had been a feature of the programme, so many respondents may not have experienced both designs.

A survey examining placement models provided in the clinical education component of professional speech-language pathology preparation programmes provided by 45 universities in Australia, Canada, Ireland, New Zealand, South Africa, the UK, and the USA found such provision was most commonly of a block or weekly [integrated] design. Respondents, however, regarded the block model as the better practice learning structure. Whilst the researchers acknowledged a relationship between how often each model was employed and its perceived effectiveness in developing student competence, it was uncertain whether efficacy had resulted in uptake of the model or if its use was being retrospectively justified. Arguably, the authors indicated their interpretation of this finding; commenting that *'the reported emphasis on student learning outcomes seems contradictory to the reported small influence of learning and teaching research on the adoption of clinical education models'* (Sheepway et al., 2011, p.183).

Peters et al (2013, p.188) explored provision of PRNP undergraduate mentorship in primary care placements via semi-structured telephone interviews with 12 Australian general practice nurses. Respondents identified a preference for the block practicum; suggesting learners given integrated placements '*needed to be constantly reorientated to the environment and routine each time they returned which wasted valuable clinical learning time.'* The researchers concluded that application of a consistent placement model could enhance practice learning experiences for both students and mentors and, although not explicitly stated within the paper, given respondent preference for a block practicum it seems reasonable to assume that this was the preferred framework to achieve such consistency.

An evaluation of placement experiences in an English language teacher preparation course at a college in Oman, involving four focus groups comprised of 26 recent graduates and interviews with 12 supervisors, indicated an overall preference for a block practicum rather than school placements of two days per week [integrated model]. Respondents believed block practice learning provided a prolonged teaching experience which helped them become more engaged in the school environment (Al-Qasmi, 2017). The total hours offered in the block practicum, however, were greater than those featuring within the

integrated placement; hence it is unclear whether participants were supportive of a block model because of its intensity, or the extra practice learning time it offered.

In the USA, Meyers et al (2017, p.7) implemented a pilot programme in which novice preservice teachers were placed with 20 cooperating teachers in '*high impact immersion experiences'* [HIIEs] lasting five consecutive weeks [a block practicum], rather than experiencing a typical one-day-a-week [integrated] placement. Interviews with 14 of these cooperating teachers indicated a preference for HIIEs; respondents believing they provided a more authentic sense of life as a classroom teacher and improved communication between preservice teachers, cooperating teachers, and the university faculty. It was not, however, explicit if students exposed to both practicum designs received the same total number of placement hours so, once again, whether HIIEs were preferred because of their intensity, or the amount of practicum experience they offered, is unclear.

In northeast England, a survey by Coghill (2018a, p.284) evaluated implementation of a Nursing Associate [NA] curriculum providing a new national second tier of registered nursing care worker. It involved 92 NA trainees from 9 healthcare organisations, all of whom were originally employed as NRCs. This study used questionnaires, focus groups and secondary data analysis of demographic and placement models, and found *'there was a mixed placement model approach implemented across the region*.' Participants, however, reported a strong preference for block practice learning. Although the researcher did not quantify or attribute this inclination, the report also highlighted many students felt *'overwhelmed by the amount of course work and trying to strike a good work/life balance'* and some indicated they struggled to uncouple their previous NRC role from their current trainee NA position (Coghill 2018b, p.356); hence the block model may have been perceived by learners as a means to help address these challenges.

A study by Adjei et al (2018) explored implementation of a new intra-semester [integrated] placement. The views/experiences of 33 Ghanaian baccalaureate nursing students in the second, third or fourth year of their programme were sought via 3 focus groups, each hosting 8 participants, and 9 in-depth interviews. Respondents reported feeling unwelcome in placements and believed that having only 2 days each week in a clinical setting adversely affected their working relationships and understanding of patient

conditions. Earlier use of an inter-semester [block] practicum structure, however, was not evaluated.

In Australia, mixed methods research involving questionnaires completed by 84 nursing undergraduates and analysis of their university performance records found the incorporation of a distributed [integrated] practice learning model within a PRNP semester offered no demonstrable benefits. Indeed, its introduction necessitated major revisions to the delivery of on-campus teaching sessions, increased workload for some students and adversely affected both their learning experiences and academic achievement during the semester. Moreover, learners '*studying within this new schedule showed little inclination to adjust their learning strategies to accommodate the timetable and workload changes*'; hence the author recommended students exposed to distributed practice learning should first be assisted to develop self-regulated learning skills if they are to effectively engage concurrently with theory and practice learning (Reinke, 2018, p.142).

At a university in Ghana, a structured questionnaire using a Likert scale [which also offered respondents scope to add qualitative comments] was administered to a convenience sample of 380 nursing students in the second, third or fourth year of their PRNP '*to assess the effects of block and distributed* [integrated] *clinical placement models on competency development.'* The researchers identified a preference for the block practicum amongst undergraduates in years three and four and a statistically significant difference in the reported clinical capability of students exposed to block and distributed practice learning. They suggested that, by offering continuity and a more consistent learning experience, the block framework provided better conditions for clinical learning and the development of nursing competence (Amertil et al., 2020, p.188). No objective assessment of the students' clinical proficiency was undertaken to corroborate their self-evaluations, however, so whilst this study demonstrates block model preference amongst more experienced nursing undergraduates, it is questionable whether a sufficiently robust case has been made to confirm this model better promotes skills acquisition.

Saifan et al (2021) interviewed 25 third year PRNP students at a college of health sciences in the United Arab Emirates to explore ways to bridge the theory-practice gap in nurse education. Many participants suggested moving from an integrated to a block practicum would help them better consolidate theory and then apply it to clinical practice. All these

students, however, had previously transitioned from block to integrated placements during their programme. In the absence of any objective assessment of their knowledge and proficiency under both conditions, preference for a block practicum might, therefore, simply be driven by greater familiarity with this framework.

7.10 Directly relevant research – integrated model advantage/preference

In South Africa, Davhana-Maselesele et al (2001) received approval to covertly observe 40 fourth year nursing students and found these learners had difficulty linking various theoretical elements of their programme to clinical situations. This difficulty was attributed to a block practicum model separating theory from practice; hence integrated placements were recommended. The researchers, however, provided no empirical evidence to support their assertion that this alternative framework would be more effective in enabling students to apply academic learning to clinical experiences.

Savage & Allen Knight (2005, p.164) describe action research related to the development of a new undergraduate nursing programme at an Australian university. Academics and industry representatives participated in the curriculum design, creating a learning programme which offered a concurrent [integrated] practicum for two days each week alongside taught sessions on the remaining days. It was argued that this framework would ensure *'the strong links between theory and clinical learning are recognised and embraced*.' Although monthly reviews to ascertain placement progress and the integration of classroom learning were reported, no evidence was provided to indicate whether the change ultimately produced the *industry-ready graduates* that employers were seeking.

A qualitative study by Ranse & Grealish (2007, p.171) sought to *'explore nursing students' experience of learning in the clinical setting of a Dedicated Education Unit using a communities of practice framework.'* The research involved data collection from focus groups attended by 25 second and third year PRNP students at an Australian university. This practice learning model involved two days placement per week alongside other student activities within the PRNP schedule and so, although not described as such, reflects an integrated practicum design. Respondents said attending the placement for two days each week helped them become more familiar with the clinical setting and staff, better enabled them to meaningfully contribute to service provision, and promoted more

effective critical reflection on practice; although the researchers commented they observed little evidence of such reflection in the focus groups. Within this study, however, it is impossible to clearly distinguish any positive effect on the student learning experience derived from provision of an integrated placement rather than the nature of the Dedicated Education Unit.

Again, in Australia, McKenna et al (2009) evaluated the implementation of continuous [integrated] clinical placements of two days per week in the same service over the final two years of a Bachelor of Midwifery course. Focus groups and interviews involving 10 students in programme years two and three suggested respondents felt the practice learning model allowed them to become more familiar with the clinical setting, strengthened trust in the midwife-student relationship, better enabled them to feel a member of the team and promoted individualised learning. Furthermore, continually engaging in practice was considered to aid knowledge and skills retention and bridge the theory-practice divide by allowing theoretical knowledge to be swiftly applied in practice and placement experiences brought back to the classroom for academic analysis. This study, however, offered no comparable evaluation of student experiences during a block practicum.

Kevin et al (2010) evaluated implementation of a weekly [integrated] placement model for second and third year Australian PRNP students. This model temporarily replaced full-time [block] practice learning normally featured in the curriculum. Within the trial, second year learners were allocated two days and third year learners three days of clinical placement per week. During their remaining weekly time, students had scheduled lectures, skills laboratory sessions and tutorials. The new model was implemented over 7 weeks for second year learners and 11 weeks for third year learners. This study involved both qualitative and quantitative analysis of a questionnaire completed by 39 nursing students. Results indicated respondents found the weekly model made it easier to understand connections between theory and practice, promoted familiarity with the placement setting and enabled clinical staff to become more aware of what they should expect from learners. Problems regarding a lack of time, increased fatigue, and disruption to the students' personal lives, however, were also associated with weekly practice learning. Furthermore,

this evaluative study provided no similar data regarding comparable student experiences during a full-time placement.

In Singapore, Nonis & Jernice (2011) examined the experiences of 33 pre-service special education [PSSE] teachers undertaking a Diploma in Special Education during a block practicum lasting 10 weeks within a special school. Although the survey results indicated that most enjoyed the experience, concerns were expressed regarding difficulties adjusting to a block practicum after full-time academic study. The researchers therefore recommended this course should be re-designed to include at least one day of [integrated] placement experience every week; believing this would help PSSE teachers more easily settle into the placement and so reduce transitional stress.

Research involving 208 undergraduates studying physiology in Australia, comprised of 105 learners who only attended theory sessions and 103 of whom were also concurrently enrolled on a physiology practicum [integrated placement], found *'students taking both physiology theory and physiology practicum attained a significantly higher result in online tests compared to those who took the theory subject alone.'* This difference occurred even though the university entry scores for students experiencing both conditions were not substantially different (Schuijers et al., 2013, p.153). The investigation, however, did not compare these findings with the effect of completing a freestanding physiology practicum *after* attending the theory sessions [a block design] upon subsequent academic achievement.

Johnston (2016, p.138) evaluated a new Master of Science course in Applied Behavior Analysis delivered over one year at a university in Alabama, USA. Offered as an alternative to a more traditional programme lasting two years, it involved 20-25 hours of weekly practicum time alongside academic classes [an integrated model]. The evaluation was undertaken after 33 learners in three cohorts had engaged with the course. Whilst students described the experience as arduous, the author reported they also found it invigorating, '*learned about hard work, careful scheduling, and self-management'* and began *'to depend on each other in preparing for classes and exams, in all aspects of their practicum work, and at a personal level*.' No comparison was provided with placement provision in a two-year programme.

Also in the USA, Bailey & Willey (2017, p.71) evaluated a new practicum structure within an educational leadership programme provided by a university in Texas using a survey completed by 42 students. The framework featured '*15 hours of field experience embedded in each of five courses* [an integrated design] *leading up to an 85-hour field-based capstone course'* and replaced an earlier design in which students had completed all 160 practicum hours in a capstone experience during the final programme semester [a block placement]. Most respondents reported these embedded field experiences positively affected their ability to apply academic learning to practice. No similar evaluation, however, had been undertaken in respect of the earlier, exclusively block, placement design.

An England-wide evaluation of the NA programme by Vanson & Bidey (2019, p.4) captured data from early, mid-point and end-point surveys of 2,477 NA trainees, a mid-point survey of 531 of their line managers, programme recruitment and attrition records, '*three rounds of deep dive visits to test sites to speak to trainees, patients, supervisors and other local stakeholders'* and feedback from attending community of practice meetings at each test site. In contrast to the earlier regional programme evaluation (Coghill 2018a; Coghill 2018b), the study found 59% of trainees and 77% of their line managers preferred an integrated practicum. This design was regarded as more effective in facilitating application of theory to practice, offered more regular interaction with academic staff, provided a better work/life balance, and was easier for healthcare employers to accommodate.

During the second phase of an Australian study, 22 undergraduates experiencing the ICLM in years two and three of a Bachelor of Nursing programme said it made them feel more like part of the team within the practice setting, allowed them to better reflect on experiences, consolidate learning, and integrate theory and practice. These focus group attendees also believed integrated placements enabled them to rapidly apply new knowledge from academic studies to a clinical setting and allowed them to maintain their work/life balance more effectively by making it easier to undertake paid employment to support their family life and programme studies. The researchers, however, conceded it was unclear whether some perceived benefits of the ICLM were attributable to the intensity of the practicum or the nature of placement supervision (Boardman et al., 2019). Furthermore, although these students had previously undertaken block placements in

older peoples' services and acute care, no comparison with a block mental health practicum was provided.

Using participant observation and focus group discussions, Mensah et al (2021, p.30) explored the intra-semester [integrated] placement experiences of 12 nursing and midwifery students in the first, second or third year of their programme at a tertiary hospital in Ghana. They concluded that *'exposure to the clinical components in their training enhanced their experiences in management of some disease conditions they have been taught in the classroom*.' The research, however, provided no comparison of student learning within a block placement.

A study by Salifu et al (2022, p.11) explored the clinical learning experiences of 40 Ghanaian nursing students and 15 post-registration nurses using focus groups. These participants had experienced PRNP block placements lasting 2 weeks and reported that during these practice learning experiences *'they were used as extra working hands and expected to perform full-time duties, as if qualified staff, which neglected the accomplishing of their learning objectives*.' The researchers believed the placement model may have contributed to such treatment and generated some of the reported student discontent. Nevertheless, no comparison with an integrated practicum was possible and other practice learning problems which might have accounted for these negative experiences, including random assignment of students to placements and a perceived lack of learner support in these clinical settings, were also identified.

7.11 Directly relevant research – student experience/circumstances affect practicum model advantage/preference

The placement needs of nursing students may vary at different stages of their programme (Andrews et al., 2005). A questionnaire completed by 210 students on one of four undergraduate PRNPs in two Canadian provinces found first and second year students preferred a non-block [integrated] clinical rotation; believing it better facilitated application of theoretical knowledge in practice, enhanced formative development and feedback from supervising nurses, improved their work/life balance, and provided more varied patient engagement. Year three and four learners, however, preferred a block model; suggesting it offered better theoretical preparation prior to placement, allowed

them to exclusively concentrate on clinical learning during the experience, promoted continuity of care, strengthened working relationships with nurses in the practicum, and more effectively consolidated and enhanced their clinical skills and decision-making (Rohatinsky et al., 2017).

In Australia, a descriptive, exploratory study involving focus groups and individual interviews with 22 third year PRNP students which explored the impact of block versus distributed [integrated] placements on student learning experiences found both models had *'inherent advantages and disadvantages that might be magnified depending on the individual student's circumstances.'* Participants reported they were more likely to be accepted as a member of the clinical team during a distributed placement and that this model better facilitated an awareness of ward routines, enhanced communication skills acquisition, offered a better work/life balance and facilitated the integration of theory and practice. Nonetheless, a block placement was deemed to offer a more realistic and authentic experience of ward activities and the RN role, allowed them to focus exclusively on practice learning, and promoted greater consistency in the teaching and support offered by supervising nurses (Birks et al., 2017, p.16).

Further work in Canada by Rohatinsky et al (2018, e2) surveying 141 undergraduate nursing students from five universities, *'all of whom had completed at least 1 clinical rotation in any year of their program'*, and 52 instructors [supervising nurses] also found no overall preference for either model across both respondent groups. Once more, learners in the early stages of their course generally preferred non-block [integrated] placements, whilst those who had progressed further favoured clinical experiences in blocks and neither model appeared to affect levels of student stress related to practice learning. The researchers argued the development of nursing knowledge appeared to be more effectively facilitated by the non-block model, whilst immersion and transitioning into clinical practice was better promoted by block experiences and they therefore recommended that PRNPs should expose students to both practicum types.

7.12 Conclusion

Although practicum experience is widely regarded as a fundamental and resource-intensive component of nursing programmes, most work in the field to date has focused

on the supervisory practices of clinicians and educators, rather than exploring how placement duration and intensity may influence practice learning. Whilst multiple sub-variants exist, it is argued there are essentially only three key models used to structure clinical learning experiences in PRNPs and, of these, only the block and integrated approaches are primary components of such curricula. Much professional literature recommends longer student practicum experiences but lacks detail as to exactly how longer placements benefit nursing students and such work seldom clarifies whether an extended block placement or a transition to an integrated model of practice learning is being recommended.

Studies evaluating innovative projects offering concurrent paid carer employment to pre-registration students display similar features to an integrated practicum within The OU PRNPs, although several key differences limit the extent to which these findings can be applied to such provision. Even where research evaluates implementation of a structural placement model, it often only examines the impact of the new design rather than undertaking a comparative analysis in relation to the model used previously. Amongst those very limited studies offering such comparison there is a lack of consensus regarding the most desirable placement model for a programme; strengths and limitations being highlighted in respect of both the block and integrated frameworks.

Investigation within the field and collation of evidence to formulate best practice in this aspect of curriculum design, however, are adversely affected by inconsistent use of language. In this review, 18 alternative terms were identified for an integrated practicum and 7 to describe the block model. Furthermore, each descriptor was only included when several published examples of its use were found and all illustrative citations originate from academic texts, journal articles, government agency publications, post-graduate theses, or the website of a learning organisation. Consistent use of terminology regarding such frameworks is therefore urgently needed to consolidate the body of knowledge associated with structural placement models.

There are modest signs the most desirable duration and intensity of a practice learning experience may be associated with the student's position in a programme and their personal circumstances. Spence et al (2019, p.458) therefore maintain that *'different models for clinical learning are appropriate for different contexts and stages of student*

development'. Nevertheless, given the relative international paucity of high-quality research comparing block and integrated placement models, it is questionable whether there is yet sufficient evidence to present a compelling argument regarding which structure is most appropriate for specific periods of learner development, or indeed what student characteristics more favourably dispose an individual to practice experience based on either framework. This research study aims to meaningfully contribute to the current limited body of knowledge within this sphere of nurse education.

7.13 Reflections on the entire realist synthesis within this thesis and the selected research methods

Reflecting upon the complete realist synthesis undertaken as part of this investigation, it is clear that a multitude of diverse factors may directly affect the practice learning experiences of PRNP students, including the duration of a practicum, the culture within a clinical service and the behaviour/values of a student's peers, academic staff, mentors, and other clinicians within this setting. A number of other variables, such as perceptions/values in respect of different nursing specialisms, specific learner characteristics, the mode of programme study, and the distinctive features of a university's PRNP curricula may also have an indirect influence. It is therefore important to consider how these differences may affect stakeholder preferences/perceptions of block and integrated practicum designs and, potentially, the findings of this study. As a result, such considerations are addressed later in the thesis [see Chapters 11, 13 & 16].

Nonetheless, the complexity of this situation should not distract from evidence that there appears to be a paucity of robust research comparing the two predominant placement models used within nurse education and, hence, the merit of additional investigation within this specific field. To address the broad research question posed by this study, namely what effect a practicum design may have upon the student learning experience and retention/achievement, literature also indicates a need for use of qualitative and quantitative data collection/analytical tools, an approach which is harmonious with critical realist philosophy.

The next chapter examines data collection, sampling, and ethical issues directly related to the implementation of this research. Since the majority of data acquired is qualitative

[seeking to capture the views/experiences of different practicum models from the perspective of respondents within four stakeholder groups], greatest consideration is given to use of semi-structured interviews, their suitability to address the research question, and the ethical challenges which interviewing may create. Brief reference, however, is also made to the quantitative analysis within the study [which examines whether any statistically significant relationship exists between exclusive student exposure to a placement model and retention/achievement] and, therefore, the status of the entire investigative activity as mixed methods research.

Chapter 8. Data collection, ethical approval, and sampling

8.1 Introduction

Nursing research aims to generate empirical data enabling practitioners and educators to develop and enhance service provision (Parahoo, 2014). Feuer et al (2002, p.8) suggest no research method '*is good, bad, scientific, or unscientific in itself: rather, it is the appropriate application of the method to a particular problem that enables judgments about scientific quality.'* Traditionally, an investigation's status has been determined by the type of evidence it generates; quantitative randomised controlled trials being deemed the *gold standard* and wholly qualitative studies holding the lowest position in this hierarchy (Hewitt, 2009; Sellman, 2010). Nevertheless, qualitative research has several key redeeming characteristics. Stiles (1993, p.596) argues *'describing an experience in words abstracts it and simplifies it, but not nearly so much as does projecting it onto any manageable number of quantitative dimensions',* whilst Gorard & Cook (2007, p.312) assert '*valid causal knowledge has often come from non-experimental and nonquantitative sources.'*

Based upon the literature examined within the earlier realist synthesis, it appeared a mixed methods design would be required to address the identified research question for this study [i.e., what effect a practicum design may have upon the student learning experience and retention/achievement]. The first four phases of this research generated qualitative data from semi-structured interviews with regional stakeholders involved in The Open University [OU] pre-registration nursing programmes [PRNPs]; capturing their perceptions/experiences of block and integrated placement models. Data were then exposed to qualitative content analysis. In the fifth phase of the study, quantitative data were obtained from two UK-wide cohorts of OU PRNP students to establish whether any statistically significant relationship existed between exclusive exposure to one of the two practicum models and student retention/achievement.

This chapter discusses the identified benefits of a mixed methods approach to critical realist research generally and, in particular, to this study. It examines the value, limitations, and considerations of using in-depth interviewing as a research method and how potential

problems associated with this form of data collection were mitigated within the investigation. Finally, this section of the thesis outlines the ethical approval process, sampling and complementary quantitative analyses undertaken.

8.2 Mixed methods research

Mixed methods research [MMR] involves using both quantitative and qualitative methods within the same study (Tariq & Woodman, 2013) and its use is advocated by critical realists as well as members of the wider nursing and educational research community. It *'has been hailed as a response to the long-lasting, circular, and remarkably unproductive debates discussing the advantages and disadvantages of quantitative versus qualitative research'* (Feilzer, 2010, p.6). In the social sciences, there has been a growing trend to design studies that draw upon multiple methods (Gale et al., 2013; Swedish Society of Nursing, 2016), based on the assertions that '*no single method is likely to afford a comprehensive account of the phenomenon under investigation'* (Torrance, 2012, p.113) and *'some questions can only be appropriately answered by examining a range of data sources'* (Dixon-Woods et al., 2005, p.45). Indeed, an investigation of published research within 10 disciplines [anthropology, business, cultural studies, economics, educational research, family studies, nursing, political sciences, psychology, and sociology] found 42% of all MMR undertaken across these fields was located in nursing and 28% in educational research (Timans et al., 2019).

MMR enables use of a range of '*tools, methods,* [and] *technologies to justify knowledge production'* (Reed, 2006, p.37). Additionally, an investigation employing quantitative and qualitative methods can often support stronger scientific inferences (Feuer et al., 2002), combining the strengths of extensive and intensive designs (McGhee & Grant, 2017; Miller & Tsang, 2010). MMR studies facilitate '*confirmatory, corroborative and cross-validating checks on data collection, analysis and interpretation'* (Bisman, 2010, p.12) and if specific events *'can be investigated in a number of different ways and those different ways concur, then the researcher may then believe that their account is a truer description of those events'* (Scott, 2007, p.11). More fundamentally, it is argued '*the real world is complex and multidimensional'* and *'so a combination of approaches may be necessary to provide a more comprehensive outcome'* (Mingers, 2006, p.214).

In respect of this study, undertaking MMR enabled more diverse data collection related to block and integrated practice learning. Arguably, combining the strengths of qualitative semi-structured interviews [capturing the placement experiences/views of stakeholders] with quantitative data [to ascertain whether use of either practicum design affected student withdrawal/achievement rates] meant the investigation generated richer and more authentic evidence on which to evaluate the effect of both models.

8.3 Interviews – purpose, structure, and cautions

Interviews are one of the most widely employed data collection methods, especially within qualitative research (Bryman, 2016; Silverman, 2013). Gray (2018, p.379) defines interviewing as '*a basic form of human activity in which language is used between two human beings in the pursuit of cooperative inquiry.*' Within qualitative research, in-depth or semi-structured interviews are specifically designed to '*learn what another person knows about a topic, to discover and record what that person has experienced, what he or she thinks or feels about it, and what significance or meaning it might have'* (Mears, 2017, p.183). Interviews are often incorrectly regarded as a simple approach to data generation and insufficient attention given to the importance of interview practices within studies (Alvesson, 2003b).

The interview is an important research tool (Cohen et al., 2018); not least because skilful, sensitive, and insightful interviews generate *'a rich set of accounts of the interviewee's experiences, knowledge, ideas and impressions'* (Alvesson, 2003a, p.168) and facilitate understanding of individuals' public and private lives (Kvale, 2006) as well as their thoughts and emotions (Mears, 2017). Congruent with critical realism, and therefore the basis of this study, interview-based research may also enable development of new frameworks and theories to explain human behaviour (Anderson & Jack, 2016). In-depth interviewing is a flexible data collection tool (Cohen et al., 2018), which allows the managed transition from one relevant topic to another (Ryan & Bernard, 2003). It is also well-suited to research, such as this investigation, where the respondent's opinions are of greatest interest (Bryman, 2016) and a rich picture is sought (Gray, 2018).

Fossey et al (2002, p.731) argue *'good qualitative research is characterized by congruence between the perspective (or paradigm) that informs the research questions and the*

research methods used.' Similarly, Fusch et al (2018) claim one important method by which a researcher mitigates bias is through application of a data collection method that is suitable for the study. Use of semi-structured interviews within this investigation is therefore not only harmonious with a critical realist approach but might also be deemed a key technique promote and enhance impartiality.

Interviews can capture verbal and non-verbal data (Cohen et al., 2018) and may be open to qualitative and quantitative analysis (Feilzer, 2010). Indeed, Gray (2018, p.378) argues that '*the interview may be considered the most logical research technique where the objective of the research is largely exploratory.'* In a critical realist investigation, research questions cannot simply be converted into interview questions, since the former are designed to identify what needs to be better understood, whilst the latter must be devised to best elicit such data (Maxwell, 2012). In this study, it was therefore necessary to formulate less direct interview questions which sought to capture key factors that may be associated with the practice learning models [see Appendices 1-4]. Although a traditional interview approach may be adequate to *'appreciate the interpretations of their informants and to analyse the social contexts, constraints and resources within which those informants act'* (Smith & Elger, 2012, p.6), a more comprehensive '*realist interviewing technique*' involving three consecutive phases of interviews for the purpose of theory gleaning, refinement and consolidation has also been proposed (Mukumbang et al., 2020). Time and resource constraints, however, did not permit application of this framework within the study.

Interviewing is often regarded as *'a democratic, emancipating form of social research'* (Kvale, 2006, p.480), since it may provide scope to present the views and experiences of those whose voices may otherwise fail to be heard. Within healthcare, such research may be *'capable of overcoming alienation and changing social practice through a participatory meaningful process of knowledge translation'* (Cordeiro & Soares, 2016, p.333) and is therefore, once again, harmonious with the emancipatory aspirations of critical realism. Moreover, in educational research there has been a growing movement towards ensuring the student voice is recognised, based on the assertion that '*if students' attitudes and opinions are proposed as a vital link between the environment and their learning experience, then it seems important to consider them'* (Woolner et al., 2010, p.3). Since

this study seeks to capture the voice of PRNP undergraduates both directly and indirectly, it also offers an opportunity to provide such recognition.

A well-planned interview guide helps ensure effective interviewing (Mears, 2017). It should be long enough to address all the issues of interest to the researcher, avoid irrelevant questions and provide a degree of flexibility to explore unexpected opportunities (Arksey & Knight, 2011). Devising an interview guide with these qualities, however, may be difficult. The language used in interview questions may affect the identity of the interviewee (Alvesson, 2003b). Words can have multiple meanings (Graneheim & Lundman, 2004), be interpreted differently by different people (Peterson, 2011) and are affected by context (Mears, 2017).

To ensure interview questions are unambiguous, a researcher may need to learn the language employed within a specific discipline or organisation and formulate culturally appropriate questions (Bryman, 2016). The sequence of presented questions may also affect interviewee responses (Silverman, 2013). Reflecting on his own research, Morrissey (2003) reports that postponing tougher questions until later in interviews facilitated more fulsome responses. With these factors in mind, all questions within this study were scrutinised by at least one disinterested academic colleague and some revisions made in accordance with their feedback. Questions addressing issues which were more sensitive, such as whether OU nursing students were treated differently to learners from other universities, were also delayed until later in the interview [see Appendices 3-6].

Researchers who have similar professional socialisation to those whom they interview may have an advantageous cultural awareness. Nevertheless, if such individuals are outsiders to the organisations in which respondents are located, they may need to develop their appreciation of local operational and political issues within these services. In contrast, if the investigator is a member of one or more of these organisations, then they may need to examine their beliefs about these services to ensure familiarity does not distort their approach to planning, implementing, and interpreting these interviews. As a nurse who works in the region in which this doctoral study was undertaken, the researcher had experienced a similar professional socialisation to those whom he was interviewing and so arguably had some relevant cultural understanding. Nonetheless, he remained an outsider to the organisations in which the work of respondents was taking place and so developing

his awareness of local operational and political issues within these services was also important and was achieved via dialogue with colleagues regularly liaising with these services.

Anderson & Jones (2009, p.293) claim '*places are partially responsible for how knowledge is formulated, accessed and articulated'*; asserting that space is therefore never simply *'neutral, passive or a backdrop to action*.' Accepting that setting influences behaviour, however, necessitates acknowledging that the context in which interviews take place may affect data generation. It is recommended that an interview location should be quiet, private (Ryan & Bernard, 2003) and carefully arranged in respect of seating, furniture and the proximity of interviewer and respondent (Gray, 2018). An interviewer needs not only to be '*familiar with the setting in which the interviewee lives or works'* (Bryman, 2016, p.471) but also select an interview environment *'to exploit its capacity to break down common power structures'* (Anderson & Jones, 2009, p.292).

The time of day in which interviews are undertaken may further affect interviewee responses due, for example, to specific work activities, social commitments, domestic routines, or fatigue (Arksey & Knight, 2011; Miltiades, 2008). For example, a researcher may schedule them to take place in a healthcare environment at a time chosen by the respondent in the expectation this approach will best help put individuals at ease and encourage their responses to be geographically located. Using such environments for this purpose, however, may mean the researcher cannot control the characteristics of chosen interview venues or the time they occur and that there may be a significant risk interviews will be disrupted by service demands. Within this study, interviews were arranged in stakeholder workplaces or, later, by Skype for Business or Microsoft Teams [due to COVID-19 pandemic restrictions] at times chosen by the respondents as a means to empower respondents. Holding them in such locations, however, meant it was impossible to control interview environments or their timing and so there were indeed occasional disturbances.

Interview recording is a further important consideration. Whilst qualitative researchers commonly make audio recordings and then transcribe them (Bryman, 2016), the necessary technology can be distracting (Mears, 2017) and unsettling for interviewees who may be alarmed that their precise words are being preserved (Bryman, 2016), thereby hindering responses (Beuving & de Vries, 2015). Morrissey (2003) suggests

interviewers may experience even greater anxiety about using recording equipment than respondents; becoming so concerned about its set-up that their interviews are adversely affected. In this study a simple, unobtrusive, high-definition audio application installed on a mobile phone was used and, although always advised when recording would commence, respondents rapidly appeared at ease with the process; perhaps because the proliferation of such technology now leads it to effectively be hidden in plain sight. The sound quality of remote recordings was less impressive but still adequate.

Although practice in using recording equipment may minimise interviewer anxiety (Bryman, 2016) researchers also need to consider the perceived importance of non-verbal communication within their study (Gray, 2018). Bonello (2001b, p.20) suggests being '*constantly aware of verbal and non-verbal communication of each participant*' during an interview is an important form of triangulation. Non-verbal utterances (Atkins & Wallace, 2012), silences (Sangster, 2016), voice tone and emphasis (Gray, 2018) may be evident in an audio recording, but their analysis may increase the risk of misinterpretation rather than enhance understanding (Atkins & Wallace, 2012). In addition, such recordings do not capture all potentially significant non-vocal features (Thomas & James, 2006) but using video recording may be even more anxiety-provoking to participants. Within this investigation, video was therefore set aside in favour of audio recording and the interviewer was unaware of any deterioration in the overall quality of data collected because of failing to log non-vocal responses.

Interview data are also affected by respondent cognition and behaviour. For example, interviewees may have poor recall (Morrissey, 2003), selective memory (Frankham et al., 2014) or misunderstand questions (Ryan & Bernard, 2003) and what a respondent says may be neither predictive of their future action nor an accurate account of their past behaviour; a concept known as *the attitudinal fallacy* (Jerolmack & Khan, 2014). Even when respondent comprehension and recall appear good, the frame of reference an interviewee adopts may not correspond with that of the interviewer (Cohen et al., 2018). Furthermore, how respondents address questions can be affected by a range of social circumstances (Chase, 2010). For example, within an interview it may be unclear whether participants are presenting their personal views or regarding themselves as a representative of a specific group (Hyden & Bulow, 2003).

In this study, stakeholders were interviewed in an environment of their choosing, explicitly advised their participation was the result of an identified role in respect of The OU PRNPs [i.e., employer sponsor, student, practice tutor, or mentor] and reminded of confidentiality safeguards. Additionally, questions neither sought to capture the extent to which individual accounts reflected earlier behaviour nor future action, but instead establish experiences/beliefs. It was therefore anticipated these conditions may promote more accurate recall and a higher degree of respondent veracity.

If interviewees are uneasy about answering certain questions they may refuse to do so, deflect questions, give inappropriate responses, simply say something they believe the interviewer wishes to hear (Kvale, 2006) or delay expressing their genuine feelings/opinions until interview recording has ended (Beuving & de Vries, 2015). For various reasons, including a lack of trust in the interviewer (Ryan & Bernard, 2003), a desire to uphold individual and collective interests (Alvesson, 2003a), create a specific impression (Walmsley, 2003), provide socially desirable responses (Cohen et al., 2018) or avoid breaking taboos (Alvesson, 2003b), respondents may also highlight certain features within their answers whilst downplaying others, put on a front, mislead the interviewer, or even lie (Silverman, 2013). Alvesson (2003b, p.27) therefore suggests the interviewee is *'a political actor rather than a truth teller'.* In this research, however, it was anticipated the focus of the investigation was neither likely to make participants reluctant to respond to questions in an open manner nor lead them to feel compelled to give certain answers, since questions were largely value-neutral and examined and approved by disinterested third-party academics prior to their use.

Beuving & de Vries (2015) recommend a researcher should report back the results of an interview to the interviewee as a courtesy, to satisfy respondent curiosity and provide an opportunity for individuals to recognise themselves in their own words. Participants in all four interview phases of this study were therefore offered this option and most accepted it, although none challenged the content of the report. Transcription can be a very time-consuming activity, taking 5-6 hours to transcribe a one-hour interview (Bryman, 2016). To promote impartial, accurate and efficient transcribing, a professional transcription service regularly used by OU academics was employed for this purpose. Transcribing costs in the first two interview phases were met by funds secured via a successful case

submitted to The OU Faculty of Wellbeing, Education & Language Studies, whilst the remaining phases were funded by the researcher.

The effectiveness of interviews may be influenced as much by the interviewer as the respondent. The interviewer's background, level of experience, preparation, and approach may all affect interview outcomes (Brannen, 2005; Morrissey, 2003). Although a proficient interviewer can explore the research question from different perspectives (Mukumbang et al., 2020), Grele (2003, p.40) claims *'many interviewers are poorly trained and far too many are willing to settle for journalistic standards of usefulness.'* Researchers may even distort the interview process to obtain the data they seek (Cohen et al., 2018; Elo et al., 2014). This phenomenon, termed *the interviewer effect* (Bryman, 2016), may be unconscious or unintended but may also have conscious, deliberate dimensions. For example, Bornat (2003) acknowledges her efforts to be considerate, sensitive, and supportive to interviewees were well-intentioned but motivated by one aim; to elicit useable material.

Arguably, perceiving interviews as a conversation which fulfils mutual interests is illusory, given it only takes place to meet the needs of the interviewer (Kvale, 2006). Moreover, Slim et al (2003, p.114) suggest interviewers may *'put unnatural pressure on people to find ready answers, to be concise and to summarise a variety of complex experiences and intricate knowledge'*, thereby potentially disregarding respondent wellbeing. Although in this instance the researcher sought to be thorough, considered and objective in his interview approach [having no vested interest in the study producing any specific outcome] and to draw upon his own understanding of PRNP placement and practice experiences as a registered nurse to adopt a more empathic approach, he nevertheless recognises the time constraints imposed on interviews and the focus of the work upon both answering the research question and fulfilling the requirements of his doctoral programme. He cannot, therefore, be regarded merely as an impartial facilitator in the data collection process.

It is equally important to consider the effect of the relationship between interviewer and interviewee on a study (Gray, 2018). Mann (2011) describes interview data as collaboratively produced by both parties, whilst Morrissey (2003, p.108) argues *'to reduce interviewing to a set of techniques is, as one person put it, like reducing courtship to a*

formula' and ignores the influence of interpersonal issues. The interview relationship involves a fundamental power asymmetry (Duarte et al., 2015) since the interview is an instrumental one-way dialogue over which the interviewer often has a monopoly of interpretation (Kvale, 2006). Various researcher and respondent characteristics may exacerbate this power inequity, including differences in age, sex, ethnicity, class, hierarchical status, and the nature and extent of any pre-existing relationship between both parties (Mann, 2011; Miltiades, 2008). Developing an effective rapport, enabling respondents to relax, regard the interview as a collaborative activity, begin to trust the researcher and speak openly and honestly are therefore regarded as fundamental to effective interviewing (Beuving & de Vries, 2015; Gray, 2018; Mears, 2017). Doing so also requires the interviewer to carefully consider and manage power asymmetries if they are to move towards situational equality between both parties (Cohen et al., 2018).

Although nurses and nursing students cannot be described as vulnerable groups, there may still be individuals within a respondent sample who could be vulnerable (Anderson & Kiger, 2008) and, clearly, there may be power inequities between the researcher and these respondents. In this study, the interviewer was neither routinely involved with student nor mentor respondents, so it was unlikely that any pre-existing relationship would impact on the interview process. Nonetheless, he was aware of the power imbalance underpinning such interviews and sought to minimise any impact of this imbalance within his interpersonal style and the location in which they were undertaken. The researcher, however, had pre-existing working relationships with employer sponsors outside the research context and was the line manager of two practice tutors within the sample, although these conditions did not appear to adversely affect the interview process. Indeed, he suspects it may have facilitated more relaxed participation.

Interviewers must be non-judgemental (Bryman, 2016), sensitive (Mann, 2011), receptive to alternative perspectives and ensure respondents understand their role (Walmsley, 2003). In addition, they should strive to appreciate the interviewee's position, pursue detailed responses to questions, seek illustrative examples (Morrissey, 2003) and avoid making hasty interpretations (Anderson & Jack, 2016). *Reflexivity,* which Alvesson (2003b, p.25) suggests is evidenced by *'conscious and consistent efforts to view the subject matter from different angles and avoid or strongly a priori privilege a single, favored angle and*

vocabulary', is arguably one of the most important skills the researcher needs to acquire if they are to ensure their work is robust, valid, and reliable (Sipe, 2003).

Inevitably, there were age, status and sex differences between the researcher and many interviewees within this study. Furthermore, all respondents were employed by organisations involved in delivering The OU PRNPs, so it was essential for these stakeholders to be reassured regarding the anonymity of any statements they made, the security surrounding raw interview data and the value of their contributions to developing better nursing curricula. This was particularly important given the claim '*people want to give a good impression of themselves and also the institutions with which they identify and/or feel they represent'* (Alvesson, 2003b, p.21) and hence the risk all participants in this study may be eager to present themselves and their organisation in a positive light. Reflexivity, to ensure scrutiny of the researcher's interviewing technique and values, was also essential to avoid the common problems associated with this data collection method [see Chapter 18 for more detail].

Interviews can be a sensitive and powerful research tool, but in themselves are *'neither ethical nor unethical, neither emancipating nor oppressing'* (Kvale, 2006, p.497). The interview is not merely a data collection method, but a complex form of social interaction shaped by a wide range of social, physical, intrapersonal, and interpersonal variables including beliefs, values, experiences, culture, class, language, socialisation, sex, age, ethnicity, and context. The acquisition of any objective truth via interviews will therefore always be an unachievable goal. Nevertheless, when a study has a methodology congruent with its ontology and epistemology, exhibits compelling evidence of reliability and validity in its data collection and analysis, demonstrates researcher reflexivity in relation to the planning, implementation and interpretation of interviews and provides *'a clear answer to the "so what?" question'* (Arksey & Knight, 2011, p.49), then the results of such work may provide new insights that make an important contribution to a body of knowledge.

During any interview there are inevitably potential sources of influence that cannot be minimized or controlled (Alvesson, 2003a). Within this study, the interviewer therefore sought to improve his appreciation of these influences, consider their impact on the data generated and accept his inability to implement an entirely consistent interview

experience for all respondents. Proficient use of this data collection method is both complex and challenging but the nature of the investigator's research question demanded that he sought to acquire the knowledge and skills to effectively address these difficulties.

8.4 Ethical considerations, access, and approval

Whilst there may be considerable value in using interviews as a data collection method, various practical issues may complicate this activity. Access to suitable interviewees may be restricted by gatekeepers (Miltiades, 2008) and securing an adequate sample of respondents can be problematic. In this study, engagement with key stakeholders required approval from two university research ethics committees [The OU Human Research Ethics Committee and the Newcastle University Faculty of Humanities & Social Sciences Research Ethics Committee] and The OU Student Research Projects Panel [who assess whether student input to a study is appropriate; for example, prohibiting inclusion of those who may already be participants in other research or whose involvement might negatively impact upon their studies].

The investigation was undertaken in accordance with the Nursing & Midwifery Council [NMC] (2015) code of professional standards by which the researcher is bound as a Nurse Educator and Registered Mental Health Nurse [RMN] and the Royal College of Nursing (2009) research ethics guidance for nurses. Engagement with employers and mentors also required informal approval from respective healthcare organisations. Interviewees may be dispersed across a large geographical area (Morgan et al., 2016) making access both difficult and time-consuming (Bryman, 2016) and since respondents in this study were located at multiple sites across much of northeast England and Cumbria, a combined area of 5,930 square miles (Office for National Statistics, 2017; HMICFRS, 2022), proximity was indeed one challenge which needed to be overcome.

Participants must give their informed consent to being interviewed (Gray, 2018; Mears, 2017) but securing genuine informed consent may be difficult (Sangster, 2016). Reflecting on her own research, Walmsley (2003) acknowledges it was not always clear interviewees were consenting to being interviewed so much as feeling they had no choice. Of equal concern is the potential for more subtle manipulation of participants into giving their consent and questionable adherence by researchers to this principle. For example,

Alvesson (2003b, p.28) claims interviewers can modify '*the interviewee's assumption through framing the project in various ways'*, whilst Kvale (2006, p.482) argues deadlines may lead researchers to ethically stretch *'subjects' privacy to get some printable information*.' In this study, all interviewees were briefed as to the purpose of the investigation and their participation in the study, use of the information/data, potential benefits, and disadvantages of taking part, mechanisms if something went wrong, contacts for further information, data management, and institutional ethical approval [see Appendix 1 example] before being asked to sign a consent form [see Appendix 2].

Since respondents may be asked to share their private thoughts and emotions (Silverman, 2013) and not feel clear and confident regarding how their interview data will be used (Alvesson, 2003b), it is perhaps unsurprising they may be reluctant to discuss some subjects (Bryman, 2016) and ultimately regret what they have disclosed (Kvale, 2006). The topic under investigation in this study was not an obviously emotive or controversial one, email invitation to potential respondents arguably facilitated greater freedom to decline such an invitation and participants were fully briefed regarding the nature of the study, their involvement and how data would be used. Furthermore, the interview data collection process was undertaken across four years; hence deadline fulfilment was less pressured.

Interviewees may be adversely affected by remembering (Perks & Thomson, 2016). Even when a study does not directly ask sensitive questions, encouraging practitioners or healthcare students to reflect on care experiences may trigger traumatic memories, so researchers intending to undertake in-depth interviews must consider how their study may affect participants (Mears, 2017) and how they will support any individuals who display distress arising from recollection. One should also not overlook the impact upon interviewers who may *'face difficult situations, emotional distress and psychological pressure'* (Bocci et al., 2002, p.299). Although this study did not involve sensitive questions, within practice experiences both qualified nurses and PRNP students are inevitably exposed to patients with serious physical/mental health problems, pain, suffering, death and dying. It was therefore recognised questions encouraging reflection on practice experiences could trigger traumatic memories and the value of the researcher's own professional background as an RMN was available, although not required, to support any

respondents who might have expressed or shown distress arising from recalled events. It also helped him to manage his own stress related to implementing these interviews.

8.5 Qualitative sampling

Irrespective of the data collection methods employed, *saturation*, or the point at which no fresh data are evident, is important in any investigation (Fusch & Ness, 2015). An in-depth interview sample can be deemed adequate when enough data has been collected to represent the experience under investigation (Elo et al., 2014; Mears, 2017), but the type of sampling considered appropriate will be determined by the philosophical perspective which underpins the research. From both a critical realist and qualitative research perspective, *intentional*, or *purposive*, sampling is considered desirable, since it may provide a richer understanding of the phenomenon being investigated (Miller & Tsang, 2010; Sandelowski, 2000).

The first four phases of this research involved semi-structured interviews with a purposive sample of employer sponsors, students, practice tutors and mentors. All individuals were approached because of their direct involvement in at least one OU PRNP programme and were based in northeast England or Cumbria. Between 8-10 respondents from each stakeholder group were interviewed and qualitative content analysis suggested the sample size achieved saturation. Ryan (2016) also argues use of more modest respondent samples is harmonious with the intensive research strategy deemed appropriate for studies underpinned by critical realism.

8.6 Quantitative analysis and sampling

Using SPSS software (version 27), the fifth phase of the study employed quantitative bivariate analyses, or examination of two variables at a time to identify whether they are related (Bryman, 2016). Two such analyses were undertaken to examine whether any statistical relationship was evident between the practicum model experienced and student retention/attrition, as well as this model and the student's degree classification. The study subsequently employed regression analyses to examine whether there appeared to be a relationship between a dependent variable [in this instance, student retention or degree classification] and several independent variables [in this case, student age, sex, and programme type as well as the placement framework] (Cohen et al., 2018).

To ensure an adequate sample, quantitative data for the bivariate and regression analyses were obtained from anonymised OU nursing students across the UK. All subjects included in this sample had only experienced either block or integrated placements throughout the entirety of their programme and commenced their studies in the academic year 2015/16 or 2016/17. This generated a total sample of 460 students. The curriculum for the programmes [determined by the university and based on UK-wide NMC standards] ensured a consistent learning design irrespective of geographical location [see Chapter 12 for more detail].

8.7 Conclusion

As noted earlier, critical realism supports the view that whilst an objective reality exists, it is shaped by subjective perception/interpretation [see Chapter 2]. Researchers undertaking studies based upon the philosophy, such as this investigation, are therefore expected to present their investigative approach, assertions, and conclusions in a way which readily exposes them to third-party scrutiny. Moreover, they should select what they deem to be the most appropriate data collection and analysis tools, assume different forms of data may have equal value, and ultimately seek to identify potential underlying causative mechanisms to account for observed phenomena and in so doing promote emancipatory outcomes. In this study, adopting a mixed methods design to address the research question [involving semi-structured interviews with a purposive sample of respondents and bivariate and regression analyses using a much larger sample] and clearly explaining how data collection and sampling were both considered and undertaken are therefore activities harmonious with a critical realist approach.

Although researchers are warned to be extremely careful when planning, implementing, and analysing in-depth interviews, in this instance the data collection method appeared to be one of very few approaches able to effectively address the research question. The investigator considered the potential impact of his own role within this study [see Chapter 18] and the research proposal was scrutinised and approved by two university research ethics committees, so he was satisfied that the investigation would not adversely affect the wellbeing of any participants. Heavy reliance upon qualitative data within this research and the inevitable risk of investigator bias, however, necessitated detailed consideration of techniques to ensure the validity and reliability of its findings. The study

also needed to show a rigorous and systematic approach to analysis of the interview data. The next chapter of this thesis concentrates on these issues.

Chapter 9. Validity, reliability, and qualitative data analysis

9.1 Introduction

Given that four phases of data collection within this study are underpinned by a desire to better understand stakeholder perceptions of block and integrated placement models [with the ultimate goal of improving curriculum design], its use of semi-structured interviews may be easily justified. Nonetheless, having chosen this method it becomes necessary to consider the nature of validity and reliability within qualitative research and, more specifically, what tools can be used to best promote them in this instance. It is also incumbent upon the researcher to show the study employs a logical and robust approach to data analysis. This chapter therefore examines validity, reliability, and data analysis in respect of qualitative research and their specific application to this investigation in order to demonstrate the approach adopted was fit for purpose. It also briefly considers the need, so far as possible, for critical realist researchers to identify potential underlying causative mechanisms in respect of observed phenomena and how this need impacted upon the direction of the study and led to a subsequent data re-analysis.

9.2 Validity and reliability within qualitative research

Noble & Smith (2015) state there are no universally agreed criteria to evaluate qualitative research and Reed (2009) recognises that defining quality in interviews is particularly problematic. Although *validity* and *reliability* have traditionally been associated with quantitative studies and, historically, were not used to evaluate qualitative research (Tatano Beck, 2009; Thorn, 2000), they are now also being applied to such studies (Anderson, 2010). There are, nevertheless, important differences in their operational definition and application within qualitative investigations.

From the perspective of qualitative research, both validity and reliability are broadly concerned with the issue of trustworthiness (Stiles, 1993); validity referring to the '*correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account'* (Maxwell, 2010a, p.280) and reliability to the *'application and appropriateness of the methods undertaken and the integrity of the final conclusions'*

(Noble & Smith, 2015, p.34). Arksey & Knight (2011) believe that, essentially, qualitative researchers must evidence reliability and validity by illustrating that their investigative actions are congruent with the purpose of their study.

Whilst Rolfe (2006b) argues responsibility for appraising a qualitative research report must ultimately rest with the reader rather than the writer, he also recommends researchers should strive to ensure the approach they adopt is systematic, rigorous, clearly described, appropriately justified, and exhibits a robust design. Bias inevitably exists in all social science investigations (Smith & Noble, 2014) because social influences can never be completely controlled or removed (Ryan, 2019). Indeed, within qualitative studies there are multiple potential threats to validity (Arksey & Knight, 2011), including '*distortion by investigators', participants', and readers' expectations and values*' (Stiles, 1993, p.613). Since Maxwell (2010a) claims that failing to adequately consider validity threats is a common reason for research proposals to be rejected, it is perhaps reassuring that no such concerns prevented the approval of this study.

9.3 Tools to promote validity within qualitative research

Although no method or procedure can guarantee validity, various tools greatly assist in the reduction of validity threats and increase the credibility of conclusions reached within a research study (Maxwell, 2010a). Mears (2017, p.187) argues *'the validity of interview research is related to its appropriateness for studying what it claims to inform and its veracity in reporting*' and various techniques may be employed to strengthen validity. Use of audio or video recording devices, rather than researcher notes, allow scrutiny of raw data (Gray, 2018); whilst sufficient engagement with participants to acquire meaningful information (Anderson & Kiger, 2008) combined with the production of verbatim interview transcripts instead of selective interviewer notes, termed *rich data*, provide a deeper and more revealing picture (Arksey & Knight, 2011). In this research, all interviews were captured on a digital audio recording device and transcribed in full by an independent professional transcription service, thereby permitting such scrutiny and reducing the risk of researcher bias in the production of these records.

Within a qualitative study, data can be inappropriately discounted (Gray, 2018), so *'identifying and analysing discrepant data and negative cases is a key part of the logic of*

validity testing in qualitative research' (Maxwell, 2010a, p.284). This approach, sometimes referred to as *contradictory evidence* or *deviant cases*, requires the researcher to seek out, examine and account for evidence which might otherwise be deemed to challenge their conclusions and in so doing reduce the risk an investigator merely sets aside such material to strengthen their argument (Smith & Noble, 2014). Contradictory data were evident in this study and so, as a further means to enhance validity, the researcher sought to capture, present, and explain its occurrence [see Chapter 10].

Validity may also be substantiated by *member checking*, which involves the researcher confirming the accuracy of their understanding with participants during the data collection process (Gray, 2018). Within this investigation, the researcher employed member checking in all interviews by echoing, paraphrasing, and seeking further clarification on respondent comments where these appeared ambiguous and, in so doing, allow the interviewees an opportunity to confirm or correct his interpretation. He also followed advice about being alert to the tone and emphasis within both respondents' speech and his own utterances (Rutakumwa et al., 2020) and sought to monitor if an interviewee's verbal and non-verbal communication appeared harmonious and, therefore, seemed to demonstrate authenticity (Bonello, 2001b).

Beuving & de Vries (2015, p.44) suggest an overall test of validity related to the findings from a qualitative research study can also be undertaken at the end of the process by sharing the report and providing an opportunity for participant feedback. Nevertheless, they stress that, in isolation, interviewee agreement with the findings does not demonstrate validity and, similarly, a rejection of the results by respondents may highlight an unpalatable truth rather than an inaccurate conclusion. Whilst recognising these limitations, the researcher implemented this technique upon completion of each interview phase of the study, although no respondents challenged either the data or conclusions.

A more intensive form of member checking, termed *respondent validation*, provides an opportunity for interviewees to comment on and revise their transcribed interview record (Birt et al., 2016) and adopting such an approach may help secure respondent co-operation (Alvesson, 2003b). Implementing respondent validation in this study would, however, have increased the burden on participants and since research resources were

also limited, it was not implemented. Additionally, the researcher was aware of arguments which may discourage its use; not least that interviewees can have a partial and restricted view of a topic (Mays & Pope, 2000; Torrance, 2012) and may, having examined a transcript, suggest their responses have been misunderstood and should be revised merely to present themselves or their organisation more favourably (Burnard et al., 2008b; Cohen et al., 2018).

Within qualitative studies, many conclusions have an implicit quantitative component, for example the prevalence of a phenomenon within a setting or population (Maxwell, 2012). Use of simple descriptive numerical data, termed *quasi-statistics*, *'to make statements such as "some," "usually," and "most" more precise'* (Maxwell, 2010b, p.475) is therefore proposed as a valuable supplementary form of evidence to promote validity in a predominantly qualitative investigation. Capturing the frequency of respondent experiences and preferences in respect of a model of practice learning was therefore another way in which the researcher sought to make this study more robust [see Chapter 10, Table 1].

Neutrality is described as *'a requirement that the researcher considers their own role in the research'* and the aim *'is not to try to standardize researchers, but to have them reflect on the ways in which their background (class, gender, race, special concerns), personality (which is critical to achieving rapport and trust), mind set (assumptions and preconceptions), and actions have contributed to their account'* (Arksey & Knight, 2011, p.55). Whilst actual neutrality may be unachievable (Diebel, 2008), striving for it and making reflections explicit in a research report are deemed valuable activities which assist investigators to demonstrate rigour within their work (Bekhet & Zauszniewski, 2012; Erlingsson & Brysiewicz, 2013). Within this thesis a conscious effort has therefore been made to capture the researcher's values and reflections associated with different aspects of the study [see, in particular, Chapter 18].

In critical realist research, quality and bias reduction can be promoted through an elaborated form of triangulation termed *critical multiplism* (Davies & Fisher, 2019; Tanlaka et al., 2019). Critical multiplism proposes that a research approach should be systematic without being rigid, justified by appropriate scientific argument, and based upon an acknowledgment that there are problems in social research which a study must

seek to identify and overcome (Patry, 2013). Essentially, triangulation compares results from two or more different data collection methods and/or two or more sources; researchers looking for patterns of convergence which enable them to formulate or corroborate an overall interpretation of the findings (Beauving & de Vries, 2015; Fusch et al., 2018). It is argued *'no single method is likely to afford a comprehensive account of the phenomenon under investigation'* (Torrance, 2012, p.113) and that data from different sources may offer complementary perspectives on the same construct (Scott, 2007). Hence, use of multiple methods, especially qualitative and quantitative approaches, provide a further opportunity to demonstrate confirmation and completeness (Bekhet & Zausziewski, 2012) and so help promote validity within this investigation.

Indeed, Barbour (2001, p.1117) argues the *'heavy reliance on triangulation in grant applications testifies both to the respect accorded to this concept and to its perceived value in demonstrating rigour*.' Within this research, gathering qualitative data on practice learning within The OU pre-registration nursing programmes from four different stakeholder groups offered such triangulation and helps demonstrate '*the research design explicitly incorporates a wide range of different perspectives so that the viewpoint of one group is never presented as if it represents the sole truth about any situation'*; an approach termed *fair dealing* (Mays & Pope, 2000, p.51) or *truth value* (Arksey & Knight, 2011). Supplementary quantitative analyses of the relationship between the two models of practice learning employed within the programmes and student retention/achievement rates could also be utilised to corroborate or challenge the qualitative results. Furthermore, and of equal importance, such triangulation may provide a more compelling argument regarding the reliability of findings (Gray, 2018).

9.4 Tools to promote reliability within qualitative research

Demonstrating reliability, sometimes referred to as *dependability* (Erlingsson & Brysiewicz, 2013), *confirmability* (Jensen, 2008), *transferability* (Anderson & Kiger, 2008), or *consistency* (Arksey & Knight, 2011), within a qualitative investigation is challenging because, unlike quantitative research, there are no available statistical tests for this purpose (Sutton & Austin, 2015). Within interviews, reliability may be enhanced by greater control of, and uniformity within, the interview process. By imposing such structure, however, validity can be adversely affected as the interaction becomes more

stilted and less relaxed; ultimately increasing the risk participants feel inhibited and less likely to provide full, frank, and accurate accounts (Cohen et al., 2018). A key element of reliability within such investigation is that '*the researcher shows how the research has been done and decisions have been made, so that the reader could conduct an 'audit trail', examining the good sense and plausibility of the researcher's thought and actions'* (Arksey & Knight, 2011, p.54). Transparency and detailed description of the rationale for the research design and its implementation (Fitzgerald & Dopson, 2011) should therefore provide an opportunity for a reader to evaluate reliability within this study.

Another widely advocated tool to promote reliability in qualitative research is use of *multiple coding*; also referred to as *peer review, consistency checks* or *intercoder reliability* (Gray, 2018; Smith & Noble, 2014; Vaismoradi et al., 2013). This approach, described as the equivalent of inter-rater reliability within a quantitative study (Barbour, 2001), involves data being independently analysed (Ryan & Bernard, 2003) and although there is *'a debate as to whether qualitative researchers should have their analyses verified or validated by a third party'*, it is also argued *'this process can make the analysis more rigorous and reduce the element bias'* (Burnard et al., 2008b, p.431). Preliminary categories/themes were examined by a second disinterested academic in all interview phases of this research and revisions undertaken based on the feedback; not least in several instances where respondent comments were deemed not to be mutually exclusive illustrations of a particular category/theme. The approach to qualitative data analysis employed within this study is discussed shortly.

Bisman (2010) asserts one of the main criteria for judging the quality of a critical realist study is *replicability*. Stiles (1993, p.602) refers to replicability as *procedural trustworthiness* and suggests it *'concerns whether the observations are repeatable (after allowing for contextual differences) and whether the investigator's report conveys what you would have seen if you had been observing'*, so is deemed a key consideration in determining reliability within qualitative research. Clearly, audio recordings and full interview transcriptions offer considerable opportunity to establish procedural trustworthiness. The availability of such data in this study may therefore enhance its reliability.

9.5 Qualitative Content Analysis

Qualitative researchers can now choose from a wide range of theoretically and technically sophisticated data collection methods (Sandelowski, 2000) but if their work '*is to yield meaningful and useful results, it is imperative that the material under scrutiny is analysed in a methodical manner*' (Attride-Stirling, 2001, p.386). *Thematic analysis*, also termed *Qualitative Content Analysis* [QCA], has been defined as '*a method for identifying, analysing, and reporting patterns (themes) within data'* (Braun & Clarke, 2006, p.79) and is described as particularly useful when, as is the case in this study, there is only limited existing theory or research literature addressing a phenomenon (Hsieh & Shannon, 2005). It is a method in which researchers adopt a reflexive, interactive and intuitive approach in which they continuously modify treatment of data to accommodate additional material and new insights about these data (Sandelowski, 2000).

QCA aims to '*systematically transform a large amount of text into a highly organised and concise summary of key results'* (Erlingsson & Brysiewicz, 2017, p.94), which both describe a phenomenon under investigation and help it to be understood as a structure, model, system, or map (Elo & Kyngas, 2008). It is commonly used within both nursing research and the wider social and health sciences (Elo et al., 2014; Graneheim & Lundman, 2004; Hsieh & Shannon, 2005); perhaps because of its compatibility with various epistemological approaches (Vaismoradi et al., 2013), including critical realism, and its suitability for abductive, inductive, deductive, and retroductive research (Graneheim et al., 2017). It was therefore selected to analyse interview data within the first four qualitative phases of this retroductive study.

Analysing qualitative data can be challenging and time-consuming (Erlingsson & Brysiewicz, 2017) and there is no single 'right' way of undertaking QCA (Elo & Kyngas, 2008). Nevertheless, rigorous analysis is a *'necessary component of the research endeavour and is critical to the generation of good evidence'* (Green et al., 2007, p.549). Graneheim & Lundman (2004, p.106) argue it is important for a researcher using QCA to *'decide whether the analysis should focus on manifest or latent content'*, but what type of content the conclusions of a study are deemed to reflect when examined against the qualitative data may itself be a matter of debate, since both the specific meaning of words and the wider use of language is subject to individual interpretation.

Qualitative data cannot be presented in a wholly impartial way (Sandelowski, 2000), so it is important that researchers remain aware of their '*pre-understandings in order to avoid bias during analysis and in results*' (Erlingsson & Brysiewicz, 2017, p.99). Indeed, Stanton et al (2017) claim such awareness itself helps to guard against inadvertent investigator bias. Moreover, Braun & Clarke (2006) stress QCA never enables themes to simply 'emerge' or be 'discovered' and argue such description denies the active role investigators always have in identifying and shaping themes. In contrast, clearly and systematically explaining how results were created (Elo et al., 2014; Noble & Smith, 2014) and using authentic citations within a research report can help readers to ascertain the trustworthiness of the analysis and claims derived from it (Braun & Clarke, 2006).

This study undertook QCA in accordance with the three-stage model described by Elo & Kyngas (2008). The first stage, termed *open coding*, involved repeated reading and annotation of all complete interview transcripts to describe and summarise their content [see Appendix 7 example]. This commenced with the researcher examining the transcripts and using reviewing and highlighting tools within word-processing software to formulate initial codes. The second stage, known as *category creation*, clustered similar or contrasting content and related annotations into higher order categories [themes or abstract concepts], which illustrated a specific characteristic or phenomenon; a process in which 'cut and paste' functions and the creation of separate documents were used to reorganise data into distinct groups [see Appendix 8 example].

Ryan & Bernard (2003, p.89) suggest *'repetition is one of the easiest ways to identify themes'*, and such repetition was evident within the interview transcripts generated within this research and reflected in the report. Finally, general category descriptions [themes or abstract concepts] were developed, refined, and operationally defined; a process referred to as *abstraction* (Elo & Kyngas, 2008). This involved the categories being repeatedly examined and led to the development of some sub-categories [see Appendix 9example and Chapter 10]. Congruent with the advice of Braun & Clarke (2006), the activity continued until refinements no longer appeared to make any substantial difference. As noted earlier, second and final stage categories derived from interview analysis in each of the first four phases of the research were scrutinised by a disinterested academic and some modifications made.

9.6 Critical realist research, underlying causative mechanisms, and subsequent data re-analysis

From a critical realist perspective [see Chapter 2], causal explanation is regarded as much more important than description (Wilson & McCormack, 2006) and the destination of an investigation based on this philosophy cannot be known until it is reached (Edgley et al., 2016). At the start of this critical realist study, it was unclear how, or indeed whether, a causative mechanism associated with practicum preferences/experiences might be identifiable. During the research, however, various theories were found which might provide such an explanatory basis. Although not originally planned, after qualitative and quantitative data collection and analysis were completed, work examining the merits of each of these theories as causal mechanisms was undertaken [see Chapter 14]. This activity led to a full re-analysis of the qualitative data against key propositions within the *theory of human relatedness* (Hagerty et al., 1993) [see Chapter 15]. It also led to explanation of the theory as a potential causative process shaping placement preferences/experiences and the development of associated recommendations regarding changes to the curriculum and quality assurance processes of nursing programmes [see Chapter 16].

9.7 Conclusion

Although qualitative research can make an important contribution to better understanding key elements of nurse education, it is vital such studies are designed and implemented in a way that enables practitioners to have confidence in their results. Historically, qualitative data have been regarded merely as supplementary to quantitative data (Hesse-Biber, 2010) and wholly qualitative studies judged to be an inferior form of investigation (Corry et al., 2018). Qualitative researchers must therefore demonstrate carefully considered application of appropriate tools to evidence validity and reliability within their work.

As identified earlier, applying many of the techniques described in this chapter as well as utilising an established approach to QCA, should help illustrate that this research can be deemed both valid and reliable. As an investigation based on critical realism, further work requiring re-analysis of the qualitative data against key propositions within the theory of human relatedness also needed to be undertaken to identify potential causal mechanisms

associated with stakeholder preferences/experiences of practice learning models [see Chapters 15-16]. The next section of this thesis provides both quasi-statistics and identified themes derived from QCA in respect of the qualitative results from the first four data collection phases of the study.

Chapter 10. Qualitative results – establishing the *'what'*

10.1 Introduction

The qualitative components of this research involved semi-structured interviews with representatives of four stakeholder groups, namely employer sponsors, students, practice tutors and mentors [see Appendices 3-7 for interview schedules]. Written informed consent was sought and obtained from all participants prior to their involvement in the study [see Appendices 1 & 2] and the transcriptions anonymised. All employer sponsors were managers within National Health Service [NHS] Trusts who determined placement model selection for Open University [OU] nursing students on either a BSc (Hons) Adult and/or Mental Health [MH] Nursing degree programme whom they employed as non-registrant Healthcare Assistants [HCAs], Auxiliaries, Nursing Assistants [NAs], Support Workers, or Assistant Practitioners [APs]; collectively referred to as *non-registrant carers* [NRCs]. Mentors [more recently re-termed *practice assessors*] were experienced registered nurses [RNs] on the Nursing & Midwifery Council [NMC] live register who were employed by healthcare organisations in which OU nursing students were located and who assessed student competence. Practice tutors were university staff monitoring learner progress and supporting students/mentors in practice settings; activity including simultaneous dialogue involving all three parties and termed *tripartite meetings*. As detailed earlier [see Chapter 9], the data was exposed to qualitative content analysis in accordance with the model proposed by Elo & Kyngas (2008).

10.2 Respondent quasi-statistics

Provision of quasi-statistics outlining simple descriptive numerical data can illustrate some results more clearly than use of words such as *'most'* or *'some'*, as well as better evidence the validity of specific assertions [see Chapter 9]. Before the thematic results are presented for each stakeholder group, key quasi-statistics are provided in Table 1. In the first column of this table, the number of respondents within each of the four stakeholder groups [i.e., employer sponsors, students, practice tutors and mentors] are identified as well as their sex [zero results excluded] and practice background [i.e., Adult or MH nursing]. Recording these variables was considered to be a means by which to provide richer quasi-statistics, although it is acknowledged that other data, which may have been equally informative

[such as student ethnicity, socioeconomic status, or their highest academic qualification on entry to the nursing programme], could not be readily acquired. The subsequent columns identify the number of respondents within each stakeholder group who have direct experience of block and/or integrated placements and whether they express a preference for one of these two models; the sex and nursing discipline of respondents also being recorded in respect of these responses.

Table 1: Respondent quasi-statistics

Respondent subset (Sex and Adult or MH nursing)	Respondent experience of block placement model	Respondent experience of integrated placement model	No respondent placement model preference	Respondent preference for block placement model	Respondent preference for integrated placement model
Employer Sponsors: 9	**9**	**3**	**1**	**6**	**2**
Female: 9	Female: 9	Female: 3	Female: 1	Female: 6	Female: 2
Adult: 7	Adult: 7	Adult: 1	Adult: 0	Adult: 6	Adult: 1
MH: 2	MH: 2	MH: 2	MH: 1	MH: 0	MH: 1
Practice Tutors: 8	**8**	**6**	**3**	**3**	**2**
Female: 8	Female: 8	Female: 6	Female: 3	Female: 3	Female: 2
Adult: 5	Adult: 5	Adult: 3	Adult: 2	Adult: 2	Adult: 1
MH: 3	MH: 3	MH: 3	MH: 1	MH: 1	MH: 1
Students: 12	**6**	**6**	**3**	**7**	**2**
Female: 9	Female: 6	Female: 2	Female: 2	Female: 5	Female: 1
Male: 3	Male: 0	Male: 2	Male: 1	Male: 2	Male: 1
Adult: 8	Adult: 4	Adult: 4	Adult: 4	Adult: 4	Adult: 1
MH: 4	MH: 2	MH: 2	MH: 0	MH: 3	MH: 1
Mentors: 8	**8**	**4**	**0**	**6**	**2**
Female: 7	Female: 7	Female: 4	Female: 3	Female: 5	Female: 2
Male: 1	Male: 1	Male: 0	Male: 1	Male: 1	Male: 0
Adult: 5	Adult: 5	Adult: 3	Adult: 4	Adult: 5	Adult: 2

MH: 3	MH: 3	MH: 1	MH: 0	MH: 1	MH: 0
Total of respondent subsets: 37	**31**	**19**	**7**	**22**	**8**

10.3 Qualitative thematic results

Five common themes were identified within the results derived from all four stakeholder groups, namely *difference*, *affinity, carer work & service delivery, role transition* and *higher priorities*, although in all four groups at least one additional unique theme was evident. Braun & Clarke (2006) argue provision of authentic citations within a research report can help readers to ascertain the trustworthiness of the analysis and claims derived from it, hence within this thesis the key characteristics of each theme are described before supporting respondent comments are presented. Results from the four stakeholder groups are shown in the same order as the interview phases were undertaken. Respondent roles, i.e., employer sponsor [E], student [S], practice tutor [PT] or mentor [M], are identified against all illustrative data.

To facilitate comprehension, actual respondent words are presented in italics, some aspects of speech dysfluency have been removed and clarifications provided in brackets. For confidentiality, some factual details have been removed and replaced in brackets by more generic descriptors. Each participant is assigned a consistent female pseudonym, although [as evident in Table 1] some respondents were male. The naming of respondents, rather than merely assigning them a number, is a small but deliberate action designed to recognise their individuality.

10.4 Employer sponsor results

Data analysis led to the development of five themes: *difference*, *affinity, carer work & service delivery, role transition*, *valuing & retaining,* and *higher priorities*.

10.4.1 Employer sponsor theme: *Difference*

This theme captures the perception of The OU and its pre-registration nursing programmes [PRNPs] and students as distinctive, unique, or different compared to nursing courses

provided by other universities and their students, as well as efforts to minimise or mitigate any perceived difference:

> **Cerys** [E]**:** '*The OU's* [students] *are different without a shadow of a doubt*'
>
> **Erin** [E]**:** '*They're* [OU] *not a normal pre-reg student*'
>
> **Harriet** [E]**:** '*So, if I think about them* [OU students] *in practice, they were different*'

The nature of perceived difference in respect of OU PRNP students included a greater level of knowledge and experience, both academic and practice-related, than their peers on PRNPs provided by other universities:

> **Anisha** [E]**:** '*With Open University, in particular, because the students are coming from, they've got lots of experience*'
>
> **Cerys** [E]**:** '*You're* [OU students are] *generally seen as more knowledgeable. Not just, well for several reasons, one, because I've got that previous experience of working within the Trust and I know how the Trust works as well as kind of maybe particular interventions and the tests they've had to do anyway. And two, I think it's also been noted that the students have a larger theoretical background*'
>
> **Erin** [E]**:** '*We've got an advantage with The Open University students, these are experienced. They're experienced associate practitioners* [APs] *who have got a lot of knowledge*'

OU PRNP students were also described as having greater motivation, independence and confidence compared to their peers studying other nursing programmes and more likely to show initiative in their learning and learning support:

> **Erin** [E]**:** '*They're* [OU students] *quite used to being independent and professional and taking responsibility for their own learning, which is a big issue, because a lot of the traditional students don't - they want to be spoon-fed*'
>
> **Cerys** [E]**:** '*It's quite recognised that these* [OU students] *are the qualified nurses to watch for in the future quite frankly. With other programmes we still see a little bit where the students are expecting to be spoon-fed if you like and pushed along*'

Anisha [E]**:** '*They're* [OU students] *very motivated and they're very enthusiastic and knowledgeable and have the communication skills to be able to do it…They* [OU students] *have their own networks and contacts*'

Gemma [E]**:** [OU] '*candidates are self -motivated individuals, who have support from their families and can manage their work/life balance effectively. The* [OU] *students rely on each other for peer support'*

Not all perceived differences, however, were positive. Participants expressed concern about the challenges OU PRNP students faced returning to study as mature learners and fulfilling the programme's academic requirements:

Imke [E]**:** '*Our healthcare assistants who've been working here* [and become OU students]*, some might have been working here for quite a long time and studying is no longer familiar to them. The academic element will, the way that they approach that and manage that will be very different'*

Fidelma [E]**:** '*Doing theory in their own time is a massive – I'm sure that must be really, really hard, the amount of work. You know, thinking back to when I did my degree, the amount of work that you have is a lot and to think that you've got a fulltime job, that must be really hard. It is distance learning, so if they have got families and things at home, they're going to struggle with juggling family demands'*

Several participants highlighted The OU PRNPs lacked familiarity within their organisation and reported uncertainty regarding the status of students on the programme amongst the wider workforce:

Anisha [E]**:** '*So a* [OU] *student might go into an area where the mentor is not familiar. So it might be 'what are we going to do with you, what's different about your programme?''*

Fidelma [E]**: '***We've only ever worked with* [name of university] *for a long, long time and there are only* [number] *of The OU students. They're not well known. The programme isn't well known. There's still that question of 'are you going to be a real nurse at the end of it?''*

> **Diane** [E]**:** '*I think when the mentors feel like that* [frustrated], *that transfers to the students. So the students lose confidence in their mentors as well if the mentors feel like 'oh this isn't what I'm used to, I don't know what I'm doing with this''* [student]
>
> **Imke** [E]**:** '*I do worry that sometimes The Open University students come onto the ward. They are there as nursing students. They are wearing, however, a different uniform to nursing students* [from another university]*...so first of all that makes them look a bit different, and people perhaps then start to think of them a bit differently. They come along with practice assessment documentation, and I think it's just we know that sometimes change perhaps from a mentor's point, from everybody's point of view, change can unsettle. I would hate to think of a student going somewhere and somebody saying 'well why can you not be like the normal students?''*

In some instances, a programme difference was implied in participant comments. Although not presented in any obvious derogatory way, other academic institutions delivering traditional PRNPs were commonly described as the *'university*' or '*universities*'; appearing to suggest that The OU was regarded as some alternative academic institution:

> **Erin** [E]**:** '*So if you know you've only got a six-week window to slot them* [OU students] *into, you know when you've got the pre-reg students from the universities, and that's why it's easier to do it and say well, I know you've got this 19 weeks to do that 16 weeks in, but if you do that week, there's no other students in the area''*
>
> **Fidelma** [E]**:** *'It's hard enough for The OU students because within our Trust we only have* [name of university] *students…We can pick the placement* [for OU students]*, so it's not like the university'*

Most participants expressed a strong desire to create organisational conditions which minimised the perceived difference between The OU PRNPs and nursing programmes provided by other universities working with the organisation and accentuate their similarities. Respondents believed an inconsistent placement model for nursing students from different universities might adversely affect the learning environment and interpersonal relations; hence the desire to align the practicum arrangements of OU nursing undergraduates with those in place for more numerous learners from other academic institutions:

Diane [E]**:** *'We do try and keep a similar model and a similar process for all of the different routes. So that the mentors can easily identify this is the stage where this person's at and this is what I need to do. So, although the documentation will be different, there will still be the same sort of meeting at the beginning, middle and end'*

Imke [E]**:** '*When everything is similar and really the only elements that change are the student's uniform and the practice assessment document, then I feel that that would allow students to get the best experience. You know, we don't want them* [OU students] *to be alienated in something completely different to our traditional students from our traditional and usual provider.* [We want them] *just to be treated in exactly the same way as their counterparts from alternative universities'*

Striving to minimise the extent to which staff in clinical services might perceive differences between OU nursing students and learners on other nursing programmes was a common motivating factor underpinning selection of a block practicum:

Diane [E]**:** '*It* [the block model] *keeps students in line with other students and other learners that's on the ward as well. I think particularly for students who are only going in for two days a week* [integrated model]*, they would probably be a bit lower down the priority list from a mentor's point of view. Because they don't know them as well, they're not as invested in them; whereas when they're there all the time* [block model] *they kind of do get a little bit more protective of them: 'it's my student, I want them to do this, this is what they need''*

Imke [E]**:** '*And although probably that's not the right reason* [to use the block model]*, it's familiarity. Mentors are very familiar with students coming every single day for a set period of time and actually that familiarity will continue to make them comfortable in their role as a mentor. So, I suppose to stop any dis-settlement from a mentor's point of view which may then impact on the student or their learning experiences or how a mentor perceived them in their current role'*

Fidelma [E]**:** '*Because it's* [OU block model] *similar to the usual pre-reg, say,* [name of university] *style of a block four-week placement. The fact that they* [OU students] *follow a similar placement model* [to other nursing students] *with the blocks, I think,*

makes it more – I don't know what the word is, but – robust, maybe. Rather than a bit of a part-time student that's just coming in for two days a week'

Harriet [E]**:** '*Having that intense period of consolidation over that space* [block placement] *makes them more like other students as well, so more like other students from* [name of university] *or from* [name of university]. *So their experience is comparable-ish'*

Where resource/operational issues necessitated such learners having an integrated placement, several employer sponsors described how they considered if a service had previously accommodated students on both practicum models and whether a potential mentor had experience of supporting undergraduates on an integrated placement before any student assignment was made. Moreover, where a service and/or mentor was unfamiliar with the OU nursing programme and/or use of an integrated practicum, they reported efforts to convey this alternative provision in a positive way:

Imke [E]*: 'So we're trying to get the message across and prepare well actually when you see a student with an Open University uniform this is what you need to know about them. Actually, their nursing programme is no different. The competencies they need to achieve are no different. They may be written differently, and they may be in a book that looks a bit different but be prepared for that. Saying to somebody, 'if you get an OU student and actually you don't know what to do with them or you're worried or you're panicked, please don't pass that worry or panic onto the students, put them somewhere, come away, phone me and say what do I do?''*

Cerys [E]**:** '*We need to have some kind of process really that's a little bit more savvy about making sure that mentors realise the differences'* [between The OU and other PRNPs]

Gemma: [We are] 'p*roviding additional support for mentors i.e., briefing sessions/mentor masterclasses to review the relevant documentation/understanding of The Open University programme'*

10.4.2 Employer sponsor theme: *Affinity*

This theme captures the importance respondents assign to students feeling they are a team member during placements, building effective working relationships and meaningfully participating in service provision. Employer sponsors commonly suggested that a block practicum offered better opportunities for learners to engage in group interactions that occurred during the placement:

> **Diane** [E]**:** '*I did the BSc programme with* [name of university]*, but all of my practice placements were two days a week. So I had two days at university, two days in practice and one day as study a week, and from my personal experience, just being a student nurse for two days a week, I didn't feel part of the team. And that sort of fed into my experience and also then my feelings towards having the block placements that students would then feel part of the team, they would be there as part of the workforce for that period of time rather than just kind of visitors to the ward for those two days a week'*

> **Erin** [E]**:** '*The students then knew who they were. They retained an identity as an Associate Practitioner* [AP] *or a student on the programme. They weren't here one day, then doing that, and we thought it would be better for the student to retain their identity that they were removed from the area: they knew for that six weeks they were going to be a student and that was their role'*

> **Imke** [E]**:** '*It allows them to know who they are and have that strong identity of a student nurse without any of the confusion, they're always going to be supernumerary and hopefully with that they always have in their head, you know, 'I'm here to follow, be part of the team', but follow the learning opportunities that present themselves. They're supernumerary, but they are part of the team, they are on the roster. … staff work shifts, so some weeks you'll be in different days to others, some weeks you could be in on nights. But I think it* [block placement] *gives the impression of allowing more consistency: you're a fulltime member of staff for six weeks'*

> **Harriet** [E]**:** '*I think what they* [OU students] *feel is that it* [block placement] *does enable them to get immersed in the team that they're working in'*

Participants saw practice experiences as helping students understand the patient journey and providing opportunities to reflect on and consolidate learning. Responses suggested the nature of the service in which the practicum took place may affect the extent to which a student had a consistent and meaningful practice learning experience. For example, block placements were generally seen as more desirable within services in which nursing intervention for a patient commonly lasted between several days and one or two weeks [such as a medical, surgical, or acute MH in-patient ward] because the model was deemed to optimise the likelihood of the student being exposed to the provision of nursing care for the entirety of a patient's engagement with the service:

> **Erin** [E]**:** '*One of the biggest compelling arguments for the block placement is you do get continuity of care. They get to know the staff. They get to know the procedures, the policies, the rationale for the care they're delivering, but then if you do that for two days and then you don't come back for nine, ten days* [integrated practicum]*, you've lost it again and you're relearning all the time*'
>
> **Gemma** [E]**:** [In the block model] '*students experience patient journey, holistic care, continuity of care in relation to admissions, transfers, and discharges*'
>
> **Cerys** [E]**:** '*With it being a block period you can, if it's 24/7 that's where the nights and the twilights can happen as well, and that further deepens the experience and knowledge of that person and how they function, not just throughout the weeks, but obviously through the hours of the 24-hour day as well. They can, dependent on the person, obviously, they're going to be there continuous through the initial placement, as it were, and to see that intensive work that's done through assessment and then getting on to the treatment and then discharge. If they were there two days a week* [integrated practicum]*, they might see the patient start to engage with them, have another two days with them and then they might be discharged*'
>
> **Diane** [E]**:** '*If there were set days* [integrated placement] *there might be some clinics or some learning opportunities that they wouldn't have access to*'

In contrast, where nursing interventions were unlikely to extend beyond several hours [such as care in an out-patient clinic, or input from an MH crisis team] or might last more than several weeks [such as community nursing care for chronic/enduring conditions or an

orthopaedic trauma ward] an integrated practicum was generally perceived as more appropriate. This was largely because respondents believed such a placement would not adversely affect and may even increase the probability of the student observing, understanding, and engaging in, the entire patient journey within the service:

> **Cerys** [E]**:** '*It's generally seen by certainly the community placement that it's beneficial to do the two days a week* [integrated practicum]*. Because if they work full-time* [block placement] *then they're less likely to see the same person over a longer period of time; whereas when they work two days a week, they can do that. Because you get that continuity of the, not of the service necessarily, but of the patient journey*'

> **Fidelma** [E]**:** '*A community* [placement] *might work better as the other* [integrated] *model*'

Others emphasised potential benefits of an integrated practicum model in consolidating learning:

> **Imke** [E]**:** '*With the integrated model, I do see the potential for students to perhaps have a longer period as a student nurse, therefore when they do their two shifts for example a week as a student nurse, I do see the opportunity in between time for them to go off and consolidate what they've done as a student nurse and come back the following week perhaps richer in knowledge'*

> **Diane** [E]**:** '*One of the advantages of the OU programme is that you've got four years. You've got even longer. And the fact they're* [OU students] *working in practice, that they're not just seeing registered nurses practising while they're a student on a placement; they're also seeing registered nurses practising when they're a nursing assistant*'

10.4.3 Employer sponsor theme: *Carer work & service delivery*

This theme addresses implications for the base location when an OU nursing student is away from their NRC role. The positive impact OU PRNP students had in disseminating good practice when returning to work as NRCs was recognised:

> **Anisha** [E]**:** '*I mean somebody in particular has said to me today, I've been able to give them advice about, you know, but you should refer to this other team because that's*

exactly what they do. So being able to share, they're [OU students] *like little bees and pollinating everywhere'*

Belinda [E]**:** '*They* [OU students] *can bring things back to the areas* [the NRCs' workplaces] *as well, some of the student experience, which is very helpful. So, they can bring back a deeper knowledge of how things work in different areas and contribute to the team meetings'*

Participants, however, also acknowledged the challenge faced by services in releasing NRCs for supernumerary practice learning as OU PRNP students:

Anisha [E]**: '***Some supporting managers have got backfill for their student, so that's from the trust budget, but it's meant less of an impact on their team. Other teams have not got backfill, so they're kind of absorbing that cost themselves where they've not been able to replace that person'*

Fidelma [E]*: 'They won't be getting cover for this person, so I know it is difficult for the areas to release the members of staff'*

Most concluded that a block placement was less problematic:

Imke [E]**: '***We have to remember that ward managers and department managers are releasing these staff at a time where staffing is difficult and there are pressures on staffing levels. We felt that to set specific dates and say that students would be gone from this date to this date fulltime would benefit the student'*

Harriet [E]**:** '*Our preference would be the blocks because once you're doing it, it's manageable'*

Erin [E]**:** *'To organise a placement for six weeks, it's short, it's sharp and they can go and do it and they'd get the learning'*

Fidelma [E]**: '***It was felt like it would be easier to get cover within the AP's usual workplace for a block time. So, it* [their absence] *would be like them being on holiday'*

Nevertheless, several respondents recognised a preference for the integrated model amongst some service providers:

Diane [E]**:** *'Managers, when we met with them, they did prefer the two days a week* [integrated practicum] *because they would have just been able to get backfill for the two days'*

Belinda [E]**:** [Using the integrated model] *'they're not out for a whole block from their healthcare assistant role, so they don't lose touch with developments in the service* [and] *managers do have staff continuity'*

In striving to respond to the needs of services where OU nursing students were employed as NRCs, participants valued the autonomy they felt they had in determining student learning experiences:

Erin [E]**: '***You give them the opportunity to develop in a very flexible way'*

Fidelma [E]**:** '*So, we can handpick the placements with the manager to tailor-make that placement programme of how is this nurse going to come out the best they possibly can when they qualify'*

Cerys [E]**:** *'That's the beauty of The Open University course to be honest with you because it is so flexible. And it can be tailored to meet individual needs, not just of the programme but also the work environment'*

10.4.4 Employer sponsor theme: *Role transition*

Role Transition addresses the perceived challenge OU PRNP students face arising from the need to concurrently undertake NRC and PRNP student roles/responsibilities.

Belinda [E]**:** '*One of the things that has come out is the adjustment side of it, from changing the role, understanding that they're a pre-registration student when they're on placement and then they're back to healthcare assistant'*

The magnitude of this task was commonly regarded as being reduced by the block model, since the approach removes concurrent practice as an NRC and PRNP student:

Gemma [E]**:** [With the block model] '*there is no blurring of roles for student/HCA; these are clearly defined'*

Erin [E]**:** '*It was felt that it would be an easier transition for them to leave for a portion of time and then come back and do their job, rather than be here, then back, then here, then back'*

Harriet [E]**:** '*It's about taking the HCA hat off and putting the student hat on within the same week. So, well for her one day a week I'm a healthcare assistant, two days a week I'm a student, and we felt it would be quite difficult to chop and change. 'Who am I? What am I today?''*

Imke [E]**:** '*I think it's much easier in a block to remember who you are and what you do and what your job role allows you to do. It gives them six weeks of being a student nurse. It's not 'what hat do I have on today?''*

Nevertheless, implementation of the block model was not always regarded as a solution to this tension:

Imke [E]**:** '*I've got a worry that students will not be able to, even in the block model, will not even be able to differentiate between the two things* [roles] *that they're doing'*

Indeed, one participant suggested that the integrated model may better facilitate transition between the NRC and PRNP student role, whilst promoting adaptability and developing communication and negotiation skills which would ultimately assist individuals within their practice as RNs:

Belinda [E]**:** '*There's not such a jump as there would be from the block back to practice. Maybe they have more of a consistency going on because the student is both experienced in a healthcare* [assistant] *role and a student role more frequently so they're not having to adjust so massively. They have to liaise with their manager, they have to liaise with their placement area, and they talk to me, and it gives them that leadership and the understanding of how you need to put the service need first and how you need to liaise with lots of different professionals to sort out your placement. So, I think in some ways that gives a good feel to them back in their area as a healthcare assistant; it gives that professionalism. I think they do learn a lot of versatility and they learn the fact that in a very changing environment things change*

so quickly. That's just another aspect of having to adapt, and I think in the future there's going to be a lot more adaptability needed amongst nurses'

Some participants identified the tension OU PRNP students may experience in wanting to use skills acquired as an NRC during practice learning periods as a PRNP student but failing to realise this may not be permissible:

Erin [E]**:** '*The big danger lies that you've got a student who still thinks they're an AP and 'I can take those bloods, I can do that'; whereas you've got to make the distinct difference between I'm no longer an HCA working on so-and-so, I'm a student'*

Anisha [E]**:** '*There is some pressures for the* [OU] *students themselves, their own experience and they want to be helpful. There was a crisis and alarms and another student wanted to respond to that but was, and they wanted to do it because it was that person's ward. And they knew exactly what they were going to have to do and had to be prevented from responding. 'No, no, you can't do that', but they really wanted to do it.* [There was] *another occasion where a student wanted to perform some clinical duty that they were very skilled at, but it's not a student duty, and that had to be robustly managed as well'*

Imke [E]**:** '*If they're already healthcare assistants, they're, say, performing a skill like venepuncture in their area, but they have to act as a student in their placement area, then they do have no, that feel of 'I can't do that as a student, until I've actually learned it as a pre-reg student and then the theory, etc'…So that can be a little bit of a learning curve for them to adjust in that sense as well'*

Conversely, some OU PRNP students were deemed not to appreciate the activities undertaken by RNs and therefore had incorrectly concluded that, during their placements, they were often being expected to perform NRC tasks:

Harriet [E]**:** '*When I did my training, I never ever thought that I wasn't doing the job of a nurse, regardless of whether I was doing the basic nursing care. I didn't think 'they're using me as a healthcare assistant'. So, I don't know whether it's a mind shift or what, but lots of students will say it and I think because perhaps they're coming into nursing older, so they've had experience of care, so they might have worked in that role and*

they're then coming to work as a student and then thinking 'well this should be something different' and they're wanting to do the clinical. They think there's something around the clinical element of the role that's far more sexy than being with the patient'

Imke [E]**:** '*We do often have students say 'well I feel like I'm being used as a healthcare assistant'. And when I say 'would you like to elaborate on that?' very often students will say 'well, you know, I've been washing patients, I've been bathing patients, I've been feeding them, I've been helping them to the toilet, I've been…'. 'OK so if you weren't doing that who would be doing that?' 'Well a healthcare assistant'. 'Or?' 'Well maybe or my mentor'. 'Yeah, the role of a registered nurse. All of the things that you're talking about, you're seeing the overlap with the healthcare assistant role''*

A common concern amongst respondents was the belief that, due to their experience and status as an NRC, OU PRNP students may project a level of expertise in respect of certain clinical skills which they actually lack:

Erin [E]**:** '*You get the healthcare assistants who look and think 'I can do that. I can do that', you know, and they can't. And I think the big problem is getting them to admit that they have to ask questions, and that is because they're going to lose their credibility as being the HCA who knows everything'*

Fidelma [E]**:** '*I think it's sometimes hard for the APs with the Foundation Degree to step out of that role. Some of them are quite well-known across the Trust. They might be, not overconfident, but, you know, they think they're already there before they're not quite there'*

Such inaccurate self-perception was, in some instances, also considered to be reinforced by the views of other staff within placements:

Imke [E]**:** '*The fact that they are healthcare assistants and therefore there was that expectation: 'oh well you already know how to do this'. Well actually yes from a practical point of view I know what I'm doing. But they still need to develop as all other students do as to why they're doing it and be encouraged to develop the theory that underpins that practical skills'*

Another concern expressed by participants was the enhanced risk to supernumerary student status arising from OU learners also being NRCs within the Trust. This threat was deemed greater within an integrated practicum:

> **Anisha** [E]**:** '*There's the risk that because they're our employees they may be pulled into work where there's a crisis'*

> **Imke** [E]**:** '*We imagined a situation where they were doing a sort of two-day release, would it be that their place of work, their employer said 'actually I know you're set to go on your placement for Monday and Tuesday, but we are really short staffed and we need you to change your placement days to Thursday, Friday... And I think in a position as a healthcare assistant and a student nurse, they may not feel that they can say 'well actually no I've got set days with my mentor on my placement and I must be there''*

Whilst several respondents presented this problem as a hypothetical risk, one described a real situation when it arose:

> **Anisha** [E]**:** '*The pressure came from the service, and it was kind of a senior management level was trying to pull that student. So, I think it would be a very assertive student who said no to that manager and in that instance, they were protected by the mentor, so that didn't happen'*

10.4.5 Employer sponsor theme: *Valuing & retaining*

This theme reflects use of The OU PRNP as a means by which NHS Trusts demonstrate employees are valued and, in doing so, retain staff. The opportunity these programmes provide to recognise and develop home-grown talent was widely acknowledged:

> **Fidelma** [E]**:** '*It encourages the very experienced, really very good APs and HCAs to be able to complete the course that they might not otherwise be able to. We're helping other career pathways for those HCAs, it's showing that we value our workforce'*

> **Harriet** [E]**:** *'The biggest one* [opportunity] *is being able to recognise in your own group of staff who would go on to make a good nurse. And I think that's very positive for the healthcare assistants in their current role because they've got that recognition from somebody else'*

Anisha [E]**:** *'We've got talented employees who would otherwise have a limit to their career development. So, it provides that* [development opportunity]*, very popular'*

Erin [E]**:** *'I think definitely it's the investment ensuring that you do value the staff that you've got and the commitment they've given and that you're going* [to] *develop them'*

Similarly, participants saw benefits for the Trust offering the programme to NRCs:

Gemma [E]**:** [It helps in] '*retaining our own staff within the Trust once they qualify as registered nurses'*

Harriet [E]**:** 'W*e're going to keep them* [NRCs completing The OU PRNP] *at the end of that four years because we've invested that time'*

Anisha [E]**:** *'It* [The OU PRNP] *also kind of, I suppose, encourages the loyalty to the organisation'*

Erin [E]**:** '*It is massive investment and it's showing that they're valued, and it raises morale, and you get the retention then. You know, you don't get them thinking 'oh well I'm not staying here because they don't value me'. We need to nurture that for the environment to become a learning environment. Where we do nurture, and you get ownership then and loyalty'*

10.4.6 Employer sponsor theme: *Higher priorities*

This theme captures those issues which respondents deemed more significant influences on student learning than the practicum model. The challenge of providing suitable placements and mentors, irrespective of the model used, appeared to be of greatest concern:

Cerys [E]**: '***It's just a capacity issue more than anything'*

Diane [E]**: '***Capacity is always an issue, but I did plan the placements so there was less students out in practice so that their capacity wasn't, the students are within the capacity of that area'*

Fidelma [E]**: '***The capacity for students is terrible. So, there's not enough mentors so we struggle for the placements'*

Erin [E]**:** '*Most of my mentors are looking after one pre-reg student and three or four others'*

Participants were also aware of the pressure high mentor workloads exerted on both RNs and practice learning environments:

Anisha [E]**: '***That would be unfair to be continually asking placements and mentors to take more than they've actually audited for'*

Erin [E]**: '***You get mentor fatigue and, you know, they do get the continual, keep putting students in and they lose their momentum and their enthusiasm'*

Diane [E]**:** '*It is about making sure the students then get the support they need and access to the learning opportunities that are available. If there's too many learners in one area, then they're all fighting over the learning opportunities'*

In terms of placement and mentor capacity, most participants suggested implementing the integrated model was less logistically challenging due to its lower intensity of demand during any given practicum week:

Anisha [E]**:** *'It can be easier to place a student on a clinical area if they're in the split* [integrated] *model because it's not such a burden on placements where they have continual students from other areas, other HEIs* [universities]*. So, I think it can sometimes feel you can fit somebody in somewhere and it's only two days a week with a mentor and perhaps that would mean we could go over the usual audited capacity'*

Cerys [E]**: '***The people* [students] *who do the part-time* [integrated] *placement, so the two days a week, they don't necessarily get counted in the capacity numbers because it's not a fulltime placement. So, it doesn't necessarily affect capacity unless we've got two OU students working in the same service, which we've just trialled out recently, and that then, because it's four days a week, counts as one capacity'*

Imke [E]**: '***You've got an Open University student who is only doing 15 hours per week on placement* [integrated practicum] *they only needed to spend 40-50% of the time with their mentor, actually somebody who was a mentor and worked 12 hours, because we do have, the wards they have random hours for staff to work, then we would be able to utilise those staff better because they're only, because the short*

number of hours they work would allow them to support the Open University student and still meet the NMC' [requirements]

It was suggested there may even be benefits for mentors supporting OU PRNP students within the integrated practice learning model:

Cerys [E]**: '***If somebody mentors time after time, one after another, because it's a small team, sometimes it's quite refreshing to have an OU student, because then you've still got those three days* [integrated placement] *whereby you can do whatever you're doing. So, providing that teaching and learning, both will enjoy that generally'*

10.5 Student results

Data analysis led to the development of seven themes: *difference*, *affinity*, *role transition*, *carer work & service delivery*, e*ffective programme learning*, *paying the price,* and *higher priorities*.

10.5.1 Student theme: *Difference*

This theme captures participants' reflections on being perceived and treated differently to students on other PRNPs and the advantages/challenges of this difference. Unlike employer sponsors, most students initially suggested they were treated by practicum staff in the same way as learners from other universities:

Elizabeth [S]**:** '*I haven't been treated any different'*

Fatima [S]*: 'Generally speaking I've been treated the same'*

Glynis [S]**:** '*All the students are trained the same way'*

Helen [S]**:** *'I would say I've been treated fairly and the same really'*

In almost all instances, however, participants later identified key differences:

Corinne [S]**:** '*Straightaway they know that you're not a normal student as in you've never worked in the Trust. I don't know why, they just know'*

Bryanna [S]**:** '*They always say that they can tell that we work on a ward as an auxiliary nurse* [HCA] *compared to other students. Don't know whether it's just because you just get on with it'*

Damita [S]**:** *'I think once they know that you're an auxiliary* [HCA]*…I think they've got higher expectations of you, like you should know what you're doing sort of thing, even when it's stuff that I haven't done as a* [student] *nurse or an auxiliary'*

Julie [S]**:** *'They'll say 'ah like well I know she's a healthcare* [HCA]*, she can do this'. And so yeah, they do expect a little bit more from you'*

Several respondents suggested different treatment to PRNP students from other universities was justifiable:

Ana [S]**:** '*They* [placement staff] *might take it for granted I knew a little more than them'* [students from other universities]

Elizabeth [S]**:** *'They* [placement staff] *find the experience different because we* [OU students] *already have a lot of years' experience with patients'*

Damita [S]**:** *'So they* [students from other universities] *shouldn't know what it's like. You think if you want to be a nurse you should know, do you know what I'm trying to say, but they've just been flung straight into a ward'*

Difference was described by some participants in positive terms:

Ida [S]**:** *'When the qualifieds are saying that I was mid-second year from the Open University, it was more like people who were qualifying like. I just overheard that, I wasn't supposed to hear that... But yeah, I took that as a positive that I must be doing something right'*

Karen [S]**:** *'The mentors that I've had up to now have both said that they could tell a massive difference when they first got me as a student in terms of a student nurse who has got quite a bit of experience as a healthcare assistant versus a student nurse who has come straight from sort of college'*

Corinne [S]**:** '*They've given us more opportunity to have a say in our placements. They don't want to send us anywhere; they want to send us somewhere'*

Others, however, highlighted problems arising from such difference:

Fatima [S]**:** *'My last placement, again I'll not mention any names, but I believe I was the first Open University student they'd ever had. From day one they had me, it was*

written in black and white on the lovely mentor board, and I was written on there as a nursing apprentice [the student was not an apprentice]*, which I asked them to change but they didn't. So that immediately separates you from the* [university name] *lot'*

Julie [S]**:** *'So she* [nurse in placement] *told me that if I didn't take this patient's blood pressure* [before having been assessed as competent] *and anything happened to them it would be my fault. But that was my first day because she seen me as a healthcare* [HCA]*, instead of a student nurse, and I said to her I wasn't allowed to take a blood pressure until she'd observed me'*

Luna [S]**:** *'The NAs are Band 2* [salary scale]*, and* [when] *they find out you're a student and you're earning a Band 3 wage, they're like 'well they can do more, they can do more work''*

NRC experience was occasionally described as adversely affecting the feedback and support individuals received; leading to uncertainty about the quality of their nursing student performance, reducing the amount of guidance provided by placement staff and creating a reluctance to disclose the limit of their existing knowledge/skills:

Julie [S]**:** '*I said 'oh how am I doing?' She* [mentor] *said 'well actually I forget that you're here because you just get on and do it'. And so I went to her 'well is that a good thing or is that a bad thing?' Because you look at it from both sides. Yeah, I just get on and do it, but does that mean I should be just getting on and doing it or should be waiting for them to tell me what I should be doing?'*

Corinne [S]**:** *'I have had comments from my placement saying 'oh well you're not a proper student because you know what you're doing'. I might know what I'm doing but I'm not here to be an AP. I can write a book on how to be an AP, but I'm here to be a student nurse, and that's a role that I don't know how to be'*

Damita [S]**:** *'Well sometimes if I don't know, I almost feel stupid for not knowing. But it would have never been in my auxiliary* [HCA] *role to know. But I just think that they should, they would be thinking 'well doesn't she know, she's an auxiliary''*

10.5.2 Student theme: *Affinity*

This theme captures the importance respondents assign to feeling they are a team member during placements and the impact of this membership. Most participants felt a block practicum model best enhanced their experience:

> **Bryanna** [S]**:** '*On a block placement I don't know, I feel like you get to know people a lot more, you're spending more time with them*'

> **Julie** [S]*: 'We've got block areas* [placements] *for quite a long time. So, then you get used to the routine, you get used to the people. You get used to all the paperwork and how things should be done*'

> **Elizabeth** [S]**:** *'When I come away from my* [block] *placements as well, so I'm like oh I've made those kinships*'

Nevertheless, several participants suggested being treated as a team member could adversely affect their supernumerary nursing student status:

> **Julie** [S]**:** *'Since I've been back on this ward since October I haven't done any late shifts. They always seem to be early shifts. So, on the morning when they're doing the drugs round, and they're very busy and we've got new staff, I don't get to do any drugs rounds. But then I finish at 3:30 so I don't get to do any of the – so I've asked if I can do lates, but she* [ward manager] *said oh she'd rather have me on the earlies*'

> **Luna** [S]**:** '*There has been times where I've been counted in the numbers. Because I've asked to go on a different ward because there was a learning experience available there, and they said 'oh no we can't afford it, we're short this afternoon', and I said 'well I'm not in the numbers', and they went 'it doesn't matter, we need you here as an extra pair of hands'. I was like 'so I am in the numbers.' 'That's not what I'm saying, we just need you here as an extra pair of hands''*

10.5.3 Student theme: *Carer work & service delivery*

This theme addresses the implications of individuals being away from their NRC role to undertake a placement. Respondents identified that they were often missed by colleagues:

Bryanna [S]**:** *'When I'm going back to my ward it's like who are you, we haven't seen you for so long'*

Elizabeth [S]**:** *'I get a lot of feedback from my colleagues at work that I'm terribly missed. So, I think that's not just as a support worker, not just the role is missed, but me as a person is missed'*

Similarly, students also missed their workplace colleagues:

Bryanna [S]**:** *'It's also hard in a way that you're away from like my work base, I'm not seeing anyone from there'*

Fatima [S]**:** '*For me I have missed patients, I've missed the team of lasses I work with'*

Most participants suggested workplace colleagues accepted, were supportive of their involvement in the PRNP and treated them no differently in their NRC role despite their concurrent nursing student status:

Glynis [S]**:** '*I've never had any problems with the teams at all, any of them'*

Helen [S]**:** *'They're very supportive. So, there's not been any adversity or anything'*

Corinne [S]**:** '*Me being away from them, they don't ever treat me like a student – which is good, because obviously I don't want to be treated like a student in my own* [NRC] *role'*

Work colleague responses, however, were not always positive and it was recognised certain behaviours might be regarded as the adverse consequence of their new nursing student status:

Ida [S]**:** *'I work with some pretty feisty characters here and some of them I think resent me a little bit that I wasn't here that long'* [before starting the PRNP]

Luna [S]**:** *'I've found myself turning around to one of my colleagues and going 'oh can you just come' and asking them to do something. Which there's nothing wrong with it, but when you're the same level as them it could be sort of conceived as being bit, a bit up myself or whatever, and it's important not to do that'*

Many respondents believed the integrated model had a less detrimental effect on the service in which they worked as an NRC, and this may have been the reason their employer sponsor chose it:

> **Fatima** [S]**:** *'The potential impact it might have on your regular team. Because I work for* [service]*, so maybe it's more made for like a three/four-week chunk* [block placement]*, it would have a massive impact and potentially it's not a sort of, they couldn't get any backfill'*

> **Luna** [S]**:** *'It's so that you're not gone from the ward. If it's only two days a week* [integrated practicum]*, you're still there constantly, you're not disappearing for eight weeks'* [block placement]

> **Ida** [S]**:** *'Suppose you'd keep me three days in this post every week, I suppose you're not going to backfill a post for six weeks at a time* [block practicum]*. You'd lose a full member of staff, don't you? Whereas, technically, if I work three days here, I'm part-time, so they'll only lose me for two days'* [integrated placement]

An integrated practicum was also considered a way to prevent located NRC knowledge and skills from deteriorating:

> **Karen** [S]**:** 'O*bviously* [in an integrated placement] *I'm still here in my capacity as a healthcare assistant*, *so I'm still keeping all of those skills up to date. There's some of the skills that I can do as a healthcare assistant that I'm not allowed to do as a student nurse, which is like venepuncture and back slabs and dressings and stuff that I would only do sort of further on down the line as a student nurse'*

> **Luna:** '*If I was gone for whatever length of time, let's say ten weeks* [block practicum]*, I'd feel uncomfortable coming back because I'd feel like right what have I missed, how much has changed'*

Not all participants, however, suggested the integrated model was deemed preferable by service managers:

> **Damita** [S]**:** '*Easier to cover my hours as a block than two days a week. If they've got a good run of getting someone to cover for quite a while'*

> **Elizabeth** [S]**:** '*The service was going to lose a support worker role. And that was a massive disadvantage. But the way my manager saw it was it committed me to do my nurse training, and so they wanted me to get the best out of it*' [by having block placements]

Irrespective of the model of practice learning on which their programme was based, those respondents holding an NRC caseload appeared to face additional challenges. Participation in the block model created upheaval and guilt:

> **Glynis** [S]**:** *'They're already overloaded* [workplace colleagues] *and I'm handing my caseload back to them, so I feel awful…When I come back it's like I'm starting with absolutely no patients, and I've got to learn who the new patients are, what their needs are, and start again'*

The integrated model, however, risked an individual holding a disproportionately large caseload for the number of days they retained in their NRC role:

> **Ida** [S]**:** '*I'm more inclined to try and squeeze more days' worth of work because I had a caseload here. So, some people I couldn't pass over to other people, I had to keep hold. So I was doing probably more than the three days' worth of work, I was probably doing four'*

10.5.4 Student theme: *Role transition*

This theme reflects the challenges and opportunities associated with concurrently having NRC and nursing student roles. Two respondents suggested that moving between these roles was not normally problematic:

> **Fatima** [S]**:** *'For me it's easy in my head to know which two days I'm a student'* [integrated practicum]

> **Karen** [S]**:** *'When I come here as a healthcare assistant and I've got me pale blue scrubs on and that's me and I'm here and just doing the same as I've always done but then when I go to placement I go directly to the area of placement and I'm in me student uniform so it's all quite separate'*

Most, however, highlighted transitional difficulties:

Elizabeth [S]**:** *'You've got to take your hat off and go back to your support worker role. So, it's almost like five steps forward and five back'*

Ida [S]**:** *'It's hard to change hats. I found that difficult because I think along the lines of a nursing student all the time and I find that difficult working as a band 3* [NRC] *where I've got to revert back to that role'*

Julie [S]**:** *'It's hard at the beginning going from your healthcare* [HCA] *role to your student nurse role then back to your healthcare role and not doing your student nurse role. It took a long time to get used to which hat I'm going to be wearing that day in that area'*

Several participants highlighted the problem of different knowledge and skills they are permitted to employ in both roles:

Julie [S]**:** *'I'll say 'can I have a bag of fluid'? And they'll say 'no' because I'm a healthcare* [HCA]*. But yet on the* [placement] *ward, they'll stand there and observe you to do it. So it's like. And then I can take bloods down here. I'm not allowed to take bloods on the ward* [placement] *even though I've been doing it for years'*

Karen [S]**:** *'I didn't know until I went there that a lot of nurses on the ward* [placement] *don't actually do venepuncture or cannulation. So, to kind of see on some days there'd be sort of three or four patients that just needed their bloods checking and then dependent on their blood results might actually be getting discharged, we'd be waiting until sort of like midday for either a phlebotomist or a doctor to come round and do the bloods. That bit of it was like quite frustrating because I thought 'I've applied for the job and I can do it'!'*

Elizabeth [S]**:** *'There's certain times when I've been, say, on the hospital ward in my support worker role where I've thought 'I know about this, I've learned about this, I know the answer to this, but I'm a support worker''*

Others noted being an NRC made it harder to be a supernumerary nursing student; especially during periods when placement staff were under pressure:

Bryanna [S]**:** *'I know how hard it is as an auxiliary nurse* [HCA] *to find somebody to help you, so I always feel pressure that I've got to go and help auxiliaries even when I'm trying to do something that I'm learning'*

Corinne [S]**:** *'Going into a student role, which is something I've never really been in, you still want to work as an AP because that's what you do naturally'*

Damita [S]**:** *'Like when we're doing the medicines. As a student, and there's a buzzer going off, your mentor will say 'leave it, we're doing the medicines'. But in my auxiliary* [HCA] *head I'm thinking 'I need to get that''*

As well as their desire to revert to an NRC role during busy placement periods, respondents also recognised the potential risk practicum staff may see value in their stepping outside a nursing student role:

Julie [S]**:** *'All of my colleagues in* [name of placement] *are really supportive; however, at times like this where you've got all the pressures and it's all going a bit wrong, it would be really easy for them to expect and for me to just slip back into* [a] *healthcare assistant'* [role]

Corinne [S]**:** *'I've had to stay within my* [student] *boundaries, because I think given the opportunity, they* [clinical staff] *would let you come out'*

Nevertheless, many participants acknowledged overlapping NRC and RN duties, so were willing to undertake tasks as a nursing student which might be regarded as NRC work:

Bryanna [S]**:** *'I do do a lot of my healthcare assistant role as a student, but I would expect to do that; it's part of a nurse's role regardless, you've still got to wash patients as a nurse'*

Corinne [S]**:** *'One particular ward I went on, their pressures were really high, I mean they didn't have enough staff. And the nature of the patients they looked after were really poorly. And now and again they did say to me are you OK to special people* [individual patient observation]. *And that's fine, I don't mind helping out, because even as a nurse I will special people'*

Karen [S]**:** *'I have come across students from other universities when I've been on placement that sort of aren't keen to participate in personal care or because they're a student nurse, and that to me, that's wrong as a healthcare professional because whether you're a student nurse or a qualified nurse, if your patient needs cleaning or whatever and they can't do it themselves, it's ultimately your responsibility'*

Several respondents suggested a block model reduced the challenge of transitioning between their two roles:

Bryanna [S]**:** *'I know that when I'm on placement I'm on placement for a block period of time; I'm not back in my healthcare assistant role until I'm back there. And then when I know that I'm back in that block role as a healthcare assistant that I can't do the stuff that I'm doing as a student nurse'*

Corinne [S]**:** *'When I come out of my AP uniform and put my student uniform on for those four or five-week blocks that I'm doing, I am a student and I've accepted that. So personally, I've found that easier with the transition'*

Elizabeth [S]**:** '*So I'm not going to work and being a support worker, and being embroiled in the work role, and then on a Tuesday and then having to go to bed and wake up a student nurse on a Wednesday, and think 'right take that hat back off now''*

Others experiencing integrated practice learning identified the problems encountered within this model, and it was evident some students had not contributed to the decision-making process regarding the placement type they were assigned:

Luna [S]**:** *'Initially I really struggled with it. I was, because I was doing, it wasn't necessarily two days on placement and then separately from my two days on the ward. I would say it could have been placement, ward, placement, ward, and that I really struggled with to start off with'*

Fatima [S]**:** *'I'm annoyed that I wasn't given the option of the other one* [block model]. *Only because it's hard. Firstly, you never know what hat you're putting on in a morning. You've got to switch from one to the other. I still, even though I'm this close to the end* [of the PRNP]*, I still have difficulties switching off from my healthcare* [HCA] *head. So,*

I have been criticised for being on a ward and just disappearing and getting on with some jobs. Because that's what I've always done as a healthcare' [assistant]

Ida [S]**:** '*I would have preferred a block placement where I went away and came back, could have focused on six weeks on placement where you deal with your caseload or with your patients on the ward*'

Many participants recognised useful transferable learning and personal development between their nursing student and NRC roles:

Luna [S]**:** *'Learning stuff in a previous placement that I was able to bring back here* [NRC workplace] *straight away'*

Elizabeth [S]**:** *'My feedback* [from NRC manager] *is that my language is changing and the way I present myself is changing, and they can see the confidence grow'*

Ida [S]**:** *'I don't think I could have made some of the decisions in practice as a student as what I would have made two years ago because I wouldn't have had the knowledge to make them'*

10.5.5 Student theme: *Effective programme learning*

This theme highlights the challenges respondents face in engaging with various aspects of academic and practice learning within the PRNP and what they regard as the best way to manage these challenges. Those who had experienced block placements identified practicum length and intensity as problematic:

Corinne [S]**:** *'You had to build it up quite quick, because I was only there for a short period'*

Glynis [S]**:** *'I don't think they feel long enough, the four weeks* [block] *placement. It's like I'm coming to the end of my placement now, and I feel like there's so much more I could do, but it's almost over'*

Elizabeth [S]**:** '*I just feel like I've literally got my feet on the ground and I'm gone*…Being here *five days* [a week] *certainly is one of the things that makes me feel exhausted'*

Integrating academic study and retaining study momentum outside blocks of practice learning were also seen as complications:

Bryanna [S]**:** '*I find it quite hard to do all my academic work when I'm on placement and studying. That part of it's hard…The practice learning module was like can you apply, can you go and speak to your mentor and talk about this. But it's like I'm not on placement at the moment, so that's the hard thing*'

Helen [S]**:** '*The only thing I would say about block placements is you spent a lot of time, a big clump of time, away from your placements. And sometimes that means that you can, your portfolio* [competence record] *gets neglected*'

Corinne [S]**: '***When I'm a student I tend to do more of my theory side of it what I have to do as well. But when I'm working fulltime you forget sometimes that you're a student*'

Glynis [S]**:** *'I reflect sometimes on my everyday* [NRC] *practice rather than* [as a nursing student]*, but some of them yes, it's like I'm not even in* [nursing student] *practice and I don't know this*'

Not all participants, however, believed academic study requiring reflection on nursing student practice need be difficult outside a block practicum:

Helen [S]**:** *'You reflect on something that you've done in a student* [role] *when you've been in a student capacity. I would reflect on that. You've got a memory, haven't you*?'

What capacity exists within a placement for mentor-student discussion, facilitating reflection on practice and consolidating learning were other factors which appeared to affect the perceived quality of knowledge and experience derived from it. Integrated placements were regarded by some students as offering more scope to reflect upon and consolidate clinical learning:

Ana [S]**:** *'So had I been there only that particular time I would not know what had happened after. So it would be just the basics to start with…And also you get time to go through it in much more relaxed way, rather than crowding it at one particular point*'

Ida [S]**:** *'When you start to work with someone, it's part of the nursing process isn't it where you see them at the start, you oversee the treatments and then you see the*

recovery and then you discharge don't you, and that's part of validation for me…it makes you know you've done a job. I've done something positive for that person'

Glynis [S]**:** *'I'm pulled out of that, and then put back in. So it's starting again, at least for the first week to get back into how the routine goes. You carry over some skills, but not all of the everyday routine stuff…I think if I did it two days a week continuously it would stay with me a lot easier'*

Respondents having integrated practice learning also spoke of proactively structuring their working/practicum week, changing their days to optimise learning, and accepting that longer, less intensive, placements would mean certain opportunities may not be available so quickly:

Luna [S]**:** *I've sort of found a system that's worked for me where I can have my two days on placement and then I'll have my two days on ward where I'll break them up with a day and then come in for my days on the ward'*

Ana [S]**:** *'The manager is quite helpful. So* [at] *the moment I can pick and choose, I can pick the shifts. But if I tell them I need to go on* [placement] *this day, they will definitely accommodate my request'*

Karen [S]**:** *'Say if there was something happening that we knew about in advance that I particularly wanted to be a part of to just try and make sure that I was around on those days…I think you've probably just got to be a little bit patient because yes, if I'd been there for sort of five days a week* [block practicum]*, I probably would have had that opportunity sooner'*

Individuals advocating the block model described practice learning that was less fragmented, more immersive and provided the opportunity to experience nursing intervention from start to finish:

Damita [S]**:** *'It's better to learn in a block than bits here and bits there… If you just do two days a week and then, well I would feel that you would just be back to square one the next time'*

Fatima [S]**:** *'I might learn something on here for two days. Sometimes I'm here for one full day or two half days* [integrated placement]*, that's the way I've been doing it. And*

I learn something new, and I'm away again and I have to wait a full week. And I come back and I think 'oh I forget how you do that'. I've got a crap memory so my retention's terrible. So, from that point of view a chunk [block practicum] *would have been better'*

Glynis [S]**:** *'Because it's intense learning for those block placements. You're not pulled away at all, you're focused totally on the learning of the things they do on that ward or that placement...You can get in there, you can get your teeth into what's going on, like on a ward or at the minute I'm on community placement. I just feel as though I wouldn't be torn between my role as an HCA or a support worker, and my role as a student as much'*

Participants also recognised valuable learning could be acquired from observing both good and bad practice:

Ana [S]**:** *'Your mentor can be a good role model for you, just to do what she does or what he does. At the same time, that particular nurse can be a good role model how not to be a nurse like him or her*'

Elizabeth [S]*: 'I like to get a sense of who that person is, and how they practice. Because sometimes there's things you see in people you don't want to pick up. There's certain aspects of people that you don't want to model yourself on. But then there's certain aspects* [nurses] *who are complete inspirations and I want to be that practitioner'*

Fulfilling all academic requirements within the programme was considered extremely challenging irrespective of the placement model which participants experienced:

Elizabeth [S]**:** *'There's a lot of aspects of learning to be done as a student nurse. It's not just with patients and processes, it's with leadership and management. And there's so much to learn. And I think you need to take that onboard and move that through each service you go to, learn a little bit and move it along. But it is really difficult'*

Luna [S]**:** '*At times it can be quite tough. At the minute it's sort of the assignments and the iCMAs* [module assessment] *are coming thick and fast so it's trying to prioritise them'*

> **Glynis** [S]**:** *'I had a bit of a breakdown last week, but just for a day until I got things done – because there was too much all at once. We had the TMA* [module assessment] *was due while we're in practice, and that was just very difficult. And some of the, I find that I'm able to spread things out quite well. It's when you've got competing modules, it's hard to keep what's relevant to one separate from what's relevant to another'*

Undertaking academic studies on the programme via distance learning was an added complication:

> **Elizabeth** [S]**:** *'I feel that because it's online, and because it's never really there. So, your practice placements are live, they're happening, they're there, you've got to go. But with your academic studies you know that they're there but you're able to put that off a little bit more'*

10.5.6 Student theme: *Paying the price*

This theme captures the psychological, social, domestic, and financial costs associated with being an OU PRNP student. Several respondents spoke of regularly working weekends in their NRC role to accommodate their placements or using days off and annual leave to fulfil the academic demands of their programme. Most, however, expressed no animosity about doing so:

> **Helen** [S]**:** *'I give up some of my weekends to do my academic work, but that's not a chore to me. I think 'God, how lucky am I to be in this position where I'm not losing any money, I've still got my fulltime job'? So to me I'm in a good position, so I don't ever look at it negatively'*

> **Corinne** [S]**:** *'I don't think I realised how hard it would be when I first started…My days off are given up to benefit my university degree, but that's fine because I'm happy to do that'*

> **Ana** [S]**:** *'The only constraint on that is your schedule where you work, having to accommodate that team. I used to get round that by doing Saturdays and Sundays'*

> **Elizabeth** [S]**:** *'What I tend to do is use my annual leave to do my academic studies…It's a sacrifice I've made, but at the end of the day it's something I want to do'*

Participants also tended to solely regard themselves as responsible for their academic progress:

> **Corinne** [S]**:** '*I think if you want it it's up to you to put your work in, because it is all online. If I don't do something the week that I'm meant to, I fall behind, so then it's me that has to catch up. So, you've got to be very strict with yourself*'

> **Elizabeth** [S]**:** *'The best place to be is organised, just to say right at the beginning we need to have a meeting on this placement, or can I have access to your diary and get some availability...It's just about managing your time'*

> **Helen** [S]**:** *'My experience of being a student is you get out of a placement what you put into it*'

As well as the study commitment, respondents highlighted the financial, domestic, and emotional cost of being an OU nursing student. In these matters, some suggested the integrated practice learning model was preferable:

> **Fatima** [S]**:** *'I need to do bank* [additional NRC work] *because I'm skint, so I do do quite a bit of bank work as well in different areas'*

> **Luna** [S]**:** *'From a financial perspective if I was full-time on placement, I'd lose out on enhancements'* [NRC unsocial hours payments]

> **Glynis** [S]**:** *'I don't know why they* [employer sponsor] *would* [choose the block model for placements]*; I do believe the other one* [integrated placements] *works better for personal, well personal and professional* [reasons]*…I've got children to get to school and things like that. So having two days a week would be much better personally than having the full block placement and having to cover four weeks, six weeks, ten weeks of childcare, whereas two days a week my mum and dad could handle that'*

Several participants suggested the demands of the programmes may be too great:

> **Corinne** [S]**:** *'Given this opportunity again I don't know if I would take it'*

> **Fatima** [S]**:** *'It's hard, I wouldn't recommend it for anybody my age'*

More often, however, respondents perceived their programme experience positively and expressed gratitude at being permitted the opportunity to become a nurse:

Ida [S]**:** [Line manager asked] *'if I had the option again would I choose this again or would I go for the learning disability degree full-time in* [university name]*? And I said even if I analysed them both I still would choose this'*

Corinne [S]**:** *'I want to say thank you to The OU for getting with the Trust and giving us this opportunity. Because this is my only opportunity to do my training, because financially I would never have been able to go back to university and give up my fulltime job'*

Fatima [S]**:** *'I'm just very grateful for the opportunity of secondment because they're few and far between. I've had to wait until I'm nearly 50 to get one, and I've worked since I was 25 in healthcare. So it's been a long time coming, and I'm grateful and I will finish the damn thing'*

10.5.7 Student theme: *Higher priorities*

This theme captures issues which respondents deemed more significant influences on their learning experience than the practicum model. There was consensus regarding the importance of an effective mentor:

Corinne [S]**:** '*She* [mentor] *was very protective of me being supernumerary*'

Ana [S]**:** '*It's been really nice that you're feeling protected* [by your mentor] *and safe in that kind of practice*'

Elizabeth [S]**:** '*He is a really good mentor. And I often think that he's got his workload to do and teaching me at the same time. And at the end of the day, he must go home exhausted*'

Karen [S]**:** *'my mentor has been quite good at sort of saying 'right let's sit down and go through your file and we'll sign off the ones that I can sign off now and then we'll go back through and look at the ones that still need signing off and we'll work out ways in which you can meet them'*

Not all reported experiences with mentors, however, were positive and scheduling contact time could be problematic:

Fatima [S]**:** *'I was allocated to a mentor and she would, obviously you'd spend time together, very little communication. Actually sat and talked to a* [university name] *student instead of me'*

Luna [S]**:** *'There has been like a few occasions where we've been like right we'll pencil this in to go through your portfolio, we'll pencil that in for tomorrow, and then it's come to the day and it's been a very busy day and we're like right OK we'll have to do it next week. And then I'll come in next week and me mentor has gone on to nights and we'll do it the week after'*

10.6 Practice tutor results

Data analysis led to the development of six themes: *difference, affinity, carer work & service delivery*, *role transition*, *effective programme learning*, and *higher priorities*.

10.6.1 Practice tutor theme: *Difference*

This theme captures participants' reflections on the different ways in which OU nursing students and their programmes are seen. Several respondents initially suggested these learners were neither perceived nor treated differently to students on PRNPs provided by other universities:

Barbara [PT]**:** '*I don't think* [OU students are] *treated differently*'

Frances [PT]**: '***I don't think anybody saw that person or that* [OU] *student as being different to any other students*'

More commonly, however, respondents commented such differences were evident:

Christine [PT]: '*Different student profile all together...They're* [OU students] *aware of the career choice that they've made because more often than not they're already employed in a healthcare assistant role. So, they're very well aware of sort of like working with patients…Some* [non-OU students] *aren't aware of the career they're getting into, the background hasn't been done*'

Dee [PT]**:** '*OU students are unique, they're different from students from other universities. They already come in with this experience of being a healthcare*

assistant…They are mature, they are able to take control of their learning, and maybe identify what it is that they need to explore'

Ariana [PT]: *'Initially they* [OU students] *sort of felt a little bit as though they're outside the norm and possibly even, I don't mean second class but sort of - I'm not a regular* [PRNP] *student therefore am I as valued as a regular student?'*

Dee [PT]**:** '*It almost feels as if every placement where they* [OU students] *go that staff or nurses expect them to be fully capable. And they forget that at the end of the day they are still students'*

Similarly, several PTs believed OU PRNPs were unfamiliar to many clinical staff:

Frances [PT]**:** '*I think a lot of staff are still not aware that The Open University does nurse training'*

Gail [PT]**:** *'Sometimes people express surprise that* [nursing] *students can be trained, educated via The Open University'*

Some participants suggested this unfamiliarity generated challenges for staff based in practice settings to which OU nursing students were assigned:

Ariana [PT]: '*I think the mentors not necessarily fully understanding our portfolio and system and things'.* [Mentors may say] '*This doesn't feel like a first-year student' because obviously they are HCAs who've got really good patient skills'*

Enid [PT]**:** *'With anything different mentors sometimes struggle to understand the difference because they're used to a particular university…They thought they were an apprentice and when we explained that they're not, they're actually just doing a different model, and at a different university they understood. But I think that was the initial, students felt a bit unappreciated as well'*

Dee [PT]**:** *'Initially they* [mentors] *found it difficult trying to find out what it is that they were meant to do with these students…I got the impression that most nurses or most mentors had no idea what OU student nurses did. It almost felt as if they were this foreign entity that just kind of landed'*

Often, however, differences in The OU PRNP and its students were perceived positively:

Gail [PT]**:** '*Mentors and other staff I've met on the departments praise the* [OU] *students very highly. I think they appreciate the fact they are a member of staff in that particular Trust. But also, every one of them also said The Open University model is much more straightforward than the standard university that they're dealing with'*

Barbara [PT]**:** '*I think mentors will often say, unsolicited that they really like the model. They really like the portfolio. They support the* [OU] *programme'*

Christine [PT]**:** *'I say to them* [managers and mentors] *'what's different?' Yes. I always throw that back. 'What's different? What do you like about the OU students?'.* [They reply] *'well, they come to us and they can hit the ground running. They know all about the Trust values. They know where to locate policies and procedures. They are well orientated towards the services that the Trust provides. They understand the communication systems. They can get on and complete records as a student, but they know of the electronic recording system inside out. They're already up and running on IT systems, so there's no delay or time wasted at the start of the placement''*

Dee [PT]**: '***They would rather have OU students because they don't have to be babysat*'

Indeed, several respondents specifically stressed the importance of OU PRNPs being different:

Dee [PT]**:** *'I don't see why we should get rid of the* [integrated] *model because it does appear to work even if there are negatives'*

Christine [PT]**:** '*You wouldn't use just one intervention or one treatment for a patient so you wouldn't use one education system to meet all student needs. It just wouldn't work...It needs to be different because otherwise what we've got is more of the same and we know more of the same isn't going to work*'

10.6.2 Practice tutor theme: *Affinity*

This theme reflects the importance assigned by participants to students feeling part of the team in a placement, building effective working relationships, and immersing themselves in learning experiences. Once again, the block model was commonly preferred:

Dee [PT]**:** *'If they're* [students] *only there for two days* [integrated model]*, and I think that sometimes can have a negative impact on developing those relationships on placement …Sometimes it becomes difficult fully immersing themselves into a certain role when they're going back the next two days to maybe the role of healthcare assistant'*

Gail [PT]**:** *'If they're full-time on* [block] *placement they kind of become more part of the team I think, than if they're in and out one or two days* [integrated model]*...I think if they're there full time, they're more likely to see members of staff repeatedly and get to know them and get accepted as part of the team'*

Ariana [PT]**:** *'The total immersion* [of a block placement] *works quite well because actually it's such unfamiliar territory, it's very good to get stuck in there… people who've had a block placement* [preferred it] *because they got to know people, because again people are working on different shifts and if you only do two days a week* [integrated model] *you often only meet people once or twice whereas if you're doing all this, then you work with most of the members of staff eventually. So, I think from the point of view of belonging it probably works better to have a block'* [practicum]

Barbara [PT]**:** *'It was too bitty to not do it on block* [placement]*, they* [employer sponsor] *felt that they* [students] *would feel more a part of the team, better communication, have a better run at it'*

There was, however, recognition that for some students an integrated practicum may be less anxiety-provoking:

Ariana [PT]: *'So for some of them it's less traumatic to have an integrated staff* [placement] *for longer and they gradually get integrated into it'*

One respondent expressed concern about the lack of immediate peer group support OU PRNP students have during placements compared to learners from other universities due to the infrequency with which more than one OU student would be assigned to the same location:

Frances [PT]**:** *'I think they* [students] *were seen as being more isolated in a way…A lot of the students* [from other universities] *would go, if they were on breaks they would*

see each other in the canteen, they'd go to things like that together. Whereas The Open University student didn't have that group of peers'

Another participant, however, dismissed the importance of belonging within the practice learning environment:

Christine [PT]**:** 'A *student role is that they are there to learn, not to be a member of the team'*

Some interviewees believed the block model made contact and relationship development between the student and mentor more problematic:

Enid [PT]**:** *'Some Trusts only do 12-hour shifts, so they may only have three opportunities in a week to, if they're on a block model to have that, and if they're not working with their mentor on one of those days that reduces it again'*

Frances [PT]**:** [The mentor] '*went off sick then, which meant that student being on a block placement missed quite a bit; whereas, if they maybe had been out for two days a week* [integrated practicum]*, we would have been able to catch up with that member of staff'*

Gail [PT]**:** *'The only other potential issue, which I haven't come across yet, but it's always going to be there, is that the mentor has holiday. And if it's a short placement that's going to lead to, I think, difficulties of meeting the 40%.'* [NMC requirement of student time spent with their mentor]

Ariana [PT]**:** '*A problem is that if they have, let's say it's four weeks when they're going to be there all the time* [block placement]*, several times we've found that the mentor suddenly is having a holiday'*

Not all participants, however, regarded block placement as potentially detrimental to the mentor-student relationship:

Barbara [PT]**:** '*No one* [mentor] *has ever said it's* [block placement] *over too quickly or anything like that*'

The risk a minimum expected level of contact between a student and their mentor becomes the effective maximum in an integrated practicum was also identified:

Dee [PT]: '*I know students are meant to work half the time with their mentors. If they are on an integrated model, I think what I've seen in the past is that mentors do try and maybe work with students maybe just one day, one of those two days*'

Respondents had differing opinions regarding the model which best facilitated tripartite meetings. Some believed that organising them was easier in a block placement:

Ariana [PT]: '*It's easier to suggest days when you might be able to see them there because, again, they are more likely to be there rather than being there just one and a half days a week*' [integrated practicum]

Frances [PT]**:** '*With a block model I think it's easier to arrange and facilitate them, because they are there over a period of time. So, you don't have, you're not confined to only being able to see them for two days*'

Dee [PT]**:** *'The students on the block model, there is more urgency to arranging the meeting than the students on the integrated model. It hasn't proved to be a difficulty really, it's just finding a way of working around them and finding out what I need to be doing first, which has been fine…For those students on an integrated model, it becomes difficult because they have to not only find a time when they're free to see me on those two days when they're already pressured to look at a lot of things that they might actually miss if they don't*'

Others, however, regarded the integrated model easier for scheduling such meetings:

Christine [PT]**:** *'In the integrated model they're* [student] *out for a longer period in total weeks, not in hours or days obviously but in weeks. So, in some sense you've got longer to fit in'* [tripartite meetings]

Barbara [PT]**:** *'It's hell when they do it* [placement] *on block because they tend to start at a time that is convenient to them because they can get it done quicker and sometimes it's kind of almost over before it's started*'

Gail [PT]: '*If the* [block] *placements are quite short, the shortest one is about four weeks. It is sometimes difficult to catch the mentor, to make an appointment where you've got to see the student and the mentor and have at least an hour with them…*

With the integrated model where they're there for a much longer stretch of time it's maybe easier'

10.6.3 Practice tutor theme*: Carer work & service delivery*

This theme details the implications associated with employer sponsors selecting a placement model for those services in which OU students are employed as NRCs. Some respondents regarded the integrated model as a pragmatic choice to accommodate service needs:

Dee [PT]**:** *'I can see how that can benefit the employers, because it means that the student is only away for two days and they can come and fulfil their role in the remaining two days'*

Heidi [PT]**:** *'Their employer couldn't see a way of releasing them for a whole block of time. So, they negotiated two days a week'*

Christine [PT]**:** *'Some managers who say 'oh it's great this integrated model of practice because we know two days that student's not available on the ward, it's only two days so it's easy to backfill''*

Others, however, believed the block model was selected for the same reason; especially where student practice learning experiences were sought outside the organisation:

Frances [PT]**:** *'I think from an organisational staffing point of view it possibly is easier with blocks'*

Christine [PT]**:** *'Some managers come back and say it's really difficult to backfill for only two days a week* [integrated practicum]*. It's easier to do* [it] *with block placements'*

Gail [PT]**:** *'It might just be easier for the employer to take that member of staff out for that* [block] *period, and say we're going to manage without them, rather than being in and out'*

Heidi [PT]**:** *'The benefits are that when they're negotiating placements with other stakeholders that they're not having to negotiate two days a week for a long period of time; they're negotiating one block period of time'*

A key anxiety regarding the integrated model was that service pressures might force a student to be recalled from supernumerary practice learning with the reassurance that lost placement time would be assigned later:

> **Enid** [PT]*: 'I haven't seen this happen recently, where when employers are extremely busy, they're under pressure, they* [students] *sometimes get pulled out of their 15 hours'* [weekly supernumerary practice learning]
>
> **Frances** [PT]: *'I know two of them* [students] *definitely have had discussions with their managers, and they felt it may be confusing to them to be a healthcare assistant, and for the other staff, that they weren't going to then get pulled in on their supernumerary days'*
>
> **Gail** [PT]**:** *'Previous experience has always shown if you're on your place of work, there's always the likelihood you'll get dragged back into the day-to-day routine of 'you're a healthcare assistant and we need you today, so you can't go on placement, can you do it next week?''*

10.6.4 Practice tutor theme: *Role transition*

This theme reflects the challenges associated with OU PRNP students concurrently having NRC and nursing student roles. The difficulty in role transition and potential for role conflict was recognised by almost all respondents:

> **Gail** [PT]**:** '*I think with experienced healthcare assistants, there's always, there appears to be a difficulty with role transition from being an experienced healthcare assistant to being a student*'
>
> **Frances** [PT]**:** *'Some of the students have discussed this with us previously last year that sometimes it is difficult to wake up and think 'what head am I putting on today?', and jumping from one role to another'*
>
> **Dee** [PT]**: '***They already come in with this experience of being a healthcare assistant and sometimes it is difficult for students to switch off from that*'
>
> **Christine** [PT]**:** *'I think the biggest difficulty is, for some of them it goes back to role conflict, is holding back, because what they can do as a healthcare assistant, they're*

not necessarily able to do as a student nurse. And as a student nurse there are times when they just have to stand back and observe and reflect and learn and that's difficult'

Several believed integrated placements could increase student role transition difficulties and the potential for role conflict:

Dee [PT]: *'If they* [students] *are on the integrated model, it doesn't give them enough time to actually adjust to that role for two days and then go back to their healthcare assistant role the other two days'*

Barbara [PT]**:** *'Students will express that conflict and frustration* [in the integrated model]*. Being a student and not being able to do things that they would do in their substantive role for example. And the confusion that other people have about their role'*

Christine [PT]**:** *'You've probably got a bit more conflict because the student is moving between healthcare assistant role and the student role. And I guess that's really difficult for some students to get to grips with that and change those hats within the integrated model'*

Similarly, a block practicum was deemed more effective in allowing OU nursing undergraduates to perceive themselves as students:

Dee [PT]**:** *'Most students who were on block placements found it easier, because what they then say to me was that during the time when they're on placement they don't actually have to think about their role as a healthcare assistant*'

Frances [PT]**:** '*I think the consensus amongst the students were they actually quite liked the block placement…They actually felt like student nurses...If you're in a block you're looking at things through a student nurse, sort of like a different role, a different set of eyes'*

Christine [PT]**: '***Some students prefer the block placements because it removes some of that conflict out the way so whilst doing that block placement, they are a student*'

> **Gail** [PT]**:** *'Better for the student in terms of if they're out of their original place of work, and on another placement as a block, then they possibly become more in the student mode'*

Nevertheless, the block model was not unanimously regarded as better in reducing role transition and conflict problems:

> **Christine** [PT]**:** *'If you've had a student out in practice on a block placement, once that block placement comes to an end does it* [they] *then have difficulty in reverting back to the HCA role'*

10.6.5 Practice tutor theme: *Effective programme learning*

This theme highlights the challenges students may face in engaging with various aspects of academic and practice learning within the PRNP and what PTs regard as the best management of these challenges. Several PTs actively encouraged students to integrate theory and practice:

> **Christine** [PT]: '*When I go out to see the students and the mentors together, we're looking at the portfolio. We're looking at the competencies. And I always try to reiterate, what are you doing in your modules? What activities have you completed? How can you integrate those activities within your portfolio?'*

> **Heidi** [PT]: '*The assignments are practice related, and often either, sometimes they're drawn on portfolio* [competence record] *evidence, or the portfolio evidence is the basis of the assignment. So, they're writing that for their portfolio, which they would talk to me about.'*

Others expressed concern about block placements causing misalignment of academic and practice learning:

> **Ariana** [PT]**:** '*A student pointed out to me this was why I know about it because it's actually happened for her. So, she did the hospital bit* [practicum] *and then about a month or two later she had to think of a case study that she could go through and reflect and discuss about and things but that had all been before'*

> **Heidi** [PT]**:** *'Because they're* [students] *back in their* [NRC] *workplace, their block placements have finished, which is another issue of block placements. Their block placements have finished for their entire module, but they've got another seven months, six months for actually the module* [academic studies]…*So they've* [students on the block model] *almost had to do their assignments sooner than they would have done...Whereas if they were on the integrated model when the assignments and things come up in their module learning materials, they would still be going into a practice area, and be able to apply that* [learning] *on a more regular basis*'

Nonetheless, one respondent recognised there may be benefits to such apparent misalignment:

> **Heidi** [PT]**:** '*The issue with the assignments being not when they're* [students] *in placement could be considered a good thing, because they're not in placement and trying to write assignments*'

In contrast, the integrated model was perceived by others to better consolidate and bridge academic and practice learning:

> **Enid** [PT]**:** *'The integrated model, because it's longer, they've* [students] *got more weeks doing TMAs* [assessment] *and different activities…They can learn a little bit at a time, so they can think oh well I'll think about that this week, I'll think about that. And as they're doing their practice it becomes part of the thing that they learn'*

Consistency and continuity were perceived as crucial features of effective practice learning, but there was no consensus amongst respondents as to which placement model best promoted these qualities:

> **Heidi** [PT]**:** *'The integrated model would work better because they* [students] *would* [experience] *more consistency over the long term'*

> **Barbara** [PT]**:** [In a block model] '*if you're there you* [student] *won't see the patient, perhaps, from admission to discharge, whereas if you're there over nine weeks* [integrated model] *you may see them'*

> **Christine** [PT]**:** *'A number of mentors again endorse that* [block model] *approach because they feel they've got that student with them for a prolonged period of time so*

there's some continuity to the learning experiences and they can plan to meet the learning needs really quite robustly…She [student] *struggled with the two days a week* [integrated placement] *from the consistency perspective, from accessing learning opportunities. She felt she was a bit disadvantaged in comparison to some of the traditional students'*

Dee [PT]**: '***They* [students] *also highlighted that sometimes it becomes difficult following the patient pathway, because they would have been on placement maybe* [the] *first two days of the week* [integrated practicum]*. And then if they're on an acute ward, by the time they get back patients they would have maybe helped admit to the ward would have been discharged'*

10.6.6 Practice tutor theme: ***Higher priorities***

This theme captures issues which respondents deemed more significant influences on student learning experiences than the practicum model. The quality of mentor and placement support were identified amongst these issues, as were the learning opportunities provided in this environment and whether they were suitably individualised:

Ariana [PT]**:** '*It's important to make decisions about what type of placement is offered but actually the mentor is 300 times more important*'

Dee [PT]**: '***I think it's all about how confident the student feels about their environment and how much support that they feel they're getting'*

Christine [PT]**: '***It depends on the individual student. It depends on the actual placement as well. It depends how much background work that student is prepared to do…It's about fitting the placement to the person'*

Greater focus on integrating and ensuring consistent academic and practice learning were also identified as key factors, with one suggestion made as to how this could be achieved:

Ariana [PT]: *'Whether it's an integrated model or not, the complementarity of what you're* [student] *doing in your academic work and what you're doing in the practical, that's the biggest example I've found'*

Christine [PT]**:** *'The consistency of learning. I think that's where the impact or the barriers to bridging that theory practice gap could occur'*

Heidi [PT]**:** *'It might even possibly be better if the PT and the module tutor were the same person, if the PT role actually took on the module part of that as well. Because then you would be facilitating all parts of that, a bit like a personal tutor in a more conventional nursing programme'*

10.7 Mentor results

Data analysis led to the development of six themes: *difference*, *affinity*, *carer work* & *service delivery*, *role transition*, *placement learning & the patient experience,* and *higher priorities*.

10.7.1 Mentor theme: *Difference*

This theme captures participants' reflections on ways in which OU nursing students and their programmes are seen as different. Once again, several respondents initially suggested these learners were neither perceived nor treated differently to students on PRNPs provided by other universities:

Caren [M]**:** *'I don't really think there was that much difference'*

Evie [M]**:** '*As far as I can tell they're not treated any different*'

Deirdre [M]**:** *'The actual students I don't find them* [different]'

Continued exploration, however, identified differences in student records used to capture competence, termed the *portfolio*:

Deirdre [M]**:** *'It's just their portfolios and the different, the bureaucracy of it's different*'

Evie [M]**:** *'The thing that I noticed with* [name of student] *was all of her paperwork was still paperwork, it's a book isn't it? And we haven't, certainly in the* [name of university] *I haven't seen a book like that for four years'*

Gillian [M]: *'I think sometimes the* [name of university] *students are at a slight disadvantage, although all the staff do have access to computers or laptops. The* [name of local online portfolio] *document is actually quite time-consuming,*

particularly on shift. And I think that sitting down and getting out a paper portfolio can sometimes be quite quicker'

More commonly, respondents commented that differences were evident with OU nursing students compared to those studying comparable programmes with another university and frequently attributed this difference to the individual's NRC role or employee status:

Caren [M]**:** *'She* [student] *didn't seem to have any issues when moving from department to department. She seemed very comfortable. And yes, I suppose because of having the background within the trust, from that respect yeah, it's got to be easier…I think she's* [OU nursing student] *got a few years* [experience], *quite a few years and it does give them a good background…Certainly when starting off, having worked in the hospital setting makes a big difference'*

Hanneke [M]**:** '*You can tell she* [OU student] *was experienced. She was probably a lot more confident than I was at that point in my pre-registration. She was totally competent, an absolutely exemplar student really. Probably noticeably more comfortable than some of the students we've had from, I don't know, other mainstream universities. She obviously already had many of the skills you possess that she's gained through her experience'*

Beatrice [M]**:** '*We know that these* [OU] *students have some experience, so that maybe we're a bit more confident in allowing them to do certain tasks or jobs with patients or with ourselves, maybe a little bit more confident than we would be with somebody who was just a student and didn't have any healthcare* [HCA] *experience…These* [OU] *students have work experience within the hospital, so they're able to use the skills that they've already got, they're able to transfer those skills over to other areas wherever their placement may be'*

Deirdre [M]**:** *'They* [OU students] *come with a lot more experience, they know a lot more. They've got all the basics in the bag. You have a lot higher level of education with them. Most of them have been doing it for a long time and the basics are there, so you can have stuff at higher level of conversation. They have the understanding, the knowledge, most of them know the patient experience, they know the downfalls of an admission and they know, they're just a lot more knowledgeable'*

Not all respondents, however, believed that NRC employment experience was beneficial. Indeed, one interviewee suggested it could complicate the student's practice learning:

> **Evie** [M]**:** *'If somebody's got a decade or more years' experience as a healthcare* [HCA] *and as an AP or whatever, it doesn't necessarily mean they're going to come into a community team, especially if they're ward based. To come into a community team from a ward is a massive transition'*

One respondent suggested a notable difference in the organisational challenges OU students experienced during a practicum compared to other PRNP learners:

> **Beatrice** [M]**:** '*With other universities their shifts can be so different week to week that it's probably harder to juggle the academic side as well as the placement side…A lot of Open University students were in on that placement on the same day each week, which was easier for them to organise their study time and their academic time'*

It was suggested sometimes such differences adversely affected the relationship between these nursing students:

> **Fionnuala** [M]**:** *'There's potential animosity there'* [between OU and other students]
>
> **Beatrice** [M]**:** *'On some occasions members of staff, as well as other students from for example* [names of three other regional universities]*, feel a sense of resentment maybe towards Open University students, because of the fact that, irrespective of the fact that it takes longer to qualify as a nurse with the Open University compared to* [name of university] *for example, but because of the difference in experience, in that they are paid as a health carer* [NRC] *for two shifts of the week* [integrated model]*…I think that causes a feeling of tension and resentment between the staff in the department, the Open University student and the external student from another university'*

There was even a suggestion that OU PRNP students may not always be supernumerary during placements; even though this is an NMC requirement:

> **Fionnuala** [M]**:** *'The Open University students have sometimes said they* [non-OU students] *get treated differently because they are supernumerary…I think because*

they [OU students] *are paid members of staff, they are always going to therefore be counted in some form of skill mix and numbers on the wards'*

10.7.2 Mentor theme: *Affinity*

This theme captures the importance assigned to students being a team member during placements and building effective working relationships. Once again, the block model was commonly viewed as preferable in fostering the student's sense of belonging within a practicum. Respondents described challenges, either experienced or predicted, related to finding time to discuss competences and develop an effective working relationship with students on an integrated placement:

Beatrice [M]**:** *'It's difficult anyway to get the evidence and competencies organised. But I think with one shift per week* [integrated placement] *it's even more challenging…*A lot of us have to come in sometimes on our days off to sort things out. Which can be quite, I mean we'll do it because we want these student nurses to succeed obviously. But it's a big ask to come in on your day off to sort out. Sometimes that's the only way to get it done'

Caren [M]*: 'The hardest bit was finding time to sit down and discuss how she* [OU student] *was doing and were there areas that we still needed to develop'*

Hanneke [M]**:** *'If you* [the student] *were to do like an integrated placement with ward hours, it would be quite flaky really, you* [the mentor] *wouldn't be seeing as much of them'*

In contrast, mentors reported finding it easier working with students on block placement, even though the total number of practice learning hours are ultimately the same:

Evie [M]**:** '*If I've got a student with me all the time* [block model] *I know exactly where they're at. I'm spending that much more time with them, the time that I do spend is quality time, there's not a lot of pressure...So, it definitely benefits me in terms of being a better mentor'*

Gillian [M]**:** *'You've got the opportunity* [within a block model] *to then follow it up, rather than waiting until perhaps the next week when they're on shift, something could happen. I think it supports, it gives the student more support'*

Nevertheless, one respondent still highlighted problems with mentor-student time within a block practicum, whilst another suggested a positive relationship could still be established in an integrated placement:

> **Hanneke** [M]: '*It was only like a short full-time* [block] *placement, so we did struggle… I ended up taking it* [the student's portfolio] *home to be honest on one night, just so I could really not feel rushed to look at it. But that was my choice and that fit in with me and it just meant that I was able to really consider it more'*

> **Alison** [M]**:** *'She* [OU nursing student on integrated model] *was here enough to establish that relationship'* [with the mentor]

Several mentors highlighted the impact of the practicum model on perception of the student by the wider clinical team and the learner's sense of belonging within this team:

> **Gillian** [M]**:** '*I think it* [block model] *allows the staff, supervisors, and assessors to support the students more effectively and spending regular contact time with them'*

> **Fionnuala** [M]**:** '*I think it's a lot easier from a team perspective to be within that team for again a longer* [block] *period. Otherwise, you become unfamiliar, and it can be quite daunting I think for students to be popping in and out*'

> **Hanneke** [M]**:** '*They* [OU nursing students] *voiced that they preferred the block method, they found it easier to, as I say slot them self into the team…It* [integrated model] *just more feels like someone doing a bank shift* [itinerant nursing staff input] *with that, rather than getting that full learning experience*'

During the early stages of the Coronavirus pandemic in the UK, the NMC (2020) decision to permit final year nursing students to undertake extended paid placements with reduced supervision, combined with increased work pressures, were seen by several respondents to have affected the role of OU nursing students:

> **Alison** [M]**:** *'The majority of students that are coming through with* [the] *COVID* [exceptional arrangements] *will come in as paid employees through the clinical support worker and aspirant nurse programme. So essentially it felt like working just alongside other colleagues really, which was probably a little bit easier. Because obviously when you're a student there's certain things that you have to be mindful that*

they can't do, or they've got to be supervised. Where when they're in a paid capacity it was easier to let them spread their wings a little bit'

Beatrice [M]**:** *'The staff knew that these individuals could do certain tasks and jobs because of their healthcare* [HCA] *experience, so instead of recognising that these individuals weren't with us as health carers, they were with us as nursing students to learn. Because of the extra hands, because of the help that we were given by having these individuals with us as nursing students, that was almost overlooked…Some of these* [student] *nurses are very close to qualifying and the things that they had in their mind, their expectations of their management placement didn't turn out to be what they thought, what it might have been under normal circumstances'*

Finally, one mentor noted a slightly surreal consequence of COVID-19 on the mentor-student relationship:

Hanneke [M]**:** [Name of OU nursing student] *'was at work, so we were all* [attending] *via a Zoom* [meeting]*, and I think that's probably the first time she saw my actual face and that was right at the end. You might not think of that as a big deal, but for the whole time she didn't actually know what my face looked like because of this mask'*

10.7.3 Mentor theme: *Carer work & service delivery*

This theme highlights the implications for the base location when an OU nursing student is away from their NRC role. The retention of an NRC within the workplace, albeit at a reduced level, made possible by an integrated practicum was most highly valued in those instances where staff backfill was not provided or where specialised knowledge or skills might be difficult to replace if this individual was entirely absent from the workplace for weeks at a time. It was noted, however, that reciprocal placement arrangements could offset such staff loss, although this comment appeared to set aside the difference between losing an NRC, but gaining a supernumerary nursing student:

Beatrice [M]**:** *'The integrated model is more appealing to the NHS Trusts, because it allows the student to work like you say for maybe one shift a week as a student nurse, but then they are utilised maybe for three extra shifts that week as a healthcare assistant for example. I find that in some ways must be more cost effective for the*

Trusts because they don't have to then say to that person 'OK, you have to leave your healthcare [HCA] *role and just do your placement as a student'. They kind of get to keep the healthcare assistant for example and then have that one shift a week where they're just doing a placement'*

Alison [M]**:** [It helps] *'to keep that member of staff as part of their team* [integrated model]*, rather than releasing them for a long period of time and having to backfill those shifts with somebody else'* [block model]

Caren [M]**:** *'It was beneficial for us because she was able to continue doing the job that she'd been doing prior to starting the training. She had quite an important role in that she managed the diabetic side of our intravitreal injections, and she knew all the patients when they were due and everything. And so, to have her still within the department made our lives a lot easier'*

Fionnuala [M]**:** *'It is a bit easier to have your ward staffed for a longer period of time, rather than having staff coming and going* [integrated practicum]*. So generally, when I send my staff to a block environment* [placement]*, I would then get somebody else's Open University student back to backfill that gap. So, it actually made it quite feasible to maintain that everywhere still had the same staffing levels'*

10.7.4 Mentor theme: *Role transition*

This theme addresses transitional issues associated with OU nursing students having concurrent NRC employment. Most respondents acknowledged the challenge these learners experienced moving between the two roles:

Gillian [M]**: '***You do have to remind them you need to take off your healthcare assistant hat and put on your student nurse hat*'

Deirdre [M]**:** '*The students find it difficult to flip in and out'*

Fionnuala [M]: *'People* [OU nursing students] *are actually going and they weren't getting confused between the two roles …When they're in their healthcare* [HCA] *role they know how to do various other things that other healthcare* [students] *don't know how to do and I think sometimes they would like to support the nursing team when we're busy, when we're needing things done, but actually they're not allowed to do*

that at that time, because they're not in that role on that day. So, I think they can sometimes feel held back'

Beatrice [M]**:** *'All the students who were coming up to the end of their studies,* [in] *their management placement* [they] *had the choice to choose to do their management placement in an area where they had been health caring* [NRC role]*, and they chose to opt into that idea where they would swap over and go from a health carer* [NRC] *for example on general surgery where they were the healthcare* [assistant]*, to then a student nurse. I found that very confusing for the students. Because they were expected, because the level of expectation then changed from a healthcare responsibility to a student nurse responsibility, it's a very different role'*

Interestingly, despite majority support for the block model, integrated placements were deemed more beneficial in addressing some aspects of role transition; being easier to manage and promoting a greater sense of student security:

Caren [M]**:** *'It* [integrated model] *her was certainly easier for, definitely easier for her to manage. And yeah, I suppose it was for me'*

Beatrice [M]**:** *'The students felt a sense of security maybe that they still kept their healthcare* [assistant] *role, but had one shift a week where they could concentrate on being the student nurse…I find that in the integrated model for example a student knows which day of the week they're going to be in their practice placement and that is maybe easier for them to organise their academic life and their academic study'*

10.7.5 Mentor theme: *Placement learning & the patient experience*

This theme reflects the extent to which mentors believed OU nursing students acquired a fulsome understanding of service provision within the placement setting and meaningfully engaged with patient care. The block model was described by many as more effective:

Gillian [M]**:** '*There's far more learning opportunities available to them* [in a block placement]*, rather than on a day release* [integrated practicum]…[Name of organisation prefers] *the model of block delivery, because it means that we can completely remove the student to the practice area where they'll be learning to the placement area. We felt that if they were to remain in their own workplace and be*

released for the day [integrated practicum]*, it still remains difficult and there's that risk where they perhaps lose some of the learning opportunities'*

Fionnuala [M]**:** *'They* [nursing students] *prefer to go away and have that longer period of time* [block model] *to take in everything'*

Alison [M]**:** *'It might have been better to have it as one block placement, to actually get a full flavour of the ward routine, rather than just certain days'* [integrated placement]

Evie [M]**:** *'My feeling is it's* [block model a] *much more valuable experience. I think it enables students much better to, because we're a fairly fast paced service, we're* [service type]*, so we get an awful lot of referrals all the time, it's like you're fighting fire with fire. But what* [name of OU nursing student] *managed to achieve was she would see somebody through right from the initial referral'*

Not all respondents, however, perceived the block model as the best structure:

Caren [M]**:** *'Sometimes the blocks are not long enough. Whereas when she was doing a bit here and a bit with us and a bit elsewhere* [integrated model]*, I don't know, it just seemed to fit together quite nicely'*

Deirdre [M]**:** *'They* [students] *can integrate their current learning into the role and educate themselves, and question, when they go back into practice* [as an NRC]*, why are they doing that and have more understanding in their role so that they're getting two lots of education really. Really to reflect on what they've learned on the two days out of their normal* [NRC] *practice* [integrated placement] *and then they can take it back and integrate it in. And it makes you look at things with fresh eyes'*

Several respondents also said practicum design affects patient experiences and student understanding of them. The block model was perceived by most as reducing missed opportunities:

Fionnuala [M]*: 'Basically it's* [block model] *quite good for continuity of care for patients if that member of staff has seen them regularly…If they've just come in for one day a week* [integrated practicum]*, they're actually not potentially going to see the whole experience of the patients. Whereas basically when you're there for a week*

say, you're actually more likely to see them come in and be admitted and being discharged, so good for the patients and for the student'

Deirdre [M]**: '***A lot of my patients are near end of life, so if they're* [student] *off, we might go through two days where you're meeting with the family, having discussions. So, they miss out maybe on the, they'll come back and say oh how's that man and they'll have died, so they've missed out that bit of continuity*' [due to the integrated model]

Hanneke [M]**:** *'They* [OU students] *were able to build rapport with the service users, because obviously there was more consistency, they were there more* [in the block model]…*She* [OU nursing student] *said she preferred the block placement. She felt that when she did the integrated placement, because she was doing more like a day here and there, she'd miss out. Say if there was something going on on a Tuesday, but she didn't work the Tuesday, she was obviously missing out*'

Evie [M]**:** [In a block model, the nursing student] **'***would be able to develop a relationship with that person. She could care plan, she could risk assess and she actually could see it through to discharge. Now with the students that are not here all the time* [integrated placement] *like the apprentice for instance, which is the other end of the spectrum isn't it, where I might have, in a seven-day period I might have a student that worked with me three of those days. They could be split days, they could be like say Monday, Tuesday, Friday, and there's major, there's no continuity…I think the clients benefit* [from the block model]*, I think ultimately because what we've got effectively is another person that is solely focused on their care because my students always get the opportunity to key work somebody…I feel like they* [OU nursing students on integrated model] *miss out. I feel like because it might be, because we are very fast paced and we're very much, we plan, we have to plan, we have to set discharge dates. I've got two discharges today for instance and they have to happen, they simply have to happen. I can't wait until that student comes back on Monday to allow that student to experience the discharge process*'

The extent to which a mentor had control over their personal workload and could adjust it to accommodate individual student learning needs also appeared to influence practicum

model preference. Those mentors with a high degree of autonomy perceived integrated placements more positively, noting the potential this structure offered them to plan events from which learners might derive greatest benefit on placement days and ring-fence time for their administrative work [deemed to be of limited learning value] at other times:

> **Alison** [M]**:** *'There wasn't really many missed opportunities* [due to the integrated model]'

> **Deirdre** [M]**:** *'For me it's quite good not having a student constantly. So you have that, you can give them the time. Because you know they're with you on a set day or two days, you can alter your workload so, you know,* [I think] *'well I've got the student that day, I'll go and do that that day, that'll be good for her'. But you can get on with the rest of your work that wouldn't be of interest, because a lot of it she wouldn't find beneficial, so I wouldn't do that on the days I had the student. I think 'oh that will be really good experience for her, we'll do that on that day when she's here'. You can rearrange your work to accommodate yourself, so that you know that you're not overloading yourself on that day that you do have the student*'

Respondents suggested the impact of the Coronavirus pandemic on placement learning had been remarkably modest. An adverse effect on the scope for 'spoke' visits [i.e., short periods of student engagement with services outside their main placement, which is sometimes known as the 'hub'], however, was identified:

> **Gillian** [M]**:** *'There's been an impact on perhaps spoke visits, particularly for the competencies in the other fields, so child aspects, maternity and we did have plans in place, the students did have planned spoke visits, but* [these] *were cancelled*'

> **Hanneke** [M]**:** [Spoke] *'opportunities are scarcer because people are more frightened about taking a student for a day'*

Otherwise, participants suggested student placement experiences were either only minimally affected or largely unaffected by the impact of the pandemic:

> **Evie** [M]**:** *'Really in the grand scheme of things it hasn't stopped us doing our job. We go out and we see people just the same as we always did. The only difference is we've got masks on… This was in the middle of lockdown. So, she* [OU nursing student] *didn't*

manage to do the entire placement, but when she did come, she worked completely full-time here'

One respondent even suggested the pandemic may have enhanced placement learning:

Fionnuala [M]**:** '*I don't think it's* [COVID-19] *been detrimental to learning. I think actually they've probably seen more things than they might normally, because obviously we've had different kinds of patients'*

10.7.6 Mentor theme: *Higher priorities*

This theme captures issues interviewees deemed more significant influences on the student learning experience than the practicum model. A view amongst some participants was that the student's personal character and qualities were more important factors than the placement design they experienced:

Evie [M]**:** *'She didn't indicate she was struggling at all, but I think that's the sort of person she is'*

Deirdre [M]**:** *'I think one of them* [OU nursing student] *had a lot of family issues going on as well, as we do. And because they all tend to be older, because they've worked, I think they have that side of it. They all have families, elderly relatives. So, there are very, they have to be very structured. The more mature a student you are, the more structured you need to be, because you've got a lot more going on'*

Finally, one respondent questioned the appropriateness of the current nursing curriculum:

Beatrice [M]**:** *'They're* [current nursing students] *very caught up in the holistic and the art side of nursing, which is fine, but they don't see the science part'*

10.8 Conclusion

Results from these four qualitative interview phases provide a wealth of information and range of common issues necessitating more detailed discussion. The next chapter provides such discussion and, congruent with critical realism, presents a series of associated recommendations. Nevertheless, subsequent reanalysis of these interviews, to help fulfil the expectation that critical realist research should also strive to identify probable

underlying causative mechanisms, ultimately led to further recommendations [see Chapters 15 & 16].

Chapter 11. Discussion of qualitative results

11.1 Introduction

This chapter discusses the results of the first four phases of data collection within the study [i.e., semi-structured interviews with members of the four stakeholder groups focusing upon practice learning] and their implications. On the basis of this discussion, associated recommendations are then made. Further implications and recommendations in respect of subsequent aspects of the investigation are identified later within the thesis [see Chapters 13 & 16].

11.2 Results in the context of the wider body of subject knowledge

Interviewees from all four stakeholder groups displayed an overall, but not unanimous, preference for block placements and a high degree of congruence in respect of their perception of the two practicum designs. This congruence is perhaps best reflected by identification of five common themes yielded from qualitative content analysis of the interviews, namely *difference*, *affinity*, *carer work & service delivery, role transition* and *higher priorities*.

The reported desire for block placements amongst these stakeholders is consistent with results from earlier nursing studies in Australia (Peters et al., 2013), Canada (Rohatinsky et al., 2017; Rohatinsky et al., 2018), England (Coghill, 2018b), Ghana (Adjei et al., 2018; Amertil et al., 2020) and the United Arab Emirates (Saifan et al., 2021), as well as research within occupational therapy (Bonello, 2001), speech-language pathology (Sheepway et al., 2011), social work (Rock & Ring, 2010) and teacher education (Al-Qasmi, 2017; Chittleborough et al., 2010; Meyers et al., 2017). Participants, however, suggested the integrated model offered greater organisational and operational benefits to the location where Open University [OU] Pre-Registration Nursing Programme [PRNP] students normally undertake their non-registrant carer [NRC] work.

11.3 Employer sponsor responses

Employer sponsors consistently described OU PRNP students as more independent, knowledgeable, confident, self-reliant, and motivated than their peers from other higher

education institutions [HEIs] due to their maturity and experience as NRCs and were regarded as a valuable means by which to disseminate good practice within the organisation. The OU was seen as flexible and accommodating in respect of the structure and implementation of PRNP practice learning experiences, but in some instances appeared not to be perceived as a university. Employer sponsors were concerned about the academic challenges for students who, in many instances, may not have undertaken any recent accredited study might face on the programmes. They also recognised the considerable demands associated with undertaking academic studies in addition to NRC practice hours irrespective of the practicum model. Such concerns are congruent with the results of previous research into learners studying under similar conditions (Evans et al., 2007; Hasson et al., 2012; Nicholl & Timmins, 2005; Rochford et al., 2009; Rock & Ring, 2010; Timmins et al., 2011).

Although employer sponsors valued OU PRNPs and having students on these courses, they were acutely aware of differences, both in terms of programme design and student characteristics, associated with this provision. Indeed, perceived difference and unfamiliarity, exacerbated by the small number of OU students within the Trust's total nursing student population, appeared to cause greatest concern. Participants feared significant differences in the operational structure of practice learning within OU PRNPs compared to programmes delivered by other HEIs operating within the organisation could have an adverse effect on the mentor-student relationship and ultimately the practice learning experience for OU students. This anxiety appeared to be a primary reason underpinning choice of a block rather than an integrated placement model for most Trusts. Once again, concern about such perceived difference is supported by the findings of earlier comparable work (McDaid, 2009; O'Driscoll et al., 2009; Wood, 2006). Employer sponsors also suggested uninterrupted block placements were critical to reinforce the similarity of The OU PRNP and its students to more mainstream nursing programmes and to enable OU learners to acquire a sense of belonging within a practicum and a distinct nursing student identity.

The challenges OU undergraduates face moving between NRC and nursing student roles were recognised and again reflect the results of earlier research related to such staff engaging in PRNPs (Brennan & McSherry, 2007; Draper et al., 2014; Roberts, 2006). Most

participants believed role confusion arising from OU students having to 'wear two hats' [a phrase often employed by respondents] was lessened by adopting the block model, despite its use meaning academic studies continued during periods when students have no concurrent practicum experience on which to reflect. One respondent, however, argued the integrated model avoids marked changes from an NRC to nursing student role which occur in the block model and might better equip students with the adaptability skills they may need as a registered nurse [RN]. None, however, suggested that it might assist in bridging the theory-practice gap by facilitating reflection on practice and more effectively assimilating academic and practice learning.

Employer sponsors expressed concern some OU PRNP students were frustrated at being unable to use existing skills acquired in their NRC roles and that these individuals may also overestimate their current knowledge and abilities. Additionally, they suggested the block model may reduce this tension by providing individuals with consistent episodes of practice learning as a nursing student. The view some respondents expressed that OU PRNP learners occasionally believed they were being used as NRCs during periods of supernumerary practice learning, also identified in earlier work (Park & Nam, 2016; Prescott-Carter & Onuoha, 2016; Sharif & Masoumi, 2005), was largely interpreted as learners failing to appreciate the range of work undertaken by RNs. Nevertheless, respondents recognised an ongoing risk to supernumerary practice arising from service demands drawing these individuals back into an NRC role. Using block placements was considered a means to reduce this risk, although only one instance was reported in an integrated practicum where intervention was actually needed to prevent it occurring.

Understanding the patient journey, continuity of care and consolidation of learning were generally seen as best facilitated by block placements. Some employer sponsors, however, recognised this may not be the case in all nursing services and acknowledged The OU programme provided more time for consolidation of student learning than is the case in traditional PRNPs. The suggestion of any hidden curriculum within practice settings, a lack of effective student preparation for practice and inappropriate mentor expectations, including student passivity, highlighted elsewhere (Allan et al., 2011; Jack et al., 2018; Lassche et al., 2013; Ntho et al., 2020; Petit dit Dariel et al., 2014) were not evident in this study; although one clearly cannot disregard the potential that such issues might be set

aside by respondents seeking to promote a desirable professional image and positively influence impression formation.

Employer sponsors regarded providing opportunities for NRC employees to join The OU PRNP as an important way to demonstrate their organisation valued them, and most participants believed this investment would ultimately translate into retaining these staff as RNs. In contrast to almost all other areas explored within the study, finding placement capacity to accommodate OU students was considered less challenging when adopting the integrated model and that its use might also provide some part-time RNs with the opportunity to mentor when this would otherwise be impossible. The fact most Trusts used the block model, however, suggests operational factors were not their only consideration.

In common with other respondent groups, employer sponsors also regarded several other issues as more important than the model of practice learning. Most notably, such issues included student allocation to suitable mentors with a workload that allows them to provide effective learner support and securing a sufficient number of appropriate high-quality placements.

11.4 Student responses

Results from the second phase of the study involving student respondents echo various findings from the first. Both the belief that OU PRNP students are perceived and treated differently to nursing undergraduates who are not employees of the organisation and who study programmes offered by other universities, as well as concerns regarding the added complications for individuals in managing concurrent roles as an NRC and nursing student were echoed. Also congruent with the views of employer sponsors, but in contrast to the findings of earlier research (Roberts, 2006; Wood, 2006), most learners interviewed in this study felt the perceived difference had positive consequences and staff in placements saw them as having greater initiative and possessing better developed nursing knowledge, skills, and experience than nursing students on other programmes. Respondents also suggested more consideration was given to the selection of their placements.

Nonetheless, several students believed perceived difference occasionally threatened their supernumerary status, reduced the supervision, support and performance feedback they

received and that some practitioners misunderstood The OU PRNPs. Indeed, one respondent even spoke of animosity from non-registrant staff caused by their becoming a nursing student. Perhaps most importantly, some individuals disclosed anxiety regarding situations where they felt placement staff expected them to be knowledgeable and skilled, but they did not feel they had yet acquired relevant competence. Whilst it is difficult to determine whether such anxiety is genuinely the result of greater expectations of competency, there is clearly a need to ensure placement staff are appropriately briefed about the nature of the OU programmes and existing student skills.

As well as the potential external 'push' by placement staff for these nursing students to be an 'extra pair of hands' when the workload was high, participants also described an internal 'pull' towards reverting to their NRC role under such conditions; perhaps because of their greater appreciation of the challenges staff in these environments face when busy and a desire to make a meaningful contribution to 'getting the job done'. Such tensions reflect the findings of earlier work (Arrowsmith, 2016; Brennan & McSherry, 2007) and some participants reconciled the transient loss of supernumerary nursing student status, whether compulsory or voluntary, by emphasising their need to display flexibility when providing nursing care and the overlap in the duties of an NRC and RN. Given that 39% of respondents in a recent UK survey involving over 20,000 nursing staff believed supernumerary nursing student status was commonly ignored (Castro-Ayala et al., 2022), this appears to be a widespread problem.

Again, in most instances and irrespective of the practice learning model, respondents regarded a block practicum as more effective in reducing role transition and enabling emersion in the nursing student experience. Virtually all participants recognised useful transferable learning and personal development between their nursing student and NRC activities. That said, those given block placements also identified problems retaining a sense of nursing student identity outside these periods, managing the end of an intensive and satisfying block practicum, and having NRC skills and knowledge deteriorate due to relatively long, continuous episodes away from the workplace. In contrast, those expressing support for the integrated model described a less hurried opportunity to reflect upon and consolidate new learning and the value of maintaining an NRC role every week.

The greatest role transition difficulties were reported by students who normally hold an NRC caseload. Where such individuals experienced block placements, they spoke of guilt handing over an entire caseload to already over-burdened colleagues when their practicum commenced and the stress of picking up completely new work when they returned. Those participating in the integrated model, however, reported retaining a disproportionately large caseload given the number of days they continued to work as an NRC because of patient reallocation problems. It seems therefore that, irrespective of the practice learning model selected, greater consideration is needed to ensure appropriate workload management of such individuals before they enter the programmes.

Respondents described belonging as an important dimension of practice learning; a finding echoed in earlier research (Gilmour et al., 2013; Grobecker, 2016; Shivers et al., 2017; Vinales, 2015). Students appeared to believe continued acceptance by the team where they worked as an NRC might also be placed at risk by their nursing student role. Hence, these learners were eager not to behave in ways that might lead them to be regarded as 'changed' by their participation in the PRNP and were reassured when work colleagues interacted with them no differently after they commenced the programme.

Almost all student respondents believed the integrated practice learning model was preferable to the block approach in minimising any negative impact of their nursing student role on activity within their NRC workplace. The focus of this study has been on exploring what effect a sponsor's decision to adopt an integrated or block model of practice learning for those OU PRNP students whom they employ as an NRC has on the student learning experience and retention/achievement. Arguably, however, these findings trigger a different yet equally pertinent question beyond the scope of this study; namely *'what effect does a sponsor's decision to adopt an integrated or block model of practice learning for those OU PRNP students whom they employ as an NRC have on the workplace from which this student is released*?'.

Once more, the block model was regarded by most students as providing a less fragmented, more immersive practicum experience that provides the opportunity to see nursing interventions from start to finish and in which they could be a key participant. The model, however, was still regarded as problematic; especially in terms of the speed with which the experience may be over, emotional exhaustion and the difficulty in retaining a

nursing student identity outside block placements. Such responses therefore suggest it may be wise to consider how networking opportunities can be developed to better support such learners and their undergraduate identity when not in placements.

Many students highlighted the considerable demands resulting from programme attendance whilst retaining an NRC role and several suggested they may not have applied for the course had they been fully aware of them. The financial, domestic, and emotional costs of being an OU PRNP student were highlighted as well as needing to use annual leave, off-duty days, and free time after a working day to keep up with academic studies. Arguably, reviewing the way in which potential students are briefed regarding the commitments associated with joining the programmes and examining the nature and extent of on-course pastoral support should therefore be priorities.

Nevertheless, most students appeared to display high emotional resilience, regarding such sacrifices as a price worth paying to achieve a goal which, until they were made aware of the employer-sponsored OU PRNP, the majority believed was unobtainable. Rather than reflecting negatively on undertaking a PRNP via this route, respondents generally expressed gratitude to their employer sponsor and the university for this opportunity and a determination to become an RN. Of course, such gratitude should not be regarded as accepting and endorsing any notion of the programmes as 'tests of endurance'.

Finally, students commonly regarded the behaviour of their mentor as one of the most important determinants of a positive placement experience. Some, however, highlighted a constructive working relationship with this nurse was not a consistent feature of every practicum. This might therefore suggest a need for more appropriate mentor/practice assessor preparation.

11.5 Practice tutor responses

In the third phase of the study, practice tutors also believed learners on The OU PRNPs are perceived and treated differently to nursing students on programmes offered by other universities who are not service employees, as well as concerns regarding the added complications for individuals in managing concurrent roles as an NRC and nursing undergraduate. Congruent with the views of employer sponsors and students, most practice tutors felt this perceived difference had positive consequences and that staff in

placements saw OU learners as having greater initiative and better developed nursing knowledge, skills, and experience than students on other PRNPs. Nonetheless, several believed such perceived difference occasionally threatened the quality of practice learning OU students received, recognised that these learners may feel added pressure to already be knowledgeable and skilled by virtue of their NRC experience, and felt the lack of an immediately accessible peer group could lead to social/academic isolation. This final issue, problematic for all such students given their comparatively small numbers in any one organisation, is certainly another matter for further consideration.

In almost all instances, practice tutor respondents regarded the block model as more effective in reducing the challenge of role transition and allowing OU undergraduates to feel more like conventional open-entry nursing students. Moreover, most described affinity as an important dimension of practice learning and believed the block model provided a less fragmented, more immersive placement experience. This model, however, was not deemed unproblematic; especially in terms of the practicum duration, the greater potential adverse effect of mentor absence on student learning, the risk that learners may fail to engage with some patients from admission to discharge, the danger that the student being regarded as a team member becomes more important than their being perceived as a learner, and the difficulty in scheduling tripartite meetings. Practice tutors also suggested greater consideration needed to be given to the specific design of assessment processes for OU nursing students consistently assigned block placements; primarily because their use could lead to repeated misalignment of academic work requiring reflection on practice with the times when learners had a practicum.

Many practice tutors believed employer sponsors saw an integrated placement as preferable to a block practicum in minimising any negative impact on service provision resulting from releasing NRCs. That said, some participants expressed concern the integrated model may increase the risk nursing students are temporarily removed from their placement to allow a short-term return to their NRC role because of service pressures. Overall, there was no expressed opposition to using either practice learning model. Indeed, several respondents specifically argued it was important for the university to continue to offer both designs.

Practice tutors also suggested other issues may be more important influences on the practice learning experience than the placement model. These included mentor support, the quality of the learning environment, student ability and confidence, and the degree to which academic and practice learning on the PRNPs are harmonious and synchronous. One respondent even proposed an integrated practice tutor/module tutor role to address this final issue.

11.6 Mentor responses

Results from the fourth and final interview phase display considerable similarity with findings from earlier phases. Beyond document differences in The OU PRNPs, most mentors, re-termed *practice assessors* in the UK since this research commenced (Nursing & Midwifery Council [NMC], 2018b), believed nursing students on the programmes are perceived and treated differently to those who are not employees and who study PRNPs offered by other universities. They recognised experience delivering nursing care often enhanced the performance of OU nursing students but highlighted the added complications for these individuals in managing their concurrent NRC role.

In addition, some respondents believed NRC proficiency only provided a short-term advantage or argued it may even make learning in unfamiliar placements harder. For the first time within the research, respondents also reported some tension, resentment, and animosity between OU nursing students and learners from other universities; both parties sometimes feeling their treatment during a practicum was inequitable. Of equal concern was the implication that employment of an OU nursing student by the organisation in some way justified reduced compliance with their entitlement to supernumerary practice learning; a finding also identified within previous research (Draper et al., 2014).

Most mentors preferred the block model, suggesting it provides more immersive student experiences and lessens the risk of missed learning opportunities. Indeed, some suggested it enables students to develop stronger relationships with patients and service users, provides more consistent care and thereby improves nursing quality within a service. Interestingly, this assertion was also made by one mentor based in an accident and emergency department where, presumably, it would be much less likely a student would have repeated contact with a specific patient/service user.

Arguably, the importance of consistency in a practicum is affected by the nature of the service provided; that is to say, where nursing intervention lasts for only a brief period [for example, within an out-patient department or mental health crisis team], consistency of experience may be less important than is the case in a setting where care is provided over successive days or weeks [for example, an orthopaedic ward or older people services community mental health team]. It may also be influenced by the degree of autonomy within the mentor's clinical role. For example, a community nurse acting as a mentor who managed her workload in a largely independent way said the integrated model enabled her to optimise student learning, since she could schedule specific activities on those days when this learner would be on placement and complete administrative work [which it would be of limited value for the student to witness] on days when the individual was absent; an advantage of this model identified in earlier research (Curl & Cary, 2014).

Respondents often described the block model as a better framework within which to undertake their mentor responsibilities; not least because they believed intensive co-working strengthened the mentor-student relationship. Indeed, one participant suggested this model enabled her to be a more effective mentor. Nevertheless, and irrespective of the model of practice learning assigned to the student, mentors commonly described difficulty finding sufficient time to review competences and plan future student learning opportunities. This led several respondents to meet the student and review their learning on days when the mentor was off duty, or to examine portfolios at home.

Block practice learning was also deemed to improve student interaction with other members of the clinical team. Respondents spoke of staff providing better student support within this practicum design and that it promoted greater familiarity between the learner and other practitioners. It was suggested undergraduates on block placements more easily slotted into the team; whilst those receiving integrated practice learning were perceived like bank nursing staff [i.e., peripheral, itinerant workers]. The fact learners allocated an integrated practicum would be present within the clinical setting for a much longer period compared to the block model and ultimately spend the same number of learning hours in this service were not generally seen as compensatory features.

Surprisingly, the impact of COVID-19 on the mentor role, mentor-student relationship and student learning opportunities appears to have been modest. The Coronavirus pandemic

was raised as an issue during interviews in this phase of the study because to ignore it would arguably be to disregard a significant factor that may have affected health, wellbeing, nursing practice, and educational experiences. Whilst mentors acknowledged the pandemic had restricted some aspects of student learning, others suggested service provision and associated learner activities had largely carried on as usual and, where changes had occurred, these had sometimes been beneficial in widening learning opportunities. None of the respondents suggested student progress within either practicum model had been seriously affected by service responses to COVID-19. This apparent stability may, of course, have been affected by the concurrent employee status of all OU nursing students since disrupted practice learning for learners on other UK nursing programmes was reported during the same period (Jones-Berry, 2020).

The issue of role transition in respect of both placement models was a topic on which there was no overall mentor preference. Within the integrated model, some respondents suggested both staff and students struggled at times to accurately recognise and accommodate the individual's practice identity [i.e., whether the employee should be regarded as an NRC or nursing student at a given time]. Nonetheless, it was also argued the integrated model often suited both the service and the learner and may provide more security for the student, be more manageable, and facilitate transferable learning between roles. Again, compliance with supernumerary practice learning entitlements was brought into question by an assertion that reciprocal placement arrangements could be used to offset the loss of an NRC undertaking a practicum as a student elsewhere by taking a nursing undergraduate in their place.

Finally, mentors argued other issues may be more important influences on the student practice learning experience than the placement model, including the appropriateness of the current nursing curriculum and the student's personal character and qualities. The former assertion is interesting, given that all UK universities offering PRNPs have since introduced new curricula based on changes to the *'Standards of Proficiency for Registered Nurses'* as part of the *Future Nurse* initiative (NMC, 2018a) and a revised *'Standards framework for nursing and midwifery education'* (NMC, 2023a). Whether these changes are ultimately regarded as giving a greater emphasis to the science of nursing practice, as desired by one mentor, remains to be seen but the relationship between art and science

within nurse education certainly continues to be a subject of interest within the discipline (Myrick & Pepin, 2015).

Research within the fields of medical (Carr et al., 2014), nursing (Buhat-Mendoza et al., 2014; Oducado et al., 2019) and podiatric education (Yoho et al., 2012) suggest a positive correlation between academic learning and practice performance. Studies involving various undergraduate students have also suggested a positive correlation between academic performance/satisfaction and conscientiousness (Chamorro-Premuzic & Furnham, 2008; de Koning et al., 2012; Grigorescu et al., 2018). Furthermore, a similar statistical relationship has been identified between conscientiousness and academic and clinical performance in medicine (Doherty & Nugent, 2011) and more recently between conscientiousness and emotional resilience and academic and clinical performance in nursing (Pitt et al., 2014). Arguably, as a group comprised almost exclusively of mature learners with existing nursing experience who undertake much of their PRNP studies via distance learning, OU students may be more likely to demonstrate the higher level of practice performance associated with academic achievement [supported by The OU's high PRNP retention levels] and possess the conscientiousness and emotional resilience positively correlated with better academic and clinical performance. The assertion made by respondents that a student's personal character and qualities may, therefore, be more important than the model of practice learning within which they acquire their clinical experience is arguably supported by such research.

11.7 Recommendations

For critical realist researchers, recommending changes and promoting emancipatory outcomes are regarded as central to academic enquiry (Corry et al., 2018; Sweetmore, 2021; Wise, 2019). In the qualitative phases of this study, stakeholder views on the desirability of both practicum models appear to have been affected by four key variables evidenced within the themes; namely the student's personal circumstances, the service where The OU PRNP student is normally employed as an NRC, the clinical role undertaken by the mentor/practice assessor and the nature of the placement. Issues in respect of these variables are summarised in Table 2 and, based upon the results of this study combined with the findings of earlier research involving more experienced pre-registration healthcare students, should arguably be carefully considered when seeking to determine

the most suitable practice learning model for individual employer sponsored PRNP students. Doing so may not only improve the practicum experience for all key stakeholders but also help overcome oppressive or unjust structures, systems or behaviours related to placement design and thereby promote emancipatory changes to student learning.

Table 2: Variables and key considerations in determining the potential suitability of a practicum model for an employer sponsored PRNP student

Variable	Key considerations:
The nursing student	• Whether the student has significant non-work commitments, such as parental or informal carer responsibilities • Whether the student holds a caseload in their substantive employment role • What, if any, preference a student indicates in respect of their model of practice learning
The service in which the student is normally employed in their NRC role	• The normal duration of any single period of nursing intervention for a patient within the service • The potential effect of staffing changes on the quality of care • What, if any, provision has been made for staff backfill during employer sponsored PRNP student absence
The mentor/ practice assessor	• The extent to which the mentor/practice assessor has control over their personal workload and can adjust it to accommodate individual student learning needs • Whether the mentor/practice assessor has previously supported students on both practicum models
The placement	• The duration of any single period of nursing intervention for a patient/service user within the service, from shorter-term [such as an Accident & Emergency department, out-patients clinic, or a mental health crisis team] to longer-term [such as community nursing care for chronic/enduring conditions, an orthopaedic trauma ward or a forensic in-patient mental health unit] and its effect upon student understanding of, and engagement in, the patient journey • The normal length of working day/shift and therefore how many days a week a nursing student within an integrated placement would be expected to engage in

	practice learning and the maximum number of days that they could be away from the service during this practicum • Whether the placement employs any part-time RNs whose working week means they may be able to act as a mentor/practice assessor for a student on an integrated placement but not for one assigned a block placement • Whether the placement concurrently accommodates nursing students from other universities and whether any inconsistency in the placement models to which these different students are exposed might adversely affect the learning environment/interpersonal relations • What provision is available in the placement to facilitate student reflection on practice and the consolidation of learning • How the team within the placement normally communicate, express, and consolidate their collective identity • Whether a placement has previously accommodated students on both practicum models

Although beyond the focus of the original research question, some concerns expressed by respondents from the four stakeholder groups appear to necessitate wider PRNP action on the part of the university. These specific recommendations are outlined in Table 3.

Table 3: OU-specific PRNP recommendations derived from qualitative content analysis of the interview phases of the study:

	Recommendations
.	To consider methods to better ensure appropriate workload management of nursing students irrespective of which model of practice learning is selected by an employer sponsor
.	To discuss how networking opportunities may be developed to better support learners and strengthen nursing student identity when they are not engaged in practice learning
.	To identify and implement strategies which might help to prevent and/or reduce nursing student social/academic isolation
.	To consider further research exploring the question '*what effect does a sponsor's decision to adopt an integrated or block model of practice learning for those OU PRNP students whom they employ as an NRC have on the workplace from which this student is released?*'

4. To review the way in which potential students and other stakeholders are briefed regarding the structure and study commitments associated with the programmes
5. To examine the nature and extent of pastoral support provided to students
7. To review the specific design of assessment processes for OU nursing students consistently assigned block practice learning, given the risk of misalignment of academic work requiring reflection on practice with these placements
8. To examine the proposal for an integrated PT/Module Tutor role as a means to better integrate academic and practice learning
9. To audit employer sponsor compliance with the requirement for nursing students to be supernumerary

11.8 Limitations

It is acknowledged that the interview schedule was not piloted prior to its implementation [action which may have strengthened reliability and validity within the study] and that the total respondent sample [37] employed in this four-phase qualitative content analysis was relatively modest. In addition, it only included stakeholders involved in PRNPs delivered by one university; all of whom were located in northeast England and Cumbria. Moreover, the researcher was not a disinterested third party, although his prior interaction with virtually all stakeholder participants for other purposes was either limited or absent. Whilst he acted as the line manager for several practice tutor respondents, the topic under investigation is not value-laden and both practicum models were offered within the PRNPs provided by The OU and without institutional preference, so it seems less likely that any pre-existing relationships would have affected the responses given.

In respect of the overall preference for a block practicum design, the possibility that student preference for this placement structure may be different during the earlier stages of the PRNPs should not be overlooked, since all undergraduates interviewed in this study were in Stage 2 or 3 of their programme. Indeed, similar findings have been reported in previous studies of block and integrated placements involving more experienced PRNP students (Amertil et al., 2020; Rohatinsky et al., 2017; Rohatinsky et al., 2018). Furthermore, one cannot disregard the attractiveness of the well-known as an influencing factor upon interviewees from all four stakeholder groups. That is to say, since most placements on UK PRNPs have traditionally been based on a block model (Humphries et

al., 2020), such a preference may also be driven by greater familiarity with this practicum design.

11.9 Conclusion

To summarise, these four phases of the study identify an overall preference across respondent groups for block practicum use and indicates the importance employer sponsors assign to minimising any perceived difference of The OU PRNPs compared to those open-entry programmes delivered by other universities also operating within their organisation. Most participants regarded immersion in a practice learning environment, acquiring a sense of belonging within the team and having a clear and sustained break from the NRC role as critical to the effective development of a distinct identity as a nursing student and that a block placement best fulfilled all these goals.

Whilst geographically and institutionally specific, the findings still contribute to the relatively small body of knowledge currently available regarding the influence duration and intensity of a practicum may have on practice learning and appears to offer the only investigation to date which focuses on block and integrated placement models in the context of employer sponsored PRNPs. The work has also raised a number of programme-specific issues which, whilst not directly related to the original research question, may necessitate further scrutiny [see Table 3].

It is hoped that, when shared via publication, these investigative activities will ultimately stimulate further academic discussion regarding placement models, encourage additional research within this field and facilitate more considered and targeted utilization of both practicum designs. Further work to apply and evaluate the variables outlined earlier [see Table 2] when assigning PRNP students who are sponsored by their employer to a block or integrated placement may be particularly valuable. Similarly, greater consideration of the practicum type on providing emancipatory student learning experiences warrants more detailed scrutiny.

Nevertheless, given the range of factors which may affect the suitability of a placement model, it seems highly unlikely either design will be more desirable and emancipatory under all conditions. As noted earlier, one practice tutor respondent [Christine] commented, *'you wouldn't use just one intervention or one treatment for a patient, so you*

wouldn't use one education system to meet all student needs.' Academic investigations related to the effectiveness of block and integrated placements and the efforts of educators to facilitate an individualised approach to practicum model selection must, therefore, be maintained and developed.

The next chapter of this thesis describes the work undertaken in respect of a subsequent quantitative analysis to examine whether any statistically significant relationship exists between exclusive student exposure to either block or integrated placement learning and retention/achievement levels.

Chapter 12. Quantitative data analysis and results

12.1 Introduction

To examine whether a relationship may exist between the placement model experienced by Open University [OU] pre-registration nursing programme [PRNP] students and levels of retention/achievement, a quantitative analysis was undertaken as the fifth phase of this research. Students on an OU BSc (Hons) Adult or Mental Health [MH] Nursing programme [both of four years duration] anywhere in the UK were selected for this purpose. Two PRNP cohorts were included; namely those commencing in either the academic year 2015/16 or 2016/17, since these anonymised students were expected to complete their programmes during the academic year 2019/20 or 2020/21. A further inclusion criterion was that learners must have exclusively been assigned either block or integrated placements throughout the entirety of their programme.

12.2 Data collection

Despite ethical approval being granted in respect of this activity and all the required data protection safeguards met, accessing the relevant information proved problematic for various reasons:

- The nationwide parameters of inclusion meant data related to student recruitment/registration and employing organisations needed to be drawn from university records located on 12 different OU servers used by PRNP teams in various UK locations. Permission to access them needed to be sought from their owners in all instances except one, where the researcher had an academic role in the faculty team serving northeast England and Cumbria.
- Whilst placement records were held for every nursing student in these cohorts, no single record existed which stipulated whether a block or integrated placement design had been used consistently throughout the student's practice learning experiences [such a document had never been deemed necessary]. Determining practicum arrangements would therefore have necessitated manual scrutiny of records pertaining to the eleven placements [the total number in both programmes] each

student had completed. Given that the selected cohorts included 656 students, such scrutiny was impractical. Instead, efforts therefore focused on identifying employer sponsors who consistently chose a block or integrated practicum for *all* the staff they supported as nursing students on the programmes.

- Once again, however, the university does not require any formal record to be kept in respect of the practicum model chosen by an employer sponsor for those staff whom they support on these nursing programmes. As a result, data regarding which students in these cohorts had exclusively been assigned either block or integrated placements throughout the duration of their programmes had to be acquired from local OU staff tutors [university academics with responsibility for liaising with sponsors and approving individual placement plans]. Inevitably, some staff tutors had left OU employment during the period between these learners commencing their studies and data collection being undertaken, so the practicum model/s chosen by every employer sponsor for nursing students within both cohorts in all geographical areas could not be readily ascertained.

Three key *exclusion criteria* were therefore applied to the data collected in respect of PRNP students within the two cohorts:

- All nursing students in UK locations where staff tutor changes meant it was now impossible to readily ascertain the practicum model chosen by specific employer sponsors for those staff whom they supported on the PRNPs.
- All nursing students employed with healthcare provider organisations reported to have used both block and integrated practicum models [either in a blended way for an individual student's placements or varied within the total group of OU nursing students who were employed by the organisation].
- All nursing students who, due to study deferral and/or resit/resubmission, had not completed their programme by the point of data collation [March 2021].

12.3 Results

Devore et al., (2021) state descriptive statistics *'summarize and describe important features of the data'* (p.2), whereas inferential statistics provide *'techniques for generalizing from a sample to a population in a precise and objective way'* (p.4). Within the quantitative analysis undertaken during this phase of the investigation (using SPSS

software, version 27) both descriptive and inferential data were acquired and examined. The identified sampling parameters meant data associated with 460 nursing students employed by 116 different healthcare organisations were included in the quantitative analyses.

The 2015/16 cohort accounted for 215 [out of 298] students and the 2016/17 cohort for 245 [out of 358] learners in the data set. Of these 460 undergraduates, 202 had exclusively experienced block placements and 258 had been assigned only integrated practice learning. All students were based in one of the following OU locations: east of England, East Midlands, London, northeast England & Cumbria, Northern Ireland, Scotland, southeast England, southern England, Yorkshire, and the West Midlands. No data was included from northwest England [there were no remaining staff able to comment on use of practicum models selected by local employer sponsors during this period] and Southwest England [there was a reported mixed use of practicum models within all healthcare organisations supporting students during this period] or Wales [OU PRNPs did not commence in the principality until 2018].

Once recruitment and employer sponsor information located on OU servers had been used to acquire initial student personal identifier numbers for those learners meeting the inclusion criteria, individual student records were searched via VOICE [an OU database] to capture details including age [see Table 4], sex, programme type, withdrawal, or degree classification on completion. These variables were included to provide richer descriptive statistics, although it is acknowledged that other variables that could not be readily acquired [such as student ethnicity, socioeconomic status, or their highest academic qualification on entry to the nursing programme] may have been equally valuable in illustrating the characteristics of the sample.

Table 4: Student age ranges within the quantitative analysis sample:

Age categories (March 2021)	Number of students in data set
21-25 years	6
26-30 years	130
31-35 years	102

36-40 years	71
41-45 years	57
46-50 years	53
51-55 years	35
56-60 years	5
61-65 years	1

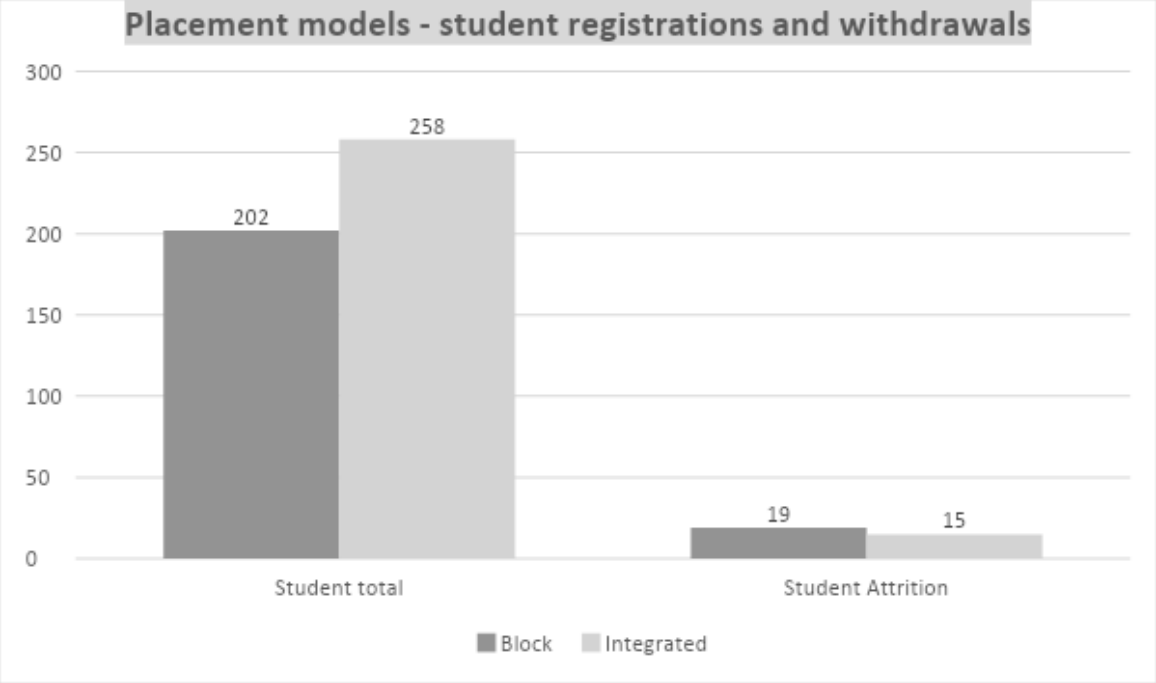
As noted in Chapter 3, the definition of a mature student varies but is commonly described as 21 years or older on course commencement (James & Beck, 2016, Reid, 2020). In this instance, only 6 students in the data set were 25 years or younger as of March 2021 [the point at which VOICE records were accessed] of which only 5 were younger than 21 years when they commenced their program in 2016/17. Hence, 455 of the 460 students [98.9% of the sample] can be deemed mature learners.

In the data set, 386 students [83.9% of the sample] were registered on the BSc (Hons) Adult Nursing course and 74 students [16.1% of the sample] on the BSc (Hons) MH Nursing programme. In total, there were 396 female undergraduates, 346 of whom were registered on the Adult Nursing degree [89.6% of programme registrations] and 50 on the MH Nursing degree [67.6% of registrations]. Male students totalled 64, of whom 40 were completing Adult Nursing studies [10.4% of programme registrations] and 24 were undertaking MH Nursing studies [32.4% of registrations]. Estimates suggest 89.3% of adult nurses in the UK (Royal College of Nursing, 2018c) and between 62% (Health Education England, 2015) and 80% (National Audit Office, 2020) of MH nurses in England are female, hence this sample largely corresponds with the sex composition in these two specialisms across the nation. Data suggests most employer sponsors [at least 70.1%] of the 656 students in the two cohorts consistently used a block or integrated placement model for all staff they supported on the programmes and so implies an individualised approach was not being applied to the selection of a practicum model.

Of the 460 students in the sample, 426 [92.6%] graduated and 34 [7.4%] failed to successfully complete their studies [19 of whom experienced block practice learning and 15 integrated placements]. Of the undergraduates who did not successfully complete this programme, 10 left during Stage 1, 19 withdrew in Stage 2 and 5 departed at Stage 3 of

their studies. An attrition rate of 7.4% compares very favourably with a UK average PRNP value of 24% (The Health Foundation, 2019). The specific attrition rate amongst all students only experiencing block placements was 9.4%, whilst for those students exclusively assigned integrated placements it was 5.8%. Figure 1 presents this data as a bar chart.

Figure 1: Bar chart – placement models and student registrations/withdrawals within the sample.

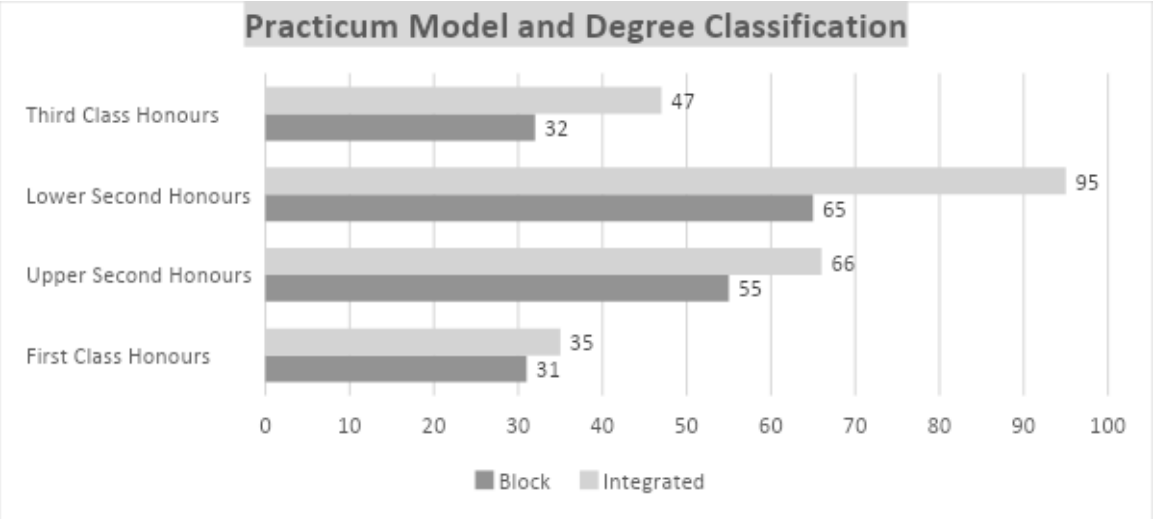


Inferential statistical analysis of PRNP attrition in relation to the practicum model experienced, however, failed to indicate any significant difference between the two conditions. Two-sided asymptotic significance of the chi-square statistic applied to this data was greater than 0.10 and so is not significant; hence exposure to a specific practicum model cannot be regarded as a factor clearly affecting student attrition.

Within the total sample of students who graduated, 15.5% achieved First Class Honours, 28.4% Upper Second-Class Honours, 37.6% Lower Second-Class Honours and 18.5% Third Class Honours. Of those students successfully completing their programme who only experienced block placements, 15.3% gained their degree with First Class Honours, 27.2% with Upper Second-Class Honours, 32.2% with Lower Second-Class Honours and 15.8%

with Third Class Honours. Amongst those students exclusively assigned integrated placements, 13.7% achieved a degree with First Class Honours, 36.8% with Upper Second-Class Honours, 36.8% with Lower Second-Class Honours and 18.2% with Third Class Honours. Figure 2 presents these data as a bar chart.

Figure 2: Bar chart – Degree classification of students undertaking block or integrated placements within the sample.



Nevertheless, once again, the two-sided asymptotic significance of the chi-square statistic applied to these data was greater than 0.10 and so is not significant; hence exposure to a specific practicum model cannot be regarded as a factor clearly affecting degree classification.

Having identified no statistically significant relationship between PRNP student exposure to placements based exclusively on one practicum model and retention rates or degree classification using crosstabulation, multinomial logistic regression analyses were undertaken. This analytical tool was selected since it is designed to predict a nominal dependent variable associated with three or more independent variables (IBM, 2017; Laerd Statistics, 2018). In this instance, these analyses sought to identify whether a placement model might, in combination with other potential independent variables [including student age, sex, and programme type], provide a more sensitive tool to robustly predict student attrition or degree classification [dependent variables] on the nursing

programmes. Whilst degree classification can be deemed ordinal data, multinomial logistic regression may also be used for such analysis (Ellis, 2021; Grace-Martin, 2022). For consistency and, given the size of the dataset and its ability to address the research question, this tool was therefore employed in the analysis of both dependent variables.

Regarding PRNP student attrition in relation to the placement model experienced, programme type, age, and sex, analysis suggests the variables added [i.e., placement model experienced, programme type, age, and sex] do not improve the model compared to the intercept alone [i.e., with no variables added] in any statistically significant way [see Table 5].

Table 5: Model fitting information - student attrition in relation to the placement model experienced, programme type, age, and sex.

Model Fitting Information

	Model Fitting Criteria	Likelihood Ratio Tests		
Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	157.413			
Final	154.257	3.156	4	.532

The *likelihood ratio* is deemed most '*useful for nominal independent variables because it is the only table that considers the overall effect of a nominal variable'* (Marquier, 2018, p.6), also indicates the placement model experienced, programme type, student age, and sex are not statistically significant independent variables since none have a value of $p < .05$ [see Table 6].

Table 6: Likelihood ratio tests - student attrition in relation to the placement model experienced, programme type, age, and sex.

Likelihood Ratio Tests

	Model Fitting Criteria	Likelihood Ratio Tests		
Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	154.257[a]	.000	0	.
Age (May 2021)	154.257	.000	1	.987

Block (1) or Integrated (2)	156.182	1.924	1	.165
Adult (1) or MH (2)	154.258	.001	1	.980
Sex F(1) M(2)	155.252	.994	1	.319

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

Once again, analysis of degree classification in relation to the placement model experienced, programme type, student age, and sex suggests the added variables do not improve the model compared to the intercept alone in any statistically significant way (p = 0.763) [see Table 7].

Table 7: Model fitting information - degree classification in relation to the placement model experienced, programme type, student age, and sex.

Model Fitting Information

	Model Fitting Criteria	Likelihood Ratio Tests		
Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	826.715			
Final	814.997	11.718	16	.763

Similarly, the likelihood ratio tests also indicate the placement model experienced, programme type, student age, and sex are not statistically significant independent variables since none have a value of p < .05 [see Table 8].

Table 8: Likelihood ratio tests - degree classification in relation to the placement model experienced, programme type, student age, and sex.

Likelihood Ratio Tests

	Model Fitting Criteria	Likelihood Ratio Tests		
Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	814.997[a]	.000	0	.
Age (May 2021)	815.617	.620	4	.961
Block (1) or Integrated (2)	818.089	3.092	4	.543

Adult (1) or MH (2)	819.015	4.018	4	.404
Sex F(1) M(2)	818.099	3.102	4	.541

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

12.4 Conclusion

Descriptive statistics indicates some variation in both the degree classification and retention of students exclusively exposed to either a block or integrated placement model. Nevertheless, neither analysis of the acquired quantitative data using crosstabulation nor multinomial logistic regression provides any statistically significant relationship between the placement model experienced [and, in the case of multinomial logistic regression analyses, other independent variables], and attrition rates/degree classifications. Discussion of these results and potential reasons to account for them are addressed in Chapter 13.

Chapter 13. Discussion of quantitative results

13.1 Introduction

Semi-structured interviews with representatives of four stakeholder groups [employer sponsors, mentors, students, and university practice tutors] involved in the provision of The Open University [OU] pre-registration nursing programmes [PRNPs] found most expressed a preference for clinical learning experiences to be based on a block model. Nonetheless, quantitative analyses undertaken within the fifth phase of this study found no evidence that employing this model has a beneficial effect on either learner attrition rates or degree classifications. Since clinical learning is a substantial and fundamental component of a PRNP, the lack of evidence regarding any such associations is perhaps surprising; especially given earlier research indicating academic performance may be affected by a practice learning model (Reinke, 2018; Schuijers et al., 2013) [see Chapter 7].

Clearly, adverse practice learning experiences may occur within either block or integrated practicum structures. Nonetheless, research suggests that a programme exclusively involving block placements may create a greater disconnect between academic and practice learning, students may feel pressured to be a member of the team within a practicum and 'get the job done' rather than concentrate on their achievement of relevant learning outcomes and may not acquire as rich an understanding of the workplace culture. In contrast, those having only practice learning within an integrated design may be more likely to feel detached from the core team/routine of a service in which placements are based, be de-prioritised by clinicians, or even treated as itinerant nursing care providers and used simply to address staffing shortfalls [see Chapter 7]. Negative experiences within both practicum models therefore display the potential to adversely affect student progression and success.

This chapter briefly explores those factors which might account for the lack of any statistically significant effect of a placement design upon the identified performance measures within this phase of the study. It then considers the implications of the results if potential issues associated with sampling, the sensitivity of the measurement tool, and measurement of other dependent variables are set aside.

13.2 Potential issue: sample size

It is possible that the sample size of 460 OU PRNP students [of whom 202 had exclusively experienced block and 258 integrated placements] was insufficient to capture any statistically significant differences in retention/achievement between both groups. Time and resource constraints, however, prohibited analysis of a larger sample. Nevertheless, this issue could be addressed in a subsequent study.

13.3 Potential issue: other associated independent variables.

Multinomial logistic regression analyses were undertaken to identify whether exclusive student exposure to a block or integrated practicum might, in combination with other potential independent variables [namely, student age, sex, and programme type], provide a more sensitive tool to robustly predict student attrition or degree classification [dependent variables] on the nursing programmes. Additional independent variables [for example, student ethnicity, socioeconomic status, or their highest academic qualification on entry to the PRNP] were not included in these analyses, since such data could not be readily acquired. It is therefore feasible that multinomial logistic regression analyses including these variables might have generated statistically significant results. Once again, it would be feasible for such characteristics to be considered in a future investigation.

13.4 Potential issues: atypical student characteristics within the sample and a moderating effect of mentor and wider stakeholder disposition to these students

Arguably, the atypical OU PRNP student population compared to those enrolled on nursing degrees delivered by most other United Kingdom [UK] universities may mitigate, and therefore obscure, any adverse effects associated with learning experiences based upon a specific placement model. For example, OU nursing undergraduates are almost exclusively mature learners, so may have stronger emotional resilience and forbearance acquired through greater and more diverse life experience; thereby enabling them to ‘ride the storm’ in relation to a practicum which may be less effective in facilitating clinical learning due to its design. Indeed, earlier nursing research in Norway by Bjork et al (2014) supports this possibility [see Chapter 6]. Such maturity might even positively affect stakeholder perceptions of the student and accommodation of their learning needs, despite problems

arising from the type of practicum model underpinning the placement and any reservations that these stakeholders may have about the chosen model.

Unlike most PRNP students in the UK, those studying with The OU are also employed as non-registrant carers [NRCs] who undertake their academic studies with their employer's support. Concurrent practice as an NRC may offer complementary, and potentially compensatory, opportunities. For example, an individual might use the scope for informal learning afforded by their NRC workplace to offset any shortcomings of a less effective placement experienced within their nursing student role. Additionally, these learners may be more confident than conventional PRNP students to challenge ineffective clinical learning experiences or express concern about support which they deem limited, inadequate, or poor, and which may potentially originate from negative stakeholder views of the practicum model on which their placement is based.

Such confidence may not only be attributable to maturity, but enhanced understanding of what nursing students should reasonably expect, derived from NRC experience via, for example, observation of mentor-student interaction in their regular workplace. As one interviewee, Diane [employer sponsor], commented *'they're* [OU PRNP students] *working in practice, that they're not just seeing registered nurses practising while they're a student on a placement; they're also seeing registered nurses practising when they're a nursing assistant'* [NRC]. Furthermore, mentors and other stakeholders might be more favourably disposed to OU nursing students because of their NRC role and organisational employment, regarding such individuals as 'one of us', and thereby compensate for any adverse perception of the placement design affecting the implementation of a student's practicum.

13.5 Potential issue: insufficiently sensitive measurement tool

Satisfactory fulfilment of all relevant competences is necessary for a student to successfully complete their studies on any PRNP delivered within the UK and thereby become eligible for entry to the Nursing & Midwifery Council [NMC] register. The level of proficiency a learner displays in respect of their nursing skills, however, is not a factor which influences the classification of degree they are awarded. In respect of the curricula underpinning the PRNPs of students featuring within this study, the NMC (2010, p.82) state educational

institutions must ensure that '*outcomes, competencies and proficiencies of the approved programme are tested using valid and reliable assessment methods.'* Similarly, guidance in respect of current UK PRNP curricula stipulate such providers must demonstrate *'assessment is fair, reliable and valid to enable students to demonstrate they have achieved the proficiencies for their programme'* (NMC, 2023a, p.12).

Nonetheless, in both instances this regulatory body imposes no obligation on universities to employ assessment techniques which have sufficient sensitivity to discriminate between different *levels* of satisfactory competence/proficiency. Indeed, Dawson (2018, p.150) comments that all UK nursing students *'have to meet the same level of clinical competence at the end of their training.'* Efforts are not, therefore, normally made to identify learners exceeding, rather than simply meeting, this level of competence and to what extent they demonstrate skill beyond any minimum requirement.

If a student's clinical proficiency is normally determined only by assessment against NMC competency standards which the individual is deemed either to have met or not yet demonstrated, it is plausible that exposure to a specific practicum model may affect learner proficiency but simply being based on fulfilment of minimum standards, the current approach to practice assessment is too blunt an instrument to capture such difference. Most competence assessment for UK PRNP undergraduates is undertaken by a registered nurse [RN] whose primary role is associated with the provision of nursing care, not student education. Whilst assessment by practitioners may enhance the clinical credibility of decisions regarding learner competence, it may also necessitate a less resource-intensive approach which removes scope for more sophisticated measurement of degrees of proficiency.

The objective structured clinical examination [OSCE] has been used in both pre-registration and postgraduate nursing courses since the 1970s (Liddle, 2014). It is not a required assessment approach within UK PRNPs and, where implemented, tends to be only a supplementary tool to assess the student's clinical ability. Nevertheless, an OSCE is one of a two-part *Test of Competence* which the NMC requires all RNs and midwives who gained their qualification outside the UK to successfully complete as a pre-requisite for entry to the register (University of Northampton, 2019).

Whilst OSCEs vary in their format and structure (Dawson, 2018), they are commonly employed to identify whether an individual simply meets a competency standard and so often may not be sufficiently sensitive to measure increasing levels of expertise (Wood & Pugh, 2020). Some institutions, such as the University of Arizona (2019) and University of Woollongong (2014), however, apply a more sophisticated grading rubric to such tests. Cost, consistency, and workload considerations may make routine application of such graded student performance assessment tools within UK PRNPs impractical. This is unfortunate, since it might be one approach with sufficient sensitivity to highlight any differences in the level of clinical competence achieved by students experiencing the two different practicum designs.

13.6 Potential issues: other variables associated with exposure to a specific practicum design

In those interviews undertaken within this research it was evident that some, but not all, OU PRNP students participated in the selection of a placement model to underpin their clinical learning experiences. Unfortunately, within the quantitative analyses of this study it was not possible to establish whether individual learners were involved in the selection of the practicum framework they experienced and therefore whether a practice learning model may have a significant positive impact on retention/achievement in those instances where the student chose, or at least contributed to, its selection.

A practicum model could also influence other measures associated with a learning experience not examined within these quantitative analyses. For example, a placement may affect the extent to which practitioners in this setting value the student's contribution to service provision and thereby indirectly influence a learner's self-esteem, self-efficacy, receptiveness to learning opportunities and, ultimately, their competence/performance. A placement design might also affect the individual's transitional experiences and capability when commencing practice as an RN. Given evidence indicating nurses often leave the discipline within a year of qualification (Flott & Linden, 2016; Tsang et al., 2016; Wong et al., 2018) [see Chapter 5] and, in countries including Canada, the UK and the United States of America, such departures may account for between 30% and 60% of new nursing graduates (Lydal, 2021; Wray et al., 2021), it would be interesting to examine

whether consistent exposure of PRNP students to a specific practice learning model has any effect on how many leave the discipline as newly qualified nurses.

13.7 Key implications of the quantitative findings

In contrast to the sample used within the quantitative analysis, which included PRNP students from various locations in the UK, interviewees were all based in northeast England and Cumbria. The apparent incongruity between an overall preference for a block practicum identified within interviews and the lack of any statistically significant data to suggest this model has a beneficial effect on student retention/achievement might, therefore, be attributed to geography. Since stakeholder-specific roles within both the National Health Service and The OU have a high degree of consistency across the UK, NMC standards and the PRNP curricula are the same for all four nations and there is no geographical variation in university programme entry requirements, however, it seems unlikely that location would affect stakeholder preference. Setting aside possible issues related to confounding variables, the sensitivity of measurement tools, and other dependent variables not considered within these quantitative analyses, it is necessary to consider the implications of these results if they are taken at face value.

Traditionally, higher education institutions have most commonly delivered practice learning based on a block model (Humphries et al., 2020; Kirkman et al., 2022). Increasing student numbers on pre-registration programmes within various health professions, however, have intensified demand for healthcare placements (Imms et al., 2017; Kessler et al., 2021; Markowski et al., 2021). In England, the introduction of employment-based programmes enabling learners to acquire a nursing degree and join the professional register, termed *Nursing Degree Apprenticeships* [NDAs], have created an extra challenge, namely addressing the requirement for 20% of an apprentice's paid employment to be regularly set aside for off-the-job learning (Department for Education, 2019). Recently, curriculum designers in this nation have therefore been compelled to consider complementary use of alternative practicum models to optimise placement capacity, accommodate NDA needs, and ensure supply continues to meet demand.

As a result, more UK universities now appear to be using, or planning to use, integrated placements within their nursing curricula. Nonetheless, consideration and implementation

of structural changes to practice learning have so far been undertaken without almost any empirical evidence being available to indicate if student exposure to a specific practicum design might impact on retention/achievement. Results from these quantitative analyses, however, suggest neither programme withdrawal rates nor degree classifications are affected in any statistically significant way by use of block or integrated placements and so, in terms of these output measures, curriculum designers need not be concerned about employing either practicum model. Moreover, development of undergraduate apprenticeship provision within other health and social care disciplines, including dentistry (Health Education England, 2021b), dietetics (British Dietetic Association, 2022), medicine (Health Education England, 2021c), occupational therapy (Royal College of Occupational Therapists, 2022), paramedic practice (Skills for Health, 2017), pharmacy (Pharmacists' Defence Association, 2022), physiotherapy (NHS Careers, 2022), podiatry (Royal College of Podiatry, 2022), radiography (Health & Care Professions Council, 2022), social work (Skills for Care, 2022) and speech and language therapy (Royal College of Speech & Language Therapists, 2023) is likely to increase the wider level of interest in such findings.

13.8 Conclusion and the potential limitations of quantitative analysis within critical realist research

The apparent absence of any statistically significant effect of a practicum design upon the identified performance measures within this phase of the study might be attributable to the sample size, the atypical characteristics of OU nursing students, a moderating effect of mentor and wider stakeholder disposition, the extremely limited consideration of proficiency levels in the completion of PRNP degrees and/or the selection of dependent variables. It would, therefore, be interesting to see if similar quantitative findings are identified amongst larger cohorts of more conventional open-entry nursing students based in other UK universities or academic institutions who have been exclusively exposed to either block or integrated placements and whether practicum design might affect other variables. Nevertheless, by helping to fill an apparent lacuna in this investigative field, these results may be reassuring to those UK academic institutions and healthcare providers who have recently introduced NDAs, other apprenticeships and/or sought ways to increase placement capacity and, as a result, are now using integrated practice learning experiences within PRNP and other health and social care courses.

In closing discussion regarding this phase of the study, it would perhaps be inappropriate not to acknowledge the scepticism some critical realist researchers express regarding use of any quantitative methods within an investigation. As noted earlier [see Chapter 2], several writers question the value of applying such tools because they cannot uncover underlying causal mechanisms and so may primarily have only descriptive value (Hastings, 2021; Kirby, 2013; Zachariadis et al., 2010; Zachariadis et al., 2013). Such researchers might, therefore, claim detailed analysis and discussion of quantitative data within this study is a distraction from the more important qualitative and theoretical analyses. The next chapter of the thesis turns attention towards those theories which may help identify potential causative mechanisms affecting practicum model preference/experience.

Chapter 14. Possible theories as causal mechanisms

14.1 Introduction

Within critical realist research, causal explanation is much more important than description (Wilson & McCormack, 2006) and researchers are expected to examine potential theories for their explanatory power to account for results (Parpio et al., 2013). The initial qualitative content analysis undertaken in this study [see Chapter 10] produced a set of key considerations to determine the potential suitability of a practicum model for an employer sponsored nursing student, as well as a series of institutionally specific recommendations [see Chapter 11]. It did not, however, address the fundamental critical realist goal of identifying potential causative mechanisms.

In the context of this research, the most compelling causal explanation would arguably be provided by a theory which offers sufficient detail to account for the widest range of experiences/impressions directly and indirectly associated with practice learning, as expressed by participants both within this study and in earlier research [see Chapters 5-7 & 10], and one which is able to do so in a coherent, precise, and comprehensive way. This is likely to necessitate explanation of the ways in which social, cultural, environmental, interpersonal, and intrapersonal variables may impact upon such encounters/perceptions. In some respects, these criteria correspond with those proposed by Billett (1992, pp.151-152), who suggests a robust theory of workplace learning '*would have both a specific and general theoretical utility'*, *'stand outside of the existing model of learning through formal settings'*, have *'a role for the learning process based around observation, imitation and mediation'* and explain how the potential of a setting for effective workplace learning can be realised.

Six key theories derived from multiple literature searches in respect of this study appeared potentially useful in determining what may be the most influential mechanisms affecting practice learning within nurse education; namely the *distributed practice effect*, c*ontextual interference effect*, s*ituated learning theory*, s*ocial identity theory, sociocultural activity theory*, and the *theory of human relatedness*. To date it is questionable, however, as to the extent each theory has been shown to support use of block or integrated practicum models

within pre-registration nursing programmes [PRNPs] or been applied in a manner which fully explains the potential causal mechanisms associated with practice learning. This chapter of the thesis seeks to briefly describe each of the identified theories, consider their application to practice learning, and appraise the extent to which they appear able to satisfactorily address all of the variables which may affect practice experiences/views identified earlier.

14.2 The distributed practice effect [DPE] and contextual interference effect [CIE]

The DPE, also termed the *spacing effect*, is one of the most researched and widely recognised memory effects in cognitive psychology (Küpper-Tetzel, 2014). Essentially, this effect suggests increased time between practice opportunities improves retention of information (Tenison & Anderson, 2017) and Benjamin & Tullis (2010, p.228) claim *'the advantages provided to memory by the distribution of multiple practice or study opportunities are among the most powerful effects in memory research.'* Moreover, Simmons (2017) argues the beneficial effects of distributed practice have been identified in the development of numerous motor skills and Kaipa et al (2020) assert that similar advantages have now also been observed in cognitive-based tasks.

Various explanations for the DPE have been presented, including the possibility spacing facilitates learning by stimulating changes in cognitive processing (Tenison & Anderson, 2017). For example, Küpper-Tetzel (2014) suggests studying a piece of information repeatedly may lead to storage of a range of different contextual components related to the information within its memory trace and subsequently any overlap between the contextual components that are present during a final test session and the ones stored in memory enhances an individual's performance.

Kaipa et al (2020, p.17) examined retention of eight novel French utterances by 50 native English-speaking participants randomly assigned to massed or distributed practice groups. Their findings suggested *'participants involved in distributed practice demonstrated better learning over participants involved in massed practice'* and postulated that distributed practice was superior in consolidating memory. Work by Simmons (2017) investigated the effect of time intervals between practice sessions on musicians' learning and found that, amongst 29 non-pianists, significant performance improvement was observed when

practice sessions were separated by a period of 24 hours rather than either 5 minutes or 6 hours. Cepeda et al (2009) claim many studies examining the DPE indicate a gap of one day from exposure to a learning experience and testing of learning optimises performance but note that very little robust work has been undertaken to examine the DPE over longer periods. Their laboratory studies measuring recall of foreign vocabulary, facts, and names of visual objects included test delays of up to six months and found that learning was optimised by gaps of months, rather than days or weeks, between learning sessions.

Merbah & Meulemans (2011) highlight a related concept, the CIE, which refers to the advantage of a 'random' over a 'blocked' practice condition in skill learning tasks but conclude that field-based studies have so far consistently failed to demonstrate this effect. Research by Cheong et al (2010, e42) on the acquisition of hockey skills for players with no prior game experience, however, challenges this assertion. Their investigation discovered *'the random group practicing in a random practice order was more accurate than the block and randomised-blocks groups practicing under repetitive or combination conditions respectively'* and so supports CIE beyond the laboratory environment.

If improved practice learning results from intervals of several days between a learning experience and a subsequent learning experience/test, then this appears to suggest the integrated practice learning model is a preferable PRNP placement design. If, however, gaps of weeks or months between a learning experience and a subsequent learning experience/test optimise learning, then this seems to support block placements as the best structural option. Alternatively, if random practice/testing is most beneficial then a combination of both models might be desirable.

At present, however, the type of tests undertaken in this area and the limited available evidence in comparable field-based studies means the relative strengths of both practicum designs in respect of the DPE and CIE remain unclear. More importantly, these theories do not fulfil most of the proposed criteria for a compelling causal explanation of the encounters/impressions of students exposed to practice learning detailed at the start of this chapter. Arguably, they are simply too narrow in scope to explain the diverse range of factors which may affect nursing student practice learning experiences/perceptions as reflected in the responses of stakeholders interviewed within this study and those

participating in previous research [see Chapters 5-7 & 10]. In this instance the DPE and CIE are not, therefore, afforded any further consideration.

14.3 Situated learning theory [SLT]

'Knowledge is not only contained within written texts, but also within disciplinary and professional organisations, in institutions and in social relationships' (Harden, 1999, p.209). Congruent with this assertion, the concept of *informal learning* describes *'the learning that takes place in the spaces surrounding activities and events with a more overt formal purpose.'* Such learning is commonly invisible; either because it is taken for granted or simply not recognised as learning (Eraut, 2004, p.247). Within nurse education, it has been argued there is a need to acquire a better understanding of the social structure of the professional learning community (Bergjan & Hertel, 2013); not least because the largest element of a nursing student's learning experiences may be informal and unplanned (Wotton & Gonda, 2004) and *'clinical practice is where student nurses are socialised into a professional role and acquire the distinct behaviour, attitudes and values of the nursing profession'* (Thomas et al., 2015, e4).

Some theories therefore regard informal learning as far more influential than formal education. For example, SLT *'focuses on understanding learning contexts rather than individual learning styles'* (Fairbrother et al., 2016, p.46), proposing that learning is primarily embedded in the social relationships and linguistic processes that predominate within a culture and that effective socialisation within a *community of practice* [CoP] is fundamental to a newcomer achieving full legitimate status (Lave & Wenger, 2002). Additionally, '*the identity of the novice or beginner is built through performing tasks and the subsequent reflection and automatization of the new concepts and activities'* (Martínez-Arbelaiz et al., 2016, p.528). SLT claims *'it is the social situation, social practices and social relationships that create the possibilities for learning'* (Wisdom, 2011, p.13) and these influences are inseparable from the nature of learning (Whiting, 2009).

A CoP is not a specific physical environment, nor a clearly defined social or occupational group, but *'an activity system about which participants share understandings concerning what they are doing and what that means for their lives and for their communities*' (Lave & Wenger, 2002, p.115) and is oriented by mutually held historical and social resources

(Wareing, 2012). The CoP enables novices and experts to interact with one another (Booth et al., 2007) and it is considered natural for these participants to discuss their experiences and knowledge in various ways (Smith & Gray, 2001; Choi, 2006). For example, storytelling enables participants to *'contribute to the construction and evolution of "communities of interpretation" and through the continued development of these communities, the shared means for interpreting complex activity is formed, transformed, and transmitted'* (Murphy & Schwen, 2006, p.539). From an SLT perspective, learning is not, therefore, a passive process treating the uninitiated as empty vessels to be filled (McClimens et al., 2013) but one in which the newcomer both affects, and is affected by, the CoP; *'acquiring the shared repertoire and displaying it through participation in social activities'* (Martínez-Arbelaiz et al., 2016, p.527). Effective student learning does not always occur automatically within a CoP but may instead be a dynamic process that requires nurturing (Morley, 2016) through, for example, access to effective role models, peer support and pre-entry placement preparation (Bifarin, 2016; Houghton, 2014).

Watts (2009, p.687) argues *'becoming a professional involves the undertaking of professional education and training that are founded on a broad base of learning and culture that serves as a professional apprenticeship'*; hence cultural awareness of, and social interaction within, a discipline are deemed fundamental to understanding the principles of professional practice. Indeed, Rennie (2009) concedes that, within nursing, it is difficult to determine if clinical skills training or the placement environment has the greatest effect upon practice learning. For new entrants to a discipline, learning within a CoP involves participating in socially valued activities and, in so doing, *'facilitates a move from being at the fringes of a community to engaging in more centralised performances'* (Linehan & McCarthy, 2000, p.437). Such *legitimate peripheral participation* [LPP] within a CoP is fundamental to an individual's acceptance, integration, and professional learning. Hence, within SLT it is participation, rather than experience, that is deemed to be the primary determinant of learning (Quay, 2003).

LPP is also seen as a pre-requisite in moving towards recognition as a member of the CoP, professional mastery (Hall, 2006) and '*full participation in the socio-cultural practises of a community'* (Mikkonen, 2005, p.23). These assertions are supported by research involving interviews with 12 occupational therapy students at a United Kingdom [UK] university, who

spoke of the need to *'play the game'* or become *'aware of rules, both written and unwritten, and learning to conform to (or at least comply with) the systems in place*' (Clouder, 2003, p.217). Similarly, Ousey (2007, p.39) interviewed 15 adult nursing students in the UK about their placement experiences and discovered '*when they learn the language, they begin to feel part of the ward team as they can communicate with other members of the staff in their own language.'*

A study in Scotland using semi-structured interviews to explore the clinical practice experiences of a purposive sample of 10 final year nursing students reported respondents believed they were valued as team members when they were directly involved in legitimate nursing activity (Anderson & Kiger, 2008). In Australia, Newton et al (2009b, p.632) found it was only by contributing to the work of a ward team that nursing students became accepted by other practitioners in their practicum and allowed these learners to develop their initial status as a peripheral team member. Furthermore, interviews with eight final year nursing students in Norway exploring learning experiences in a nursing home placement identified the importance such learners assigned to being invited into the working community, offered planned situated learning, engaging in professional dialogues, and having co-responsibility and supportive mentoring (Jacobsen et al., 2020).

According to SLT, apprentice competence is acquired through knowledge and understanding of the practice culture by interaction with both peers and masters, rather than simple mimesis [observation and imitation], but masters in a setting may also act as gatekeepers regarding opportunities for LPP (Lave & Wenger, 2002). Within nurse education, mentors, and to a lesser extent the wider body of registered nurses, are arguably masters within a practicum and so nursing students may strive to ensure their actions align with those promoted in the immediate CoP to optimise scope for their LPP. Congruent with the assumptions of SLT, Thomas et al (2015, e5) assert *'professional socialisation remains fundamental to the practice of nursing'* and '*if negative consequences occur during its process at the beginning of a student nurse's journey, they may well impinge on their ability to nurse and to ultimately provide care.'* From an SLT perspective, therefore, the most desirable practicum model which a PRNP could employ would arguably be one which best facilitates LPP, promotes professional mastery and ultimately leads to effective socialisation, and full participation, within the CoP.

Also harmonious with the propositions of SLT, it has been argued that care quality (Arkan et al., 2018) and practice learning (Lee et al., 2018) may be enhanced by students having long placements. Indeed, research by Warne et al (2010) concluded that students whose participation in the nursing process occurs over prolonged periods and with the same patients may acquire a better understanding of the role of the nurse than those simply undertaking a series of disconnected tasks during a shorter practicum. They also noted that a longer placement enhanced overall student satisfaction, created a stronger learning culture in the clinical setting, and improved the quality of supervisory relationships.

In Ghana, research using focus groups to explore the practicum experiences of 40 nursing students and 15 nurses found concerns about use of a specific practicum model were unrelated to its effectiveness in developing clinical competence and were instead associated with its impact upon *'comfort issues'* (Salifu et al., 2022). Whilst the researchers did not specifically identify the nature of these *'comfort issues'*, it seems reasonable to assume that these may be associated with socialisation and participation within the CoP.

Morley (2016) claims that whilst the value of SLT has been widely acknowledged, it has had little impact on practice learning within the UK and Fuller & Unwin (2003) criticise the theory for failing to indicate any clear role for formal education institutions within the new entrant's learning process. In the context of this study, SLT offers potential explanations for some of the factors which may shape the nature, extent, and views of learning in a practice setting. Arguably, however, it fails to explain how LPP and professional mastery within a CoP may affect the views/encounters of placement stakeholders in any precise and comprehensive way.

In addition, the theory's focus on social processes means it is unable to account for variation which may be attributable to individual differences; for example, why the same placement may be evaluated very differently by participants within the same stakeholder group, or problems experienced by an individual being attributed to their own perceived knowledge and/or skills deficit. Furthermore, SLT does not address any effects arising from the inevitable interrelationship between other aspects of a student's life and their practicum experiences, commonly highlighted by respondents in this study and those in earlier investigations as factors affecting their workplace learning [see Chapters 5-7 & 10].

14.4 Social identity theory [SIT]

Whilst '*little research has been conducted into the development of the professional identity of nurses'* (Willetts & Clarke, 2014, p.165), written records provide one method by which to understand the culture of a profession (Williams & Sibbald, 1999). Yap et al (2014, p.242) claim the cultural identity of nursing is evident in its *'values, visions, norms, nomenclature, systems, symbols, beliefs, and habits'*, and this identity affects the way nurses interact with one another, different professional groups, those receiving care and other stakeholders. SIT, developed by psychologists Henri Tajfel & John Turner in the 1970s and early 1980s, suggests social identity emerges from '*people's identification with the groups and social categories to which they belong'* (Crocetti et al., 2014, p.282). Each social category [such as a work group], into which an individual either falls or feels an association, provides a definition of who this individual is in terms of the defining characteristics of this category (Hogg et al., 1995).

SIT argues social identification initially involves the formation of *'a reflexive knowledge of group membership'* [acquired, for example, via professional education and training] and then the development of *'an emotional attachment or specific disposition to this belonging'* [for example, through subsequent practice experience] (Benwell & Stokoe, 2006, p.25). Categorization and a drive for self-enhancement affects an individual's beliefs about relations between their own *ingroup* and identified *outgroups*; accentuating both the perceived similarities between the individual and other ingroup members and their differences to outgroup members (Stets & Burke, 2000). Although these differences may have no basis in reality, they still affect how group members behave in order to enhance their sense of self (Hogg et al., 1995).

According to SIT, individuals seek to acquire and maintain a positive and secure social identity (Hornsey, 2008) and enhance their self-esteem by making favourable comparisons between the social group to which they belong, the ingroup, and other different relevant outgroups (Brown, 2000); a process known as *social comparison* (Skevington, 1981). This often leads outgroups to be reductively characterised by members of the ingroup, leading to stereotyping and prejudice (Benwell & Stokoe, 2006). According to SIT, a member of a low status group can acquire a positive social identity, an action called *social change* (Skevington, 1981), by various means. These include making comparisons that are more

flattering to the subordinate group, downplaying the less desirable aspects associated with their group, seeking to overturn the existing hierarchy (Hornsey, 2008), reinterpreting aspects of the group in positive ways, or highlighting new, distinctive, or desirable dimensions about the group (Skevington, 1981). Members of an inferior group may even choose to enhance their self-esteem by leaving it (Hornsey, 2008).

From a SIT perspective, the most appropriate placement model may be one that best enables nursing students to form strong, positive, emotional attachments with members of the clinical team within a practicum, identify themselves as members of this group and perceive it as having high social status. Presumably when learners feel no affinity with placement staff, however, they may instead create a social identity based upon membership of another group; for example, being an undergraduate within the university or a member of the nursing student group in a practicum. Such conditions might lead students to regard practitioners within their practicum merely as members of an outgroup with whom they are compelled to interact. Moreover, these perceptions could lead them to hold negative views of this staff group, be challenging towards them, critical of their practice and/or the service they offer and adversely affect their practice learning.

Vinales (2015, p.534) claims that the failure of a nursing student on placement to identify themselves as part of the team *'has the potential to hinder his or her learning and ability to progress from the theoretical elements of nurse education to the practical elements of nursing in the real world'* and various studies appear to support this assertion. For example, a UK survey completed by 6,329 healthcare students across clinical learning environments in northeast England and Yorkshire found over 25% of respondents who were unlikely to recommend their practicum said this was because it had not felt inclusive; whilst over 55% of respondents who indicated they were likely to recommend their placement would do so specifically because it had felt inclusive (Health Education England, 2021a). Similarly, interviews in Norway with five physiotherapy interns and five third year physiotherapy students highlighted feeling both welcome and included as one of four key descriptive categories yielded by the study (Skøien et al., 2009). Perhaps such responses reflect the extent to which these learners acquired a positive social identity as a member of the clinical team within their practicum.

Despite the potential value of SIT to examine the relationship between nursing students and practitioners within a practice learning environment, several limitations of this theory have been highlighted. Whilst SIT has been used to retrospectively explain intergroup activity it has been much less effective in predicting such behaviour (Korte, 2007) and research has so far not provided evidence of a strong correlation between the individual's self-esteem and the perceived status of their ingroup (Brown, 2000). Hogg et al (1995) add that SIT fails to explicitly articulate the specific psychological and social factors involved in group processes.

This theory recognises both psychological and interpersonal dimensions which may be relevant to explaining stakeholder encounters/impressions of practice learning. Clearly, identity may affect, and be affected by, an individual's environment; thereby shaping both the nature and perception of their experiences. SIT, however, does not appear to satisfactorily account for several key identity-related phenomena reported by interviewees within this investigation and earlier studies. For example, during interviews, some nursing students described positive feelings associated with the absence of any group involvement during a practicum [and, presumably, an associated lack of fundamental identification with the practitioner group in this setting], situations where one-to-one relationships, rather than group identity, were seen as most important, or where negative experiences were attributed by the individual to personal feelings of inadequacy rather than a failure to identify themselves as a member of the clinical team [see Chapters 5-7 & 10]. As a comprehensive and precise causal mechanism for placement experiences it seems that SIT can, therefore, also be set aside.

14.5 Sociocultural activity theory [SAT]

SAT seeks to recognise and elaborate upon the interplay between cognitive and social factors to explain concepts such as workplace learning. It proposes that the goal-directed behaviour individuals display has historical and cultural origins, but that engagement in specific activities may trigger cognitive re-evaluation which affects development and future performance (Billett, 2003). This theory proposes that '*human consciousness develops within practical social activity settings in which relations between human agent and environmental objects are mediated by tools.'* An educator is therefore regarded simply as an element of the larger social setting, but one who provides pedagogical tools

to mediate such relations. Repeated use of and/or exposure to these tools ultimately leads individuals to internalise ways of thinking in respect of specific practices within a culture or discipline, a state termed '*appropriation*'. Such appropriation occurs on a continuum, ranging from achieving mastery to a complete lack of any internalisation of practices (Dang, 2013, p.48).

The sociocultural setting is comprised of various components, including the *object*, *community*, *rules*, and *division of labour*. The object refers to the desired goal/s to be achieved within the activity system [for example, the delivery of high-quality nursing care within a health service]. The community is the membership within this activity system [for example, students, supervising staff, and other practitioners]. Rules are the '*regulations, norms, and conventions that constrain actions and interactions*' within the workplace activity [for example care plans, clinical procedures, and modes of inter-professional working], whilst division of labour reflects the nature of working relationships between different members of the community and the associated power dynamics within these relationships (Dang et al., 2022, p.420). According to SAT, the nature and extent of an individual's workplace learning is therefore affected by the interplay between their earlier experiences and personal characteristics with the object, community, rules, and division of labour in this environment.

Arguably, the most desirable practicum model from the perspective of SAT may be one which most effectively accommodates the learner's cultural and historical perspective, provides specific activities to develop cognitive re-appraisal of this individual's behaviour [and, in so doing, enhances their appropriation and proficiency], best promotes their understanding of the object and rules, facilitates supportive interaction between members of the community, and involves a positive division of labour. How such conditions can be created, however, appears less clear.

Billett (2011, p.52) claims that in the context of workplace learning, SAT provides valuable recognition of the *'relational interdependence between personal and social factors and contributions'*, whilst Gamble (2013) adds this theory has encouraged a move away from a narrow focus upon standards-based approaches to learning with one that considers the active processes of knowledge construction. Moreover, several studies support its efficacy in explaining workplace learning. Greenhouse (2013) discusses how SAT provides a

framework to help understand how activity within a multi-agency team may be restructured, giving appropriate regard to cultural and historical changes in practice. Similarly, research by Dang (2013) applied this theory to explain the multiple difficulties student teachers in Vietnam experienced during a practicum and the way their professional identities evolved.

Indeed, some investigations drawing upon SAT have even specifically concentrated on the learning experiences of nursing students. In the United States of America [USA], Munyaka (2017, p.53) undertook mixed methods research involving 882 participants, 41.5% of whom were nursing undergraduates, to examine learner success and persistence on two introductory biology courses. The work highlighted the central '*roles that participation in social interactions and culturally organized activities play in influencing psychological predispositions*' and ultimately whether students successfully completed or failed/withdrew from these courses. In Saudi Arabia, Newton et al (2018) used semi-structured interviews to explore the value/benefit of continuing nurse education [CNE] provision. The study, which employed SAT as its conceptual framework, involved six registered nurses and five nurse managers. Results suggested that the value of CNE courses was affected by an individual's personal knowledge and learning style but also by a range of sociocultural variables in the workplace, including the diversity of staff skills, language barriers, and work schedules.

SAT recognises a more extensive range of intrapersonal and sociocultural influences upon workplace learning than any of the earlier theories described in this chapter. Nevertheless, in a similar way to SLT, the theory only appears to focus upon such influences in the context of the practice setting and so largely overlooks the way other concurrent aspects of an individual's life beyond this environment may affect their placement experiences. Such a restriction is very concerning, given that interviewees within this study, and indeed those in numerous earlier investigations, often highlight how a range of social, domestic, work related and financial issues outside the placement setting may significantly affect their practicum experiences/perceptions and in so doing affect the nature and quality of clinical nurse education [see Chapters 5-7 & 10].

14.6 The theory of human relatedness [THR]

Originating from mental health nursing and initially developed to explain variation in the prognosis of psychiatric disorders, most notably depression, the THR addresses psychosocial mechanisms associated with human development and wellbeing. In common with SLT, SIT and SAT, it recognises a social dimension to learning, but places greater emphasis on '*establishing and maintaining relatedness to others, objects, environments, society and self*' (Hagerty et al., 1993, p.291) and the importance of an individual's sense of belonging within individual growth and development (Hagerty et al., 1996). Relatedness is regarded as a universal phenomenon over which people have choice and responsibility, but one affected by factors such as race, culture, age, and sex. Individuals assign meaning to their experiences of relatedness based upon their sense of self and the comfort or discomfort they feel as a result of that involvement. It is argued people also have more sensitive periods when their relatedness experiences may be greatly influenced by social interactions (Hagerty et al., 1993) and disruptions to an individual's sense of relatedness can adversely affect their physical, psychological, social, and spiritual wellbeing (Potter-Dunlop, 2017; Silvas, 2013).

Whilst there are multiple definitions of the term *wellbeing*, Dodge et al (2012) argue many merely identify its dimensions rather than state its meaning. A more recent definition of the term by Simons & Baldwin (2021, p.990), however, appears to avoid this criticism by suggesting that wellbeing can be regarded as '*a state of positive feelings and meeting full potential in the world. It can be measured subjectively and objectively using a salutogenic approach.'* This definition suggests wellbeing may be affected by any factors influencing the individual's emotional state and scope to optimise their capability. It also implies it is closely associated with health and can be ascertained by reference to personal experiences and accounts, or use of independent, external measurements.

The THR proposes four states of relatedness, namely *connectedness*, *disconnectedness*, *parallelism,* and *enmeshment* (Betz, 2004). Connectedness describes an individual's active involvement with another person, object, group, or environment that generates a sense of comfort, wellbeing, and a reduction in anxiety (Levett-Jones et al., 2009b). Disconnectedness occurs when a lack of active involvement leads someone to experience anxiety, distress, and reduced wellbeing. Conversely, parallelism refers to situations when

a lack of involvement is experienced as comfortable and promotes a sense of wellbeing; whilst enmeshment refers to conditions in which active involvement generates discomfort and anxiety (Hagerty & Patusky, 2003).

Four processes or social competencies; a sense of *belonging*, *reciprocity*, *mutuality*, and *synchrony*, promote an individual's sense of relatedness (Strobbe et al., 2012). Belonging describes the extent to which a person feels an integral part of a system or environment, whilst reciprocity reflects the *'individual's perception of an equitable alternating interchange with another person, object, group, or environment that is accompanied by a sense of complementarity.'* Mutuality refers to situations in which a person believes they share a vision, goals, sentiments, or characteristics with others; whilst synchrony occurs when a person's experiences are congruent with her/his internal rhythms and their interaction with the external world (Hagerty et al., 1993, p.294).

During the three decades since the THR was first proposed, there has been growing interest in its principles. Application of the theory to other fields of nursing practice, such as adult physical healthcare (Latimer, 2013), paediatrics (Boynton & Vis, 2011) and palliative care (Hansen et al., 2015) have been considered. Various studies have also drawn upon it in fields such as the treatment of alcohol dependency (Strobbe et al., 2012), factors related to chronic fatigue (Jorgensen, 2008), post-traumatic stress (Meagher, 2006), prevention of depression (Wilczyńska et al., 2015), the emotional effects of traumatic brain injury (Bay et al., 2005) and counselling via technology (Alvandi, 2019).

Furthermore, the THR has been applied more widely in work examining social processes associated with connectedness and consumption (Arias, 2016), loneliness in college (Asher & Weeks, 2014), youth identity and belonging (Glozman, 2015), compulsive internet use (McIntyre et al., 2015), disconnectedness amongst senior high school students (Catacutan et al., 2022) and belonging in older adults (Allen et al., 2021). It has also featured in research addressing relatedness within both a multi-disciplinary team (Nutt, 2015) and a high-performing amateur choir (De Loo & Kamminga, 2021), connectedness amongst middle school pupils (Karcher & Lee, 2002), event-generated dependence (Patusky, 2007), and undergraduate persistence in virtual communities (Laux et al., 2016).

A survey in the USA involving 1,296 National Student Nurses Association members found a strong sense of belonging in a placement had a positive impact on student learning, motivation, and confidence (Grobecker, 2016), whilst other studies have also highlighted the importance learners assign to achieving a desirable work/life balance (Birks et al., 2017; Boardman et al., 2019). Using interviews, a focus group and analysis of student journals involving a purposive sample of 12 fourth year PRNP students and six preceptors, Sedgwick & Yonge (2008, p.8) sought to describe student and preceptor experience of a remote rural clinical practicum in Canada. The researchers concluded that, for many learners, acceptance by staff was regarded as more important than the type of clinical experience and '*the importance of being a team member in the rural hospital setting where the nature of nursing practice is described as 'we work as a team', 'we're it', and 'we're family' is crucial'*. Similarly, more recent research involving focus groups attended by 19 final year nursing students in the United Arab Emirates found students commonly felt they were '*treated as part of the family in their clinical practicum'* and valued this inclusive atmosphere (Dias et al., 2022, p.5). Such findings may, therefore, be seen as reflecting the key propositions of connectedness, belonging, reciprocity, mutuality, and synchrony captured within the THR.

A systematic review of socialisation among undergraduate PRNP students by Salisu et al (2019, p.6) found '*nursing students face career-related challenges such as discrimination, disrespect and being isolated by other members of the nursing profession during training*', leading them to become withdrawn and less interested in their programmes. Semi-structured interviews with 18 nursing students in two Australian and one UK university found *'staff-student relationships (including receptiveness, inclusion/exclusion, legitimization of the student role, recognition and appreciation, challenge and support) were the most important influence on students' sense of belonging and learning'* and the findings were common to learners across all three educational institutions (Levett-Jones et al., 2009a, p.316). Concerningly, participants also spoke of conforming to clinical practices during a practicum that they knew to be incorrect to avoid '*rocking the boat*', being viewed as an outsider and endangering '*their precarious sense of belonging'* (Levett-Jones & Lathlean, 2009, p.348). Arguably, such findings may be deemed to evidence the THR concepts of disconnectedness and enmeshment.

If the underpinning assumptions of the THR are accepted, one might reasonably assert that the ideal practicum model for PRNP students is one which best promotes connectedness, belonging, reciprocity, mutuality, and synchrony, and prevents disconnectedness, enmeshment, and a need for parallelism. Preliminary examination of the THR suggested that, compared to the other theories described in this chapter, its propositions appeared to capture the broadest range of psychosocial dimensions which might determine stakeholder views/experiences of practice learning; highlighting the importance of various intrapersonal, interpersonal, social, and environmental factors, both within and beyond the workplace assigned for practice learning and reflected in the responses of interviewees within this study and earlier investigations [see Chapters 5-7 & 10]. It appears, therefore, to offer the greatest potential explanatory power in accordance with those criteria identified at the start of this chapter. Nevertheless, this initial assessment needed to be examined more robustly.

14.7 Conclusion

In accordance with the principles of critical realism, the researcher sought to examine data generated within this study to determine which underlying mechanisms might best account for earlier research findings via a retroductive process. Ultimately, the work aspired to establish which, if any, of these theories might best support and explain the results of the study within the context of the wider body of knowledge associated with practicum models and the reported accounts of nursing students in clinical settings. The relevance of the DPE, CIE, SLT, SIT, SAT, and THR to explain these findings was the focus of such activity and this preliminary review suggested the THR may provide the most complete theoretical framework to account for student placement experiences/ perceptions. Further work was therefore undertaken to apply the propositions of this theory to the acquired interview data and results from earlier research studies. In so doing, such activity strived to identify whether the THR could indeed offer greater insight into possible causative factors related to the practice learning of employer sponsored PRNP students. This work is detailed in the next chapter.

Chapter 15. The theory of human relatedness as a potential causative mechanism influencing nursing student practicum experiences – seeking to establish the *'why'*

15.1 Introduction

To further examine whether the *theory of human relatedness* [THR] proposed by Hagerty et al (1993) provides a theoretical framework which might go some way towards identifying causative factors related to the practicum experiences of employer-sponsored pre-registration nursing programme [PRNP] students, all of whom are concurrently employed as non-registrant carers [NRCs], interview data derived from the first four phases of this research were re-analysed against the THR propositions. Evidence aligned to the states of relatedness and processes/social competencies of the THR were shared for consideration by three disinterested academics, although no changes were recommended in relation to the preliminary results.

15.2 Results

The purpose of this analysis means relevant anonymised interview data are presented against the four states of relatedness described within the THR, namely *connectedness*, *disconnectedness*, *parallelism,* and *enmeshment* and the four processes/social competencies, i.e., *belonging*, *reciprocity*, *mutuality*, and *synchrony*. As with the earlier qualitative results, wherever possible, examples are drawn equally from all stakeholder groups to facilitate fair dealing. Respondent roles, employer sponsor [E], mentor [M], practice tutor [PT] or student [S] are identified in brackets immediately after each pseudonym. Once again, all actual interviewee words are presented in italics, comments that may enable recognition of any organisations except The Open University [OU] are replaced by generic descriptors, shown in brackets, and terms to facilitate comprehension are provided in the same way.

15.2.1 THR state of relatedness: Connectedness

Within the THR, *connectedness* refers to interactions with other individuals, objects, or an environment producing individual feelings of comfort, wellbeing, and a reduction in

anxiety (Levett-Jones et al., 2009b). Positive experiences of active participation in placements have repeatedly been identified as central to effective practice learning in earlier research (Cornine, 2020; Esmaeili et al., 2014; Nuuyoma & Ashipala, 2018; Siggins Miller, 2012). Congruent with the concept of connectedness, several respondents in this study recognised the need to ensure placement provision promoted student integration and accommodated the needs of the individual learner:

> **Irma** [E]: *'We are very aware that, although student nurses are supernumerary, they are expected to be part of a team'*
>
> **Christine** [PT]: *'It's about fitting the placement to the person'*

Most respondents suggested a block model of practice learning was more likely to facilitate student experiences that promoted a sense of connectedness:

> **Harriet** [E]: [Better if students are] *'able to immerse themselves in a four-week block, experience the shifts, experience how their mentor will work across that working week'*
>
> **Belinda** [E]: *'They* [students] *say that they prefer to come, be a student on block and be a part of the team and be seen as a student and own that identity'*
>
> **Hanneke** [M]: *'She* [student] *found it easier to comfortably slot herself into the team and just really know what was going on with the block placement'*
>
> **Elizabeth** [S]: *'Being a student at the end of my four-week block or whatever, I've very much made good relationships here'*

In contrast, the integrated model was seen as adversely affecting scope for connectedness:

> **Hanneke** [M]: '*If you* [nursing student] *were to do like an integrated placement with ward hours, it would be quite flaky really, you wouldn't be seeing as much of them'*
>
> **Dee** [PT]: *'People* [staff and patients] *on the placement don't actually get much time with the students if they're only there for two days* [integrated model]*, and I think that sometimes can have a negative impact on developing those relationships on placement'*

15.2.2 THR state of relatedness: Disconnectedness

The THR terms a lack of active involvement by an individual within a specific environment as *disconnectedness* and suggests such conditions may cause anxiety, distress, and reduced wellbeing (Hagerty & Patusky, 2003). In earlier studies, examples of disconnectedness within a practicum have included students being excluded from mainstream nursing activity (Minton & Birks, 2019), ignored, or alienated by other staff (Prescott-Carter & Onuoha, 2016), or feeling/being treated as a burden (Radey et al., 2019). Within this study, several employer sponsors were concerned a lack of familiarity with OU PRNPs amongst staff located in placement settings may have adverse consequences for students on these programmes which might propagate disconnectedness:

> **Diane** [E]: *'The students lose confidence in their mentors as well if the mentors feel like 'oh this isn't what I'm used to, I don't know what I'm doing with this''* [student]

> **Irma** [E]: '*They* [OU PRNP students] *are wearing, however, a different uniform to nursing students* [from other universities] *in their more, in previous, you know, and so first of all that makes them look a bit different, and people perhaps then start to think of them a bit differently*'

Unfortunately, some OU PRNP students reported practicum experiences that may have indeed contributed to a sense of disconnectedness:

> **Corinne** [S]: [Mentors have said] *'you're not a proper student because you know what you're doing'*

> **Fatima** [S]: *'From day one they had me, it was written in black and white on the lovely mentor board, and I was written on there as a nursing apprentice* [the individual was not an apprentice], *which I asked them to change but they didn't*'

> **Elizabeth** [S]: [During placements] '*there's times where I've felt a little lonely*'

The tension caused by being an OU PRNP student and an NRC was also acknowledged and so could potentially evoke a sense of disconnectedness during a placement:

> **Fionnuala** [M]: *'Sometimes they* [OU PRNP students] *would like to support the nursing team when we're busy, when we're needing things done, but actually they're not allowed to do that'*

In most instances, respondents appeared to suggest the risk of disconnectedness might be greater during integrated placements:

> **Diane** [E]: *'I think particularly for students who are only going in for two days a week* [integrated practicum]*, they would probably be a bit lower down the priority list from a mentor's point of view. Because they don't know them as well, they're not as invested in them'*

> **Deirdre** [M]*: 'So they* [OU PRNP students on an integrated placement] *miss out maybe on the, they'll come back and say 'oh how's that man' and they'll have died, so they've missed out that bit of continuity'*

Nevertheless, one student suggested a block practicum could be equally problematic in respect of their NRC work:

> **Glynis** [S]: [With block placements] *'I'm pulled out of that, and then put back in. So it's starting again, at least for the first week to get back into how the routine goes'*

15.2.3 THR state of relatedness: Parallelism

Within the THR, *parallelism* refers to situations when a lack of involvement is experienced as comfortable and promotes a sense of wellbeing (Strobbe et al., 2012). Earlier studies exploring the experiences of PRNP learners who previously worked as NRCs have recognised the tendency such students have to revert to their earlier NRC practice during placements to both better respond to service needs [sometimes with the implicit support of nurses in the practice setting] but also because such behaviour felt productive and was comfortable and reassuring to the individual (Arrowsmith, 2016; Brennan & McSherry, 2007; Draper, 2018).

In this research, only limited examples which might illustrate parallelism were evident within the interview data. Nonetheless, several OU PRNP students noted their tendency to revert to their NRC role and independently deliver care in the absence of direction or guidance from placement staff. Moreover, most appeared at ease with such parallel

working if they felt they were making a meaningful contribution to service provision within this setting. Their actions, however, were not always perceived positively by others:

> **Bryanna** [S]: *'Sometimes you can come onto the ward* [placement] *and it's kind of 'oh, you're an auxiliary* [NRC], *you know what you're doing. So, you sometimes get left to your own devices…They* [placement staff] *always say that they can tell that we work on a ward as an auxiliary nurse compared to other students. don't know whether it's just because you just get on with it'*
>
> **Fatima** [S]: *'I have been criticised for being on a ward and just disappearing and getting on with some jobs. Because that's what I've always done as a healthcare*' [NRC]
>
> **Julie** [S]: '*I said oh, during one of the – one of my mentors, I said 'oh how am I doing?*' *She said, 'well actually I forget that you're here because you just get on and do it''*

Demonstration of behaviours which may be associated with parallelism did not appear to be affected by the practicum model to which the student was exposed.

15.2.4 THR state of relatedness: Enmeshment

The THR suggests active involvement of an individual can sometimes generate discomfort, anxiety, and a lack of wellbeing. Such experiences are categorised as *enmeshment* (Potter-Dunlop, 2017). Students being assigned menial tasks during placements (Sun et al., 2016), the unrealistically high expectations of some nurses and teaching staff (Rafati et al., 2020), unapproachable or intimidating clinicians (Budden et al., 2017) and perceived learner incompetence (Tam et al., 2020) have been highlighted as features adversely affecting nursing student practicum activities and thereby potentially contributing to enmeshment. Both employer sponsors and OU PRNP students in this study were concerned that concurrent status as an NRC caused some learners to feel embarrassed about the limits of their knowledge and be less assertive during a practicum:

> **Erin** [E]: *'Healthcare assistants* [NRCs] *who have been student nurses on the traditional programmes, they haven't wanted to admit that they don't know how to do something'*

> **Irma** [E]: *'As healthcare assistants* [NRCs], *you know what your place is, you know what your role is and lots of healthcare assistants feel that their place is not to speak out because that's not the right thing'*
>
> **Damita** [S]: *'I almost feel stupid for not knowing'* [how to carry out a clinical procedure]
>
> **Julie** [S]: *'She* [mentor] *told me that if I didn't take this patient's blood pressure* [despite the mentor not having determined her proficiency to do so] *and anything happened to them it would be my fault'*

One mentor suggested OU PRNP students may also be more likely to be assigned tasks of limited educational value during a placement and their supernumerary status [although a Nursing & Midwifery Council requirement] may be perceived differently to that of open-entry nursing students:

> **Fionnuala** [M]: *'They* [OU PRNP students] *may get given more mundane jobs which aren't really great for their learning…Because they* [OU PRNP students] *are paid members of staff, they are always going to therefore be counted in some form of skill mix and numbers on the wards'*

Indeed, it was even suggested tension and animosity were sometimes evident between OU PRNP, open-entry students, and clinical staff in a placement setting:

> **Beatrice** [M]: 'O*n some occasions, members of staff, as well as other students from for example* [names of three other universities]*, feel a sense of resentment maybe towards* [OU PRNP students] *… in that they are paid as a health carer* [NRC] *for two shifts of the week'*
>
> **Luna** [S]: '*Because when the staff find out you're still getting paid. The NAs* [NRCs] *are Band 2* [NHS salary scale]*, and they find out you're a student and you're earning a Band 3 wage, they're like 'well they can do more, they can do more work''*

15.2.5 THR process/social competency: Belonging

Within the THR, *belonging* refers to those conditions which lead an individual to feel an integral part of a process, activity, or environment (Hagerty & Patusky, 1995). Earlier research has emphasised the positive effect having a strong sense of belonging (Grobecker,

2016) and being recognised and accepted as part of the nursing team (Kenny et al., 2019) has on the nursing student experience within a placement. Similarly, in this research the importance of OU PRNP students feeling they belong in a practicum was highlighted by respondents in almost every stakeholder group and, commonly, a block practicum was deemed to best promote it:

> **Irma** [E]: *'I think it* [block placement] *gives* [OU PRNP students] *the impression of allowing more consistency: you're a fulltime member of staff for six weeks'*
>
> **Gail** [PT]: '*If they're full-time* [block] *on placement they kind of become more part of the team'*
>
> **Damita** [S]: *'I think it's* [block practicum] *better, you get a rapport built up'*
>
> **Imke** [S]: [In a block practicum] *'I just feel like I'm a part of the team'*

In contrast, placements based on the integrated model were often perceived as adversely affecting the way OU PRNP students were perceived:

> **Hanneke** [M]: '*It just more feels like someone doing a bank shift* [itinerant nursing staff input] *with that'* [integrated placement]
>
> **Belinda** [E]: '*Because it was too bitty to not do it on block* [placement], *they* [the employer sponsor] *felt that they* [OU PRNP students] *would feel more a part of the team'*
>
> **Diane** [E]**:** '*Students* [on block placements] *would then feel part of the team, they would be there as part of the workforce for that period of time rather than just kind of visitors to the ward for those two days a week'* [integrated practicum]
>
> **Fatima** [S]: *'I did not appreciate being shouted at* [by the ward manager]*, but I did understand her frustration. And she kept saying 'you've been here five weeks and I still haven't seen your port'* [competence record]. *I hadn't, I've been there five shifts'* [in the integrated model]

15.2.6 THR process/social competency: Reciprocity

Related to belonging, the THR describes *'reciprocity'* as an *'individual's perception of an equitable alternating interchange with another person, object, group, or environment that*

is accompanied by a sense of complementarity' (Hagerty et al., 1993, p.294). Arguably, reciprocity is illustrated in earlier studies that recognise the importance of nursing students feeling they are contributing to the service and the team associated with their practicum and, in return, receiving appropriate educational support within this environment (Birks et al., 2017; Kevin et al., 2010; Newton et al., 2009b). In this research, a key illustration of reciprocity in respect of OU PRNP student activity was the scope for such individuals to disseminate the learning they acquired in one setting to others in which they had a role:

> **Anisha** [E]: '*So being able to share, they're* [students] *like little bees and pollinating everywhere'*
>
> **Belinda** [E]: *'They* [students] *can bring back a deeper knowledge of how things work in different areas and contribute to the team meetings'*
>
> **Deirdre** [M]: *'I find that I learn from them* [students] *and then they learn from me'*
>
> **Karen** [S]: [NRC workplace managers have] '*said that they can see a massive difference in terms of sort of* [my] *competence and communication with the patients'*

Interestingly, the potential for OU PRNP students to demonstrate reciprocity via disseminating their learning from different settings was largely seen as being enhanced by integrated placements:

> **Deirdre** [M]: *'To reflect on what they've* [students] *learned on the two days out of their normal practice* [integrated practicum] *and then they can take it back and integrate it in. And it makes you look at things with fresh eyes'*
>
> **Enid** [PT]: *'Students on the integrated model, because it's longer they reflect more on the practices that they're doing, and they can think about where they are as a healthcare assistant* [NRC]*. And they start to integrate those changes in practices into their everyday'* [NRC work]

15.2.7 THR process/social competency: Mutuality

In the context of the THR, *mutuality* describes situations in which a person believes they share a vision, goals, sentiments, or characteristics with others, but can also accept recognised differences between themselves and those with whom they have contact

(Hagerty et al., 1993). The value of students acquiring a shared cultural awareness of their practice learning environment with other key participants has been recognised in earlier research (Hegenbarth et al., 2015; Rock & Ring, 2010). Indeed, in some cases it has been said to have created conditions where the learner acquired a stronger sense of professional identity (McLachlan et al., 2011) and even felt they became part of a practice family (Dias et al., 2022; Sedgwick & Yonge, 2008).

Hirsch et al (2002, p.443) define a role model as *'a person who serves as an example of the values, attitudes, and behaviors associated with a role.'* Based on this definition, it seems reasonable to conclude that, congruent with the proposition of mutuality, students who identify particular staff as role models are likely to do so as a result of believing they share a specific vision, goals, sentiments, or characteristics with this individual and therefore perceive them as someone whose conduct is worthy of emulation. The value of clinicians being perceived by nursing students as positive role models has also been identified in earlier work (Allari & Farag, 2017; Suliman & Warshawski, 2022) and whilst explicit evidence of mutuality within the data produced by this study was modest, several nursing students highlighted the way in which they perceived some registrant clinicians with whom they worked as highly desirable role models:

> **Ana** [S]: '*Your mentor can be a good role model for you,* [so you] *just* [want] *to do what she does or what he does*'
>
> **Elizabeth** [S]: *'Then there's certain aspects* [nurses] *who are complete inspirations and* [you think] '*I want to be that practitioner''*

Student expressions of mutuality did not appear to be affected by the model of practice learning underpinning their placements.

15.2.8 THR process/social competency: Synchrony

The THR suggests that *synchrony* occurs when a person's experiences are congruent with her/his internal psychological, social, spiritual and/or physiological rhythms and their interaction with the external world (Hagerty et al., 1993). This notion of synchrony is underpinned by work addressing the influence of circadian rhythms and, in particular, *Social Zeitgeber Theory* [SZT], first proposed in the late 1980s (Boland et al., 2016).

According to SZT, work routines and contact with social networks contribute to the regularity of daily routines and the stability of social rhythms (Quante et al., 2019; Sandahl et al., 2021). Moreover, '*certain life events disrupt an individual's social rhythms, which are patterns of behavior and cycles of daily life that structure one's day and help to entrain the biological clock to a 24-hour schedule'* (Levenson et al., 2015, p.870). Although not having as profound an influence as daylight (Quante et al., 2019), research suggests disruption to an individual's social routines may still have an adverse effect on biological circadian rhythms (Grandin et al., 2006) and create conditions of asynchrony, which may adversely affect physical and/or mental health and wellbeing (Brainard et al., 2015; Levenson et al., 2015).

Clearly, significant changes to the environmental, work, and social routines of nursing students may therefore destabilise their social rhythms and in so doing increase asynchrony; particularly if these are perceived as undesirable changes, are ones which complicate the fulfilment of personal responsibilities, or have negative consequences for other key elements of the individual's life. Indeed, although not making specific reference to the concept of synchrony, earlier studies (de Souza et al., 2016; Rock & Ring, 2010; Tam et al., 2020) have identified the adverse social effects nursing students may experience as a result of having to accommodate the demands of their programmes. More specifically, other research has highlighted the benefits some learners may derive from an integrated practicum in terms of a better work/life balance (Rohatinsky et al., 2017; Vanson & Bidey, 2019).

In this research, the tension and dissonance associated with moving between the NRC and OU PRNP student roles, not least in respect of appropriate conduct and skills application, was recognised by virtually all respondents. Which practicum model best contributed to synchrony, however, was a matter of greater debate. Some respondents believed an integrated placement reduced transitional problems:

> **Beatrice** [M]: [With integrated placements] *'the students felt a sense of security maybe that they still kept their healthcare* [NRC] role, *but had one shift a week where they could concentrate on being the student nurse'*

> **Frances** [PT]: '*If you are doing say two days a week* [integrated practicum], *to have* [it provides] *a little bit of time to reflect, because they're not there every day. So, if you've learned something new, or been in a new situation, when you then go back for a few days into your comfort zone so to speak, where you've worked for a long period of time, it gives you that little bit of time to think*'

Since most OU PRNP students are mature learners and therefore have other significant social and domestic commitments beyond both their course learning activities and NRC duties, the integrated model was also described as more accommodating in respect of such wider commitments and therefore more likely to promote synchrony:

> **Caren** [M]: *'It's the first time I've come across anybody* [nursing student] *doing the training this way* [with an integrated placement]. *So, I thought 'oh it's a bit odd' at first, then actually as I got to know her, I realised that it actually really suited her*'

> **Glynis** [S]: *'I've got children to get to school and things like that. So having two days a week* [integrated placement] *would be much better personally than having the full block placement and having to cover four weeks, six weeks, ten weeks of childcare'*

> **Luna** [S]: '*From a financial perspective* [if] *I was full-time* [block] *on placement, I'd lose out on enhancements'* [additional unsocial hours NRC payments]

Other respondents, however, suggested a block practicum reduced the difficulties related to fulfilling a nursing student and NRC role by enabling periods of uninterrupted clinical learning and helping the NRC role of the OU PRNP student to be set aside for longer periods; effects that may promote synchrony:

> **Hanneke** [M]: *'They* [OU PRNP students] *voiced that they preferred the block method, they found it easier to, as I say, slot them self into the team and just how the ward ran really. It made them more comfortable'*

> **Christine** [PT]: [It is] '*difficult for some students to get to grips with that* [transition] *and change those hats within the integrated model*'

> **Helen** [S]: '*I just feel as though* [in a block placement] *I wouldn't be torn between my role as an HCA or a support worker* [NRC]*, and my role as a student as much*'

> **Fatima** [S]: *'I'm annoyed that I wasn't given the option of the other one* [block placement]. *Only because it's hard* [having integrated placements]. *Firstly, you never know what hat you're putting on in a morning. You've got to switch from one* [role] *to the other'*

15.3 Conclusion

Overall, the results of this re-analysis of interview data highlight more respondents in all stakeholder groups describe the block model in ways that suggest it is best able to promote a sense of connectedness, belonging and synchrony for learners. In contrast, an integrated placement design was portrayed in terms implying that it may increase the risk of disconnectedness but might also be more likely to promote reciprocity. Insufficient data was available to identify the potential effect of either practicum design in respect of enmeshment, parallelism, and mutuality. The implications of these findings are considered in Chapter 16.

Chapter 16. Implications of the theory of human relatedness as a potential causative mechanism in nursing student practicum experiences

16.1 Introduction

Analysis of interview responses from members of the employer sponsor [E], nursing student [S], practice tutor [PT] and mentor [M] stakeholder groups against the states of relatedness and processes/social competencies of the *theory of human relatedness* [THR] suggests this conceptual framework provides a potential theoretical explanation of the factors underpinning pre-registration nursing programme [PRNP] practicum perceptions and experiences. Indeed, every key proposition within the theory, namely *connectedness*, *disconnectedness*, *parallelism*, *enmeshment*, *belonging*, *reciprocity*, *mutuality*, and *synchrony*, was evidenced within the data [see Chapter 15]. The number of responses supporting the influence of parallelism and mutuality, however, was more limited. This paucity of reported experiences reflecting parallelism may be attributable to stakeholders wishing to avoid any suggestion that such activity, which may be seen as professionally undesirable, might occur during a practicum.

Although located outside this study, the researcher has since been advised of anecdotal accounts related to mental health PRNP students in physical care placements who have responded primarily to the psychological needs of patients in the setting due to an absence of clear supervision or direction from mentors and other clinicians, but still found such work fulfilling. He has also received reports of more learners identifying specific practitioners as influential role models with whom they feel an affinity. Such information therefore suggests there may be much wider evidence of parallelism and mutuality within undergraduate nursing programmes.

Critical realist research commonly examines topics in which underlying structures and relationships may affect observed phenomena but for which it is impossible to prove a cause-effect relationship (Harper, 2011). Hence, such investigations normally seek to establish the most probable explanation for empirical findings; an approach known as *retroduction* (Meyer & Lunnay, 2013). From the perspective of critical realism, the factors

which may need to be considered when selecting the most suitable practicum model for a nursing student, as outlined earlier in this study, and recommended as a basis for model selection [see Chapter 11] were derived from data located within the *empirical* and *actual* domains [see Chapter 2]. That is to say, they are directly based upon qualitative content analysis of interviewee responses and therefore predominantly, and more traditionally, are perceptions of reality within the empirical and actual strata.

In contrast, by attempting to understand potential causal mechanisms leading to observed phenomena which may not be open to direct empirical measurement, presentation of an argument supporting the THR as a means to understand what processes may influence nursing student practicum evaluations, perceptions and experiences addresses reality in the *causal*/*real* stratum. In doing so, this analytical activity more strongly reflects a fundamental critical realist goal namely, to attempt to establish causative generalisations based on probabilistic rather than absolute truth. Since investigations founded upon critical realism also expect a researcher to recommend changes that may positively affect a situation (Sweetmore, 2021; Wise, 2019), these obligations are similarly honoured within this chapter of the thesis.

16.2 Implications of the findings

Arguably, the apparent alignment of stakeholder experiences and reflections upon Open University [OU] PRNP student placements to the key states of relatedness and processes/social competencies of the THR identified within this part of the study suggests the influence of these psychosocial variables in the context of practice learning is a subject worthy of much more attention than has so far been the case. Indeed, it may even be that these THR propositions could have as significant an impact on practicum model preference and the practice learning experiences of nursing students as, for example, the opportunities for clinical skills acquisition in a placement, the inter-relationship between classroom and work-based learning or the effect of concurrent nursing student employment – factors traditionally given far greater consideration in academic discussion related to placement organisation [see Chapters 5, 6 & 7].

Given that numerous studies located outside the discipline of mental health nursing and, indeed, the wider healthcare field have applied the THR to enhance understanding of

various phenomena [see Chapter 14], application of this theory to an educational context is much less radical than it may initially appear. Moreover, several earlier studies within nurse education have drawn upon it, although these investigations have largely focused on the importance of only one process/social competency namely, belonging, rather than seeking to apply the entire theory to practice learning.

Essentially, the findings associated with this part of the research could be deemed to infer stakeholders unknowingly base their evaluation of practicum models on criteria largely akin to the key propositions of the THR. That is to say, these propositions may reflect a set of cognitive tools implicitly employed by an individual to evaluate a practice learning model and so be collectively operating as a causative mechanism which affects an individual's view of a specific placement design. To further clarify, the extent to which a practicum model is tacitly considered to promote connectedness, belonging, reciprocity, mutuality, and synchrony, minimise disconnectedness, and enmeshment, as well as reduce any need for parallelism, might determine an individual's perception of this model more than commonly espoused considerations, such as the opportunities a particular placement framework offers for clinical skills development. If these propositions do closely correspond with the evaluative criteria individuals unconsciously employ to appraise a placement model, they can essentially be deemed to operate as causative mechanisms which account for various observed phenomena [i.e., multiple interviewee responses] within this research.

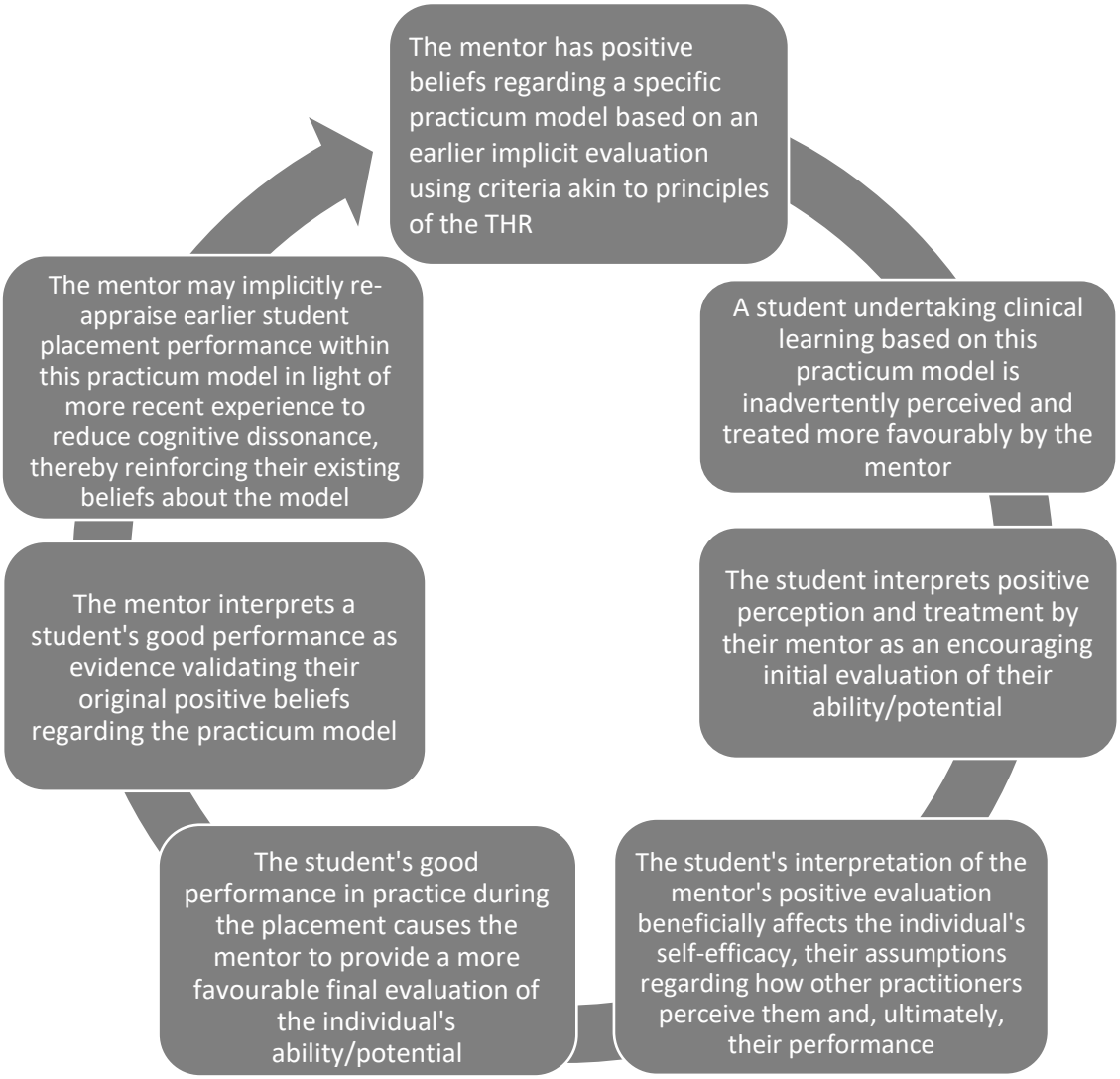
Inevitably, the concurrent NRC role undertaken by OU PRNP students prevents the influence of the workplace in which a student is employed in this role being clearly separated from their practicum experiences. Nevertheless, and still congruent with the THR, such employment may be a feature affecting an individual's appraisal of the extent to which a placement is deemed to promote a positive sense of relatedness and mitigate against the risk of negative psychosocial experiences. Furthermore, it is interesting to consider whether a stakeholder's implicit evaluation of a practice learning model [based upon analysis reflected within the THR propositions] may predispose them to perceiving a forthcoming practicum structured on this model in a favourable or unfavourable way, in accordance with their earlier evaluation. Arguably, such evaluation may even lead a

stakeholder to re-appraise their previous experiences of this model as a means of reducing potential cognitive dissonance.

Indeed, it might even be that a stakeholder merely *considering* a placement model as more or less effective in facilitating aspects of relatedness could itself affect the potential for successful student learning within any forthcoming clinical practicum structured upon this model; effectively increasing the probability of a positive or negative practice learning experience. Given the well-recognised influence other intrapersonal factors may have upon interpersonal relationships, such an effect cannot be readily dismissed. For example, similar effects have previously been reported in research related to the influence of positive and negative feedback cycles on self-efficacy associated with educational performance (Akkuzu, 2014; Pitzer & Skinner, 2017; Ruegg, 2018), entrepreneurship (Winkler & Case, 2014), work performance (Çetin & Askun, 2018), leader development (Machida & Schaubroeck, 2011), bullying (Kassem, 2015) and ageing (Chasteen et al., 2015).

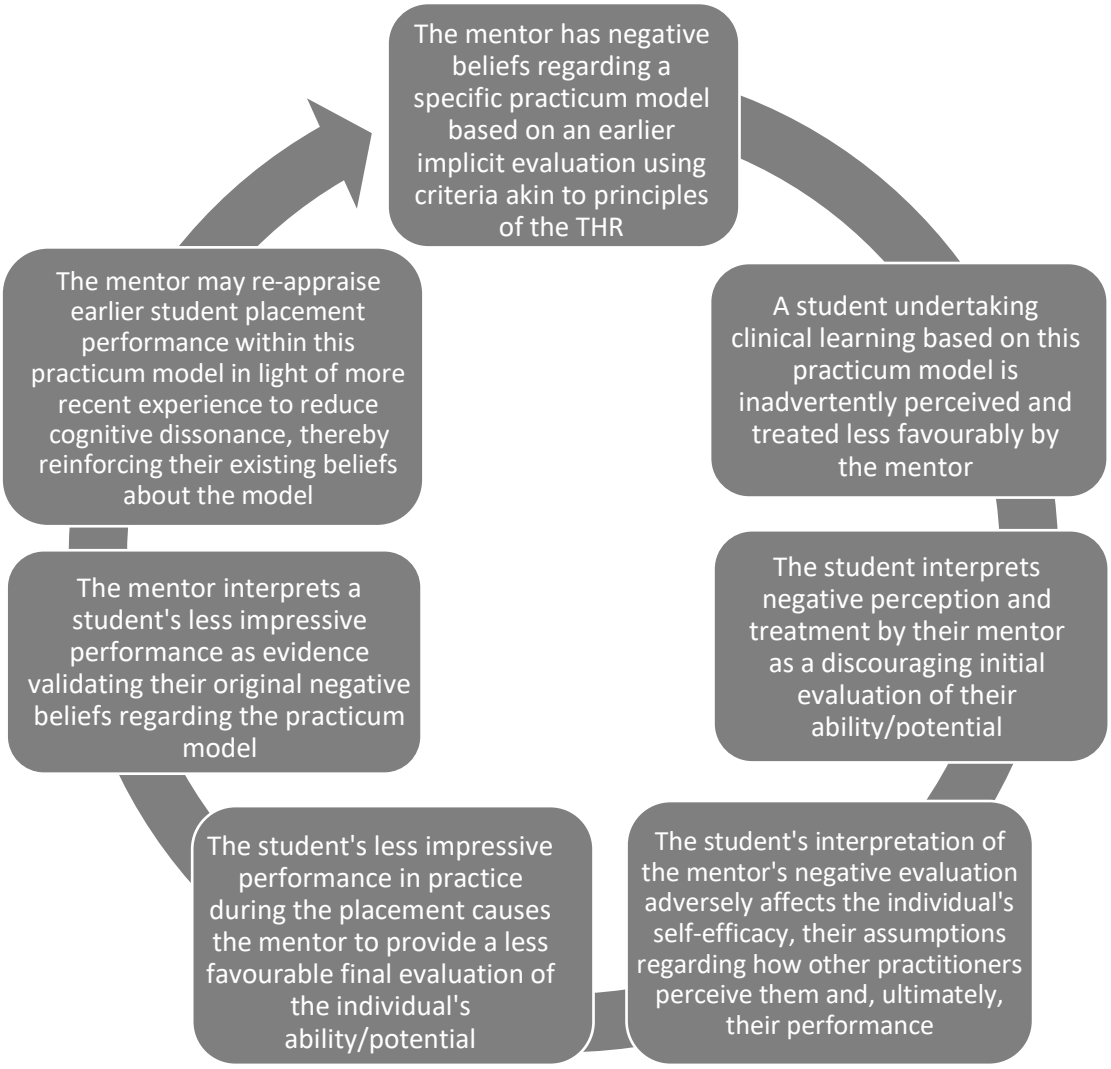
Irrespective of which specific practicum model may be favoured, the mechanism by which a student's performance and placement experience might be positively affected by, for example, a mentor's favourable perception of this model [based upon implicit analysis congruent with the THR principles] is illustrated in Figure 3.

Figure 3: Practicum appraisal by mentor – positive feedback cycle



Perhaps of greater concern is the potential adverse effect of negative perceptions of a placement design upon the practice learning experiences of PRNP students. To illustrate this effect, the mechanism by which a student's performance and placement experience might be negatively affected by, for example, a mentor's unfavourable perception of a specific practicum model [based upon implicit analysis congruent with the THR principles] is illustrated in Figure 4.

Figure 4: Practicum appraisal by mentor – negative feedback cycle



Given that a less favourable view of the integrated practicum model was widespread amongst interview respondents in all four stakeholder groups within this study, it seems plausible that such a negative feedback cycle may be activated in those circumstances where, for example, a mentor has already completed an implicit appraisal of this model and deemed it less desirable.

The results of both earlier published work and evidence from the qualitative phases of this study suggest a case can be made that some stakeholders may indeed hold negative views

of programme design features which are of sufficient magnitude to adversely affect future practice learning. For example, reviewing student experiences on a part-time PRNP [which involved practice learning being undertaken in a similar way to an integrated practicum], O'Driscoll et al (2009, p.210) found many *'felt that they had a relatively low status'* and some even considered themselves to be a *'second class citizen'* within the practice setting. Similarly, McDaid (2009, p.61) highlighted *'negative remarks from staff about their part-time status'* and some students felt *'undervalued by team members.*' Furthermore, when discussing the implications of their hermeneutical research examining '*how invitation is figured according to nursing students' understanding'*, Hemberg & Sjoblom (2018, p.689) claim negative nursing student practicum experiences, for example exclusion from key aspects of care delivery [which might indirectly occur as a result of a mentor's less favourable perception of a placement model], can lead this learner to develop a permanent unfavourable professional self-image which they may take into their future registered nurse [RN] role.

Within this current study, numerous interviewee responses appeared to provide evidence of potentially negative pre-existing views of an integrated practicum. For example:

> **Irma** [E]: [A block model was chosen] *'to stop any dis-settlement from a mentor's point of view which may then impact on the student or their learning experiences or how a mentor perceived them in their current role'*

> **Diane** [E]: *'I think particularly for students who are only going in for two days a week* [integrated practicum]*, they would probably be a bit lower down the priority list from a mentor's point of view. Because they don't know them as well, they're not as invested in them…Students* [on block placements] *would then feel part of the team, they would be there as part of the workforce for that period of time rather than just kind of visitors to the ward for those two days a week*' [integrated practicum]

> **Erin** [E]: '*One of the biggest compelling arguments for the block placement is you do get continuity of care. They* [students] *get to know the staff. They get to know the procedures, the policies, the rationale for the care they're delivering, but then if you do that for two days and then you don't come back for nine, ten days* [integrated practicum]*, you've lost it again and you're relearning all the time'*

Fidelma [E]: **'***The fact that they* [OU students] *follow a similar placement model* [to other nursing students] *with the blocks, I think, makes it more – I don't know what the word is, but – robust, maybe. Rather than a bit of a part-time student that's just coming in for two days a week*'

Hanneke [M]: *'It just more feels like someone doing a bank shift* [itinerant nursing staff input] *with that*' [integrated placement]

Beatrice [M]: '*On some occasions, members of staff, as well as other students from for example* [names of three other regional universities]*, feel a sense of resentment maybe towards Open University students, because of the fact that…they are paid as a health carer* [non-registrant carer] *for two shifts of the week*' [integrated practicum]

Dee [PT]: *'People* [staff and patients] *on the placement don't actually get much time with the students if they're only there for two days* [a week - integrated practicum]*, and I think that sometimes can have a negative impact on developing those relationships on placement*'

Fatima [S]: '*I did not appreciate being shouted at* [by the ward manager]*, but I did understand her frustration. And she kept saying 'you've been here five weeks and I still haven't seen your port*' [competence record]*. I hadn't, I've been there five shifts'* [in an integrated practicum]

16.3 Recommendations

Concerns regarding a lack of high-quality nursing student placement experiences have now been expressed internationally for several decades (Barnett et al., 2008; Brown et al., 2011; Gale et al., 2016; Kaliyangile & Ngoma, 2020; National Nursing & Nursing Education Taskforce, 2006). It has been argued there is now an urgent need for a long-term strategy to significantly increase practicum capacity in the UK (Kalitowski, 2021) and greater use of both block and integrated placement designs may need to be a key element of any such plan. It is crucial, however, not only to ensure a selected practice learning model is best suited to the conditions in which it is to be applied [see Chapter 11], but also to promote a favourable stakeholder perception of both block and integrated designs if use of practicum capacity is to be optimised. After all, even if a placement model has been

assessed and deemed the most appropriate choice given the conditions in which it would occur, the learning experience may still be a less effective and satisfying one if key stakeholders have pre-existing negative views regarding the selected model.

Arguably, any negative views of the integrated model that risk harming the quality of a practice learning experience based on this framework would perhaps be best mitigated by pre-emptive interventions designed to change individual unfavourable perceptions. For example, pre-placement preparation for nursing students and clinical staff, akin to those interventions advocated in several earlier studies (Karimollahi, 2012; Priest, 2005; Sherratt et al., 2013; van der Riet et al., 2018) [see Chapter 5], might help challenge myths and negative attitudes, offer solutions to potential problems, reduce stress, develop role confidence, and ultimately promote a more productive and satisfying integrated practicum experience for all participants.

The Nursing & Midwifery Council [NMC] (2023a, p.7) expect institutions delivering undergraduate nursing programmes to ensure *'all learning environments optimise safety and quality, taking account of the diverse needs of, and working in partnership with, service users, students and all other stakeholders*.' Hence, it is an expectation such learning providers regularly audit clinical services to ascertain their suitability for nursing students. Development of existing and potential PRNP student placements [irrespective of the anticipated practicum model/s which may be used there] could be improved by modification of existing learning environment audit [LEA] processes to better determine how this placement may, congruent with the THR, promote positive features of relatedness and prevent potentially harmful interpersonal conditions for learning.

The NMC (2023a, pp.7-8) also states *'approved education institutions, together with practice learning partners, must: have the capacity, facilities and resources in place to deliver safe and effective learning opportunities and practical experiences for students as required by their programme learning outcomes*.' Additionally, it requires these organisations to '*ensure that: there are suitable systems, processes, resources, and individuals in place to ensure safe and effective coordination of learning within practice learning environments'* (NMC, 2018b, p.5). Supplementary guidance acknowledges that how these requirements are best fulfilled, and who has responsibility for ensuring this occurs, will vary in different settings (NMC, 2019). Nevertheless, one could reasonably

assert any practice learning environment which fails, through omission or commission, to promote connectedness, belonging, reciprocity, mutuality, and synchrony, or indeed creates conditions contributing to disconnectedness, enmeshment or parallelism is not one that provides *'effective learning opportunities and practical experiences for students.'*

Possible LEA questions specifically designed to ascertain the extent to which a service might be well-suited to promoting positive states and processes/competencies of relatedness, whilst preventing negative relatedness, are presented in Table 9.

Table 9: Potential additional LEA questions to assess appropriate evidence of the THR states and processes/competencies of relatedness

	Question to explore the THR states and/or processes/competencies of relatedness	**The THR states and/or processes/competencies of relatedness considered by question**
.	What do you do in the ward/unit/department/service to help reduce anxiety, develop confidence, and promote wellbeing for students during a placement?	Assessment of environmental conditions for promoting student connectedness and any potential risk of disconnectedness
.	What team-building activities take place in your ward/unit/department/service and who participates in these activities?	Assessment of environmental conditions for promoting student connectedness and belonging and any potential risk of disconnectedness
.	In what ways does the ward/unit/department/service seek to assist students on placement to feel valued members of the team?	Assessment of environmental conditions for promoting student belonging
.	In your ward/unit/department/service, how do you enable students experiencing a placement to share their learning and knowledge with the wider team?	Assessment of environmental conditions for promoting reciprocity
.	How are the values and philosophy of your ward/unit/department/service, shared, and reviewed and who contributes to this process?	Assessment of environmental conditions for promoting mutuality

6. What action do you take to ensure that a student's wider commitments/circumstances are, so far as possible, accommodated within their allocated practice learning times during the placement?	Assessment of environmental conditions for promoting student synchrony
7. How do you ensure a student on placement in your ward/unit/department/service is both sufficiently competent and confident to undertake a specific therapeutic activity/clinical procedure/nursing duty in the workplace?	Assessment of any potential environmental risk of student enmeshment
8. What do you do in the ward/unit/department/service to enable students on placement to receive adequate supervision which both provides them with opportunities for some safe independent practice, whilst allowing them to feel supported?	Assessment of environmental conditions for promoting student connectedness and any potential risk of parallelism

Explicitly embedding learning activities to strengthen awareness and application of the THR propositions within current PRN programme curricula may enable students to better appreciate the impact of these states and processes/competencies of relatedness in the context of practice learning. It may also ultimately facilitate these learners to acquire an enhanced understanding and skills set in respect of the student support they provide on becoming RNs themselves and ultimately, mentors/practice assessors.

In addition, consideration should arguably be given to the THR in respect of the way in which practice assessment design, implementation, and feedback are undertaken. Ensuring proficiencies are assessed in real workplace settings as part of routine service delivery may optimise scope for connectedness, belonging, reciprocity and mutuality and in so doing positively affect student performance. Similarly, delaying formal assessment of practice-related skills until the student has spent several weeks in a placement may increase the likelihood that this individual has acquired a sense of positive relatedness within a service team before their competence is evaluated and thus allow their practice to be more grounded and confident. Further, it is recommended that feedback on the student's performance should be provided in a manner likely to foster a positive sense of relatedness for this individual and capture the extent to which they have been observed

to conduct themselves in a manner likely to promote affirmative relatedness in others. Both the current *'Standards framework for nursing and midwifery education'* (NMC, 2023a) and *'Standards of proficiency for registered nurses'* (NMC, 2018a) afford considerable scope to justify more detailed consideration of the THR propositions within such curricula [see Tables 10 & 11].

Table 10: NMC *'Standards framework for nursing and midwifery education'* providing scope to justify explicitly addressing the THR states and processes/competencies of relatedness within current PRNP curricula

NMC standards:
'1.10 ensure the learning culture is fair, impartial, transparent, fosters good relations between individuals and diverse groups and is compliant with equalities and human rights legislation' (NMC 2023a, p.6)
'*1.14 support opportunities for research collaboration and evidence-based improvement in education and service provision'* (NMC 2023a, p.6)
'*3.2 Students are empowered and supported to become resilient, caring, reflective and lifelong learners who are capable of working in inter-professional and inter-agency teams'* (NMC 2023a, p.9)
'3.13 students are provided with information and support which encourages them to take responsibility for their own mental and physical health and wellbeing' (NMC 2023a, p.10)
'3.14 students are provided with the learning and pastoral support necessary to empower them to prepare for independent, reflective professional practice' (NMC 2023a, p.10)
'3.15 students are well prepared for learning in theory and practice having received relevant inductions' (NMC 2023a, p.10)
'4.6 educators and assessors are supportive and objective in their approach to student supervision and assessment' (NMC 2023a, p.11)
'5.7 curricula are structured and sequenced to enable students to manage their theory and practice learning experience effectively' (NMC 2023a, p.12)

Table 11: NMC *'Standards of proficiency for registered nurses'* providing scope to justify explicitly addressing the THR states and processes/competencies of relatedness within current PRNP curricula:

NMC standards:
'1.17 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills' (NMC 2018a, p.9)
'5.1 understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making' (NMC 2018a, p.20)
'5.2 understand and apply the principles of human factors, environmental factors and strength-based approaches when working in teams' (NMC 2018a, p.20)
'5.6 exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team' (NMC 2018a, p.20)
'5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback' (NMC 2018a, p.20)
'5.10 contribute to supervision and team reflection activities to promote improvements in practice and services' (NMC 2018a, p.20)

16.4 Limitations associated with this part of the study

It is acknowledged the respondent sample [37] employed in this analysis was relatively modest and the interviews from which evidence was obtained were originally structured to capture stakeholder views, encounters and learning in the context of block and integrated practicum models for OU PRNP students rather than examine the THR as a possible causative explanation of placement perceptions. Alternative questions designed specifically to probe for features of the THR might therefore have generated more explicit responses but, since such data re-analysis was not originally planned, it could be argued the transcriptions provide a more objective evidence base and that support for the THR is strengthened by consideration of this theory having been avoided within the original research design. It is also recognised the researcher was a line manager for several practice tutor respondents although, given that the topic is not value-laden and both practicum models were offered within the OU PRNPs and without institutional preference, it seems unlikely any pre-existing relationships or power asymmetry would have affected the responses given.

Furthermore, it is acknowledged that resource restrictions did not enable similar detailed scrutiny of interview data against the core propositions of other theories identified which might offer alternative causative explanations of practice learning experiences, namely the *distributed practice effect*, *contextual interference effect, situated learning theory*, s*ocial identity theory* and *sociocultural activity theory* [see Chapter 14]. Nevertheless, following a preliminary review, these other theories did not appear to exhibit the same level of explanatory power, congruent with critical realist principles [see Chapter 2], to account for many interviewee responses within this study and the findings of earlier research addressing student practice learning experiences. Finally, whilst this analysis is harmonious with a retroductive approach, inevitably it can only present what the researcher deems to be the *most probable explanation* for the implicit evaluative processes [in this instance the underlying mechanisms] which may affect individual views of a practicum model based on the observed phenomena [that is to say, the interview data].

16.5 Conclusion

In common with other psychosocial theories of learning and development, the THR maintains the nature of an individual's involvement in an environment and the social relationships they form within it may have significant cognitive and emotional effects. Levels of self-confidence, comfort, anxiety, and a sense of wellbeing are therefore shaped by such activity. Clearly, placements may offer emotionally charged episodes of social, intra-disciplinary and inter-disciplinary interaction for students on any pre-registration healthcare programme and generate either positive opportunities for deep and meaningful learning or have negative consequences that may not only impair future professional development but cause some learners to disengage from their programmes.

Further analysis of primary and secondary data associated with nursing student placement experiences could enable additional scrutiny of the THR as a framework to explain the factors underpinning clinical learning experiences for a wider student population undertaking pre-registration health and social care programmes. Nonetheless, evidence to date already supports the assertion that nurse educators should give appropriate regard to the likely impact of features highlighted within the THR when designing curricula, and in particular arranging placements, if these are to consistently be more positive learning

experiences which enhance clinical competence, reduce stress, and promote nursing student wellbeing.

One respondent, Christine [practice tutor], argued that during a placement, nursing students *'are there to learn, not to be a member of the team.'* Both the THR and results from this part of the study, however, would refute such a view; countering that successful practice learning and positive relatedness experiences [such as those derived from a learner feeling a member of the team within a practicum] are inextricably linked. Furthermore, if negative stakeholder views of a specific placement model may adversely affect practice learning experiences and impair full and effective utilisation of limited practicum capacity, then it seems important to implement PRNP curricula changes which are designed to re-shape such views as well as ensure learning environment audits consider the potential of a clinical service to positively influence a student's sense of relatedness, irrespective of the specific placement design.

Chapter 17. Consolidating activities within this study and moving forward

17.1 Introduction

This study appears to be the first investigation examining block and integrated practicum experiences from a critical realist perspective. Extensive searches for international work published in the English language without date restrictions and involving the contribution of a literature search specialist from the Royal College of Nursing suggest it is also one of only a handful of studies employing a mixed methods approach within this particular field and to consider whether practicum design might affect student retention/achievement. In addition, it seems this research is the first to consider the effect of these models in the context of United Kingdom [UK] pre-registration nursing [PRN] degree programmes [see Chapter 7].

17.2 Qualitative analyses and further studies

Given the paucity of evidence-based guidance regarding use of block and integrated placement designs within UK PRN programmes, the qualitative results of this study have, perhaps most importantly, enabled identification of critical factors which should be considered when selecting the most suitable placement model for an employer-sponsored nursing student [see Chapter 11]. Even before the completion of this research, the author was approached by a National Health Service Foundation Trust in southern England requesting he share the findings to assist them in choosing a practicum design for future nursing students whom they intended to support. This is an encouraging early consequence of undertaking the research and one which helps illustrate its potential utility and the importance some healthcare providers may now be assigning to this issue. Further studies might usefully explore whether an employer sponsor's decision to adopt a block or integrated practicum model for PRN students whom they employ as non-registered carers [NRCs] has any effect on service provision within the workplace from which this student is released.

A preliminary examination of theories which might illustrate causative mechanisms underpinning placement experiences and preferences led to deeper scrutiny of the theory

of human relatedness [THR] and its propositions in relation to the interview data acquired earlier. Surprisingly, it seems every main proposition within this theory may be evidenced in the interviews involving members of all four stakeholder groups, extending the results of several earlier investigations within nurse education which have concentrated primarily on the application of the THR process/social competency of *belonging* to practice learning [see Chapter 14]. Furthermore, the theory could be seen as providing a possible explanatory basis for the way stakeholders evaluate a practicum model and in so doing influence the quality of practice experiences based on this design.

Again, recommendations are made regarding ways that perceptions of a specific placement design might be best appraised and negative views modified [see Chapter 16]. Hence, congruent with critical realism, this work provides both pragmatic suggestions to improve practice learning and seeks to engage with this topic at the empirical, actual, and causal/real levels. It has also led to subsequent collaborative research activity with an academic based in a higher education institution in Hong Kong examining whether the THR appears to similarly underpin practicum perceptions and experiences for students on another PRN programme offered in a nation with different social, cultural, and linguistic characteristics. It will be interesting to see whether the results support or refute the findings of this doctoral investigation.

Internationally, workplace learning experiences are a key component of pre-registration/pre-qualification programmes in many disciplines [see Chapter 7]. Scrutinising stakeholder views of block and integrated practicum designs and whether the THR propositions are equally applicable to such experiences would, therefore, also help identify the broader value of this research in both explaining and improving workplace learning. If similar results are identified within subsequent work, then the recommendations made in this study could have significant and far-reaching implications for the curricula of other practitioner programmes within fields as diverse as social work, primary, secondary, and tertiary education, law enforcement, as well as various other healthcare disciplines.

17.3 A cautionary note

Recommending changes which add content to pre-registration programmes is something that should never be undertaken lightly. Several academics express concern that adding to

an already content-laden nursing curriculum may leave education providers struggling to know what to delete (Douglas & Windsor, 2015; Shearer & Lassonen, 2018) and such inclusion may risk coverage of some topics becoming superficial (Tanner, 2010). Given evidence suggesting a potential relationship between the perception of a practicum model based on evaluative criteria akin to the THR propositions and the quality of practice learning experiences, however, asserting the value of addressing this theory in such curricula appears justifiable. Furthermore, these changes are congruent with earlier work suggesting nurse educators may need to change both the emphasis in PRN curricula and support for seconded students and former non-registrant carers to ensure a learning experience that better develops their existing knowledge (Adair, 2017; Roberts, 2006; Wood, 2006).

17.4 Quantitative analyses and further studies

After a challenging quantitative data collection activity, analysis of 460 employer-sponsored Open University [OU] nursing students in two UK-wide cohorts provided no statistically significant evidence that exclusive exposure to either block or integrated placements throughout a PRN programme affects student retention/achievement; although descriptive statistics tentatively suggest use of the integrated model might be associated with lower student attrition and higher degree classifications [see Chapter 12]. These findings may therefore be both encouraging and reassuring news for universities now introducing integrated practice learning within their curricula, either to optimise capacity and/or better accommodate Nursing Degree Apprenticeships [NDAs]. The results also led potential reasons for the apparent incongruity between an overall stakeholder preference for a block practicum, despite a lack of data to suggest it had any greater efficacy in these respects, to be considered [see Chapter 13].

Nevertheless, as noted earlier [see Chapter 13] in this study it was not possible to address additional potential independent variables which, had they featured in multinomial logistic regression analyses, might have generated statistically significant results. These variables include student ethnicity, socioeconomic status, and highest academic qualification on entry to a PRN programme. Consideration of such issues alongside learner exposure to block or integrated practicum experiences would therefore be a desirable focus for future quantitative research in the field.

Further investigation of this topic with a more diverse nursing student population and the individuals who support them may also help determine whether the distinctive characteristics of an employer-sponsored PRN programme for NRCs affects the impact of either practicum model on student retention/achievement levels. Given the growth of NDAs in England since their launch in 2017 and a concurrent increase in use of integrated placements, the scope for such research in this nation now appears much greater.

Since there has been longstanding use of both placement models in some countries [see Chapter 7], research involving an international PRN student sample would provide even greater opportunity to establish whether results from this study are generalisable. Other topics worthy of further investigation include if a practicum model has a statistically significant effect on student retention/achievement in those instances where a learner chose, or at least contributed to, its selection. Work applying graded objective structured clinical examinations to students exclusively experiencing one of the two different placement designs might also highlight whether their precise level of clinical competence differs. Furthermore, it would be interesting to examine if any relationship exists between consistent student exposure to a practicum model and newly qualified nurse retention. Finally, whilst Whatman & MacDonald (2017) argue that the integration of theory and practice should be a key consideration within any exploration of practicum design, few studies appeared to have addressed this topic, hence it also appears worthy of further investigation.

17.5 Conclusion

Although the failure of quantitative analyses to support stakeholder preferences for a block model in terms of student retention/achievement levels is acknowledged, it is argued that using mixed methods research to address this topic extended the breadth and depth of findings which are transferable to a broader student audience. Moreover, the deliberate examination of a wide range of related literature from an international perspective sought to recognise variation in terminology used to describe practicum models, highlight the common challenges associated with PRN programmes, and ensure this study was underpinned by a robust knowledge base. By adopting this approach, it is anticipated that ultimately sharing results from the study via papers published in peer-reviewed open access journals will make a meaningful and accessible contribution to current

understanding regarding the influence of block and integrated practicum designs upon student learning. Making such a contribution is both congruent with the emancipatory aspirations of critical realist research [see Chapter 2] and The OU's mission to make learning available to the widest possible audience [see Chapter 4].

Chapter 18. Thesis conclusion

In concluding this thesis, I am reminded of the comment by Edgley et al (2016) that the destination of critical realist research cannot be known until it is reached. When I reflect upon the complex and unpredictable direction of this study over the last six years, I now understand their assertion. I initially assumed that confirming whether positive practice learning within employer-sponsored pre-registration nursing programmes was best promoted by use of a block or integrated practicum would be a modest task involving little more than a brief literature review. My work, however, subsequently identified a paucity of robust evidence on this topic internationally and a tendency for most interest in practice learning to concentrate on the influence of student supervision rather than placement duration and intensity. In addition, I discovered inconsistent use of terminology describing practicum models [7 alternative terms for a block placement were identified and 18 for an integrated design], seriously complicating the literature search and realist synthesis of relevant material, and that virtually no consideration had been given to potential causative mechanisms which might underpin selection of a particular placement type within any health or social care discipline. From a personal perspective, perhaps most importantly it soon became clear this issue was worthy of detailed examination and could be the focus of a doctoral study.

Addressing the research question, however, first necessitated recognising my opinion of the two placement designs as well as the potential effect my background and mindset might have on the implementation, analysis, and interpretation of interview data. Fischer (2009, p.583) describes *bracketing* as '*an investigator's identification of vested interests, personal experience, cultural factors, assumptions, and hunches that could influence how he or she views the study's data.'* Although bracketing originates from phenomenology, many researchers carrying out investigations underpinned by other philosophical perspectives now employ this approach (Weatherford & Maitra, 2019). It requires researchers to demonstrate reflexivity by *'questioning what we, and others, might be taking for granted—what is being said and not said—and examining the impact this has or might have'* (Cunliffe, 2016, p.740). Bracketing activities can be employed before, during,

and after a study (Sorsa et al., 2015) and include personal reflection, writing memos and undertaking an extensive literature review (Tufford & Newman, 2010; Weatherford & Maitra, 2019).

McNarry et al (2019, p.141) claim researchers *are 'situated both within the power-hierarchies and norms of their research field, and in relation to the people who are the object of their study, and the readers of their research reports and outputs*.' As a registered nurse, nurse educator, university academic and doctoral student interested in practicum models, my research was clearly shaped by various vocational, occupational, organisational, and personal characteristics and motivations. Before commencing the study, I therefore reflected upon my views regarding the two practicum designs, acknowledging a preference for the integrated model. This preference was driven by my belief that the framework appeared to offer more immediate opportunity for integrating theory and practice learning; thereby enabling students to better draw upon their academic understanding to help explain, define, and shape practicum experiences, whilst using clinical reflections to evaluate theoretical constructs and their utility in nursing practice. My intention was that, by recognising this view [which was probably influenced by my role as an educator], I could try and ensure it did not impair a balanced appraisal of all relevant information.

Such awareness also led me to seek a third-party perspective on key aspects of the research process, most importantly the data collection activity, qualitative content analysis, and discussion. Some techniques I employed to moderate any impact arising from my own standpoint and practice orientation are detailed earlier in this study [see Chapters 8, 9, 10 & 15]. For example, since the scope of a literature review may be used to help manage a researcher's preconceptions (Chan et al., 2013) and is a pillar of any investigation based on critical realism, this activity was deliberately extensive, wide-ranging [see Chapters 3, 4, 5, 6 & 7], and shaped by supervisor guidance [who suggested locating the topic more explicitly within the historical context of nurse education].

With limited earlier research directly addressing use of block and integrated placement designs in nursing, the literature review/realist synthesis was also an important way to reflect the value of the study and the alternative priorities of other investigations associated with practicum experiences. Again, congruent with critical realist philosophy,

the thesis aims to lead the reader through arguments based on the supporting evidence, thereby facilitating evaluation of my assertions, conclusions, and recommendations. As other researchers have argued (Edwards, 2014; Sweetmore, 2021), adopting an approach which both rejects any notion of neutrality and strives for enhanced reflexivity may ultimately help demonstrate greater transparency and objectivity.

As features of my bracketing strategy, reflections, observations, and updates on various aspects of my doctoral research experience were regularly captured in a Newcastle University weblog and complemented by supervision session discussions and less frequent, but more detailed and focused, reflective accounts submitted as part of each annual progress review. Since the results from all four qualitative phases of the study found a consistent, but not unanimous, preference for the block model and yielded various common themes endorsed by third party reviewers, such triangulation strengthens the validity and reliability of the research results. Perhaps it also provides the most compelling evidence that the effect of my personal perspective and traits upon the research process were adequately mitigated.

As noted in Chapter 1, use of the third person is commonly recommended for academic writing except where the work is a reflective piece (Federation University, 2020; La Framboise, 2022; University of Hull, 2023; University of Arizona, 2023). For this reason, I have only written the initial and final chapters of this thesis in the first person. Nevertheless, I acknowledge that doing so could incorrectly be interpreted as implying a greater degree of research objectivity than is possible when adopting a critical realist investigative approach. I now recognise that, with hindsight, it might arguably have been more appropriate for me to write in the first person throughout the thesis and in so doing explicitly highlight the potential effect of researcher influence upon such a study.

During the first two phases of this research, I sought and received modest funding from The Open University [OU] Faculty of Wellbeing, Education & Language Studies to cover the cost of interview recordings being transcribed by an independent professional transcription service [another technique designed to promote more objective data presentation]. Within the next two phases of the study, transcriptions were also undertaken by this service, but I financed it instead. Although seeking further funding from the university to support this work was an option, bureaucracy related to developing the

necessary business cases and requirement to provide frequent progress reports led me to conclude it was easier to simply meet the remaining, and relatively modest, transcription costs myself.

Throughout my doctoral study I repeatedly received help from academics, predominantly located outside the United Kingdom [UK] and with whom I had no pre-existing working relationship, whose common interest in practicum models led them to share their knowledge, experience and, on one occasion, a manuscript submitted for publication. Similarly, even during the COVID-19 pandemic, mentors in northeast England & Cumbria showed willingness to engage with my research. Given the unprecedented work pressures many of these nurses faced during this period, I am only too aware that receiving a small gift voucher as recognition of their assistance in no way compensated them for giving up precious time to share their views/experiences of practicum models. My desire to maintain a consistent face-to-face approach for all stakeholder interviews delayed some data collection. Ultimately, the protracted effect of Coronavirus restrictions compelled me to accept some mentor interviews would have to be undertaken at a distance. Despite my reservations regarding use of Microsoft Teams or Skype for Business for this purpose, however, such technology did not appear to adversely affect interview quality.

Critical realists claim it is impossible to prevent a researcher from having some influence upon the nature and outcome of their research [see Chapter 2]. Factors such as power asymmetry within this study [given my status as a Staff Tutor/Senior Lecturer and the roles of those stakeholders involved in the interviews I undertook] could have affected the investigation; hence it was important for me to consider various strategies to mitigate potential personal influence [see Chapters 8 and 9]. It is anticipated that the approach I have adopted will enable this study to be deemed one that is methodologically appropriate, ethically sound, and which provides results that can be deemed sufficiently valid and reliable given its investigative focus.

The thesis was also enhanced by opportunities emerging from the study. As the work progressed, I was able to present aspects of the research at conferences and scholarship events hosted by Newcastle University and The OU. I was also able to re-version chapters of the thesis as manuscripts to be considered for publication by open-access, peer-reviewed journals within the fields of care, nursing, and vocational education/training.

Given The OU's mission [see Chapter 4], unsurprisingly its academics are encouraged to publish work in such journals (The OU, 2021). One such paper was co-authored with a member of my doctoral supervision team whose professional background was in medicine.

Not only did these activities develop my portfolio of publications but, more importantly, provided wider feedback on the strengths and shortcomings of my writing. For example, a manuscript based on Chapters 13 and 14 of this thesis, which was submitted to the Canadian journal *Quality Advancement in Nursing Education* and ultimately accepted for publication, initially required various revisions. The reviewers asked for changes including justification for applying multinomial logistic regression analysis to the identified variables, clarification of the age dataset, and identification of the version of SPSS software employed. These revisions were not only applied to the manuscript but also the thesis in order to improve the quality of both submissions. Feedback I received from reviewers in respect of manuscripts based on other sections of this study were equally beneficial to my academic writing.

Submitting manuscripts derived from different elements of the thesis also helped my specific academic interests to be recognised more widely and I was subsequently invited to be a reviewer for several journals. Given that medicine and nursing have a well-documented, complex, inter-professional relationship, perhaps the most unexpected consequence was that one invitation came from a medical journal. Indeed, having accepted it and completed the review, I have since been invited to consider three further manuscripts for this publication. Whilst neither having work published nor reviewing papers were new experiences, I never believed I would co-author a paper with a physician, nor become an academic reviewer for a medical journal. I believe doing so, however, has enabled me to write more effectively for a multidisciplinary audience, enhanced my ability to reflect upon and evaluate relevant research and theory from different fields and compelled me to re-appraise my views about inter-disciplinary working, especially with colleagues in medical education.

Although this study focuses on the influence of two practicum models, it would be inappropriate not to acknowledge, once again, that some respondents in all four stakeholder groups believed there were more important factors determining placement outcomes. Interviewees variously suggested practicum capacity, the provision of high-

quality mentor support, consistency and integration of academic and practice learning, student motivation and resilience, and the balance of the curriculum to address both the art and science of nursing may have greater impact on clinical learning than placement design [see Chapter 10]. This may indeed be the case, but whilst there already appears to be a considerable body of work on most of these topics [see Chapters 3, 5 & 6], the same cannot be said about the influence of practicum duration and intensity on nursing student learning experiences.

Recently, it has also been argued that nurse educators must progress beyond simply modifying existing clinical practice models and instead concentrate on radical innovations by, for example, determining what competences could be best achieved via simulated learning and in so doing reduce reliance on nursing placements (Harder, 2023). Given the new learning opportunities made possible by various technological advances, for example in artificial intelligence and virtual/augmented reality, this seems a reasonable assertion. Nevertheless, it is hard to envisage any future pre-registration nursing programme not needing to retain a significant proportion of real workplace experience if it is to effectively prepare students for the *'swampy lowland where situations are confusing "messes"'* (Schön, 1983, p.42) and in which practice as a registered nurse is located. Moreover, current Nursing and Midwifery Council (2023b) standards for pre-registration nursing programmes in the UK stipulate they must include no more than 600 hours of simulated practice learning as part of at least 2300 practice learning hours. Continued efforts to evaluate different practicum structures and so optimise use of clinical services therefore appears an equally justifiable activity.

It seems remarkable that, after almost two centuries of formal nurse education, identifying the most appropriate placement framework has apparently stimulated such limited interest within the discipline that curriculum planners still have very little empirical evidence to guide their work in this area. Given increasing global demand for suitable nursing placements, it seems vital to make best use of clinical environments by ensuring they effectively accommodate and respond to the needs of students having practice learning based upon both block and integrated designs. Doing so, however, clearly necessitates a better understanding of those factors which need to be considered when selecting the most appropriate practicum model for a nursing student and identifying

interventions to help ensure a satisfying placement experience for all stakeholders and one which effectively enables a learner's proficiency and professional identity to develop in positive ways. I believe this research study has helped contribute to meeting these goals.

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Appendix 1: Example of participant information document

(mentor/practice assessor interviewees)

Participant Information Document

Title of research project: An exploration of block and integrated practice learning models within employer-sponsored Pre-Registration Nursing programmes

1. **Introduction**

   My name is Phil Coleman. I am a Staff Tutor/Senior Lecturer within the Faculty of Wellbeing, Education and Language Studies at The Open University (OU) and involved in the delivery and operational management of this University's Pre-Registration Nursing Programme in northeast England and Cumbria. I am also a part-time post-graduate student on the Doctorate in Education programme provided by the Faculty of Humanities and Social Sciences at Newcastle University. As part of my academic role within The OU and my postgraduate studies at Newcastle University I am currently involved in research related to models of practice learning within The OU Pre-Registration Nursing programmes. This is an invitation to consider taking part in my project.

2. **Purpose of the project**

   The purpose of the project is to answer the question *'What effect does an integrated or block placement model have on the learning experience and retention/achievement rates of pre-registration nursing students concurrently employed as Healthcare Assistants or Assistant Practitioners?'* in an attempt to help determine what curriculum model will best helps students on these programmes to successfully complete their studies and be most effectively prepared for life as a Registered Nurse.

   So far, the project has involved interviewing Practice Tutors (OU staff who support mentors and nursing students in practice settings), Practice Placement Facilitators and students involved in The OU programmes working within ten NHS Trusts in northern England. During the next phase of the research, I am seeking to interview mentors who have supported OU pre-registration nursing students within the same ten NHS Trusts to gain a picture of their experiences of supporting these students within the two different models of practice learning. A final phase of the research will involve an analysis of student retention and achievement rates for an entire UK-wide cohort of OU pre-registration nursing students to examine whether there is any

statistical relationship between these rates and the model of practice learning to which students were exposed.

3. Why have I been invited to take part?

I am approaching you to see whether you might be agreeable to be a participant in this research because I understand that you have experience of mentoring OU pre-registration nursing students in this region and could therefore provide useful reflections on supporting such students in the context of one or both models of practice learning.

4. Do I have to take part?

Please be assured that you are under no obligation to participate in this research and are entirely at liberty to choose not to do so. Your participation is completely voluntary and so any decision to be involved rests solely with you. If you agree to be a participant, you will first be asked to sign a consent form which details the rights you have whilst taking part in the study. These rights include the freedom to refuse to answer any question at any time and to withdraw from the research at any time without needing to give a reason for this decision. Any data collected up to the withdrawal point would be destroyed and therefore not feature within the research.

All NHS Trusts in the region employing staff who are also OU pre-registration nursing students have been advised of this research, but they will not be informed of the names of any Trust staff participating in the study.

5. What will I need to do if I decide to take part?

If you agree to take part in the project, this will only involve one interview lasting between 30-45 minutes. The interview can be held at any NHS location on a date and time of your choosing or by telephone or a Skype for Business call. The location for the interview (which may be your workplace in the case of a face-to-face interview) needs to be somewhere reasonably private and quiet and the interview would be best completed at a time when interruptions are less likely.

A small digital voice recorder would be used to document your responses more easily. The recording would be securely stored on a password-protected university server and the written record derived from it would not include any personal data (such as your name, the names of other individuals in your workplace or the nature of the service in which you work). All records derived from this recording will be anonymised, including the removal of other possible identifying characteristics (such as the name or type of clinical service in which you work). All original data would be de-identified at the end of the project (which is expected to be in late 2022).

Although you will not receive a fee for your participation or any travel or expenses payment, you will be provided with an electronic gift voucher to the value of £15 as a small gesture of appreciation for being a participant in the study.

6. What will happen to the information/data?

The interview recording will be stored on a secure, password-protected university server. All records derived from this recording will be anonymised. This will include the removal of other possible identifying characteristics (such as the name or type of clinical service in which you work). All original data will only be accessed by Phil Coleman and would be de-identified at the end of the project, which is expected to be in late 2022.

If you request a copy of the report for this phase of the project (which you will be invited to do before being interviewed) you will be asked for an email address to which an electronic version of this report can be sent to you, but this email address will be stored in a separate password-protected folder to any other data related to the research and held on the university server.

A copy of your consent form will be kept in a locked cabinet and retained until the end of the project, at which point it will be destroyed.

7. Possible disadvantages of taking part

It is recognised that participating in the project will involve an interview of 30-45 minutes duration and therefore may need accommodation in your working day or use of personal time outside it. The interview questions will only be related to your experiences and views associated with The OU pre-registration nursing programme and so are not expected to generate any anxiety or distress.

8. Potential benefits of taking part

The opportunity to contribute to this project will allow you a little structured time to reflect on your mentor role and your experience of The OU pre-registration nursing programme and its students – good and bad - and may ultimately help me to propose future changes to the curriculum which may benefit both students, other nursing staff, as well as those receiving care.

9. If something goes wrong

It is not anticipated that participation in the study should cause any distress. If, however, any problems should arise you may contact Professor Louise Westmarland at The OU or Professor Liz Todd at Newcastle University, to raise these issues. Their contact details will be provided prior to interview.

10. Contact for further information

Thank you for considering the above invitation to participate in this project. If you require any further information, please don't hesitate to contact me. My details are as follows:

Phil Coleman, Staff Tutor/Senior Lecturer

School of Health, Wellbeing & Social Care

Faculty of Wellbeing, Education & Language Studies

The Open University

Telephone: 0191 2026996

Mobile: 07824 867808

Email: phil.coleman@open.ac.uk

11. Data management

Newcastle University will act as the data controller for this study. You can find out more about how Newcastle University uses your information at http://www.ncl.ac.uk/data.protection and/or by contacting Newcastle University's Data Protection Officer (Maureen Wilkinson, rec-man@ncl.ac.uk).

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer rec-man@ncl.ac.uk who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO) https://ico.org.uk/make-a-complaint/

At the end of the study, the data collected will be de-identified and made available as "open data" through a research data repository [https://research.ncl.ac.uk/rdm/sharing/]. This means the de-identified study data will be publicly available and may be used by other researchers for purposes not related to this study. It will not be possible to identify participants from the "open data".

12. Reference to ethical review of the study

This study has been approved by both the Newcastle University Research Ethics Committee and The OU Human Research Ethics Committee.

Appendix 2: Example of interviewee consent form (mentor/practice assessor)

Newcastle University

Faculty of Humanities and Social Sciences

Consent Form

Title of research project: An exploration of block and integrated practice learning models within employer-sponsored Pre-Registration Nursing programmes.

Name of Researcher: Phil Coleman

1. I confirm that I have read the information document dated 10 December 2019, Version 1, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐
4. I understand that a digital voice recorder will be used to document my interview responses, that the recording will be stored securely, and the written record derived from it will be anonymised and not include any personal data. ☐
5. I understand that at the end of the study, the data collected will be de-identified and made available as "open data" through a research data repository. ☐
6. I agree to take part in the above study. ☐

Participant Name: _____

Participant Signature: _____ **Date:** _____

Contact Email Address (if wishing to receive a copy of the report for this phase of the project):

_____

Researcher name: Phil Coleman

Researcher Signature: _____ **Date:** _____

Appendix 3: Employer Sponsor Interview schedule

Preamble:

The Open University Pre-Registration Nursing Programme currently offers the employers of nursing students on this programme the option of two alternative models of practice learning:

1. An integrated model in which, for example, a full-time employee fulfils the responsibilities of their substantive HCA/AP post for three days (or the nearest equivalent) per week alongside supernumerary practice as a nursing student for the remaining two days (or the nearest equivalent) of their working week.
2. A block model in which, for example, a full-time employee completes their supernumerary practice learning hours as a nursing student in shorter full-time blocks, returning to their substantive HCA/AP post outside of these blocks.

   The Open University is eager to explore the reasons that underpin an employer sponsor's decision to adopt an integrated or block model of practice learning for those nursing students whom they employ as an HCA or AP and to explore the perceived strengths and limitations of both models.

Semi-structured interview schedule:

1. Which model of practice learning do you use for those OU nursing students whom your organisation employs as HCAs/APs?
2. What reasons underpin this choice of model?
3. What impact do you believe adopting this model has upon:

- Service provision?
- Practice settings?
- The student learning experience and skills acquisition?
- The work of other stakeholders within the organisation, such as PPFs?

4. What problems/shortcomings do you believe might arise from the model of practice learning you use? Have you encountered any of these problems/shortcomings so far?

5. Do you believe that different practice settings might be better suited to either an integrated or a block model of practice learning? If so, can you provide several examples to illustrate your thinking.
6. How do you believe theory and practice are best integrated within a Pre-Registration Nurse Education Programme?
7. What do you consider to be the benefits of a part-time, in-house, Pre-Registration Nursing Programme such as that provided by The Open University?
8. What do you believe are the challenges that Trust employees face when studying on a part-time, in-house, Pre-Registration Nursing Programme?
9. What do you regard as the greatest challenges the Trust faces when supporting employees studying on a part-time, in-house, Pre-Registration Nursing Programme?

Appendix 4: Student Interview schedule

Preamble:

The Open University Pre-Registration Nursing Programme currently offers the employer sponsors of nursing students on this programme the option of two alternative models of practice learning:

1. An integrated model in which, for example, a full-time employee fulfils the responsibilities of their substantive HCA/AP post for three days (or the nearest equivalent) per week alongside supernumerary practice as a nursing student for the remaining two days (or the nearest equivalent) of their working week.
2. A block model in which, for example, a full-time employee completes their supernumerary practice learning hours as a nursing student in shorter full-time blocks, returning to their substantive HCA/AP post outside of these blocks.
   The Open University is eager to explore the student experiences of the integrated and block models of practice learning and to explore the perceived strengths and limitations of both models to improve our programme provision.

Semi-structured interview schedule:

1. Which model/s of practice learning have you experienced as a student on The Open University Pre-Registration Nursing Programme?
2. Why do you believe your employer sponsor chose this/these model/s for your practice learning experiences?
3. How do you believe you might have benefitted from your practice learning periods being based on this/these models?
4. Do you believe that use of this/these practice learning models has provided any benefits to others within your organisation?
5. What problems have you experienced with these/these model/s of practice learning within your programme?
6. Do you believe that use of this/these practice learning models have created any problems for others within your organisation?
7. During your practice learning periods:

- How straightforward has it been to achieve the knowledge and skills requirements in your portfolio?
- What factors have made it more difficult to meet these competences?
- How you feel that your mentor or other nurses/healthcare practitioners have treated you compared to nursing students from other universities?

8. How have you found managing the academic and practice learning elements of the Pre-Registration Nursing Programme?
9. How have you found managing your nursing student role alongside your work commitments as an HCA/AP?
10. Is there anything else you would like to say about your experiences as a student on The Open University Pre-Registration Nursing Programme?

Appendix 5: Practice Tutor Interview schedule

Preamble:

The Open University Pre-Registration Nursing Programme currently offers the employers of nursing students on this programme the option of two alternative models of practice learning:

1. An integrated model in which, for example, a full-time employee fulfils the responsibilities of their substantive HCA/AP post for three days (or the nearest equivalent) per week alongside supernumerary practice as a nursing student for the remaining two days (or the nearest equivalent) of their working week.
2. A block model in which, for example, a full-time employee completes their supernumerary practice learning hours as a nursing student in shorter full-time blocks, returning to their substantive HCA/AP post outside of these blocks.
   The Open University is eager to explore the stakeholder experiences of the integrated and block models of practice learning and to explore the perceived strengths and limitations of both models to improve our programme provision.

Semi-structured interview schedule:

1. With which model/s of practice learning on The Open University Pre-Registration Nursing Programme do have you experience?
2. Why do you believe this/these model/s were chosen for programme practice learning experiences?
3. What benefits might this/these models have had on the student's practice learning periods?
4. Do you believe that use of this/these practice learning models has provided any benefits to others within your organisation?
5. What problems have you experienced with these/these model/s of practice learning?
6. Do you believe that use of this/these practice learning models have created any problems for others?
7. During student practice learning periods:

- How straightforward has it been to achieve the portfolio knowledge and skills requirements?
- What factors may have made it more difficult to meet these competences?
- How you believe mentors or other nurses/healthcare practitioners have treated OU PRNP students compared to nursing students from other universities?

8. How have students found managing the academic and practice learning elements of the Pre-Registration Nursing Programme?
9. How have students found managing their nursing student role alongside work commitments as an HCA/AP?
10. Is there anything else you would like to say about your experiences related to The Open University Pre-Registration Nursing Programme?

Appendix 6: Mentor Interview schedule

Preamble:

The Open University Pre-Registration Nursing Programme currently offers the employers of nursing students on this programme the option of two alternative models of practice learning:

1. An integrated model in which, for example, a full-time employee fulfils the responsibilities of their substantive HCA/AP post for three days (or the nearest equivalent) per week alongside supernumerary practice as a nursing student for the remaining two days (or the nearest equivalent) of their working week.
2. A block model in which, for example, a full-time employee completes their supernumerary practice learning hours as a nursing student in shorter full-time blocks, returning to their substantive HCA/AP post outside of these blocks.

   The Open University is eager to explore the stakeholder experiences of the integrated and block models of practice learning and to explore the perceived strengths and limitations of both models to improve our programme provision.

Semi-structured interview schedule:

1. With which model/s of practice learning on The Open University Pre-Registration Nursing Programme do have you experience as a mentor?
2. Why do you believe this/these model/s were chosen for programme practice learning experiences?
3. What benefits might this/these models have had on the student's practice learning periods?
4. Do you believe that use of this/these practice learning models has provided any benefits to others within your organisation?
5. What problems have you experienced with these/these model/s of practice learning?
6. Do you believe that use of this/these practice learning models have created any problems for others?

7. During student practice learning periods:

- How straightforward do you believe it has been for students to achieve the portfolio knowledge and skills requirements?
- What factors may have made it more difficult for them to meet these competences?
- How you believe other nurses/healthcare practitioners have treated OU PRNP students compared to nursing students from other universities?

8. How do you think students have found managing the academic and practice learning elements of the Pre-Registration Nursing Programme?
9. How do you think students have found managing their nursing student role alongside work commitments as an HCA/AP?
10. How do you believe COVID-19 has affected nursing student support during practice learning?
11. Is there anything else you would like to say about your experiences related to The Open University Pre-Registration Nursing Programme?

Appendix 7 - Qualitative Content Analysis Stage 1 - open coding summary - student data example

Model

R1 – Integrated – preferred

R2 Block – preferred

R3 – Block – preferred

R4 – Block – preferred

R5 – Block – chosen

R6 – Integrated – would have preferred block

R7 – Block – would have preferred integrated

R8 – Block – chosen

R9 – Integrated - would have preferred block

R10 Integrated – undecided on preference

R11 – Integrated – no preference stated

R12 – Integrated - no preference stated

Key student issues

Block – for

- Easier to cover hours in day job than in integrated model
- Less fragmented and more intense learning
- Consistent role and absolute distinction
- Being a 'complete' student and immersion in experience
- Staff less confused regarding individual's role

- Greater confidence in student nurse role
- Reduced tension regarding skills in both roles
- Easier to feel and be regarded as part of the team in practice learning environment
- Setting aside enough time for academic study when on placement

Block – against

- Learning in 5 days not necessarily 2½ times greater
- Rapid planning needed due to shorter period
- Less time to consolidate learning
- Total loss of staff member from day job – made worse by no backfill
- Misses and missed in day job and adverse impact of absence on day job team
- Too short an experience
- Radical work change from block attendance complicates family commitments
- Loss of skills from one block to another
- Loss of continuity in day job and needing to constantly rebuild caseload
- Handing caseload over to already overstretched colleagues
- Two tunics not enough
- Portfolio neglected during non-practice learning periods
- Integrating practice learning and academic study when not on placement

Integrated – for

- Days can be swapped to optimise practice learning time
- Reduces less effective practice learning time during bank holidays
- Continuous practice learning allows continuous sense of being a nursing student
- Theoretical study greater when in placement

- Transition between roles not a challenge
- More relaxed pace of practice learning
- Easier to cover absence of staff member from day job
- Skills in day job not lost/degraded
- Avoids disconnect with day job
- Swifter, more seamless transferable learning between experience in both environments
- Still possible to break up roles with a day or more off in between
- Longer practice learning periods than other nursing students beneficial

Integrated - against

- Questionable how much one can learn in only 1-2 shits per week
- Groundhog day on skills learning
- Challenge of constantly switching roles
- Unrealistic expectations based on misunderstanding about shifts a student has worked
- Makes re-scheduling meetings with mentor more problematic
- Slower achievement of competences
- No consistent view of care practice
- Concurrent worrying about both roles
- Critical learning opportunities missed when not on shift
- Caseload squeezed into fewer days to accommodate practice learning
- Complicates bank work in practice learning environment

Other issues:

- Being part of the team
- Animosity from HCAs in day job

- Challenges to supernumerary student status
- Being seen as ‘up yourself’ by other HCAs in the day job
- Learning from good and bad nurses
- Protective and nurturing mentors
- Worry about the pressure exerted on a mentor by adding to their workload
- Cutting bank work to complete TMAs
- Using days off to study
- Booking annual leave to complete academic study
- Working weekends to enable effective practice learning
- More time/head space to study when an HCA
- Staff in practice learning areas believe OU nursing students know more and they expect more of them
- Risk of being left to ‘get on with it’ as an OU nursing student
- OU nursing student not a ‘proper’ nursing student
- Animosity from HCAs in practice learning environments who learn you are an HCA being paid to study
- Pressure – from self and others - to be an extra pair of hands in practice learning environment
- Frustration at not being able to use acquired skills in both roles
- Recognising common ground between HCA/AP and nursing student roles
- Expectation of self-sufficiency, self-discipline and sacrifice the price you pay for the opportunity
- Exhaustion
- Bereavement

- Growth in confidence and ability
- Loneliness and isolation
- Financial pressures

Appendix 8 - Qualitative Content Analysis Stage 2 – early category creation - student data example [identifying features redacted]

Limitations of block placement

R1 even without consciously thinking that sometimes has got a bearing on what I was doing there, it automatically comes to you. So it is a good learning experience. I really think it is. And also maybe five days together there, I don't think you're learning anything much more than that unless there are some particular days, some particular events are happening [unclear 0:05:02] is only on this day. So it's up to me to choose some based on that one, rather than just strictly following Thursday/Friday or Monday/Tuesday, you know, choose some on both days as well. Out of the two, take any two days. So I'm community, I know when the assessment days are, that's on Thursdays.

R1 So even in that kind of circumstance, you know, the mentor can kind of graduate to say this is what's happening on this day, so this particular patient, would you like to come on that day?

R1 I am in [redacted], there won't be much happening during the Christmas and New Year period in that two weeks really. But if you're allocated that period [in a Block] you've got to go and that would be not much of a patient visit either. So whereas this one you can take that time off as part of your holiday period, and then go on when the activities are in.

R3 you had to build it up quite quick, because I was only there for a short period.

R3 when I'm a student I tend to do more of my theory side of it what I have to do as well. But when I'm working fulltime you forget sometimes that you're a student.

R5 there was a lot more negatives came up letting me go for a block placement – because obviously my role wasn't going to be there for a long period

R5 they were going to lose me from my job role for a period of time. I'm experienced within the practice at work, so the actual, the service was going to lose a support worker

role. And that was a massive disadvantage. But the way my manager saw it was it committed me to do my nurse training, and so they wanted me to get the best out of it.

R5 initially they were promised some backfill, so some backfill money to able to backfill my role, but I don't think that ever materialised. So I think in all honesty that maybe next year or if the programme runs again, my manager, if she ever get some money through, might be dubious about letting somebody go on a block placement.

R5 I get a lot of feedback from my colleagues at work that I'm terribly missed. So I think that's not just as a support worker, not just the role is missed, but me as a person is missed. Because I think whether that's an individual thing, or that's the person who I am, that I do have, they can't wait to get me back. What they'll say is we miss you being here. So I'm very much valued within my service and within my team, and so that's, it weighs heavy sometimes, especially at this time year when it's Christmas, when there's lots of things going on and I'm removed from that. So I do get a lot of feedback, we wish you were back because the place isn't the same without you.

R5 I work for [redacted] so it's a very specific role as well, so I think it is about maintaining and building relationships up with your acute hospitals. So I've been missed by the acute hospital as well, so I've had feedback from actually the other service where it's like where have you been, you haven't been on our ward, and we've really missed you. We didn't know what to do with this patient, we knew that you'd know but you haven't been here, where have you been? So there is kind of a lot of attachment going on. But I do come back and it is what it is.

R5 I just feel like I've literally got my feet on the ground and I'm gone.

R6 the potential impact it might have on your regular team. Because I work for the [redacted], so maybe it's more made for like a three/four week chunk, it would have a massive impact and potentially it's not a sort of, they couldn't get any backfill for that. They did initially apparently get 15 hours for that, but due to cutbacks they didn't, they were dropped.

R7 I've got children to get to school and things like that. So having two days a week would be much better personally than having the full block placement and having to

cover four weeks, six weeks, 10 weeks of childcare, whereas two days a week my mum and dad could handle that, so personally for that reason. And also as a student I feel like there's no continuous learning. You have four weeks, and then nothing for months. And I'm in a completely different job that has nothing to do with nursing. So then I'm pulled out of that, and then put back in. So it's starting again, at least for the first week to get back into how the routine goes. You carry over some skills, but not all of the everyday routine stuff.

R7 when I'm on the ward it's intense for the block placement. So you get used to the ward and how the routines goes. And then all the different things they do on the ward, which you tend to hold onto. I don't seem to lose those skills. But when I come back onto my normal job I'm not on a ward, I'm community based. So it's absolutely the polar opposite of what I'm doing, And then when I seem to go back to the ward it's like OK, I know every ward does things a little bit differently, but it's like OK washing and dressing, all the different basic things that you do. It's like you have to get your head around it all again. I think if I did it two days a week continuously it would stay with me a lot easier.

R7 from a professional point of view in my day job, my regular job, all those patients that I see I have to handover to other people and start again. And some of them get discharged, and I would like that continuity with that as well. I'd be able to see so many patients in the three days I would be here

R7 when I come back it's like I'm starting with absolutely no patients, and I've got to learn who the new patients are, what their needs are, and start again really

R7 I don't think they feel long enough, the four weeks placement. It's like I'm coming to the end of my placement now, and I feel like there's so much more I could do, but it's almost over.

R7 Two tunics are great if you've got two days a week, but for block placements it just does not work.

R8 The only thing I would say about block placements is you spent a lot of time, a big clump of time away from your placements. And sometimes that means that you can, your portfolio gets neglected. And you're doing your TMAs and your online tutorials and

what have you, and you're doing your work, but I'm finding that sometimes I can go for a month without picking my portfolio up

R11 trying to cover both of our hours full-time for a block period that's probably more difficult than just having sort of one to two shifts for each of us per week that they can slot in. Particularly when it comes to like peak holiday times and things like that, I would imagine that that would make it more difficult for the employers to cover the shifts

R12 from a financial perspective I was full-time on placement, I'd lose out on enhancements

Limitations of integrated practice learning

R3 didn't really think there would be much you could learn in one shift a week; whereas obviously the difference between working as an AP and working as a student has been quite a difficult transition

R3 If I'd have had a week between doing that, or even two weeks or three weeks, it would have been like starting again each day; whereas as a student we've been able to keep the continuity as a student for them five weeks.

R4 easier to cover my hours as a block than two days a week. If they've got a good run of getting someone to cover for quite a while.

R4 If you just do two days a week and then, well I would feel that you would just be back to square one the next time.

R4 I couldn't imagine it being easy to switch between both for two days, and then going back to auxiliary.

R4 So I think if you're only having two days a week being a student, and then straight back in, I think it would be harder to switch your head from student mode.

R6 I might learn something on here for two days. Sometimes I'm here for one full day or two half days, that's the way I've been doing it. And I learn something new, and I'm away again and I have to wait a full week. And I come back and I think oh I forget how you do

that. I've got a crap memory so my retention's terrible. So from that point of view a chunk would have been better.

R6 by the fifth shift the manager in this department got really annoyed with us and shouted at us in the corridor, which I didn't appreciate, I did tell her. I did not appreciate being shouted at, but I did understand her frustration. And she kept saying you've been here five weeks and I still haven't seen your port. I hadn't, I've been there five shifts. There's a massive difference. But they just regard me as being there for five weeks. So although I'd been here for eight weeks, is it eight weeks now, nine weeks, it's only been probably five or six shifts. Because I've done 12 hour shifts, I've done a night shift, and I've done a couple of half hour shifts. So it's very bitty.

R6 So I know quite a bit, I'm not complacent or cocky with it. I'm here to learn and I do try to learn. Maybe things like medication say for example. I'll find out when I'm doing a drugs round what that medication was. I do it as part of my portfolio, I learn about medications. But if it's a new one, and then the following week it comes up again, I guarantee I'll forget what it's there and what it's for. So that sort of thing.

R6 competencies-wise, the portfolio, you never get to sit down with them regularly. And I think again looking at the [redacted] students who are here in a chunk, at least if you're here five days you'll find at least half an hour to sit down. I'm here one or two days a week. You haven't, I want the best I can out of my experience, and to drag [redacted] away from her patients when it's bouncing out there, it just never happens.

R8 I did say that it was difficult to go for two days on placement and then work three days as a band 3 and then have two days off and then that's the process. And it's very difficult to get any consistency with patients

R9 When you start to work with someone, it's part of the nursing process isn't it where you see them at the start, you oversee the treatments and then you see the recovery and then you discharge don't you, and that's part of validation for me. I mean that was validation for me before starting the nursing programme there, you see that, and it makes you know you've done a job. I've done something positive for that person. You know, I wouldn't have seen that otherwise. Something that fictionally I would have struggled with if I didn't have the continuity that I maybe have.

R11 I think you've probably just got to be a little bit patient because yes if I'd been there for sort of five days a week I probably would have had that opportunity sooner

R11 bit of flexibility as well say if there was something happening that we knew about in advance that I particularly wanted to be a part of to just try and make sure that I was around on those days.

Strengths of block placement

R4 it's better to learn in a block than bits here and bits there.

R2 it could get a bit confusing trying to switch between a healthcare assistant role and then come into your student role. It's like when you're a student you're doing totally different things. You've got a lot more range of what you can do. So they chose the block model, and I've got to admit it's not half as confusing as I think what it would be going.

R2 I know that when I'm on placement I'm on placement for a block period of time; I'm not back in my healthcare assistant role until I'm back there. And then when I know that I'm back in that block role as a healthcare assistant that I can't do the stuff that I'm doing as a student nurse

R2 I'd say the main advantage is the fact that I'm not getting confused between being an auxiliary one day and being a student the next day.

R2 I definitely think it would be too hard to be switching between the roles each week basically

R2 It can sometimes be a bit difficult, because you're obviously trying to get used to I can't do this as an auxiliary nurse, but it's actually not too bad. I think I prefer this way. I fit back in straightaway to be honest

R3 when I come out of my AP uniform and put my student uniform on for those four or five week blocks that I'm doing, I am a student and I've accepted that. So personally I've found that easier with the transition.

R5 I felt the block placements would be a better experience. Because then I could take my work hat off, and put my student hat on and go away and be a student for that period of time, rather than swap and change with other commitments around me as well

R5 So some of the advantages of the block placement was that I would be released from my work role, and I'd go away and be a student, and I wouldn't be worrying about anything that was going on at work. So I'd be able to run my caseload down, I'd be able to finish on say the Friday, and think right I'm not coming back for a month. And I was up to date on mandatory training, and so I was able to walk away with a fresh new start. So that appealed to me that I wasn't swapping and changing. And another benefit was that I would get more from the experience of being there for like a four week block, rather than just doing it two days a week. So have the continuity to see patients in a continuity view.

R5 if I was doing it a Monday and a Tuesday every week, a patient may have come and gone

R5 I would then I would be maybe missing quite a big chunk of that episode of care.

R5 if you were doing it in the block you had a little bit more scope of planning when the block could be. then I would be able to get in touch with my mentors and say right, I can come from now to December, is there any time that's more convenient for yourself?

R5 But for me it works perfectly

R5 It works for me because I feel that I can come and do a complete nursing role. So I can be student nurse for that period of time, and I'm not having to think I'm anything else. So people are not getting confused about whether I'm a student nurse or whether I'm a support worker.

R5 I'm coming in as a fresh pair of eyes thinking I'm a student nurse, I'm here to learn. I've took my backpack off so to speak, and I feel that it's really worked for me

R5 the block placements has enabled me to do that simply by the continuity of patients as well. So if you've got an episode of care that a patient's coming in with, you're already thinking well I know I've got a competency coming up, that patient would fit that, so I need to work alongside that patient with my mentor to be able to reach that

competency. So I'm thinking about it all the time through that placement while I'm here. Where that might have been a bit more difficult if I was only here a couple of days a week. Because I think I might have been, I'm only here two days, what can I reach in them two days? Where I get a really broad learning experience.

R5 I can just submerge myself into everything around what's going on. Feel like after a week, get my feet on the ground and start thinking right, I know where everything is now, I know what the core business is, I know what the processes are. Right, now I'll start thinking how can I meet these competencies

R6 talking to other students who get here, who are here in chunks, I think they get a better experience.

R6 I would have been here three full shifts every week to get a good feel of the place. I'd probably feel a lot more confident if I'd had that opportunity.

R7 because it's intense learning for those block placements. You're not pulled away at all, you're focused totally on the learning of the things they do on that ward or that placement. So yeah, it is good

R8 for continuity. You can get in there, you can get your teeth into what's going on, like on a ward or at the minute I'm on community placement. I just feel as though I wouldn't be torn between my role as an HCA or a support worker, and my role as a student as much

R8 It's not too bad, because there are other support workers there. The service I work for, it's not like a ward that needs HCAs or support workers. Support workers are really there as, I think they could manage without support workers if they had to

R9 I would have preferred a block placement where I went away and come back, could have focused on six weeks on placement where you deal with your caseload or with your patients on the ward and you kind of come back and do this for six weeks non-stop.

R9 if I was working five days for six weeks, because [redacted] I could have regular cases where that was better for me as a student because I would be taking [redacted] on every assessment and seeing that through for six weeks, rather than hoping that I can see them over the two days that I'm in.

Strengths of integrated practice learning

R1 So had I been there only that particular time I would not know what had happened after. So it would be just the basics to start with, and then conclusion would be drawn from what I think would have happened rather than what has happened. And also you get time to go through it in much more relaxed way, rather than crowding it at one particular point

R9 I suppose you'd keep me three days in this post every week, I suppose you're not going to backfill a post for six weeks at a time. You'd lose a full member of staff don't you? Whereas, technically, if I work three days here, I'm part-time, so they'll only lose me for two days,

R10 I don't know whether it was just to help both sides if you know what I mean and make sure that they were still covered on the healthcare side, and covered on the nursing side as well

R10 they're only at one area for a short space of time; whereas we've got block areas for quite a long time. So then you get used to the routine, you get used to the people. You get used to all the paperwork and how things should be done.

R11 obviously I'm still here in my capacity as a healthcare assistant so I'm still keeping all of those skills up to date. there's some of the skills that I can do as a healthcare assistant that I'm not allowed to do as a student nurse, which is like venepuncture and back slabs and dressings and stuff that I would only do sort of further on down the line as a student nurse.

R12 I think it's so that you're not gone from the ward. if it's only two days a week, you're still there constantly, you're not disappearing for eight weeks at a time or something.

R12 If I was gone for whatever length of time, let's say ten weeks, I'd feel uncomfortable coming back because I'd feel like right what have I missed, how much has changed.

R12 Learning stuff in a previous placement that I was able to bring back here straight away. So I was able to learn stuff there and how to treat a wound on placement and then within a week I was using it back here. And then obviously it's good being able to take

stuff from here in terms of [redacted] over on my placement.

Wearing two hats/avoiding the frustration of different role expectations/limitations/clear delineation

R3 not being able to do the things that you do as an AP has been quite a difficult transition

R4 Well even in a block, because I'm doing a block, so I'll have 10 weeks here and then I go back. Even that's sometimes harder to shift from student head to auxiliary, when you go back to work you have to hold back and think I'm not a student, I can't do that.

R5 I felt the block placements would be a better experience. Because then I could take my work hat off, and put my student hat on and go away and be a student for that period of time, rather than swap and change with other commitments around me as well

R5 It works for me because I feel that I can come and do a complete nursing role. So I can be student nurse for that period of time, and I'm not having to think I'm anything else. So people are not getting confused about whether I'm a student nurse or whether I'm a support worker.

R5 So I'm not going to work and being support worker, and being embroiled in the work role, and then on a Tuesday and then having to go to bed and wake up a student nurse on a Wednesday, and think right take that hat back off now.

R5 there's certain times where I've had to stop myself getting involved in conversations, simply because of the crossover with patients. So obviously from service to service, so say like this service is a community service, we would refer on to this service. So we talked about patients I've been involved with as a support worker. So there's times when I've wanted to say I know that patient. But then I think well what am I telling them for? If the purpose of the information I'm handing over purposeful, or is it just to let them know that I know the patient?

R5 there's certain times when I've been say on the hospital ward in my support worker role where I've thought I know about this, I've learned about this, I know the answer to this, but I'm a support worker. So what I'll say is well although I can't help you, I'm going to go and get a nurse to, because I'm a support worker so I'm able to give you advice on that certain whatever it is. I then can go back to the nurse and say this is what this patient's presenting with, this is what the doctor wants to know or the nurse wants to know. This is what I know about this, and that's been really helpful to the nurse who's then had to go out, or we've gone and done it jointly. So then I can learn from that experience as well. But yeah, I suppose it's what your boundaries are, and I think you need to be very certain and very clear of them to keep yourself safe.

R5 you've got to take your hat off and go back to your support worker role. So it's almost like five steps forward and five back, then 10 steps forward and then 10 steps back, and as I grow you're jumping from one to another.

R6 I'm annoyed that I wasn't given the option of the other one. Only because it's hard. Firstly you never know what hat you're putting on in a morning. You've got to switch from one to the other. I still, even though I'm this close to the end, I still have difficulties switching off from my healthcare head. So I have been criticised for being on a ward and just disappearing and getting on with some jobs. Because that's what I've always done as a healthcare. And then immediately after tomorrow I'm back to being a healthcare. So it's switching, that's not problematic but it's a pain in the butt.

R6 my core base is [redacted], and brilliant team, brilliant area, brilliant patients. So after a while I started going back there and bank work as a healthcare. That threw a few patients, because one minute I'm going in, giving insulin under the supervision of a mentor, and the next I wasn't. I'm there as a healthcare assistant, competent in giving insulin. But there have been a couple of comments from patients like well why isn't [redacted] here with you today, why have you got a different uniform on? So I've stopped doing that sort of bank work in areas where I'm also a student

R6 I wouldn't do it on here, not while I'm a student. I might come back later on and do bank shifts, that's different. I think it might confuse, not confuse but I think it might, there might be a conflict of interest with other staff as well. Like one minute I'm there as

a student delegating work to healthcare assistants, and the next I'm a healthcare assistant. So that might be a conflict of interest

R9 I think it's hard to change hats. I found that difficult because I think along the lines of a nursing student all the time and I find that difficult working as a band 3 where I've got to revert back to that role

R9 I think it was around where we were discussing the learning disability competencies and it was saying to this point, I'll tell you now, the LD competencies are the only things in my file that I've not signed off, and I think it's absolutely crazy that I've done this. I've worked in LD for half of my career, yet they're the only competencies I can't be getting signed off at this moment in time.

R9 I do find it difficult to change for two days a week and then to come back for another three with a different hat on. it's two days, three days, two days off, two days, three days, and that's the pattern of changing hats and that's been difficult. I must admit I think that's been one of the hardest, internally one of the hardest parts for me

R9 yeah it's difficult to change between the hats

R9 He used to ask me does anybody here even ask you, especially management, about how you're doing and what progress you're making. And I've said honestly [redacted] no. And that's the god's honest truth

R10 It's hard at the beginning going from your healthcare role to your student nurse role then back to your healthcare role and not doing your student nurse role. It took a long time to get used to which hat I'm going to be wearing that day in that area.

R10 I'll say can I have a bag of fluid. And they'll say no because I'm a healthcare. But yet on the ward, they'll stand there and observe you to do it. So it's like. And then I can take bloods down here. I'm not allowed to take bloods on the ward even though I've been doing it for years. It's getting used to what you can and can't do

R11 when I come here as a healthcare assistant and I've got me pale blue scrubs on and that's me and I'm here and just doing the same as I've always done but then when I go to placement I go directly to the area of placement and I'm in me student uniform so it's all quite separate

R12 Initially I really struggled with it. I was, because I was doing, it wasn't necessarily two days on placement and then separately from my two days on the ward. I would say it could have been placement, ward, placement, ward, and that I really struggled with to start off with. Especially with it being a new thing. But as it's gone on I've sort of found a system that's worked for me where I can have my two days on placement and then I'll have my two days on ward where I'll break them up with a day and then come in for my days on the ward. So it's broken up nicely. And sort of learning to be like what limits I have on placement and what limits I have on the ward.

R12 Go to placement having done me day on the ward and I'd be mucking in as an NA and I'd be like oh hang on I'm here to be a student. I need to take things by the horns and get involved the nursing side of things not just the healthcare.

Being part of a team/building relationships

R2 On a block placement I don't know, I feel like you get to know people a lot more, you're spending more time with them. But then it's also hard in a way that you're away from like my work base, I'm not seeing anyone from there. So it's probably good and bad.

R2 when I'm going back to my ward it's like who are you, we haven't seen you for so long [Block]

R3 me being away from them, they don't ever treat me like a student – which is good, because obviously I don't want to be treated like a student in my own role, because I'm not a student then. And that's definitely been a help to differentiate between the two as well.

R3 being away from work and being as a student [is a problem]

R4 you get a rapport built up don't you? Because the mentor that I'm with now I've been with since my first ever placement, because this is like my base ward.

R5 I get a lot of feedback from my colleagues at work that I'm terribly missed. So I think that's not just as a support worker, not just the role is missed, but me as a person is missed. Because I think whether that's an individual thing, or that's the person who I am,

that I do have, they can't wait to get me back. What they'll say is we miss you being here. So I'm very much valued within my service and within my team, and so that's, it weighs heavy sometimes, especially at this time year when it's Christmas, when there's lots of things going on and I'm removed from that. So I do get a lot of feedback, we wish you were back because the place isn't the same without you.

R5 when you're submerged for five days, they very much become a little work family. So you're here Monday through to Friday. We're here from eight o'clock in a morning until sometimes six o'clock at night. So you're spending lots of time with people on a personal level as well. I think you need to know when you're with a mentor or with different people who you're with, I like to get a sense of who that person is, and how they practice. Because sometimes there's things you see in people you don't want to pick up. There's certain aspects of people that you don't want to model yourself on. But then there's certain aspects who are complete inspirations and I want to be that practitioner. And you have to find yourself in amongst all of that as well to be at the end an independent practitioner.

R5 I work for [redacted] so it's a very specific role as well, so I think it is about maintaining and building relationships up with your [redacted]. So I've been missed by the acute hospital as well, so I've had feedback from actually the other service where it's like where have you been, you haven't been on our ward, and we've really missed you. We didn't know what to do with this patient, we knew that you'd know but you haven't been here, where have you been? So there is kind of a lot of attachment going on. But I do come back and it is what it is.

R6 obviously I miss the team when I'm not there. I miss what's happening. I mean we're lucky, we are a very small team covering apparently, I'm saying apparently, I know we cover the largest geographical in [redacted]. So our business comes from distance.

R6 for me I have missed patients, I've missed the team of lasses I work with. It can impact whereby in September and again last month I had a bit of annual leave. I had Saturday night shifts, and literally I was only with my team for one week

R7 I have to hand mine back to the professionals that are, like the [redacted], and they're already overloaded and I'm handing my caseload back to them. So I feel awful.

R7 I've never had any problems with the teams at all, any of them.

R8 They're very supportive. So there's not been any adversity or anything.

R9 I work with some pretty feisty characters here and some of them I think resent me a little bit that I wasn't here that long

R9 Like I just feel like I'm a part of the team sometimes, I'm not. You see maybe I compare that to other students who sometimes do look quite timid and they don't look part of the team, they look like a spare part or. Because they don't know what to do themselves and I just kind of get myself in there

R10 The only thing I have found when you get, they seem to put me on earlies. Since I've been back on this ward since October I haven't done any late shifts. They always seem to be early shifts. So on the morning when they're doing the drugs round, and they're very busy and we've got new staff, I don't get to do any drugs rounds. But then I finish at 3:30 so I don't get to do any of the – so I've asked if I can do lates, but she said oh she'd rather have me on the earlies.

R12 There has been times where I've been counted in the numbers. Because I've asked to go on a different ward because there was a learning experience available there, and they said oh no we can't afford it, we're short this afternoon, and I said well I'm not in the numbers, and they went it doesn't matter, we need you here as an extra pair of hands. I was like so I am in the numbers. That's not what I'm saying, we just need you here as an extra pair of hands. I've got a learning experience that is going ahead on a different ward, I should be entitled, like I feel entitled to go and yeah it got sorted.

R12 I've seen quite a positive impact. Especially in terms of the [redacted] stuff because if there has been like little cases of [redacted] that are a little bit tricky, that's been the big one, is [redacted]. We've had stuff that the doctors have been a bit like oh well I don't quite fancy doing that because it's been quite complicated. And I've said listen I've done it at [redacted], can I have a go? And the doctors have said yeah, take the nurse with you.

R12 I've found myself turning around and one of my colleagues is going oh can you just come and asking them to do something. Which there's nothing wrong with it but when

you're the same level as them it could be sort of conceived as being bit, a bit up myself or whatever, and it's important not to do that.

Mentors

R1 most mentors are more than willing to take. You know, for example I had one incident with a patient who was a member of a gang or things like that. So she didn't want me to be exposed to that. Not about the patient, [unclear 0:06:49] any longer, but then you will never know who is following who. So they have taken that extra care as well. So it's been really nice that you're feeling protected and safe in that kind of practice.

R1 if you're in [redacted], you'll hardly see, even if that person is there on that day you would hardly see because of how hectic it can be. So that's one of the, and also in an environment like this staff get injured very often. So I had about four mentors in one of my placements because… they were injured and they had to go.

R1 there are two things you can learn from your mentor: one how to be a good nurse, and how not to be.

R3 She was very protective of me being supernumerary.

R3 other mentors after that, it's been more what I've asked them for

R3 obviously I don't want people to think of me as in who does she think she is type of person. they've been quite open with my suggestions

R4 My mentor's always been really good at arranging things. Like theatre, I've been theatre and things like that. So she's always been pushing us to do a lot. So I don't think it has an impact

R5 I've got no other word to say but amazing. He's just the most, he is a really good mentor. And I often think that he's got his workload to do, and teaching me at the same time. And at the end of the day he must go home exhausted. He says he doesn't, and I know that [redacted], we have a lot of students, we do train, but I think as a staff member we do invest a lot in our students.

R5 So I think that there will definitely be a knock-on effect for my mentor being here like four weeks, and especially because at the moment he's got two students.

R6 I've stuck to two days. For me it's easy in my head to know which two days I'm a student, but then where that falls down is if my mentors aren't on them shifts I've got to go with somebody else

R6 I must have spent less than a quarter of my time on there with my mentor. This one's much better, I can fit in with [redacted]. I even night shifts last week, which I hate, I'm still recovering. But I did it because that was the only shift she was on last week.

R7 Yes always, they've been 100% with the mentors

R8 Absolutely yeah, probably the one, I think I had enough time with her, but the least time was spent was on the wards. But I think that's the nature of the beast kind of thing. They do long shifts, you can't always, she was 30 hours, I'm fulltime. She was doing a lot of night shifts two of the weeks; whereas I only had to do three. Little things like that. But I did get the quota in

R10 I spend well over 60-70% on our mentor, [redacted]. But on other wards, it wasn't as easy.

R11 I think my mentor has been quite good at sort of saying right let's sit down and go through your file and we'll sign off the ones that I can sign off now and then we'll go back through and look at the ones that still need signing off and we'll work out ways in which you can meet them so that I can sign you off. So they've been really proactive.

R11 my mentor on my ward, on my base ward, she works extra most weeks, which has been a massive help in sorting out

R11 They've probably been like 90% of the time unless they were on holiday or off sick, so yes.

R12 I've not had any problems with my mentor. If I've had a problem with anything else I've gone to me mentor to sort it out.

R12 There has been like a few occasions where we've been like right we'll pencil this in to go through your portfolio, we'll pencil that in for tomorrow, and then it's come to the day

and it's been a very busy day and we're like right OK we'll have to do it next week. And then I'll come in next week and me mentor has gone onto nights and we'll do it the week after and stuff like that so it happens but it's nature of the ward.

Juggling work and academic learning

R6 My manager says how you work them hours is up to you. So if I do a full 12 hour shift on a Tuesday I've got the Wednesday as study time, because I've done my committed hours. So that's what I do. I'll sit and do my assignments on that day. I do them on a weekend, I try and do them on a night when I get home, but obviously if I leave here at eight o'clock at night there's not much going to get done. After work I try and get some done. You squeeze a bit in when you can. And obviously if things get close to an assignment, which it is at the minute, bank work goes out the window, I'm skint for a bit longer. And then I just have to commit my days off to study and getting assignments put in. But it's hard, I wouldn't recommend it for anybody my age.

R12 At times it can be quite tough. At the minute it's sort of the assignments and the ICMAs are coming thick and fast so it's trying to prioritise them over anything else.

Juggling academic and practice learning/consolidating academic and practice learning

R2 I find it quite hard to do all my academic work when I'm on placement and studying. That part of it's hard,

R2 I feel like when I'm on placement I'm not really as good academically as what I am when I'm in my healthcare assistant role. I've got more time basically.

R2 I'm so used to my 30 hours that it does, because it's an extra day on my week that I'm coming into work. So that's a day that I'm losing out on studying really. But it's good in a way because we obviously have to get that time back. So that gets given back to us in like a block week usually. So after my placement I have a week off, and then I can study in that week.

R2 the practice learning module was like can you apply, can you go and speak to your mentor and talk about this. But it's like I'm not on placement at the moment, so that's the hard thing. Some of the tasks are difficult to do because I'm actually not on placement.

R3 even when I'm at work and I'm not a student I still have all my other student responsibilities, which is really full on. But when I am on placement and I am student, I find it easier to be a student if that makes sense.

R3 when I'm at work in my fulltime AP role, you do forget sometimes; obviously if you've got an assignment due it's different, but at the moment we only have one module running. At one point during the summer we had three, and I think there was an overlap with four at one point. So it was quite full on, so obviously you were a student fulltime then; whereas at the moment I only have one module, so it's not an intense. So it's easy to forget you're a student because you don't have so many deadlines to hit.

R4 I write everything down to be honest, and I reflect on everything in my placement. So then I've always got that to jog my memory or go back to it when we're doing it. But it more or less always links in with what we're doing anyway.

R4 time management isn't it? If I plan what I need to do, like the modules obviously week by week, if I plan within that week what I need to do, then I know I have to do it. But a lot of willpower to go home after 13 hours and think right, this is what I need to do. So it's just time management, and you have to want to do it don't you?

R5 sometimes I feel that because it's online, and because it's never really there. So your practice placements are live, they're happening, they're there, you've got to go. But with your academic studies you know that they're there but you're able to put that off a little bit more.

R7 I reflect sometimes on my everyday practice rather than, but some of them yes, it's like I'm not even in practice and I don't know this. And last year I felt that the stuff we were learning on the modules at the end of the year we should have done before we started practice. So it was like blood pressures and different observations. And it's like I

went onto a ward not ever having done observations, fluid charts or anything. So to learn that at the end of the year was not even relevant anymore. I had to learn that on the job.

R8 you reflect on something that you've done in a student, when you've been in a student capacity. I would reflect on that. You've got a memory haven't you?

R9 at times it was difficult to juggle the placement and your portfolio. To be honest at the start when there was, when your assignments were coming thick and fast, and the tutorials were thick and fast, the portfolio went on the backburner a little bit. And then when them kind of died off a little bit, again that was just managing my own time and learning really, then the portfolio took a bit of a forefront as them kind of died off and there was more space between TMAs and things

R11 you had to sort of give an account of a communication incident if you like that hadn't gone as you'd expected and that you found challenging. Well, it had to be based on your placement. Well, I hadn't actually had any of those issues on placement, so I was little bit stuck there. Had it have been generally I could have, you know, given any number of examples in role as a healthcare assistant

Juggling academic learning on different modules

R7 Very hard yes, very hard. I had a bit of a breakdown last week, but just for a day until I got things done – because there was too much all at once. We had the TMA was due while we're in practice, and that was just very difficult. And some of the, I find that I'm able to spread things out quite well. It's when you've got competing modules, it's hard to keep what's relevant to one separate from what's relevant to another. So you might be stating something in your TMA, and then go back and read it over and think it's for the other module. It's just in your head it's relevant but you're supposed to be referring to that particular module.

R7 it's like looking really daunting thinking ahead, and thinking I'm going to have three modules and this exam to study for as well. Yeah, I don't feel like it's all sinking in. And I feel like the first module that starts gets all the attention, and then it's like the second

module seems to be the TMA is due on one, and then two weeks later you're just starting that TMA.

R11 When I started in September, they set us off doing module one and module two side by side and starting placement at the same time – which was a little bit of a baptism of fire if I'm honest.

Juggling work and practice learning

R1 The only constraint on that is your schedule where you work, having to accommodate that team. I used to get round that by doing Saturdays and Sundays at work.

R1 the manager is quite helpful. So the moment I can pick and choose, I can pick the shifts. But if I tell them I need to go on this day, they will definitely accommodate my request.

R1 Your mentor can be a good role model for you, just to do what she does or what he does. At the same time that particular nurse can be a good role model how not to be a nurse like him or her.

R9 I'm more inclined to try and squeeze more days' worth of work because I had a caseload here. So some people I couldn't pass over to other people, I had to keep hold. So I was doing probably more than the three days' worth of work, I was probably doing four.

R9 Some of them have been discharged since over the last 18 months, but at that time it wasn't feasible to hand any over, so I've kept all of them.

R9 But them were the only things really that I did pick up. Yeah, it was disorientating for me. Sometimes week to week in the way I was and then you've got your academic work on top of that, which was coming thick and fast as well.

Juggling practice learning and family commitments

R7 while I'm not on placement then I pick up other people's children, and then they will pick my children up. So yes, but it's a lot to pull together.

Different treatment to other nursing students

R1 The only difference is they might take it for granted I knew a little more than them. I have definitely the advantage of having worked for the trust in different areas

R2 a lot of people say that they can tell the difference between a [redacted] student and us. They always say that they can tell that we work on a ward as an auxiliary nurse compared to other students.

R2 I don't know whether it's just because you just get on with it. Like obviously some nursing students from [redacted], they've never had experience on a ward before. So they're coming in totally blind. So it could just be that. We know what we're doing.

R3 we do have to cram more in as opposed to the three full years as a student.

R4 So they shouldn't know what it's like. You think if you want to be a nurse you should know, do you know what I'm trying to say, but they've just been flung straight into a ward placement.

R1 Actually it has worked out for my advantage I would say. Even when I am on the ward sometimes some of the nurses, some of them are so good I can't tell you, they'll point out this will be something you will be doing when you are qualified. So probably you go about this one, so you get that opportunity as well.

R2 The only thing that I think is quite difficult about doing it this way is because everybody knows when you're on placement that you're an auxiliary on another ward. Sometimes you can come onto the ward and it's kind of oh, you're an auxiliary, you know what you're doing. So you sometimes get left to your own devices, but I tag along with them.

R3 I have had comments from my placement saying oh well you're not a proper student because you know what you're doing. I might know what I'm doing but I'm not here to be

an AP. I can write a book on how to be an AP, but I'm here to be a student nurse, and that's I role that I don't know how to be. So I have had to be quite strict.

R3 straightaway they know that you're not a normal student as in you've never worked in the trust. I don't know why, they just know. I think the uniform as well obviously is different. Everyone asks you what's The OU means, so obviously you're constantly having to explain

R3 they've given us more opportunity to have a say in our placements. They don't want to send us anywhere; they want to send us somewhere

R3 as a [redacted] student they don't know where they're going to work; whereas I know I'm going to come back to my job. So it would be silly me going and spending a lot of time on say maternity or children's when I'm never going to come across that in my practice. To me it would be a waste of my practice hours.

R3 it was a bit like they looked at us as an AP initially, because obviously they know we are an AP; whereas some you can fib to other people that you're not, and some people think you are only a student, which is not only a student but an inexperienced student

R4 I think once they know that you're an auxiliary. I can't really explain it, but I think so. I think they've got higher expectations of you, like you should know what you're doing sort of thing, even when it's stuff that I haven't done as a nurse or an auxiliary I think their expectations are higher.

R5 No, I haven't been treated any differently at all. I don't think people know what the OU is. I think that's maybe the difference.

R5 it may be that they find the experience different because we already have a lot of years' experience with patients. So I think that would be helpful. But I haven't been treated any different though.

R6 My last placement, again I'll not mention any names, but I believe I was the first Open University student they'd ever have. From day one they had me, it was written in black and white on the lovely mentor board, and I was written on there as a nursing apprentice, which I asked them to change but they didn't. So that immediately separates

you from the [redacted] lot. And I was, on that unit I was treated very differently from the [redacted]

R6 I was allocated to a mentor and she would, obviously you'd spend time together, very little communication. Actually sat and talked to a [redacted] student instead of me.

R6 generally speaking I've been treated the same.

R7 Not at all, no. It's very welcoming and all the students are trained the same way

R8 I would say I've been treated fairly and the same really.

R9 Not treated differently, no. I did, on a positive note very surprisingly when the qualifieds are saying that I was mid-second year from the Open University, it was more like people who were qualifying like. I just overheard that, I wasn't supposed to hear that, I just heard that through the door because I was standing talking to a patient at the door and it was so loud you could have heard them outside. But yeah I took that as a positive that I must be doing something right.

R10 I wouldn't say I was treated any different, but what I would say is I think the courses are totally different. And I think that the way that their training is a lot different to the way I train

R10 they do ask you do a little bit more and that. It's like, what did I say, something was said. I said oh, during one of the – one of my mentors, I said oh how am I doing? She said well actually I forget that you're here because you just get on and do it. And so I went to her well is that a good thing or is that a bad thing? Because you look at it from both sides, yeah I just get on and do it but does that mean I should be just getting on and doing it or should be waiting for them to tell me what I should be doing.

R10 I enjoy the fact that we have more hours on the wards with the - and more weeks on the wards than what the other students have.

R11 Yes, but in a positive sense of it. Not in a negative sense of it. So both of the mentors that I've had up to now have both said that they could tell a massive difference when they first got me as a student in terms of a student nurse who has got quite a bit of

experience as a healthcare assistant versus a student nurse who has come straight from sort of college or whatever and hasn't really had that level of kind of patient care experience. So they've both said that they can see a massive difference in terms of sort of competence and communication with the patients

R12 Because when the staff find out you're still getting paid. the NAs are band 2, and they find out you're a student and you're earning a band 3 wage, they're like well they can do more, they can do more work. But obviously they don't see what you're doing behind closed doors. You're doing all the treatments and stuff. You're working away. But they don't see that and they just see you come out of a room and like oh you need to do this. And I was like you can't be a student nurse, not like, like I don't mind chipping in. I'll do me jobs as a NA, but I don't want to be counted in the numbers and expected to when there's nursing opportunities coming by

The 'pull' and 'push' to be an HCA/AP when a nursing student

R2 I know how hard it is as an auxiliary nurse to find somebody to help you, so I always feel pressure that I've got to go and help auxiliaries even when I'm trying to do something that I'm learning from if you get what I'm saying.

R3 going into a student role, which is something I've never really been in, you still want to work as an AP because that's what you do naturally

R3 I've had to stay within my boundaries, because I think given the opportunity they would let you come out with them.

R3 if I'm needed to do a medicine round, then they need to understand that that's what I'm there to learn first.

R4 like when we're doing the medicines. As a student, and there's a buzzer going off, your mentor will say leave it, we're doing the medicines. But in my auxiliary head I'm thinking I need to get that.

R4 sometimes it's just well it's in us because I'm auxiliary. so I struggle with that not just going and doing it, but my mentor keeps us right though.

R4 Well sometimes if I don't know, I almost feel stupid for not knowing. But it would have never been in my auxiliary role to know. But I just think that they should, they would be thinking well doesn't she know, she's an auxiliary. But even when I'm here as a student nurse role thinking why doesn't she know, so it makes you feel a bit daft really if you don't know. If you have to ask what to do

R5 there was a painter and decorator in, and the ward was particularly busy, really busy, and there was admissions and there was a painter decorator. And he used to go into the female bedrooms, and wanted to go in the spare bedroom to paint. But he needed to be observed. So I felt that I could do that, and I said I'm supernumerary, I could go and watch him paint in the bedroom, all I'm doing is standing outside just because. So I think that the nurse oh well yeah, I don't see that as a problem. She was just a newly qualified nurse, let me go, and within 10 minutes somebody come and got me, no you can't do that. And I was like no why? And she was like well we can't let you do that, because obviously you're a student nurse, you're not here to, you need to be observed, you need to be, if anything went wrong. So they really looked after me in that way, but I think the nurse possibly thought well I've worked for the trust for a long time, I'm an OU student.

R9 I've always said I feel suffocated as a band 3 and I think I have done for a long while

R10 they'll say ah like well I know she's a healthcare, she can do this. And so yeah they do expect a little bit more from you.

R10 So she told me that if I didn't take this patient's blood pressure and anything happened to them it would be my fault. But that was my first day because she seen me as a healthcare, instead of a student nurse, and I said to her I wasn't allowed to take a blood pressure until she'd observed me. And she said oh I'll observe you - then she walked off. So, and I refused to do it until she was there.

R11 I didn't know until I went there that a lot of nurses on the ward don't actually do venepuncture or cannulation. So to kind of see on some days there'd be sort of three or four patients that just needed their bloods checking and then dependent on their blood results might actually be getting discharged, we'd be waiting until sort of like midday for either a phlebotomist or a doctor to come round and do the bloods. That bit of it was like quite frustrating because I thought I've applied for the job and I can do it! People were

sitting around for hours waiting for somebody specific to come and do it. But then obviously on the back of that I do understand why they keep the two roles separate. So that we're not kind of utilised as healthcare assistants, we do get the supernumerary student nurse.

R11 all of my colleagues [redacted] are really supportive; however at times like this where you've got all the pressures and it's all going a bit wrong, it would be really easy for them to expect and for me to just slip back into healthcare assistant

Common ground

R2 I do do a lot of my healthcare assistant role as a student, but I would expect to do that; it's part of a nurse's role regardless, you've still got to wash patients as a nurse.

R3 I mean one particular ward I went on, their pressures were really high, I mean they didn't have enough staff. And the nature of the patients they looked after were really poorly. And now and again they did say to me are you OK to special people. And that's fine, I don't mind helping out, because even as a nurse I will special people, that's fine.

R11 I have come across students from other universities when I've been on placement that sort of aren't keen to participate in personal care or because they're a student nurse, and that to me, that's wrong as a healthcare professional because whether you're a student nurse or a qualified nurse, if your patient needs cleaning or whatever and they can't do it themselves, it's ultimately your responsibility qualified or not

R11 If it takes two then it would be me and another member of staff that was counted in the numbers, you know, so I think you've got to kind of be a bit realistic about it as well and not be too sort of precious

R11 So that was really quite interesting because it's a lot of things that we don't see in great detail here. And it was quite nice that some of the patients that I'd looked after here as a healthcare assistant then the next time I went on placement were actually on the ward and they'd been to theatre or whatever. So to kind of follow people on their journey, because obviously when they leave [redacted] you don't see them again you

never find out the outcome or anything, so that was quite a nice sort of joining of the two but still keeping them separate

Self-discipline, self-sufficiency, being organised and sacrifice

R3 I think if you want it it's up to you to put your work in, because it is all online. If I don't do something the week that I'm meant to, I fall behind, so then it's me that has to catch up. So you've got to be very strict with yourself. You've got to have mega time management, because it is very, it's very back to back the course itself. It's like bang, bang, bang, bang, you've got something due in all the time, and you've got things you need to read this week. And if you leave it you've got twice as much to do next week.

R3 my days off are given up to benefit my university degree, but that's fine because I'm happy to do that.

R5 I think the best place to be is organised, just to say right at the beginning we need to have a meeting on this placement, or can I have access to your diary and get some availability. And then do some joint emails and try and get that underway straightaway. Because obviously mentors' diaries are really full, wards are really busy, things can go not according to plan. But I think just keep people in the loop, and then it usually falls into place

R5 it's just about managing your time

R5 what I tend to do is use my annual leave to do my academic studies.

R5 I thought about I've got to get my seven weeks' annual leave in. So obviously it's Christmastime and summertime, I've got young children, what am I going to do? I've got TMAs, I've got EMAs coming up as well, and every good student you start out with the best kind of study plan ever. I will get that done by a certain date and hand it in, and it never goes to plan. So kind of the backup is I know I've got annual leave, or I've got all floating days where if I feel under pressure I can put an annual leave day. I've got an EMA coming up, I've got to hand it in and, you know, my hamster died for instance last year. So yeah it's a hamster, and my little boy was absolutely distraught, and for a week we had to nurse this hamster until he went. And I had a TMA coming up. And I was thinking I

can't just go, I see to [redacted] because I need. So I was like right, I'll have to put some annual leave in, while he's at school I'll get it done. So that's what I did. But it's a sacrifice I've made, but at the end of the day it's something I want to do. This nursing course is what I want to do, so that sacrifice, I was all right with that.

R6 I keep a little log of things I need to remember now, but that's just something I've learned to do for myself. It's just little things like drugs, paperwork

R8 my experience of being a student is you get out of a placement what you put into it. How motivated and enthused you are, and how much you get back.

R8 I think it's as easy as you want it to be – because if you're motivated, enthusiastic and really want to qualify, then it's not a chore.

R8 I give up some of my weekends to do my academic work, but that's not a chore to me. I think god, how lucky am I to be in this position where I'm not losing any money, I've still got my fulltime job. So to me I'm in a good position, so I don't ever look at it negatively.

R9 It was when I look back a busy time. A very busy time, you get with doing it, don't you? You do what you have to do.

R9 I had the option again would I choose this again or would I go for the learning disability degree full-time [redacted]? And I said even if I analysed them both I still would choose this

R9 this way of learning sometimes is very suited to me because I'm quite self-sufficient so I will go away and do my own thing and again it's never harmed my grades. I don't know if that's down to having good mentors or whether that's down to me being really organised because I am pretty organised.

R9 I just take one at a time. I did map out the dates to see how much weeks were between each one so I knew I could give myself enough time.

R12 And at the minute I use my fifth day to try and get study done. And like that's solely set aside so I know it's there. But if that day disappears then I have to find it elsewhere.

Last boat leaving

R3 obviously I want to say thank you to the OU for getting with the trust and giving us this opportunity. Because this is my only opportunity to do my training, because financially I would never have been able to go back to university and give up my fulltime job, because obviously I do have a home and children and a life and everything else. So obviously I feel really honoured to be given this opportunity. And I know there was a lot of people that wanted it, there's a lot of people that are never going to get it again. But it has been hard, but I think, I don't think I realised how hard it would be when I first started

R3 Given this opportunity again I don't know if I would take it at the moment in my life that I am.

R6 at the end of the day I'm just very grateful for the opportunity of secondment, because they're few and far between. I've had to wait until I'm nearly 50 to get one, and I've worked since I was 25 in healthcare. So it's been a long time coming, and I'm grateful and I will finish the damn thing

Emotional exhaustion

R5 when the block placement finishes I go back and sometimes I feel exhausted when I go back. And I didn't know what that was about, because I'm not really doing anything more than I normally would. I am learning, so I suppose my brain's doing more. But I think what it was was the relationships. So what I do is as a person I form relationships very quickly, and I maintain those. And how I felt is over the last year I've had four different jobs

R5 I've really had to explore that and how I can protect myself in the future, because it is exhausting and I will burn out. So I've got some strategies in place to cope with that now. I don't know if you want me to talk about those.

R5 So I think right, I've been to see three patients with my mentor, I've got to leave some of these assessments, I'm going to put some paperwork on, he's going to check it all after me. I'm going to book a room, I'm going to keep myself away, and I'm going to do it. So

then I'm not submerged within the team, and I'm not getting involved as much with everything else that's going on. I'm very much focused in, and I found that really works. So I've got a purposeful, meaningful student role

R5 So I think there's a lot of aspects of learning to be done as a student nurse. It's not just with patients and processes, it's with leadership and management. And there's so much to learn. And I think you need to take that onboard and move that through each service you go to, learn a little bit and move it along. But it is really difficult. I did feel in the summer I was exhausted when I came back, and that's why I sat down and did a bit of reflective practice with my manager at work. And she said it doesn't surprise me because you invest so much, and so maybe next time you need to think about how you're going to manage that, because it's another three years, well it's another two years. And that's a long to go and to be crawling to the end.

R5 I worked a day- and-a-half for a lot of years when my children were young, and I loved it. And I loved going to work, and I didn't feel quite part of the team. I went to work, I did what I needed to do, I loved the patients, but my balance of home life was really, it was top heavy. So my home life was very important, and I came to work, I loved my job, I did what I needed to do, then I came home. And I didn't have to think about the next day because I wasn't back there. So I didn't feel, I wasn't quite submerged in all the politics when I worked for a day-and-a-half because I was always quite happy, I was quite happy with change. If I had to be moved, if I had to go and do a day's work, I was happy to do that because I only worked a day-and-a-half.

R5 being here five days certainly is one of the things that makes me feel exhausted

R5 I do give myself some time off. I don't feel weightless in that annual leave, I don't feel like what we normally do, go and sit in Tenerife for two weeks and can't come back. It's always on my mind I've got something coming up,

R5 it's there all the time. I think it's there all of the time. Your work, your block placement, my support worker role, my academic work, your home life. It's constantly on the go. I don't like to think about it too much. So I'm thinking about it today, I won't think about it again until probably a good while. Because when I over-analyse it that's when I worry that I'll struggle. So I just take each day as it comes. Each EMA, each TMA, each

block placement, I take it as it comes. I think if I get through I've survived, I've managed it and I've done it well. That's OK for me.

R7 all in all it's working; I'm learning and I'm enjoying it.

Bereavement

R5 I feel a little bit bereft when I come away from my placements as well, so I'm like oh I've made those kinships, and I've met those lovely bunch of patients, and now I'm not going to see you again

R5 I felt bereft, especially on my last placement with the children.

Changing abilities

R5 my feedback is that my language is changing and the way I present myself is changing, and they can see the confidence grow.

R5 I think senior managers have seen that and maybe the confidence grow, where before I'd be going oh I don't want to do that. I'll be like yeah I'm happy to take that onboard, just tell me what I need to do, tell me what I need to research.

R5 But I've had it from the clinical side and from the managerial side that I have changed and they have seen me grow, which was a really nice thing to get feedback.

R5 you are exposed to those practice learning things, and you've got to build your confidence up, because I think that it would be hard not to. You need to have transferrable as well, so you need to transfer what you've learned from one practice area to another, and learn to build from that.

R9 I don't think I could have made some of the decisions in practice as a student as what I would have made two years ago because I wouldn't have had the knowledge to make them. I think working around the right people and having confidence to do that helps you be more confident yourself to make them decisions. I don't think I could have done that before. Now with experience as a mature student it's different

R10 I just feel like now I've built up my confidence I feel like I need to start to go in more different areas

R11 it makes you a little bit more confident in your writing that you've got that kind of background knowledge that you had before you started the course

Loneliness and isolation

R5 I must admit it is a little lonely. So there's times where I've felt a little lonely, especially working along with colleagues from say [redacted]. Because they have face to face, they have tutorials, they get to see their other nursing students. It doesn't happen for us with the OU. So fortunately I know two, well I know one of the other nursing students on the programme, and I've made friends with another nursing student on the programme who works for another trust but is in mental health. So we've got our own little group, so we've got our group where we need to ask questions, where we need to go oh my god it's coming up. We're able to have a WhatsApp group and talk to each other. It's still not the same as seeing somebody face to face.

R5 I think the downside of being an OU student is that actually it is a little lonely at times.

R5 OU Live, is that actually that you don't get that interaction, you don't get that coffee break, you don't get to know that person. So things can be interpreted very different through the way we email people.

R9 I think the face-to-face thing it's nice to see people every so often and having the supervisions. I know that they say they can get their tutor to offer that sort of thing, which I thought was very strange, but I said I like that every month. I go to them every month, I like them. It's a way of just catching up with people and having discussions

Financial pressures

R6 I need to do bank because I'm skint, so I do do quite a bit of bank work as well in different areas.

Appendix 9 - Qualitative Content Analysis Stage 3 – initial abstraction/development of themes - student data example [identifying features redacted]

[N.B. These initial themes were further refined/developed before being finalised as reflected in the main body of this thesis]

Each theme is titled and then the features it encompasses are described. Examples of these features are then illustrated by comments from the interview respondents which are grouped together (a space separates the evidence associated with a particular feature).

Preliminary theme: Being away from the day job (includes: being missed, and missing colleagues, challenges in securing staff cover, no staff backfill, feeling guilty about others taking on more work, 'day job' skills and knowledge degrading, squeezing existing work into fewer days, acceptance, disinterest, or animosity about the individual's student nurse role amongst staff in the day job)

- 'I get a lot of feedback from my colleagues at work that I'm terribly missed. So I think that's not just as a support worker, not just the role is missed, but me as a person is missed. Because I think whether that's an individual thing, or that's the person who I am, that I do have, they can't wait to get me back' (R5)
- 'when I'm going back to my ward it's like who are you, we haven't seen you for so long' (R2)

- 'it's also hard in a way that you're away from like my work base, I'm not seeing anyone from there' (R2)

- ‘obviously I miss the team when I’m not there. I miss what’s happening’ (R6)

- ‘for me I have missed patients, I’ve missed the team of lasses I work with. It can impact whereby in September and again last month I had a bit of annual leave. I had Saturday night shifts, and literally I was only with my team for one week’ (R6)

- ‘they were going to lose me from my job role for a period of time. I’m experienced within the practice at work, so the actual, the service was going to lose a support worker role. And that was a massive disadvantage. But the way my manager saw it was it committed me to do my nurse training, and so they wanted me to get the best out of it’ (R5)
- ‘suppose you’d keep me three days in this post every week, I suppose you’re not going to backfill a post for six weeks at a time. You’d lose a full member of staff don’t you? Whereas, technically, if I work three days here, I’m part-time, so they’ll only lose me for two days’ (R9)
- ‘it’s so that you’re not gone from the ward. if it’s only two days a week, you’re still there constantly, you’re not disappearing for eight weeks at a time or something‘ (R12)

- ‘trying to cover both of our hours full-time for a block period that’s probably more difficult than just having sort of one to two shifts for each of us per week that they can slot in. Particularly when it comes to like peak holiday times and things like that, I would imagine that that would make it more difficult for the employers to cover the shifts’ (R11)
- ‘easier to cover my hours as a block than two days a week. If they’ve got a good run of getting someone to cover for quite a while’ (R4)
- ‘initially they were promised some backfill, so some backfill money to able to backfill my role, but I don’t think that ever materialised. So I think in all honesty that maybe

next year or if the programme runs again, my manager, if she ever get some money through, might be dubious about letting somebody go on a block placement' (R5)

- 'the potential impact it might have on your regular team. Because I work for the [redacted], so maybe it's more made for like a three/four week chunk, it would have a massive impact and potentially it's not a sort of, they couldn't get any backfill for that. They did initially apparently get 15 hours for that, but due to cutbacks they didn't, they were dropped' (R6)
- 'I from a professional point of view in my day job, my regular job, all those patients that I see I have to handover to other people and start again. And some of them get discharged, and I would like that continuity with that as well. I'd be able to see so many patients in the three days I would be here' (R7)
- 'they're already overloaded and I'm handing my caseload back to them. So I feel awful'. (R7)
- 'when I come back it's like I'm starting with absolutely no patients, and I've got to learn who the new patients are, what their needs are, and start again really' (R7)
- 'If I was gone for whatever length of time, let's say ten weeks, I'd feel uncomfortable coming back because I'd feel like right what have I missed, how much has changed' (R12)
- 'obviously I'm still here in my capacity as a healthcare assistant so I'm still keeping all of those skills up to date. there's some of the skills that I can do as a healthcare assistant that I'm not allowed to do as a student nurse, which is like venepuncture and back slabs and dressings and stuff that I would only do sort of further on down the line as a student nurse' (R11)
- 'I'm more inclined to try and squeeze more days' worth of work because I had a caseload here. So some people I couldn't pass over to other people, I had to keep

hold. So I was doing probably more than the three days' worth of work, I was probably doing four' (R9)

- 'Some of them have been discharged since over the last 18 months, but at that time it wasn't feasible to hand any over, so I've kept all of them' (R9)

- 'I've never had any problems with the teams at all, any of them' (R7)
- 'They're very supportive. So there's not been any adversity or anything' (R8)
- 'me being away from them, they don't ever treat me like a student – which is good, because obviously I don't want to be treated like a student in my own role, because I'm not a student then. And that's definitely been a help to differentiate between the two as well' (R3)
- 'He used to ask me does anybody here even ask you, especially management, about how you're doing and what progress you're making. And I've said [redacted] no. And that's the God's honest truth' (R9)
- 'I work with some pretty feisty characters here and some of them I think resent me a little bit that I wasn't here that long' (R9)
- 'I've found myself turning around and one of my colleagues is going oh can you just come and asking them to do something. Which there's nothing wrong with it but when you're the same level as them it could be sort of conceived as being bit, a bit up myself or whatever, and it's important not to do that' (R12)

Preliminary theme: Belonging in placements (feeling a member of the team, mentor protection and support, retaining/losing supernumerary status)

- 'On a block placement I don't know, I feel like you get to know people a lot more, you're spending more time with them'. (R2)

- ‘you get a rapport built up don’t you? Because the mentor that I’m with now I’ve been with since my first ever placement, because this is like my base ward’ (R4)
- ‘they’re only at one area for a short space of time; whereas we’ve got block areas for quite a long time. So then you get used to the routine, you get used to the people. You get used to all the paperwork and how things should be done’ (R10)
- ‘I just feel like I’m a part of the team sometimes, I’m not. You see maybe I compare that to other students who sometimes do look quite timid and they don’t look part of the team, they look like a spare part or. Because they don’t know what to do themselves and I just kind of get myself in there’ (R9)
- ‘obviously I don’t want people to think of me as in who does she think she is type of person. they’ve been quite open with my suggestions’ (R3)

- ‘My mentor’s always been really good at arranging things. Like theatre, I’ve been theatre and things like that. So she’s always been pushing us to do a lot.’ (R4)
- ‘She was very protective of me being supernumerary’ (R3)
- ‘it’s been really nice that you’re feeling protected and safe in that kind of practice’ (R1)
- ‘I’ve got no other word to say but amazing. He’s just the most, he is a really good mentor. And I often think that he’s got his workload to do, and teaching me at the same time. And at the end of the day he must go home exhausted’ (R5)
- ‘I think my mentor has been quite good at sort of saying right let’s sit down and go through your file and we’ll sign off the ones that I can sign off now and then we’ll go back through and look at the ones that still need signing off and we’ll work out ways in which you can meet them so that I can sign you off. So they’ve been really proactive’ (R11)
- ‘my mentor on my ward, on my base ward, she works extra most weeks, which has been a massive help in sorting out’ (R11)

- ‘I’ve not had any problems with my mentor. If I’ve had a problem with anything else I’ve gone to me mentor to sort it out’ (R12)
- ‘They’ve probably been like 90% of the time unless they were on holiday or off sick’ (R11)
- ‘I spend well over 60-70% on our mentor, [redacted] But on other wards, it wasn’t as easy’ (R12)

- ‘I must have spent less than a quarter of my time on there with my mentor’ (R6)
- ‘There has been like a few occasions where we’ve been like right we’ll pencil this in to go through your portfolio, we’ll pencil that in for tomorrow, and then it’s come to the day and it’s been a very busy day and we’re like right OK we’ll have to do it next week. And then I’ll come in next week and me mentor has gone onto nights and we’ll do it the week after and stuff like that so it happens but it’s nature of the ward’ (R12)
- ‘The only thing I have found when you get, they seem to put me on earlies. Since I’ve been back on this ward since October I haven’t done any late shifts. They always seem to be early shifts. So on the morning when they’re doing the drugs round, and they’re very busy and we’ve got new staff, I don’t get to do any drugs rounds. But then I finish at 3:30 so I don’t get to do any of the – so I’ve asked if I can do lates, but she said oh she’d rather have me on the earlies’ (R10)
- ‘There has been times where I’ve been counted in the numbers. Because I’ve asked to go on a different ward because there was a learning experience available there, and they said oh no we can’t afford it, we’re short this afternoon, and I said well I’m not in the numbers, and they went it doesn’t matter, we need you here as an extra pair of hands. I was like so I am in the numbers. That’s not what I’m saying, we just need you here as an extra pair of hands. I’ve got a learning experience that is going ahead on a different ward, I should be entitled, like I feel entitled to go and yeah it got sorted’ (R12)

Preliminary theme: Difference (being treated the same or differently to PRNP students from other universities, expectations for OU PRNP students, OU PRNP students perceived/treated negatively or more positively, uncertainty about the acceptable level of independence an OU PRNP student can display, the advantage of also being an HCA/AP)

- 'generally speaking I've been treated the same' (R6)
- 'It's very welcoming and all the students are trained the same way' (R7)
- 'I would say I've been treated fairly and the same really' (R8)
- 'Not treated differently, no' (R9)
- 'I wouldn't say I was treated any different' (R10)
- 'it may be that they find the experience different because we already have a lot of years' experience with patients. So I think that would be helpful. But I haven't been treated any different though' (R5)

- 'I don't think people know what the OU is. I think that's maybe the difference' (R5)
- 'straightaway they know that you're not a normal student as in you've never worked in the trust. I don't know why, they just know. I think the uniform as well obviously is different. Everyone asks you what's The OU means, so obviously you're constantly having to explain' (R3)

- 'They always say that they can tell that we work on a ward as an auxiliary nurse compared to other students. don't know whether it's just because you just get on with it. Like obviously some nursing students from [redacted], they've never had experience on a ward before. So they're coming in totally blind. So it could just be that. We know what we're doing' (R2)

- ‘So they shouldn’t know what it’s like. You think if you want to be a nurse you should know, do you know what I’m trying to say, but they’ve just been flung straight into a ward placement’ (R4).
- ‘I think once they know that you’re an auxiliary. I can’t really explain it, but I think so. I think they’ve got higher expectations of you, like you should know what you’re doing sort of thing, even when it’s stuff that I haven’t done as a nurse or an auxiliary I think their expectations are higher’ (R4)
- ‘they’ll say ah like well I know she’s a healthcare, she can do this. And so yeah they do expect a little bit more from you’ (R10)
- ‘they do ask you do a little bit more’ (R10)
- ‘everybody knows when you’re on placement that you’re an auxiliary on another ward. Sometimes you can come onto the ward and it’s kind of oh, you’re an auxiliary, you know what you’re doing. So you sometimes get left to your own devices, but I tag along with them’ (R2)
- ‘obviously they know we are an AP; whereas some you can fib to other people that you’re not, and some people think you are only a student, which is not only a student but an inexperienced student’ (R3)

- ‘My last placement, again I’ll not mention any names, but I believe I was the first Open University student they’d ever have. From day one they had me, it was written in black and white on the lovely mentor board, and I was written on there as a nursing apprentice, which I asked them to change but they didn’t. So that immediately separates you from the [redacted] lot. And I was, on that unit I was treated very differently from the [redacted]’ (R6)
- ‘I was allocated to a mentor and she would, obviously you’d spend time together, very little communication. Actually sat and talked to a [redacted] student instead of me’ (R6)

- ‘So she told me that if I didn’t take this patient’s blood pressure and anything happened to them it would be my fault. But that was my first day because she seen me as a healthcare, instead of a student nurse, and I said to her I wasn’t allowed to take a blood pressure until she’d observed me. And she said oh I’ll observe you - then she walked off. So, and I refused to do it until she was there’ (R10)
- ‘Because when the staff find out you’re still getting paid. the NAs are band 2, and they find out you’re a student and you’re earning a band 3 wage, they’re like well they can do more, they can do more work. But obviously they don’t see what you’re doing behind closed doors. You’re doing all the treatments and stuff. You’re working away. But they don’t see that and they just see you come out of a room and like oh you need to do this. And I was like you can’t be a student nurse, not like, like I don’t mind chipping in. I’ll do me jobs as a NA, but I don’t want to be counted in the numbers and expected to when there’s nursing opportunities coming by’ (R12)

- ‘a positive note very surprisingly when the qualifieds are saying that I was mid-second year from the Open University, it was more like people who were qualifying like. I just overheard that, I wasn’t supposed to hear that, I just heard that through the door because I was standing talking to a patient at the door and it was so loud you could have heard them outside. But yeah I took that as a positive that I must be doing something right’ (R9)
- ‘both of the mentors that I’ve had up to now have both said that they could tell a massive difference when they first got me as a student in terms of a student nurse who has got quite a bit of experience as a healthcare assistant versus a student nurse who has come straight from sort of college or whatever and hasn’t really had that level of kind of patient care experience. So they’ve both said that they can see a massive difference in terms of sort of competence and communication with the patients’ (R11)

- ‘I said oh how am I doing? She said well actually I forget that you’re here because you just get on and do it. And so I went to her well is that a good thing or is that a bad thing? Because you look at it from both sides, yeah I just get on and do it but does that mean I should be just getting on and doing it or should be waiting for them to tell me what I should be doing’ (R10)
- ‘I have had comments from my placement saying oh well you’re not a proper student because you know what you’re doing. I might know what I’m doing but I’m not here to be an AP. I can write a book on how to be an AP, but I’m here to be a student nurse, and that’s I role that I don’t know how to be. So I have had to be quite strict’ (R3)
- ‘Well sometimes if I don’t know, I almost feel stupid for not knowing. But it would have never been in my auxiliary role to know. But I just think that they should, they would be thinking well doesn’t she know, she’s an auxiliary. But even when I’m here as a student nurse role thinking why doesn’t she know, so it makes you feel a bit daft really if you don’t know. If you have to ask what to do’ (R4)

- ‘they’ve given us more opportunity to have a say in our placements. They don’t want to send us anywhere; they want to send us somewhere’ (R3)
- ‘they might take it for granted I knew a little more than them. I have definitely the advantage of having worked for the trust in different areas’ (R1)
- ‘as a [redacted] student they don’t know where they’re going to work; whereas I know I’m going to come back to my job. So it would be silly me going and spending a lot of time on say [redacted] when I’m never going to come across that in my practice. To me it would be a waste of my practice hours’ (R3)
- ‘I enjoy the fact that we have more hours on the wards with the - and more weeks on the wards than what the other students have’ (R10)

Preliminary theme: Wearing two hats (role distinction, role conflict, common ground, transferable learning,)

- 'I couldn't imagine it being easy to switch between both for two days, and then going back to auxiliary' (R4)
- 'So I think if you're only having two days a week being a student, and then straight back in, I think it would be harder to switch your head from student mode'. (R4)
- 'So I'm not going to work and being support worker, and being embroiled in the work role, and then on a Tuesday and then having to go to bed and wake up a student nurse on a Wednesday, and think right take that hat back off now' (R5)
- 'I know that when I'm on placement I'm on placement for a block period of time; I'm not back in my healthcare assistant role until I'm back there. And then when I know that I'm back in that block role as a healthcare assistant that I can't do the stuff that I'm doing as a student nurse' (R2)
- 'I was able to walk away with a fresh new start. So that appealed to me that I wasn't swapping and changing' (R5)
- 'It works for me because I feel that I can come and do a complete nursing role. So I can be student nurse for that period of time, and I'm not having to think I'm anything else. So people are not getting confused about whether I'm a student nurse or whether I'm a support worker' (R5)
- 'I'd say the main advantage is the fact that I'm not getting confused between being an auxiliary one day and being a student the next day' (R2)
- 'I'm coming in as a fresh pair of eyes thinking I'm a student nurse, I'm here to learn. I've took my backpack off so to speak, and I feel that it's really worked for me' (R5)
- 'some of the advantages of the block placement was that I would be released from my work role, and I'd go away and be a student, and I wouldn't be worrying about anything that was going on at work' (R5)

- ‘I felt the block placements would be a better experience. Because then I could take my work hat off, and put my student hat on and go away and be a student for that period of time, rather than swap and change with other commitments around me as well’ (R5)
- ‘you’ve got to take your hat off and go back to your support worker role. So it’s almost like five steps forward and five back, then 10 steps forward and then 10 steps back, and as I grow you’re jumping from one to another’ (R5)
- ‘I think it’s hard to change hats. I found that difficult because I think along the lines of a nursing student all the time and I find that difficult working as a band 3 where I’ve got to revert back to that role’ (R9)
- ‘I’m annoyed that I wasn’t given the option of the other one. Only because it’s hard. Firstly, you never know what hat you’re putting on in a morning. You’ve got to switch from one to the other. I still, even though I’m this close to the end, I still have difficulties switching off from my healthcare head. So, I have been criticised for being on a ward and just disappearing and getting on with some jobs. Because that’s what I’ve always done as a healthcare. And then immediately after tomorrow I’m back to being a healthcare. So, it’s switching, that’s not problematic but it’s a pain in the butt’ (R6)
- ‘It’s hard at the beginning going from your healthcare role to your student nurse role then back to your healthcare role and not doing your student nurse role. It took a long time to get used to which hat I’m going to be wearing that day in that area’ (R10)
- ‘yeah it’s difficult to change between the hats’ (R9)
- ‘Initially I really struggled with it. I was, because I was doing, it wasn’t necessarily two days on placement and then separately from my two days on the ward. I would say it could have been placement, ward, placement, ward, and that I really struggled with to start off with. Especially with it being a new thing. But as it’s gone on I’ve sort of found a system that’s worked for me where I can have my two days on placement and then I’ll have my two days on ward where I’ll break them up with a day and then

come in for my days on the ward. So, it's broken up nicely. And sort of learning to be like what limits I have on placement and what limits I have on the ward' (R12)

- 'the difference between working as an AP and working as a student has been quite a difficult transition' (R3)
- 'not being able to do the things that you do as an AP has been quite a difficult transition' (R3)
- 'it was difficult to go for two days on placement and then work three days as a band 3 and then have two days off and then that's the process. And it's very difficult to get any consistency with patients' (R8)
- 'Go to placement having done me day on the ward and I'd be mucking in as an NA and I'd be like oh hang on I'm here to be a student. I need to take things by the horns and get involved the nursing side of things not just the healthcare' (R12)

- 'For me it's easy in my head to know which two days I'm a student, but then where that falls down is if my mentors aren't on them shifts I've got to go with somebody else' (R6)
- 'It can sometimes be a bit difficult, because you're obviously trying to get used to I can't do this as an auxiliary nurse, but it's actually not too bad' (R2)
- 'when I come out of my AP uniform and put my student uniform on for those four or five week blocks that I'm doing, I am a student and I've accepted that. So personally, I've found that easier with the transition' (R3)
- 'when I come here as a healthcare assistant and I've got me pale blue scrubs on and that's me and I'm here and just doing the same as I've always done but then when I go to placement I go directly to the area of placement and I'm in me student uniform so it's all quite separate' (R11)

- ‘It’s like when you’re a student you’re doing totally different things. You’ve got a lot more range of what you can do. So they chose the block model, and I’ve got to admit it’s not half as confusing as I think what it would be going’ (R2)
- ‘I’ll say can I have a bag of fluid. And they’ll say no because I’m a healthcare. But yet on the ward, they’ll stand there and observe you to do it. So, it’s like. And then I can take bloods down here. I’m not allowed to take bloods on the ward even though I’ve been doing it for years. It’s getting used to what you can and can’t do’ (R10)
- ‘I didn’t know until I went there that a lot of nurses on the ward don’t actually do venepuncture or cannulation. So, to kind of see on some days there’d be sort of three or four patients that just needed their bloods checking and then dependent on their blood results might actually be getting discharged, we’d be waiting until sort of like midday for either a phlebotomist or a doctor to come round and do the bloods. That bit of it was like quite frustrating because I thought I’ve applied for the job and I can do it! People were sitting around for hours waiting for somebody specific to come and do it. But then obviously on the back of that I do understand why they keep the two roles separate. So that we’re not kind of utilised as healthcare assistants, we do get the supernumerary student nurse’ (R11)
- ‘about patients I’ve been involved with as a support worker. So there’s times when I’ve wanted to say I know that patient. But then I think well what am I telling them for? If the purpose of the information I’m handing over purposeful, or is it just to let them know that I know the patient?’ (R5)
- ‘there’s certain times when I’ve been say on the hospital ward in my support worker role where I’ve thought I know about this, I’ve learned about this, I know the answer to this, but I’m a support worker. So what I’ll say is well although I can’t help you, I’m going to go and get a nurse to, because I’m a support worker so I’m able to give you advice on that certain whatever it is. I then can go back to the nurse and say this is what this patient’s presenting with, this is what the doctor wants to know or the nurse wants to know. This is what I know about this, and that’s been really helpful to the nurse who’s then had to go out, or we’ve gone and done it jointly. So, then I can learn from that experience as well. But yeah, I suppose it’s what your boundaries

are, and I think you need to be very certain and very clear of them to keep yourself safe' (R5)

- 'I know how hard it is as an auxiliary nurse to find somebody to help you, so I always feel pressure that I've got to go and help auxiliaries even when I'm trying to do something that I'm learning from' (R2)
- 'going into a student role, which is something I've never really been in, you still want to work as an AP because that's what you do naturally' (R3)
- 'like when we're doing the medicines. As a student, and there's a buzzer going off, your mentor will say leave it, we're doing the medicines. But in my auxiliary head I'm thinking I need to get that' (R4)
- 'there was a painter and decorator in, and the ward was particularly busy, really busy, and there was admissions and there was a painter decorator. And he used to go into the female bedrooms, and wanted to go in the spare bedroom to paint. But he needed to be observed. So I felt that I could do that, and I said I'm supernumerary, I could go and watch him paint in the bedroom, all I'm doing is standing outside just because. So I think that the nurse oh well yeah, I don't see that as a problem. She was just a newly qualified nurse, let me go, and within 10 minutes somebody come and got me, no you can't do that. And I was like no why? And she was like well we can't let you do that, because obviously you're a student nurse, you're not here to, you need to be observed, you need to be, if anything went wrong. So they really looked after me in that way, but I think the nurse possibly thought well I've worked for the trust for a long time, I'm an OU student' (R5)

- 'all of my colleagues [redacted] are really supportive; however at times like this where you've got all the pressures and it's all going a bit wrong, it would be really easy for them to expect and for me to just slip back into healthcare assistant' (R10)
- 'I've had to stay within my boundaries, because I think given the opportunity they would let you come out with them' (R3)

- ‘well it’s in us because I’m auxiliary. so I struggle with that not just going and doing it, but my mentor keeps us right though’ (R4)

- ‘I do do a lot of my healthcare assistant role as a student, but I would expect to do that; it’s part of a nurse’s role regardless, you’ve still got to wash patients as a nurse’ (R2)
- ‘I mean one particular ward I went on, their pressures were really high, I mean they didn’t have enough staff. And the nature of the patients they looked after were really poorly. And now and again they did say to me are you OK to special people. And that’s fine, I don’t mind helping out, because even as a nurse I will special people, that’s fine’ (R3)
- ‘I have come across students from other universities when I’ve been on placement that sort of aren’t keen to participate in personal care or because they’re a student nurse, and that to me, that’s wrong as a healthcare professional because whether you’re a student nurse or a qualified nurse, if your patient needs cleaning or whatever and they can’t do it themselves, it’s ultimately your responsibility qualified or not’ (R11)
- ‘If it takes two then it would be me and another member of staff that was counted in the numbers, you know, so I think you’ve got to kind of be a bit realistic about it as well and not be too sort of precious’ (R11)
- ‘So that was really quite interesting because it’s a lot of things that we don’t see in great detail here. And it was quite nice that some of the patients that I’d looked after here as a healthcare assistant then the next time I went on placement were actually on the ward and they’d been to theatre or whatever. So to kind of follow people on their journey, because obviously when they leave [redacted] you don’t see them again you never find out the outcome or anything, so that was quite a nice sort of joining of the two but still keeping them separate’ (R11)

- ‘Learning stuff in a previous placement that I was able to bring back here straight away. So I was able to learn stuff there and how to treat [redacted] on placement and then within a week I was using it back here. And then obviously it’s good being able to take stuff from here in terms of [redacted] over on my placement’ (R12)
- ‘I’ve seen quite a positive impact. Especially in terms of the [redacted] stuff because if there has been like little cases of [redacted] that are a little bit tricky, that’s been the big one, is [redacted]. We’ve had stuff that the doctors have been a bit like oh well I don’t quite fancy doing that because it’s been quite complicated. And I’ve said listen I’ve done it at [redacted], can I have a go? And the doctors have said yeah, take the nurse with you’ (R12)
- ‘my feedback is that my language is changing and the way I present myself is changing, and they can see the confidence grow’ (R5)
- ‘I think senior managers have seen that and maybe the confidence grow, where before I’d be going oh I don’t want to do that. I’ll be like yeah I’m happy to take that onboard, just tell me what I need to do, tell me what I need to research’ (R5)
- ‘But I’ve had it from the clinical side and from the managerial side that I have changed and they have seen me grow, which was a really nice thing to get feedback’ (R5)
- ‘I just feel like now I’ve built up my confidence I feel like I need to start to go in more different areas’ (R10)
- ‘you are exposed to those practice learning things, and you’ve got to build your confidence up, because I think that it would be hard not to. You need to have transferrable as well, so you need to transfer what you’ve learned from one practice area to another, and learn to build from that’ (R5)
- ‘I don’t think I could have made some of the decisions in practice as a student as what I would have made two years ago because I wouldn’t have had the knowledge to make them. I think working around the right people and having confidence to do that helps you be more confident yourself to make them decisions. I don’t think I

could have done that before. Now with experience as a mature student it's different' (R9)

- 'it makes you a little bit more confident in your writing that you've got that kind of background knowledge that you had before you started the course' (R10)

Preliminary theme: Effective learning ('fitting it all in', placement length, benefits and challenges of block and integrated models on learning, accommodating for academic and practice learning demands, making time for study, learning from good and bad practice)

- 'five days together there, I don't think you're learning anything much more than that unless there are some particular days, some particular events are happening' (R1)
- 'It's like you have to get your head around it all again. I think if I did it two days a week continuously it would stay with me a lot easier' (R7)
- 'being here [placement] five days certainly is one of the things that makes me feel exhausted' (R5)
- 'you had to build it up quite quick, because I was only there for a short period' (R3)
- 'I don't think they feel long enough, the four weeks placement. It's like I'm coming to the end of my placement now, and I feel like there's so much more I could do, but it's almost over' (R7)
- 'I just feel like I've literally got my feet on the ground and I'm gone' (R5)
- 'So had I been there only that particular time I would not know what had happened after. So it would be just the basics to start with, and then conclusion would be drawn from what I think would have happened rather than what has happened. And also you get time to go through it in much more relaxed way, rather than crowding it at one particular point' (R1)

- ‘I’m pulled out of that, and then put back in. So it’s starting again, at least for the first week to get back into how the routine goes. You carry over some skills, but not all of the everyday routine stuff’ (R7)
- ‘When you start to work with someone, it’s part of the nursing process isn’t it where you see them at the start, you oversee the treatments and then you see the recovery and then you discharge don’t you, and that’s part of validation for me. I mean that was validation for me before starting the nursing programme there, you see that, and it makes you know you’ve done a job. I’ve done something positive for that person. You know, I wouldn’t have seen that otherwise. Something that fictionally I would have struggled with if I didn’t have the continuity that I maybe have’ (R9)
- ‘I’ve got children to get to school and things like that. So having two days a week would be much better personally than having the full block placement and having to cover four weeks, six weeks, 10 weeks of childcare, whereas two days a week my mum and dad could handle that’ (R7)

- ‘it’s up to me to choose some based on that one, rather than just strictly following Thursday/Friday or Monday/Tuesday’ (R1)
- ‘the manager is quite helpful. So the moment I can pick and choose, I can pick the shifts. But if I tell them I need to go on this day, they will definitely accommodate my request’. (R1)
- ‘bit of flexibility as well say if there was something happening that we knew about in advance that I particularly wanted to be a part of to just try and make sure that I was around on those days’ (R11)
- ‘the mentor can kind of graduate to say this is what’s happening on this day, so this particular patient, would you like to come on that day?’ (R1)
- ‘I am in [redacted], there won’t be much happening during the Christmas and New Year period in that two weeks really. But if you’re allocated that period [in a Block] you’ve got to go and that would be not much of a patient visit either’ (R1)

- ‘I think you’ve probably just got to be a little bit patient because yes if I’d been there for sort of five days a week I probably would have had that opportunity sooner’ (R11)
- ‘it’s better to learn in a block than bits here and bits there’ (R4)
- ‘didn’t really think there would be much you could learn in one shift a week transition’ (R3)
- ‘talking to other students who get here, who are here in chunks, I think they get a better experience’ (R6)
- ‘by the fifth shift the manager in this department got really annoyed with us and shouted at us in the corridor, which I didn’t appreciate, I did tell her. I did not appreciate being shouted at, but I did understand her frustration. And she kept saying you’ve been here five weeks and I still haven’t seen your port. I hadn’t, I’ve been there five shifts. There’s a massive difference. But they just regard me as being there for five weeks. So although I’d been here for eight weeks, is it eight weeks now, nine weeks, it’s only been probably five or six shifts. Because I’ve done 12 hour shifts, I’ve done a night shift, and I’ve done a couple of half hour shifts. So it’s very bitty’ (R6)
- ‘If I’d have had a week between doing that, or even two weeks or three weeks, it would have been like starting again each day; whereas as a student we’ve been able to keep the continuity as a student for them five weeks’ (R3)
- ‘If you just do two days a week and then, well I would feel that you would just be back to square one the next time’ (R4)
- ‘I might learn something on here for two days. Sometimes I’m here for one full day or two half days, that’s the way I’ve been doing it. And I learn something new, and I’m away again and I have to wait a full week. And I come back and I think oh I forget how you do that. I’ve got a crap memory so my retention’s terrible. So from that point of view a chunk would have been better’ (R6)

- ‘if I was doing it a Monday and a Tuesday every week, a patient may have come and gone’ (R5)
- ‘I would be maybe missing quite a big chunk of that episode of care’ (R5)
- ‘And another benefit was that I would get more from the experience of being there for like a four week block, rather than just doing it two days a week. So have the continuity to see patients in a continuity view’ (R5)
- ‘for continuity. You can get in there, you can get your teeth into what’s going on, like on a ward or at the minute I’m on community placement. I just feel as though I wouldn’t be torn between my role as an HCA or a support worker, and my role as a student as much’ (R7)
- ‘the block placements has enabled me to do that simply by the continuity of patients as well. So if you’ve got an episode of care that a patient’s coming in with, you’re already thinking well I know I’ve got a competency coming up, that patient would fit that, so I need to work alongside that patient with my mentor to be able to reach that competency. So I’m thinking about it all the time through that placement while I’m here. Where that might have been a bit more difficult if I was only here a couple of days a week. Because I think I might have been, I’m only here two days, what can I reach in them two days? Where I get a really broad learning experience’ (R5)
- ‘I would have been here three full shifts every week to get a good feel of the place. I’d probably feel a lot more confident if I’d had that opportunity’ (R6)
- ‘I can just submerge myself into everything around what’s going on. Feel like after a week, get my feet on the ground and start thinking right, I know where everything is now, I know what the core business is, I know what the processes are. Right, now I’ll start thinking how can I meet these competencies’ (R5)
- ‘because it’s intense learning for those block placements. You’re not pulled away at all, you’re focused totally on the learning of the things they do on that ward or that placement’. (R7)

- ‘I learn about medications. But if it’s a new one, and then the following week it comes up again, I guarantee I’ll forget what it’s there and what it’s for. So that sort of thing’ (R6)
- ‘competencies-wise, the portfolio, you never get to sit down with them regularly. And I think again looking at the [redacted] students who are here in a chunk, at least if you’re here five days you’ll find at least half an hour to sit down. I’m here one or two days a week. You haven’t, I want the best I can out of my experience, and to drag [redacted] away from her patients when it’s bouncing out there, it just never happens’ (R6)
- ‘I would have preferred a block placement where I went away and come back, could have focused on six weeks on placement where you deal with your caseload or with your patients on the ward and you kind of come back and do this for six weeks non-stop’ (R9)
- ‘if I was working five days for six weeks, because [redacted] I could have regular cases where that was better for me as a student because I would be taking [redacted] on every assessment and seeing that through for six weeks, rather than hoping that I can see them over the two days that I’m in’ (R9)
- ‘you had a little bit more scope of planning when the block could be. then I would be able to get in touch with my mentors and say right, I can come from now to December, is there any time that’s more convenient for yourself?’ (R5)

- ‘when I’m a student I tend to do more of my theory side of it what I have to do as well. But when I’m working fulltime you forget sometimes that you’re a student’ (R3)
- ‘The only thing I would say about block placements is you spent a lot of time, a big clump of time away from your placements. And sometimes that means that you can, your portfolio gets neglected. And you’re doing your TMAs and your online tutorials and what have you, and you’re doing your work, but I’m finding that sometimes I can go for a month without picking my portfolio up’ (R8)

- ‘when I’m at work in my fulltime AP role, you do forget sometimes; obviously if you’ve got an assignment due it’s different’ (R3)
- ‘even when I’m at work and I’m not a student I still have all my other student responsibilities, which is really full on. But when I am on placement and I am student, I find it easier to be a student if that makes sense’ (R3)
- ‘the practice learning module was like can you apply, can you go and speak to your mentor and talk about this. But it’s like I’m not on placement at the moment, so that’s the hard thing. Some of the tasks are difficult to do because I’m actually not on placement’ (R2)
- ‘I reflect sometimes on my everyday practice rather than, but some of them yes, it’s like I’m not even in practice and I don’t know this. And last year I felt that the stuff we were learning on the modules at the end of the year we should have done before we started practice. So it was like blood pressures and different observations. And it’s like I went onto a ward not ever having done observations, fluid charts or anything. So to learn that at the end of the year was not even relevant anymore. I had to learn that on the job’ (R7)
- ‘you had to sort of give an account of a communication incident if you like that hadn’t gone as you’d expected and that you found challenging. Well it had to be based on your placement. Well I hadn’t actually had any of those issues on placement so I was little bit stuck there. Had it have been generally I could have, you know, given any number of examples in role as a healthcare assistant’ (R11)
- ‘you reflect on something that you’ve done in a student, when you’ve been in a student capacity. I would reflect on that. You’ve got a memory haven’t you?’ (R8)
- ‘I find it quite hard to do all my academic work when I’m on placement and studying. That part of it’s hard’ (R2)
- ‘I feel like when I’m on placement I’m not really as good academically as what I am when I’m in my healthcare assistant role. I’ve got more time basically’ (R2)

- ‘At times it can be quite tough. At the minute it’s sort of the assignments and the ICMAs are coming thick and fast so it’s trying to prioritise them over anything else’ (R12)
- ‘it was disorientating for me. Sometimes week to week in the way I was and then you’ve got your academic work on top of that, which was coming thick and fast as well’ (R12)
- ‘So I think there’s a lot of aspects of learning to be done as a student nurse. It’s not just with patients and processes, it’s with leadership and management. And there’s so much to learn. And I think you need to take that onboard and move that through each service you go to, learn a little bit and move it along. But it is really difficult’ (R5)
- ‘at the start when there was, when your assignments were coming thick and fast, and the tutorials were thick and fast, the portfolio went on the backburner a little bit. And then when them kind of died off a little bit, again that was just managing my own time and learning really, then the portfolio took a bit of a forefront as them kind of died off and there was more space between TMAs and things’ (R9)
- ‘Very hard yes, very hard. I had a bit of a breakdown last week, but just for a day until I got things done – because there was too much all at once. We had the TMA was due while we’re in practice, and that was just very difficult. And some of the, I find that I’m able to spread things out quite well. It’s when you’ve got competing modules, it’s hard to keep what’s relevant to one separate from what’s relevant to another. So, you might be stating something in your TMA, and then go back and read it over and think it’s for the other module. It’s just in your head it’s relevant but you’re supposed to be referring to that particular module’ (R7)
- ‘But it has been hard, but I think, I don’t think I realised how hard it would be when I first started’ (R3)
- ‘sometimes I feel that because it’s online, and because it’s never really there. So your practice placements are live, they’re happening, they’re there, you’ve got to go. But with your academic studies you know that they’re there but you’re able to put that off a little bit more’ (R5)

- ‘I feel like the first module that starts gets all the attention, and then it’s like the second module seems to be the TMA is due on one, and then two weeks later you’re just starting that TMA’ (R7)
- ‘they set us off doing module one and module two side by side and starting placement at the same time – which was a little bit of a baptism of fire if I’m honest’ (R11)
- ‘I write everything down to be honest, and I reflect on everything in my placement. So then I’ve always got that to jog my memory or go back to it when we’re doing it’ (R4)
- ‘I keep a little log of things I need to remember now, but that’s just something I’ve learned to do for myself. It’s just little things like drugs, paperwork’ (R6)
- ‘So, I think right, I’ve been to see three patients with my mentor, I’ve got to leave some of these assessments, I’m going to put some paperwork on, he’s going to check it all after me. I’m going to book a room, I’m going to keep myself away, and I’m going to do it. So, then I’m not submerged within the team, and I’m not getting involved as much with everything else that’s going on’ (R5)

- ‘there are two things you can learn from your mentor: one how to be a good nurse, and how not to be’ (R1)
- ‘your mentor can be a good role model for you, just to do what she does or what he does. At the same time that particular nurse can be a good role model how not to be a nurse like him or her’ (R1)
- ‘I like to get a sense of who that person is, and how they practice. Because sometimes there’s things you see in people you don’t want to pick up. There’s certain aspects of people that you don’t want to model yourself on. But then there’s certain aspects who are complete inspirations and I want to be that practitioner. And you have to find yourself in amongst all of that as well to be at the end an independent practitioner’ (R5)

Preliminary theme: Paying the price (sacrifice, self-sufficiency, self-discipline, bereavement, exhaustion, loneliness)

- 'I need to do bank because I'm skint, so I do do quite a bit of bank work as well in different areas' (6)
- 'my core base is [redacted], and brilliant team, brilliant area, brilliant patients. So after a while I started going back there and bank work as a healthcare. That threw a few patients, because one minute I'm going in, giving insulin under the supervision of a mentor, and the next I wasn't. I'm there as a healthcare assistant, competent in giving insulin. But there have been a couple of comments from patients like well why isn't [redacted] here with you today, why have you got a different uniform on? So I've stopped doing that sort of bank work in areas where I'm also a student' (R6)
- 'from a financial perspective I was full-time on placement, I'd lose out on enhancements' (R12)
- 'I wouldn't do it on here, not while I'm a student. I might come back later on and do bank shifts, that's different. I think it might confuse, not confuse but I think it might, there might be a conflict of interest with other staff as well. Like one minute I'm there as a student delegating work to healthcare assistants, and the next I'm a healthcare assistant. So that might be a conflict of interest' (R6)
- 'Two tunics are great if you've got two days a week, but for block placements it just does not work'. (R7)

- 'The only constraint on that is your schedule where you work, having to accommodate that team. I used to get round that by doing Saturdays and Sundays at work' (R1)
- 'I'll sit and do my assignments on that day. I do them on a weekend, I try and do them on a night when I get home, but obviously if I leave here at eight o'clock at

night there's not much going to get done. After work I try and get some done. You squeeze a bit in when you can. And obviously if things get close to an assignment, which it is at the minute, bank work goes out the window, I'm skint for a bit longer. And then I just have to commit my days off to study and getting assignments put in. But it's hard, I wouldn't recommend it for anybody my age' (R6)

- 'I give up some of my weekends to do my academic work, but that's not a chore to me. I think God, how lucky am I to be in this position where I'm not losing any money, I've still got my fulltime job. So to me I'm in a good position, so I don't ever look at it negatively' (R8)
- 'my days off are given up to benefit my university degree, but that's fine because I'm happy to do that' (R3)
- 'at the minute I use my fifth day to try and get study done. And like that's solely set aside so I know it's there. But if that day disappears then I have to find it elsewhere' (R12)
- 'after my placement I have a week off, and then I can study in that week' (R2)
- 'what I tend to do is use my annual leave to do my academic studies' (R5)
- 'So kind of the backup is I know I've got annual leave, or I've got all floating days where if I feel under pressure I can put an annual leave day'. 'it's a sacrifice I've made, but at the end of the day it's something I want to do. This nursing course is what I want to do, so that sacrifice, I was all right with that' (R5)
- 'I do give myself some time off. I don't feel weightless in that annual leave, I don't feel like what we normally do, go and sit in Tenerife for two weeks and can't come back. It's always on my mind I've got something coming up' (R5)

- 'while I'm not on placement then I pick up other people's children, and then they will pick my children up. So yes, but it's a lot to pull together' (R7)
- 'I think if you want it it's up to you to put your work in, because it is all online. If I don't do something the week that I'm meant to, I fall behind, so then it's me that has

to catch up. So you've got to be very strict with yourself. You've got to have mega time management, because it is very, it's very back to back the course itself. It's like bang, bang, bang, bang, you've got something due in all the time, and you've got things you need to read this week. And if you leave it you've got twice as much to do next week'(R3)

- 'it's just about managing your time' (R5)
- 'I think the best place to be is organised, just to say right at the beginning we need to have a meeting on this placement, or can I have access to your diary and get some availability. And then do some joint emails and try and get that underway straightaway. Because obviously mentors' diaries are really full, wards are really busy, things can go not according to plan. But I think just keep people in the loop, and then it usually falls into place' (R5)
- 'I just take one at a time. I did map out the dates to see how much weeks were between each one so I knew I could give myself enough time' (R9)
- 'this way of learning sometimes is very suited to me because I'm quite self-sufficient so I will go away and do my own thing and again it's never harmed my grades. I don't know if that's down to having good mentors or whether that's down to me being really organised because I am pretty organised' (R9)
- 'If I plan what I need to do, like the modules obviously week by week, if I plan within that week what I need to do, then I know I have to do it. But a lot of willpower to go home after 13 hours and think right, this is what I need to do. So it's just time management, and you have to want to do it don't you?' (R4)
- 'You get with doing it, don't you? You do what you have to do' (R9)
- 'my experience of being a student is you get out of a placement what you put into it. How motivated and enthused you are, and how much you get back' (R8)

- ‘If I had the option again would I choose this again or would I go for the learning disability degree full-time in [redacted]? And I said even if I analysed them both I still would choose this’ (R9)

- ‘I want to say thank you to the OU for getting with the Trust and giving us this opportunity. Because this is my only opportunity to do my training, because financially I would never have been able to go back to university and give up my fulltime job, because obviously I do have a home and children and a life and everything else. So obviously I feel really honoured to be given this opportunity. And I know there was a lot of people that wanted it, there’s a lot of people that are never going to get it again’ (R3)
- ‘at the end of the day I’m just very grateful for the opportunity of secondment, because they’re few and far between. I’ve had to wait until I’m nearly 50 to get one, and I’ve worked since I was 25 in healthcare. So it’s been a long time coming, and I’m grateful and I will finish the damn thing’ (R6)

- ‘Given this opportunity again I don’t know if I would take it at the moment in my life that I am’ (R3)

- ‘when the block placement finishes I go back and sometimes I feel exhausted when I go back. And I didn’t know what that was about, because I’m not really doing anything more than I normally would. I am learning, so I suppose my brain’s doing more. But I think what it was was the relationships. So what I do is as a person I form relationships very quickly, and I maintain those. And how I felt is over the last year I’ve had four different jobs’ (R5)
- ‘I’ve really had to explore that and how I can protect myself in the future, because it is exhausting and I will burn out. So I’ve got some strategies in place to cope with that now’ (R5)

- ‘it’s there all the time. I think it’s there all of the time. Your work, your block placement, my support worker role, my academic work, your home life. It’s constantly on the go. I don’t like to think about it too much. So, I’m thinking about it today, I won’t think about it again until probably a good while. Because when I over-analyse it that’s when I worry that I’ll struggle. So, I just take each day as it comes’ (R5)
- ‘I feel a little bit bereft when I come away from my placements as well, so I’m like oh I’ve made those kinships, and I’ve met those lovely bunch of patients, and now I’m not going to see you again’ (R5)

- ‘I think the face-to-face thing it’s nice to see people every so often and having the supervisions. I know that they say they can get their tutor to offer that sort of thing, which I thought was very strange, but I said I like that every month. I go to them every month, I like them. It’s a way of just catching up with people and having discussions’ (R9)
- ‘I must admit it is a little lonely. So there’s times where I’ve felt a little lonely, especially working along with colleagues from say [redacted]. Because they have face to face, they have tutorials, they get to see their other nursing students. It doesn’t happen for us with the OU. So fortunately I know two, well I know one of the other nursing students on the programme, and I’ve made friends with another nursing student on the programme who works for another trust but is in mental health. So we’ve got our own little group, so we’ve got our group where we need to ask questions, where we need to go oh my god it’s coming up. We’re able to have a WhatsApp group and talk to each other. It’s still not the same as seeing somebody face to face’ (R5)